Chapter 11

ERISA PREEMPTION AND EFFECT ON OTHER LAWS

2019 Midwinter Report

American Bar Association
Section of Labor and Employment
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ERISA Preemption and Effect on Other Laws

I. INTRODUCTION

A. Scope of ERISA Section 514

*Beckham v. Barnhardt (In re Barnhardt)*, 2018 Bankr. LEXIS 1279 (D.S.C. 2018). A dispute arose over the proceeds of the life insurance policy, which would have been barred due to ERISA preemption. Guardian paid the benefits at issue into the Court subject to an interpleader action. The Plaintiff alleged that this was a *de facto* distribution of benefits, and thus ERISA no longer applied to those funds. The challenger then tried to raise the state law claims for those sums that would have been preempted had the benefits not been distributed. The Court rejected this argument, holding that even though the sums had been placed with the Court, that did not amount to a distribution, and the funds were still subject to ERISA. The Plaintiff’s attempt to raise state law claims seeking those sums were preempted.

*Allied Constr. Indus. v. City of Cincinnati*, 879 F.3d 215 (6th Cir. 2018). Defendant, the City of Cincinnati, established an ordinance imposing requirements for bidders on certain city projects. It required bidders to certify that they contribute to their employees’ health care and retirement funds. Plaintiffs, a non-union party who wanted to bid on certain projects, argued that this requirement was preempted by ERISA. The Sixth Circuit rejected this argument and, relying on the “market-participant” doctrine from the NLRA, the court held that the city was free to required contributions to ERISA plans when acting in its own interests as a buyer of goods and services.

*Cognetta v. Bonavita*, 330 F. Supp. 3d 797, 2018 EB Cases 201,655 (W.D.N.Y. 2018). Plaintiff trustees of a union medical benefits plan brought an action pursuant to ERISA §503(a)(3) seeking a declaratory judgment that the plan has an equitable lien or constructive trust in the amount of benefits the plan paid against any award or settlement that Defendants might recover in a negligence action against third parties pending in state court. Granting summary judgment for Plaintiffs, the district court rejected Defendants’ contention based upon New York General Obligation Law § 5-335, stating that “no person entering into [a personal injury] settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person ... with respect to those ... expenses that have been ... paid or reimbursed by said insurer” is a statute that prohibits the plan from obtaining reimbursement from Defendants’ possible third party recovery. The court ruled that ERISA §514(a) preempts the application of Section 5-335 to the Plan because the plan is self-funded. Since the plan is self-funded and does not purchase insurance from an insurance company, the statute does not apply.
II. PLAN COVERED BY ERISA

A. Definition of Employee Benefit Plan

**Simmons v. Serv. Credit Union, 2018 U.S. Dist. LEXIS 39693, 2018 DNH 048.** Plaintiff sued Defendant employer in state court for failure to provide post-retirement health care as provided for in Plaintiff’s employment contract. Defendant removed; Plaintiff sought remand. The Court held that despite the fact that the contract pertained only to the Defendant, it qualified as an ERISA plan because it described Plaintiff’s benefits specifically and required Defendant to maintain an “ongoing administrative scheme” to ensure continued coverage and to evaluate the validity of any claims submitted. Therefore, the claims were preempted by ERISA and the remand was denied.

**Meadows v. Unum Group Corp., 2018 WL 3015253, 2018 EB Cases 212,237 (S.D. Miss. June 15, 2018).** Plaintiff physician received a disability income policy through the Supplemental Income Protection Plan offered by his employer Hattiesburg Clinic. Under the Plan, eligible employees would apply for individual policies that would be issued by Provident, and the premiums of these policies would be paid for by the Clinic. The issue the District Court addressed was whether the Plan was an employee benefit plan subject to ERISA, thereby preempting Plaintiff’s state law claims. The District Court found under the given facts that the Plan in question satisfied the elements of an ERISA employee welfare benefit plan and therefore Plaintiff’s claims were subject to ERISA preemption. In doing so, the District Court rejected Plaintiff’s argument that the Plan could not be an employee welfare benefit plan because the Clinic failed to comply with certain regulations required by ERISA, stating that the test for whether a plan is an employee welfare benefit plan does not require compliance with any regulations promulgated pursuant to ERISA.

**Baumgardner v. Cannon, 2018 WL 2722453 (D. Colo. June 6, 2018).** Plaintiff brought claims in Colorado state court for breach of contract, breach of fiduciary duty, and fraud under Colorado state law arising from Defendants’ failure to pay the full amount owed under a “Phantom Stock Unit Agreement.” Defendants removed the claims to federal court and thereafter sought to dismiss Plaintiff’s claims. Denying the motion to dismiss, the District Court found that the Agreement explicitly states that it provides for the payment of performance-based compensation while Plaintiff is an employee of the company. The District Court found that Plaintiff’s complaint established sufficient facts regarding the Agreement’s payment of an in-service annual bonus to warrant a finding that Plaintiff’s claim plausibly falls outside of ERISA. The Agreement does not appear to satisfy ERISA’s requirements for an employee pension benefit plan, and therefore Defendant’s motion to dismiss is denied.

**Rome v. HCC Life Ins. Co., 323 F. Supp. 3d 862, 869 (N.D. Tex. 2018), appeal dismissed, No. 18-10992, 2018 WL 4233705 (5th Cir. Aug. 30, 2018).** HCC Life Insurance Company issued a disability policy to the National Hockey League that covered its active players. The NHL and the NHL Players’ Association established the policy through a collective-bargaining agreement. Plaintiff suffered a career-ending injury while playing in the NHL and sought benefits from HCC. HCC denied his benefits claim, so Plaintiff filed suit in state court, asserting state law claims. HCC removed the case to federal court. The federal court held that the disability policy was an ERISA plan, because (1) the plan existed, (2) it did not come under ERISA’s safe-harbor provision, and (3) it was established and maintained by a group employer (NHL) and an employee organization.
(the Players’ Association) for the benefit of NHL employees. And because Plaintiff sought benefits allegedly owed to him under the ERISA plan, ERISA preempted his state-law claims.

United States v. Berry, 2018 U.S. Dist. LEXIS 212265 (S.D. Tx. Dec. 17, 2018). Defendants Mr. and Mr. Berry filed a motion to quash the writs of garnishment against Mr. Berry’s retirement accounts. The government filed a writ of garnishment on such accounts following Mrs. Berry’s conviction for fraud and filing a false tax return. Mr. Berry argued that ERISA preempts the characterization of his retirement accounts as community property. The court rejected the Berrys’ ERISA preemption argument on grounds that the ERISA is inapplicable after Mr. Berry rolled retirement funds over from an ERISA plan to an individual retirement account not covered by ERISA.

B. Existence of a Covered Plan in the Absence of a Formal Document or ERISA Compliance

C. Ongoing Plan Administration

Miller v. Starkey Labs., Inc., 299 F. Supp. 3d 1046 (D. Minn. 2018). Defendant removed a breach of contract claim to federal court, believing that the promise to pay executives was a part of a top hat plan covered by ERISA. The Court disagreed, finding that although the plan covered a small number of employees, there was little discretion needed to interpret and administer the Plan. It thus did not include a “ongoing administrative scheme.”

Amlani v. Baker’s Burgers, Inc., 2018 U.S. Dist. LEXIS 4709 (C.D. Cal. 2018). Defendant removed this breach of contract claim dispute over severance benefits to Federal court under the complete preemption doctrine. The Plaintiff responded by arguing that the promise to provide severance did not have the complexity necessary to become a formal ERISA plan—it was little more than a bare promise to provide severance benefits. The Court agreed, finding that the severance contract did not require any ongoing administration—rather, the calculation of benefits was entirely computational, with no meaningful discretion involved.

Christoff v. Paul Revere Life Ins. Co., No. 17-3515, 2018 U.S. Dist. LEXIS 157107 (D. Minn. Sept. 14, 2018). Plaintiff-insured filed suit seeking long-term disability benefits against Defendant-insurer under an alleged supplemental individual policy. In response to cross-motions for summary judgment under Fed. R. Civ. P. 56(a), the court found that the policy was not governed by ERISA based on the DOL’s safe harbor criteria because it was not established and/or maintained by the employer, i.e., the employer did not have a separate, ongoing administrative scheme to administer the benefits. The court explained that the employer’s role as “a conduit for payments does not create an administrative scheme as contemplated by ERISA. This involves merely deducting and remitting payments and is…also specifically permitted in the Safe Harbor Provision under the third element. 29 C.F.R. 2510.3-1(j)(3).” Id. at *19.
D. Level of Employer Involvement Necessary for the Establishment or Maintenance of a Plan

I. DOL Safe Harbor and the Cases Construing It

Vasu v. Combi Packaging Sys., LLC, 2018 U.S. Dist. LEXIS 217418 (N.D. Ohio Dec. 28, 2018). Defendant executed a contract with an insurance company to provide life insurance policies for Defendant’s employees. Plaintiff, the son of an employee, applied for benefits after his father died. The life insurance company denied the claim. Plaintiff sued, alleging breach of contract and seeking a declaratory judgment. Plaintiff filed a motion to remand after Defendant removed the case to federal court. The court considered whether ERISA completely preempts Plaintiff’s claim. The court first noted that the safe harbor exemption excluding certain insurance policies from ERISA is inapplicable because Defendant Combi contributed to the plan, which removed the policy from the ambit of the exemption. Next, the court rejected Plaintiff’s claim that an e-mail from Defendant stating that the plan was not an ERISA plan is sufficient to establish that the plan is not subject to ERISA. Finally, the court noted that Plaintiff’s claim ultimately seeks benefits owed under a plan. Therefore, the court held that it has subject matter jurisdiction over the case because ERISA preempts the claim.

Soileau & Assocs., LLC v. La. Health Serv. & Indem. Co., No. 18-710, 2018 U.S. Dist. LEXIS 138269 (E.D. La. Aug. 15, 2018). Plaintiffs-insureds filed suit against Defendant-insurer in state court related to the termination of health insurance coverage for their minor child’s inpatient mental health treatment. Plaintiffs filed claims “for breach of contract, bad faith adjusting, and failure to timely pay claims in violation of Louisiana Revised Statute § 22:1821(A) and (D).” Id. at *4. Defendant removed the case to federal court on the basis that Plaintiffs’ claims were completely pre-empted by ERISA § 502(a), and Plaintiffs moved to remand. The court agreed with Defendant’s pre-emption argument and denied Plaintiffs’ motion to remand (more below). The court also found that the DOL’s safe harbor regulations did not apply to the plan because the plan existed, the employer paid for 100% of the premiums, and it was established/maintained by the employer with the intent to provide benefits to its employees.

Christoff v. Paul Revere Life Ins. Co., No. 17-3515, 2018 U.S. Dist. LEXIS 157107 (D. Minn. Sept. 14, 2018). Plaintiff-insured filed suit seeking long-term disability benefits against Defendant-insurer under an alleged supplemental individual policy. In response to cross-motions for summary judgment under Fed. R. Civ. P. 56(a), the court found that the policy was not governed by ERISA based on the DOL’s safe harbor criteria because it was not established and/or maintained by the employer, i.e., the employer did not have a separate, ongoing administrative scheme to administer the benefits (more above).

Gann v. J&B Servs., No. 1:18-cv-00104, 2018 U.S. Dist. LEXIS 159233 (N.D. Miss. Sept. 17, 2018). This suit arose over a dispute related to life insurance benefits after the insured passed away from a work-related injury. A claim was submitted under the insured’s life insurance policy, but no benefits were paid because after the employer had taken over payment of the premiums following the insured’s injury, it also terminated the policy without informing the insured. The insured’s wife filed suit as the Plaintiff against Defendant-employer in state court for negligence, negligent misrepresentation, breach of fiduciary duty, and equitable estoppel. Defendant removed the case to federal court on the basis of ERISA pre-emption, and Plaintiff filed a motion to remand.
In assessing the motion, the court evaluated whether the life insurance policy fell within the DOL’s safe harbor exception to ERISA pre-emption at 29 C.F.R. § 2510.3-1, and determined it did not meet the first and third criteria. The court relied on the premiums paid by the employer after the injury, but before the policy was terminated, as well as Defendant’s involvement in the administration of the policy including assisting with enrollment, premium payments, and beneficiary designations. The court further determined that the life insurance policy met the other criteria for establishing an ERISA plan, and as a result, at least some of Plaintiff’s claims were pre-empted by ERISA. The court denied Plaintiff’s motion to remand.

2. Other Cases on Employer Involvement

**Tulczynska v. Queens Hosp. Ctr., 2018 U.S. Dist. LEXIS 46579, 2018 WL 1664506.** Plaintiff sued her employer in state court for enrolling her in a health plan where premiums were paid in post-tax dollars instead of the allegedly promised plan where premiums were paid in pre-tax dollars. Plaintiffs removed, and Defendants sought remand, arguing that the claims did not arise from the benefit itself but rather Plaintiff’s promise to enroll Defendant in a different plan. The Court applied Davila and held that these claims were preempted by ERISA because (1) Plaintiff’s actual plan was an ERISA plan, so Plaintiff could have sued under 502(a)(1)(B), and (2) Defendants did not owe any duty based on their alleged promise outside of ERISA. Therefore, the claims were preempted and remand was denied.

**Saginaw Chippewa Indian Tribe v. Blue Cross Blue Shield, No. 17-1932, 2018 U.S. App. LEXIS 24692 (6th Cir. Aug. 30, 2018).** Plaintiff-Native American Tribe filed suit against Defendant-administrator for breach of fiduciary duty under ERISA with relation to its two group health plans – one for tribal members, and the other for tribal employees. Plaintiff argued that both plans constituted a single ERISA plan, but the district court held, and the Sixth Circuit affirmed, that they were two distinct plans. The courts further held that ERISA only applied to the plan covering tribal employees and not the plan covering tribal members because Plaintiff “did not establish or maintain the Member Policy with the intent of providing benefits to its employees…as part of the employment relationship.” *Id.* at *15-16.

3. Multiple Employer Welfare Arrangements

E. Arrangements Excluded by Statute or Regulation

1. Vacation Pay and Other Payroll Practices

**Mostajo v. Nationwide Mut. Ins. Co., 2018 U.S. Dist. LEXIS 194392 (E.D. Cal. Nov. 13, 2018).** Plaintiffs sued Defendant, their employer, for failure to pay overtime in violation of California’s Labor Code and failure to pay accrued vacation time. The Court ruled that the vacation payments constituted a payroll practice exempt from ERISA because Defendant paid the vacation benefit from its general assets. The court also held that ERISA does not preempt Plaintiffs’ claims since the vacation benefits were not an ERISA employee welfare benefit plan.
2. Plans Maintained Solely to Provide Workers’ Compensation, Disability, and/or Unemployment Benefits

3. Other Plans

**Crosby v. Cal. Physicians' Serv., 279 F. Supp. 3d 1074 (C.D. Cal 2018).** Plaintiff was a participant in a group health plan called the California Association of Professional Employees Benefit Trust. The Plan includes, but is not limited to, employees of the County of Los Angeles. After breach of contract claims were raised based upon the denial of plan benefits, the Defendants removed to federal court under the complete preemption doctrine. The Court agreed that this plan was an ERISA plan, and was not exempt as a governmental plan. The County of Los Angeles did not sponsor the plan or maintain it. Rather, it merely allowed employees to participate in a plan administered by a private entity.

**Le v. Unum Ins. Co. of Am., 336 F. Supp. 3d 642 (W.D. La. 2018).** Plaintiff-insured sued Defendant-insurer for long-term disability benefits. The Parties filed cross motions for summary judgment under Fed. R. Civ. P. 56(a) as to whether the plan was governed by ERISA. The court granted Plaintiff’s motion and denied Defendant’s motion. The court determined that the plan was exempt from ERISA coverage pursuant to ERISA § 4(b)(1) because it was a “governmental plan.” The court then determined that it “lacks federal question subject matter jurisdiction because ERISA does not preempt the state law claims raised by Plaintiff.” *Id.* at 663.

F. Conversion Policies

**Galante v. Financial Industry Regulatory Autority, Inc., 2018 WL 2063748, 2018 EB Cases 157,138 (E.D. Penn. May 2, 2018).** Plaintiff spouse, as executor and estate beneficiary, asserted breach of fiduciary duty claim under ERISA §502(a)(3) against former employer FINRA and its plan administrator Sun Life arising from a failure to timely notify the decedent employee of his right to convert the group life insurance policy provided by FINRA to an individual policy. Granting summary judgement in favor of Sun Life, the district court held that the failure to provide Galante with notice required by Maryland law of his conversion rights was preempted by ERISA insofar as the state law requirement of providing a certificate or other notice to policyholders was not subject to ERISA’s savings clause.

**Estate of Foster v. Am. Marine SVS Grp. Ben. Plan, 2018 U.S. Dist. LEXIS 189846 (D. Mont. Nov. 6, 2018).** Plaintiff, the deceased husband’s estate, sued after Defendant denied the widow’s application for life insurance benefits owed to her as deceased husband’s named beneficiary. Plaintiff alleged multiple causes of action, one arising under a Hawaii statute governing notice of a conversion right. Under this claim, Plaintiff alleged that the decedent was entitled to notice of his right to convert his policy following his ineligibility under the plan. The court held that ERISA did not preempt the right-to-notice statute on grounds that the statute: (1) regulates insurance by establishing an obligation on insurers and policyholders that arises when an insured has a conversion right; and (2) affects the relationship between the insured and the insurer because notice is essential to an insured’s ability to exercise their rights.
III. STATE LAWS THAT CONFLICT WITH ERISA

*Bd. of Trs. of Glazing Health & Welfare Tr. v. Chambers, 903 F.3d 829 (9th Cir. 2018)*. The Ninth Circuit reversed the decision of the district court finding that Nevada Senate Bill 223 was pre-empted by ERISA § 514(a). The circuit court found that the state law did not intrude on any federally-regulated field, conflict with ERISA’s objectives, or otherwise impermissibly “relate to” ERISA plans. Instead, the circuit court found that the state law targeted an area of traditional state concern – debt collection – by paring back a state-conferred entitlement to collect unpaid debts from third-party general contractors. The circuit court further determined that the state law did not have an impermissible “connection with,” or make impermissible “reference to,” ERISA plans as is required to find pre-emption under *Gobeille*’s two part test.

**Pharm. Care Mgmt. Ass’n v. Tufte, 326 F. Supp. 3d 873 (D.N.D. 2018).* Plaintiff-trade association representing pharmacy benefit managers (“PBMs”) filed suit against various state officials/departments after North Dakota’s governor signed a law regulating PBMs and pharmacies. *See* North Dakota Senate Bills 2258 and 2301. After denying Plaintiff’s motion for a preliminary injunction, the Parties filed cross-motions for summary judgment pursuant to Fed. R. Civ. P. 56(a). Plaintiff alleged that the state laws were expressly pre-empted by ERISA § 514(a). The court disagreed, finding, in regard to the first prong of the Gobeille test, that the state laws did not impermissibly reference ERISA plans, i.e., did not act exclusively on ERISA plans or were written such that the existence of ERISA plans was essential to the laws’ operation. The court also found, in regard to the second prong of the Gobeille test, that the state laws did not have an impermissible connection with ERISA plans, i.e., did not govern a matter central to ERISA plan administration or interfere with nationally uniform plan administration.

**Omega Hosp., LLC v. United Healthcare Servs., No. 16-00560-JWD-EWD, 2018 U.S. Dist. LEXIS 154583 (M.D. La. Sept. 11, 2018).* Plaintiff-hospital filed suit against Defendant-insurer/administrator under ERISA regarding its method of identifying and recouping alleged overpayments. At issue was whether Louisiana’s assignment statute, La. R.S. § 40:2010, could save an otherwise valid claim assignment in the face of a plan’s anti-assignment provision. The court found that it could and did in fact invalidate Defendant’s anti-assignment provisions. The court rejected Defendant’s argument that the state law was pre-empted by ERISA pursuant to Gobeille. The court explained that the state law dealt expressly with assignments, which did not intrude on a fundamental aspect of ERISA because “ERISA is silent with respect to the assignability of benefits.” *Id.* at *24.

IV. THE ENIGMATIC “RELATE TO” CLAUSE

A. Early Cases Apply an Expansive View of “Relate To”

B. Limits of “Relate To”: The Travelers Trilogy

C. Supreme Court Decisions Applying the “Relate To” Clause After the Travelers Trilogy
D. Circuit Court Attempts to Define the Boundaries of Preemption

*Lavery v. Restoration Hardware, Inc.*, 2018 U.S. Dist. LEXIS 51292, 2018 WL 1524398. Plaintiff brought suit in D. Mass alleging his misclassification as an independent contractor when in fact he was an employee under state law. Among other damages associated with his state law claims, plaintiff sought the value of the benefits plan that he would have received had he been classified as an employee. Defendant argued that the claim was preempted by ERISA.

The court found that under the relevant First Circuit precedent, “ERISA preempts state law causes of action for damages where the damages must be calculated using the terms of an ERISA plan.” While the First Circuit had acknowledged that such preemption might “leave plaintiffs remediless,” and that it would “defy logic to presume that Congress intended to preempt” in that situation, it held that *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), forced such a literal reading of ERISA’s preemption provision.

The District Court wondered whether existing precedent was still good law in light of the Supreme Court’s holding in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658-59 (1995), that “acknowledged the unworkability of a literal reading of [29 U.S.C. § 1144(a)]’s ‘relate to’ standard and ruled that courts must look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.” Nonetheless, the Court found that it was bound by controlling precedent to rule the relevant claim was preempted.

*Laborers’ Pension Fund v. Miscevic*, 880 F.3d 927 (7th Cir. 2018). Plaintiff killed her husband, but was later determined to be insane at the time. Illinois law would have precluded her from recovering his life insurance benefits under a “Slayer Statute.” The Court held that this statute was not preempted by ERISA because it was an aspect of family law, a traditional area of state regulation.

*Little Wound Sch. v. Am. United Life Ins. Co.*, 2018 U.S. Dist. LEXIS 35648, 2018 WL 1175102. Plaintiff was an educational facility charted by the Oglala Sioux Tribe. In 2010, Plaintiff entered into an agreement with Defendant on a 401(k) plan for Plaintiff’s employees. Plaintiff alleged that Defendant failed to include certain compensation in the calculation of plan participant elective deferrals, resulting in missed elective deferrals, employer matching contributions and earnings. The complaint advanced three claims: fraud, negligent misrepresentation and negligence. Defendant falsely represented that it “could efficiently sponsor and design” the plan, “that it was fully familiar with efficiently running these types of plans and could responsibly handle all function,” “that it was familiar with the scope of benefits that should be provided,” to plaintiff’s employees, and “that the Plan would be appropriately designed to ensure the best interests” of Plaintiff’s employees.

Does this suit “relate to” an ERISA plan? The court held yes following the Eighth Circuit’s *St Mary’s* test, for the following reasons:

1. The case affects relations between primary ERISA entities: “Plaintiff is the employer and defendant is the fiduciary. . . . Throughout plaintiff’s three causes of action, it targets defendant’s alleged failure to disclose certain information regarding the plan and to carry out specific procedures with the plan.”
2. Plaintiff’s recovery on its claims would cause a “change in plan structure and in the relationship between primary ERISA entities that is not a ‘tenuous’ impact on the plan.”

3. Plaintiff’s recovery would impact the administration of the plan by in essence requiring plan disclosures to conform to state law as well as ERISA.

_Wengert v. Rajendran, 886 F.3d 725, 2018 U.S. App. LEXIS 8386, 2018 WL 1597405._ Plaintiff was the beneficiary of her deceased husband’s ERISA plan. The decedent had filed for divorce. One day before he died, he requested a lump sum distribution of his accrued benefits; the plan wired the money the same day. However, the wire did not clear until the business day after death. The plan administrator found that Plaintiff was not entitled to the funds because the terms of the plan held that sending the wire transfer had zeroed out the decedent’s interest in the plan. Plaintiff sued, claiming that the transfer was not complete under state law until it was accepted by the receiving bank. The district court held that the relevant state court law was preempted by ERISA and ruled that the plan administrator’s determination had not been unreasonable. The Eighth Circuit affirmed, holding that the state law was completely preempted as “a claim to recover benefits or enforce rights under an ERISA plan.”

_Pharmaceutical Care Management Association v. Rutledge, 891 F.3d 1109, 2018 EB Cases 202, 886 (8th Cir. 2018)._ Pharmacy benefits managers (PBMs) trade association brought action against Attorney General of Arkansas alleging that Arkansas statute regulating PBMs was preempted by ERISA. Affirming the district court ruling that the Arkansas statute was preempted by ERISA, the Court of Appeals ruled that the statute relates to and has a connection with employee benefit plans in that it regulates the conduct of PBMs administering or managing pharmacy benefits for health benefit plans subject to ERISA regulation.

Although not a Circuit Court case, the U.S. Department of Labor published an _Information Letter on December 4, 2018_, responding to a question about a state civil law that requires employers to obtain written consent before withholding amounts from employees’ wages for contribution to an ERISA-covered plan. The requester asked the Department’s opinion whether ERISA preempts a state law that prohibits employers from adopting and implementing automatic enrollment arrangements under which the employer automatically enrolls eligible employees in a disability benefit plan, and contributes part of the employee’s wages as contributions to the plan, unless the employee affirmatively elects not to participate. Citing past Advisory Opinions, the Department opined that such a law would be preempted by ERISA due to an impermissible relation to ERISA plans to the extent it is interpreted to limit, prohibited, or regulate an employer’s adoption of automatic enrollment arrangements in connection with an ERISA plan, or making related decisions from wages for contribution to such a plan.

E. Lack of ERISA Standing

_Houston Home Dialysis, LP v. Blue Cross and Blue Shield of Texas, 2018 WL 2562692, 2018 EB Cases 197, 189 (S.D. Texas June 4, 2018)._ Plaintiff is a medical services provider who sued Blue Cross and Blue Shield asserting claims under ERISA and Texas state law for failures to pay for medical services provided to beneficiaries of its health care insurance plans. Plaintiff alleged a general assignment of benefits from each of six patients in support of its standing to assert its
claims. The District Court, agreeing with the Defendant’s argument, ruled that a general assignment of benefits does not confer standing for all ERISA claims insofar as assignments that do not refer specifically to fiduciary duty or other non-benefits ERISA claims do not assign non-benefits claims to Plaintiff.

**Small v. Blue Cross Blue Shield of Mich., 2018 U.S. Dist. LEXIS 192415 (D.N.J. Oct. 17, 2018).** Plaintiff, an out-of-network provider, filed suit in New Jersey state court alleging breach of contract, promissory estoppel, account stated, and fraudulent inducement claims arising out of “medically-necessary” services rendered to a patient. Plaintiff billed Defendant for surgery performed on the patient after allegedly receiving prior authorization from Defendant. Defendant removed the case to federal court on grounds that ERISA § 502 completely preempted Plaintiff’s claims. The court remanded the case back to state court after holding that removal was improper. The valid, clear, and unambiguous anti-assignment clause in the patient’s health benefits plan prevented patient from assigning his ERISA benefits under the plan. Therefore, the court found that Plaintiff lacks standing to bring a claim under ERISA § 502(a).

**Alt. Shore Surgical Assoc’s. v. Adm’rs Pub. Serv. Elec. & Gas Co., 2018 U.S. Dist. LEXIS 190836 (D.N.J. Nov. 7, 2018).** Plaintiff, an out of network provider, sued Defendant alleging breach of contract, promissory estoppel, account stated, and fraudulent inducement, after Defendant failed to pay the “usual, customary or reasonable amount” for Plaintiff’s services to a patient. The Plan covering the patient contained the following anti-assignment clause: “Generally, you cannot assign your rights under the plan, but you may assign benefit payments directly to your healthcare provider.” The court relied on the *Davila* test to grant Plaintiff’s motion to remand the case back to New Jersey state court. Plaintiff’s claim failed the first prong of the *Davila* test because the plain language of the anti-assignment clause prevents Plaintiff, which does not constitute a participant or beneficiary under the Plan, from asserting derivative standing. Therefore, the court held that it lacked subject matter jurisdiction to hear the case.

**Enlightened Sols., LLC v. United Behavioral Health, 2018 U.S. Dist. LEXIS 205799 (D.N.J. Dec. 6, 2018).** Plaintiff, a healthcare provider, treated a patient covered under Defendant’s behavioral health care plan. Plaintiff and the patient executed an agreement under which the patient authorized payments from his insurance company directly to Plaintiff. Plaintiff sued patient’s ERISA plan to recover payments under ERISA. The court considered whether the Plan contained a valid anti-assignment clause, and whether Plaintiff had standing to sue for the breach of fiduciary duty claim. The court relied on the Third Circuit’s holding in *American Orthopedic & Sports Med. V. Indep. Blue Cross Blue Shield*, 890 F.3d 445 (3d Cir. 2018) to rule that the clear, unambiguous anti-assignment clause prevented the patient from assigning claims to the health care provider. Therefore, the health care provider could not pursue its claims against the Plan.

V. STATUTORY EXCEPTIONS TO PREEMPTION

A. The Saving and Deemer Clauses

**Bassel v. Aetna Health Ins. Co., No. 17-cv-05179, 2018 U.S. Dist. LEXIS 153070 (E.D.N.Y. Sept. 7, 2018).** Plaintiff-chiropractor filed suit against Defendant-insurer for reimbursement of services rendered to 57 insureds. Plaintiff filed suit in state court alleging “unjust enrichment and
violations of both N.Y. Ins. Law § 3224-a (the ‘Prompt Pay Act’) and N.Y. Gen. Bus. Law § 349, prohibiting deceptive business practices.” *Id.* at *1. Defendant removed the case to federal court and Plaintiff filed a motion to remand. The court denied Plaintiff’s motion, finding that the claims were completely pre-empted by ERISA § 502(a). The court also found that Plaintiff’s claim under the Prompt Pay Act was not saved from ERISA pre-emption on the basis of it being a state insurance regulation because it “provides the same remedy envisioned by ERISA.” *Id.* at *21.

1. Insurance Regulation
   a. Determining Whether a State Law Regulates Insurance
      i. Kentucky Ass’n of Health Plans v. Miller
      ii. Evolution of Test Before Kentucky Ass’n of Health Plans
   b. State Laws That Regulate Insurance But Conflict With ERISA’s Exclusive Enforcement Scheme
   c. Effect of the Deemer Clause
   d. Particular Categories of Cases

*Wingo v. Trover Sols. Inc.*, 2018 U.S. Dist. LEXIS 211726 (M.D. Pa. Dec. 17, 2018). Plaintiff obtained a short-term disability benefits payment under the Group Disability Plan issued by MetLife after she was injured in an accident. Defendant is a company working on MetLife’s behalf to provide payment recovery services. Defendant submitted a subrogation letter to Plaintiff after she obtained a settlement from a lawsuit against the tortfeasor in the accident. Plaintiff then filed a suit in Pennsylvania state court alleging that Defendant violated a Pennsylvania statute prohibiting entities from seeking reimbursement of certain claims. Defendant removed the case to federal court on grounds that ERISA § 502 preempts Plaintiff’s claim. The court analyzed the issue using the *Davila* test. The court reasoned that because the disability benefits plan at issue constituted a fully insured, rather than a self-funded plan, ERISA does not preempt the Pennsylvania state law prohibiting the subrogation from a claimant’s tort recover pursuant to coordination of benefits (e.g., a policy of insurance). Therefore, the court reasoned, this statute provided an independent legal duty that implicates Defendant’s actions. Thus, ERISA does not preempt Plaintiff’s claim.

2. State Banking and Securities Laws

*Lawrence v. Potter*, No. 2:17-CV-1239 TS, 2018 WL 3625329 (D. Utah July 30, 2018). Premier Computing Inc. established an employee stock ownership plan. The plan purchased company stock from the sole shareholders, Julie and Dale Potter, through loans it obtained from Premiere. Once the plan had obtained 48% of the company stock, the Potters entered into an agreement with it, requiring that the plan pay a control premium for new purchases. Plaintiff-participants sued under ERISA and the Utah Uniform Securities Act, alleging that the plan purchased company stock at artificially inflated prices. To determine whether complete ERISA preemption applied, the court looked to *Davila* and its two-part complete-preemption test (i.e., whether the claim falls within the scope of ERISA section 502 and whether the claim implicates a legal duty independent of ERISA). The court first noted that *Davila* involved section 502(a)(1)(B) claims only. Looking to Tenth Circuit precedent, the court held that it was “somewhat unclear” whether *Davila* and its complete-
preemption test extended to ERISA section 502(a)(2). The court therefore declined to apply complete preemption to Plaintiffs’ state-law claim, as the relief they sought did not fall within the scope of section 502(a)(1)(B). But even assuming that complete preemption did apply, the court still found that ERISA did not preempt Plaintiffs’ state securities-law claim, because the state statute established a legal duty separate from those created by ERISA and the plan’s terms—namely, a duty to not make material misrepresentations in connection with the purchase of a security. Therefore, the court held that Plaintiffs’ state securities-laws claims were not subject to ERISA preemption.

B. Generally Applicable Criminal Laws

C. Hawaii Prepaid Health Care Act

D. Multiple Employer Welfare Arrangements

E. ERISA Interaction With Other Federal Laws

F. Effect of Section 514 on Pre-ERISA Events

VI. REMOVAL ISSUES

Estate of Griffin v. Goree, 2018 WL 4701828 (W.D. Tex. May 3, 2018). As part of the divorce decree, Goree was ordered to be divested of any interest in two insurance policies covering Griffin’s life. Griffin did not change beneficiaries after the divorce and when she died Unum distributed the life insurance proceeds to Goree as designated beneficiary. Griffin’s mother, as the administrator of her estate, brought suit in probate court to recover the proceeds from Goree. Goree removed the case to federal court asserting that ERISA pre-empted Plaintiff’s claims. Plaintiff moved to remand the case arguing that ERISA preemption did not apply. The district court found the issue whether Goree agreed to waive all rights to the decedent’s life insurance policy in the decree was simply “an issue of contract law.” Since post-distribution suits seek to enforce the consensual terms of a contractual agreement to prevent the named beneficiary from retaining the proceeds they do not interfere with ERISA’s objectives and therefore ERISA does not apply. The case was remanded to state court.

Sheehan v. Kaiser Foundation Health Plan, Inc., 2018 WL 2376634, 2018 EB Cases 187,442 (N.D. Calif. May 25, 2018). Plaintiff brought suit following termination of her employment claiming breach of the implied covenant of good faith and fair dealing, age discrimination and harassment in violation of California Fair Employment and Housing Act, discrimination, retaliation and harassment based on family medical leave in violation of the California Family Rights Act, and wrongful termination in violation of public policy. Plaintiff’s first and fourth claims were based in part on her former employer’s decision to terminate her to avoid paying pension benefits under an ERISA covered retirement plan. Defendant removed the case to federal court on the basis of ERISA’s complete preemption doctrine. Denying Plaintiff’s motion to remand, the District Court found that Plaintiff’s allegation that “Kaiser timed [her] termination so as to occur approximately three months before the …date on which [her] retirement benefits
otherwise would have vested” indicated that the employer had a pension-defeating motive in terminating the employment, and thus her claims were completely preempted by ERISA.

*Halberg v. McLean Hospital*, 2018 WL 2209216, 2018 EB Cases 170,175 (D. Mass. May 14, 2018). Plaintiffs asserted five state-law claims against McLean, all based on the idea that McLean wrongfully induced Plaintiffs to pay directly for treatment that should have been paid by the plan. Plaintiffs allege that McLean misrepresented to them that certain medical treatment was “medically necessary” and was not covered by Plaintiffs’ health insurance company, United Behavioral Health (“United”). Defendant McLean removed the action alleging that Plaintiffs’ claims were completely preempted by ERISA. In remanding the case, the District Court held that the Plaintiffs’ suit was not a claim to recover benefits but rather one to recover damages for amounts paid above whatever benefits should have been paid by the plan and to recover damages for interreference with the provision of benefits—in other words, a suit not to recover the benefits themselves, but rather to recover damages from a third party arising out of the failure to receive benefits from a plan. Since Plaintiffs could not have asserted an ERISA §502(a) claim against Defendant, the District Court had no subject matter jurisdiction and remanded the case to state court.

*Hoeft v. Time Warner Cable, Inc.*, 2018 WL 2078814, 2018 EB Cases 158,371 (C.D. Cal. May 2, 2018). Plaintiff asserted twelve claims arising from her employment at Time-Warner for violations of the California Fair Employment and Housing Act (“FEHA”), Cal. Gov’t Code §§12940 et seq., other California statutes and common law. Defendants removed the action under ERISA’s complete preemption doctrine. In response, Plaintiff filed a motion to remand on the grounds that ERISA does not apply because she alleged that Defendants engaged in disability discrimination and retaliation against her in response to her disabilities and in violation of FEHA and other California law. Granting the motion to remand, the District Court found that Plaintiff’s complaint did not allege that she claims her employment termination was motivated by Defendant’s desire to avoid paying her disability benefits and therefore ERISA preemption did not apply.

**VII. APPLICATION OF PREEMPTION TO PARTICULAR CLAIMS**

A. Benefit Denials and Processing of Benefit Claims

*Farias v. Mass. Laborers’ Health & Welfare Fund*, 2018 U.S. Dist. LEXIS 3432 (D. Mass. 2018). Plaintiff was informed by her group health plan that she would be placed in a special program that require her to purchase her prescription drugs from certain predetermined pharmacy locations. Due to certain issues with her doctors, she was unable to get her prescriptions and attempted suicide. Plaintiff brought claims against her plan’s prescription drug benefit manager, which moved to dismiss them as preempted by ERISA. The Court agreed, finding that the managers’ requirement that it would only pay for drugs prescribed by her primary care physician was a “necessary part of the administration of an ERISA plan. Her negligence and other tort claims were therefore preempted.

death benefits to the estate. Defendant argues that it denied accidental death benefits after reports revealed the presence of nonprescribed drugs in the decedent’s system at the time of death. Plaintiff alleged that Defendant denied duties pursuant to Kentucky state law when Defendant denied its claims. The court applied the Davila test and held that ERISA § 502 preempted Plaintiff’s state law claims because: (1) Plaintiff alleges conduct regarding the process to used to assess benefit claims; and (2) the state law duties are not independent from ERISA rights and duties.

Scarber v. United Airlines, Inc., 2018 U.S. Dist. LEXIS 181475 (N.D. Ill. Oct. 23, 2018). Defendant offered a lump sum benefit to employees in exchange for their voluntary severance of employment. Plaintiff, an employee, went to Defendant’s office to receive assistance from Defendant’s employees with the severance benefits application. Plaintiff later sued Defendants for enforcement of rights and benefits under ERISA, negligence, and negligent supervision, after Defendant denied his claim for benefits on grounds that Plaintiff never submitted an application, despite receiving assistance from Defendant’s employees with the application process. The court considered whether the negligence arose from breach of an ERISA-imposed duty and held that ERISA preempts Plaintiff’s negligence claims on grounds that Plaintiff failed to establish that Defendants owed a non-ERISA-imposed duty to provide him adequate assistance.

Howerton v. Kandarian, No. 1:17-cv-1908, 2018 U.S. Dist. LEXIS 138049 (M.D. Pa. Aug. 14, 2018). Plaintiff-beneficiary filed suit against Defendants-employer and insurer for constitutional violations and state law tort claims related to Defendants’ partial payment of his deceased wife’s group life insurance proceeds. Defendants filed a counterclaim/interpleader action and moved for judgment on the pleadings pursuant to Fed. R. Civ. P. 12(c). The court ruled that Plaintiff’s state tort law claims should be dismissed as expressly pre-empted by ERISA § 514(a), along with Plaintiff’s claims for extra-contractual relief because he was limited to only those remedies available under ERISA § 502(a). The court also recommended approval of the insurer’s interpleader request because “jurisdiction for its interpleader ERISA claims” had been established. Id. at *18.

Soileau & Assocs., LLC v. La. Health Serv. & Indem. Co., No. 18-710, 2018 U.S. Dist. LEXIS 138269 (E.D. La. Aug. 15, 2018). Plaintiffs-insureds filed suit against Defendant-insurer in state court related to the termination of health insurance coverage for their minor child’s inpatient mental health treatment. Plaintiffs filed claims “for breach of contract, bad faith adjusting, and failure to timely pay claims in violation of Louisiana Revised Statute § 22:1821(A) and (D).” Id. at *4. Defendant removed the case to federal court on the basis that Plaintiffs’ claims were completely pre-empted by ERISA § 502(a), and Plaintiffs moved to remand. The court denied Plaintiffs’ motion, reasoning that “Plaintiffs clearly bring suit complaining of a denial of coverage for medical care, which they believe they were entitled to because of the terms of the insurance policy. Therefore…Plaintiffs’ claim for benefits fall within the scope of Section 502(a)(1)(B) of ERISA and federal-question jurisdiction exists.” Id. at *21.

Tellep v. Oxford Health Plans, No. 18-392, 2018 U.S. Dist. LEXIS 164043 (D.N.J. Sept. 25, 2018). Plaintiff-insured filed suit against Defendant-insurer for wrongfully terminating coverage of a brand-name medication for his seizure disorder. Plaintiff alleged that switching to the generic version of the drug caused his seizures to return. Plaintiff filed a 25-count complaint against Defendant for, amongst other things, breach of contract, breach of fiduciary duty, negligence, and
various claims under New Jersey consumer fraud, claim settlement, and discrimination laws. Although Plaintiff received health insurance coverage through his employment, all claims were based on state law. Defendant moved to dismiss Plaintiff’s complaint in its entirety pursuant to Fed. R. Civ. P. 12(b)(6) based on complete ERISA pre-emption. The court explained that “a claim based on an administrator’s eligibility decision is preempted by ERISA, but a claim based solely on a medical treatment decision is not preempted by ERISA.” Id. at *9. The court determined that the underlying wrongdoing was a denial of benefits, based solely on Defendant’s administration of benefits, and Plaintiff had identified no other independent legal duty that existed. The court thus found that complete pre-emption under ERISA § 502(a) had been established and granted Defendant’s motion to dismiss.

B. Laws Regulating Fiduciary Conduct, Reporting, Funding, and Disclosure

**Moore v. Apple Cent., LLC**, 893 F.3d 573, 577 (8th Cir. 2018). James Moore worked for Apple Central, LLC. Apple provided its employees with voluntary life insurance benefits through Guardian Life Insurance Company. James enrolled in the life insurance plan, electing to receive basic coverage plus “voluntary term life coverage.” Apple withheld premiums for the voluntary coverage from James’s paychecks, but it did not forward his enrollment form or premiums to Guardian. When James died, Guardian refused to pay the full amount of elected coverage to his beneficiary, Megan Moore. Megan sued Apple in state court, Apple successfully removed the case to federal court, and Megan filed an interlocutory appeal challenging the removal. The Eighth Circuit held that ERISA preempted Megan’s state-law claims, because any harm she suffered arose from Apple’s breach of its fiduciary duties as the plan administrator, and not from some independent legal duty Apple had to Megan.

**Scevola v. New York Sports & Joints Orthopaedic Specialists PLLC**, 2018 U.S. Dist. LEXIS 202533 (S.D.N.Y. Nov. 20, 2018). Plaintiff sued Defendant in New York state court alleging breach of contract and violations of New York Labor Law for failure to pay a bonus, benefits, and wage supplements. Defendant removed the case to federal court on grounds that ERISA preempted the claims. The court applied the Davila test to hold that ERISA § 502 does not preempt Plaintiff’s state law claims. First, the court noted that Plaintiff’s claims fail the first Davila prong because Plaintiff’s claims derived from a promise to enroll her in ERISA plans, not from rights and obligations under the plan. In addition, Plaintiff alleges breach of her employment agreement rather than breach of a promise in relation to an ERISA plan. Finally, the Defendant’s action implicated duties arising outside of the terms of an ERISA plan.

**Brincefield v. Studdard**, 2018 U.S. Dist. LEXIS 205462 (E.D. Va. Dec. 4, 2018). Plaintiff, an employee of a large commercial real estate firm, participated in his employer’s ESOP program. Plaintiff sued after the price of his stock dramatically declined, alleging ten claims that include state and common law conspiracy and breach of contract. Plaintiff alleged that the directors designed the ESOP program to enrich themselves. The court noted in its analysis that conspiracy claims related to an ESOP generally overlap with ERISA’s remedial scheme. In addition, claims alleging that ESOP trustees breached their duties involving relationships regulated by ERISA “relate to” an ERISA plan. Therefore, the court held that ERISA preempts Plaintiff’s conspiracy and contract claims.
Defendant is Plaintiff’s insurance provider. Defendant mailed Plaintiff a letter with a large window on the envelope, which displayed Plaintiff’s name, address, claim number, and information disclosing his HIV status. Plaintiff sued Defendant, alleging multiple state law claims that include breach of contract, negligence, negligent infliction of emotional distress, and invasion of privacy. Defendant filed a motion to dismiss, and argued that ERISA preempts that Plaintiff’s state law claims. According to the court, the essence of Plaintiff’s claims is that Defendant mishandling sensitive health information, not claims against the administration, processing, or denial of claims under an ERISA plan. Thus, ERISA § 514 does not completely preempt the claims. However, the court found that ERISA § 502 preempts the breach of contract, negligence, and negligent infliction of emotional distress because Plaintiff failed to plead facts sufficient to show the existence of an independent legal duty.

Plaintiff-insured filed suit against Defendant-insurer in state court related to its inadvertent disclosure of his HIV-positive status to his landlord via a mailing in a windowed envelope that resulted in his subsequent eviction. Plaintiff specifically filed claims for “(1) violation of California’s Confidentiality in Medical Information Act; (2) violation of California’s HIV disclosure laws; (3) violation of constitutional right to privacy under Article 1, Section 1 of the California Constitution; (4) negligence; (5) negligence per se; (6) intentional infliction of emotional distress; and (7) unlawful, unfair and fraudulent business acts and practices.” Id. at *4-5. Defendant removed the case to federal court, but Plaintiff moved for remand. The court granted Plaintiff’s motion, finding that his claims were not completely pre-empted by ERISA § 502(a) under both prongs of the Davila test. The court found that Plaintiff was not asserting his claims for relief based on an ERISA plan and Defendant “was independently obligated by several federal and state laws to protect Plaintiff’s” health information. Id. at *13.

This suit arose between Plaintiff-Enforcement Section of the Massachusetts Securities Division of the Office of the Secretary of the Commonwealth and Defendant-broker/dealer in relation to the DOL’s now-vacated “Fiduciary Rule.” Plaintiff filed an administrative complaint with the Securities division, Defendant removed the action to federal court, and then Plaintiff filed a motion to remand. The court first determined that it was not bound by the Fifth Circuit’s decision vacating the “Fiduciary Rule” in Chamber of Commerce of United States of Am. v. United States Dep’t of Labor, 885 F.3d 360 (5th Cir. 2018) because the circuit court did not state that its decision applied nationwide. Nonetheless, the court determined Plaintiff’s claims could be resolved without reference to the “Fiduciary Rule” because they were based on Massachusetts securities laws. The court further held that because “the Enforcement Section is not the kind of party that can bring a claim pursuant to § 502(a), ERISA does not completely preempt either claim in the administrative complaint and neither claim ‘arises under’ ERISA. This Court lacks subject matter jurisdiction and plaintiff’s motion to remand will be allowed.” Id. at 355.

The Texas state appellate court upheld the decision of the trial court dismissing Plaintiff’s claims related to an ERISA retirement plan because it lacked subject matter jurisdiction. The appellate
court reasoned that Plaintiff “asked the trial court to impose statutory penalties based on [the] refusal to provide information concerning an alleged profit sharing plan…See [29 U.S.C.] § 1132(c)(1)(B). Therefore, Dr. Ozcelebi’s ERISA claim revolves solely around the imposition of section 1132(c)(1) penalties and does not concern the recovery, enforcement, or clarification of benefits, rights, or terms of a plan pursuant to section 1132(a)(1)(B) that would allow for filing in state court. See id. § 1132(e).” Id. at *78.

C. Wrongful Death Claims

D. Service Provider Claims

1. Claims by Plans, Participants, Employers, and Fiduciaries Against Service Providers

**Gilmour v. Intertek USA, Inc., 2018 WL 3059682 (S.D. Tex. May 30, 2018).** Plaintiff, as Trustee of the Victory Medical Center Southcross, LP (VCMS), who was an out-of-network healthcare provider, filed suit against Intertek USA, Inc. Health Benefit Plan (Plan), a self-funded health benefit plan, to recover the difference between the amount VMCS billed for the treatment of Patient and the amount actually paid by the Plan. Patient executed an assignment of benefits form in favor of VMCS, who subsequently filed suit against the Plan under ERISA and state law. The state law claims included promissory estoppel and violations of the Texas Insurance Code. Recommending the grant of summary judgement for the Defendant Plan, the Magistrate Judge ruled that the Plan’s anti-assignment language rendered the purported assignment invalid, and Plaintiff’s state law claims were preempted by ERISA, finding that the state law claims were dependent on and derived from the rights of the Patient to recover benefits under the terms of the Plan.

**Med. Mut. of Ohio v. Air Evac EMS, Inc., No. 1:16 CV 80, 2018 U.S. Dist. LEXIS 158131 (N.D. Ohio Sept. 17, 2018).** After Defendant-air ambulance company filed suit against Plaintiff-insurer in state court for breach of implied contract and quantum meruit, Plaintiff filed this suit against Defendant seeking, amongst other things, a declaratory judgment that ERISA pre-empted the previously filed state law action. Defendant filed a counter-claim for breach of implied contract, and the Parties filed cross-motions for partial summary judgment under Fed. R. Civ. P. 56(a) on the applicability of ERISA to Defendant’s counterclaim. The state court stayed its action pending the resolution of this case. The court granted Defendant’s motion, finding that the remedy sought by Defendant’s counterclaim was not “primarily ERISA plan related.” Id. at *11.

**Wigdahl v. Fox Valley Family Physicians, S.C., No. 18 C 3513, 2018 U.S. Dist. LEXIS 161625 (N.D. Ill. Sept. 21, 2018).** Plaintiff brought this suit against Defendant-administrator of her now-deceased husband’s group health plan in state court for negligence and a claim under the Illinois Survival Act. Defendant removed the case to federal court on the basis of complete ERISA pre-emption pursuant to ERISA § 502(a), and Plaintiff filed a motion to remand. The court granted Plaintiff’s motion, reasoning that Plaintiff “focuses her claim on the quality of care [Defendant] and its employees Suzette and Nurse Mary provided, not any denial of specific benefits under [the deceased]’s insurance plan. Therefore, her claims against [Defendant] do not rest upon the terms of [the deceased]’s plan or require interpretation of that plan, and so ERISA does not completely preempt her claims.” Id. at *9.
2. Claims by Providers Against Plans, Employers, and Fiduciaries

Schwartz v. Associated Emplrs. Grp. Benefit Plan & Trust, 2018 U.S. Dist. LEXIS 7477 (D. Mo 2018). Plaintiff was a health care provider who allegedly provided services to a participant in a group health plan. Prior to providing these services, the medical provider was assured that the participant was eligible for the benefit in question under the terms of their group health plan. When the insurer failed to pay, the provider sued both under ERISA (as an assignee of the participants), but also for promissory estoppel under their own right. The Court agreed that the promissory estoppel claim could go forward.

Salzberg v. Aetna Ins. Co., 2018 U.S. Dist. LEXIS 40152, 2018 WL 1275776. Plaintiff was an out-of-network provider who alleged underpayment by defendant plan administrator for surgery on a plan participant. Plaintiff had received an assignment of benefits from participant. After removal, Plaintiff sought remand. The Court applied the Davila test, finding that Plaintiff could bring a 502(a)(1)(B) claim because (1) it had a valid assignment of benefits and because the claims could be properly construed as claims for benefits (thereby disproving the argument that Defendant’s alleged underpayment was motivated by findings that certain of Plaintiff’s activities were not covered under the terms of the plan), and (2) Defendant’s pre-approval letter did establish an independent legal duty to pay because precertification was required by the plan and was therefore inextricably intertwined with the plan. Therefore, the state law claims were completely preempted.

E. Coast Advanced Plastic Surgery v. AmeriHealth, 2018 U.S. Dist. LEXIS 38900, 2018 WL 1226104. Plaintiff was an out-of-network provider who alleged the defendant plan administrator underpaid for surgery on a plan participant. Defendant removed the case, arguing both complete and express preemption. Plaintiff sought remand. The Court held that plaintiff could not have sought relief under 502(a)(1)(B) because it was not a plan member nor was seeking to enforce the participant’s rights. Therefore, the claim was not completely preempted. The district court remanded the case to state court because it lacked subject matter jurisdiction to decide express preemption issue.

Glastein v. Horizon Blue Cross Blue Shield of Am., No. 17-cv-7983, 2018 U.S. Dist. LEXIS 135911 (D.N.J. Aug. 13, 2018). Plaintiff-medical provider filed suit against Defendant-administrator for re-imbursement of out-of-network medical services rendered for its insureds. Plaintiff filed suit in state court “for breach of contract, promissory estoppel, account stated and fraudulent inducement.” Id. at *3-4. Defendant removed the action to federal court and then moved to dismiss pursuant to Fed. R. Civ. P. 12(b)(6). The court granted Defendant’s motion, finding that Plaintiff’s claims “‘relate to’ an employee benefit plan, and as such, each cause of action is expressly preempted by ERISA” § 514(a). Id. at *7-8. The court further explained that it “cannot analyze Plaintiff’s claims without referencing the Plan.” Id. at *9 (internal citations omitted).

Sharp Mem'l Hosp. v. Regence Blueshield of Utah, No. 16cv2493, 2018 U.S. Dist. LEXIS 141968 (S.D. Cal. Aug. 21, 2018). Plaintiff-hospital sued Defendant-insurer based on diversity jurisdiction for coverage of approximately four months of hospital services rendered to an insured shortly after she underwent weight-reduction surgery in Mexico. “However, the plan specifically excludes services related to obesity or weight reduction/control, and any complications arising therefrom.” Id. at *4. After Plaintiff presented its case-in-chief at trial, Defendant moved
for judgement as a matter of law pursuant to Fed. R. Civ. P. 50(a). The court granted Defendant’s motion as to all claims except Plaintiff’s implied-in-fact breach of contract claim based on California state law, but further held that such claim was likely expressly pre-empted by ERISA § 514(a) because it relates to an ERISA plan.

*Stokes v. N. Coast Obstetrics & Gynecology, Inc.*, No. 1:18CV368, 2018 U.S. Dist. LEXIS 144440 (N.D. Ohio Aug. 24, 2018). Plaintiff-doctor/employee filed suit against Defendant-former employer, a medical practice, in state court for breach of contract in relation to his employment agreement. Defendant removed the case to federal court and Plaintiff filed a motion to remand. The court rejected Defendant’s argument that because Plaintiff alleged a loss of benefits based on Defendant’s breach of the employment agreement, Plaintiff was making a claim for benefits under an ERISA plan. The court found that the Defendant’s duty to make certain benefit contributions was not derived from an ERISA plan, but instead laid out in the employment agreement. That claim also made up a very small part of the other compensation/damages sought by Plaintiff. The court thus concluded that Plaintiff’s claims were not pre-empted by ERISA, and granted Plaintiff’s motion to remand.

*Kindred Hosps. Ltd. P'ship. v. Aetna Life Ins. Co.*, No. 3:18-CV-1099, 2018 U.S. Dist. LEXIS 150725 (N.D. Tex. Sept. 5, 2018). Plaintiffs-long-term care hospitals sued Defendants-insurers in state court “to recover unpaid insurance payments based on Aetna’s representations that insurance would cover the charges.” *Id.* at *3. In this second attempt by Defendants to remove the suit to federal court, the court again granted Plaintiff’s motion to remand finding that Plaintiff’s claims were not completely pre-empted by ERISA § 502(a). The court specifically found that Plaintiffs were disputing the rate of payment received, not the right to payment under an ERISA plan. The court also found that Plaintiff’s claims failed the second prong of the *Davila* test in that they were based on independent legal duties.

*Bassel v. Aetna Health Ins. Co.*, No. 17-cv-05179, 2018 U.S. Dist. LEXIS 153070 (E.D.N.Y. Sept. 7, 2018). Plaintiff-chiropractor filed suit against Defendant-insurer for reimbursement of services rendered to 57 insureds. Plaintiff filed suit in state court alleging “unjust enrichment and violations of both N.Y. Ins. Law § 3224-a (the ‘Prompt Pay Act’) and N.Y. Gen. Bus. Law § 349, prohibiting deceptive business practices.” *Id.* at *1. Defendant removed the case to federal court and Plaintiff filed a motion to remand. The court denied Plaintiff’s motion, finding that the claims were completely pre-empted by ERISA § 502(a). The court found that Plaintiff’s claims satisfied both prongs of the *Davila* test, and specifically explained, “[t]hough he is an out-of-network provider, Bassel accepted a valid assignment of benefits from his patients, and is therefore the ‘type of party’ who can bring ERISA claims. Additionally, Bassel asserts a ‘colorable claim for benefits,’ as his claims involve the right to payment under his patients’ plans, and not merely the amount of payment for which he seeks reimbursement. There is no ‘other independent legal duty that is implicated’ by Aetna’s actions.” *Id.* at *5 (internal citations omitted).

*Alameda Cty. Med. Ctr. v. Laborers Health & Welfare Tr. Fund*, No. C 18-03565, 2018 U.S. Dist. LEXIS 155777 (N.D. Cal. Sept. 12, 2018). Plaintiff-hospital sued Defendant-plan in state court for breach of an implied contract and quantum meruit. Defendant removed the action to federal court on the basis of complete pre-emption pursuant to ERISA § 502(a). Plaintiff filed a motion to remand, which was granted by the court “[b]ecause plaintiff’s state law action could not...
be brought as a participant or beneficiary under Section 502(a)(1)(B) and because plaintiff relies on legal duties that are independent from duties under any benefit plan established under ERISA.” *Id.* at *3-4. More specifically, the court explained that Plaintiff’s claims failed both prongs of the *Davila* test. In regard to the first prong, the court explained that “[t]he dispute is not over the right to payment under the plan, which could depend on the patients’ assignments to plaintiff. Rather, the dispute is over the remaining balance that has not been paid. Payment of this balance depends on the implied contract established when plaintiff called to verify patient eligibility and defendants and their agents authorized treatment.” *Id.* at *7. The court further reasoned that “[P]laintiff’s action could not have been brought by an enrollee, because no enrollee was a party to the implied contract between plaintiff and defendant.” *Id.* at *8. In regard to the second prong, the court explained that “plaintiff asserts state law claims arising out of an alleged oral contract for the reasonable value of their services. This duty exists independently from the right to payment under an ERISA plan.” *Id.* at *9.

**E. Coast Advanced Plastic Surgery v. Horizon Blue Cross Blue Shield of N.J., No. 18-7718, 2018 U.S. Dist. LEXIS 200404 (D.N.J. Sept. 14, 2018).** Plaintiff—medical practice group filed suit against Defendant—insurer for payment of an operation performed on one of its insureds. Defendant removed the case to federal court on the basis of complete pre-emption under ERISA § 502(a) and Plaintiff filed a motion to remand. The court recommended granting Plaintiff’s motion, finding that Plaintiff’s claims failed the first prong of the *Davila* test because “its claims are based on an implied-in-fact contract that was created based on its dealings with BCBS.” *Id.* at *11. The court further concluded that Plaintiff’s claims related to the amount that should be reimbursed, not its right to payment under an ERISA plan, and were thus independent of such. The court explained that “courts within this district have consistently held that § 502(a) does not preempt a dispute over the amount of payment to the provider.” *Id.* at *12-13.

**Glastein v. Aetna, Inc., No. 18-9262, 2018 U.S. Dist. LEXIS 162857 (D.N.J. Sept. 24, 2018).** After Defendant—insurer removed this breach of contract, promissory estoppel, account stated, and fraudulent inducement state court case to federal court, which was filed by Plaintiff—surgeon for unpaid medical services, Defendant filed a motion to dismiss pursuant to Fed. R. Civ. P. 12(b)(6). Defendant “argue[d] that Plaintiff’s Complaint must be dismissed because its state common law claims are expressly preempted by ERISA” § 514(a). *Id.* at *3. The court disagreed. In support of its decision, the court explained that “[t]he state laws at issue here…neither ‘refer to’ nor have an ‘impermissible connection with’ an ERISA plan…The central purpose of ERISA is to protect plan participants and beneficiaries…[and] claims brought by a provider against an insurance company do not implicate ERISA’s goals of protecting participants and beneficiaries.” *Id.* at *4-5.

**Plastic Surgery Ctr. v. Aetna Life Ins. Co., No. 17-13467, 2018 U.S. Dist. LEXIS 166514 (D.N.J. Sept. 26, 2018).** Plaintiff—medical provider filed suit against Defendant—insurer for breach of contract, promissory estoppel, and unjust enrichment related to a procedure performed on one of Defendant’s insureds. Defendant removed the case to federal court and then moved to dismiss Plaintiff’s claims pursuant to Fed. R. Civ. P. 12(b)(6) because they were expressly pre-empted by ERISA § 514(a). The court granted Defendant’s motion. The court reasoned that Plaintiff’s healthcare plan was an ERISA plan, and Plaintiff had not established “the existence of a contract sufficiently independent from the [] Plan.” *Id.* at *17. The court also explained that Defendant’s
reimbursement obligation was at the core of each of Plaintiff’s state law claims, and “[a] dispute over reimbursement for a procedure performed on a patient insured by an ERISA plan is ‘squarely within ERISA’s ambit.’” *Id.* at *18 (citations omitted).

**Goldberg v. Aetna Ins. Co., 2018 U.S. Dist. LEXIS 38573, 2018 WL 1226025.** Plaintiff was out-of-network provider who alleged underpayment by defendant, the plan administrator, for surgery on a plan participant. Plaintiff had received an assignment of benefits from participant, but the plan contained an anti-assignment provision. Defendant removed to federal court, arguing that plaintiff’s claims were completely preempted by ERISA; plaintiffs sought remand. Under the *Davila* test, plaintiff’s claim could only be completely preempted if plaintiff could have sought relief under 502(a)(1)(B). Here, the court held that the plan’s anti-assignment provision was valid. Therefore, plaintiff could not have sought relief under 502(a)(1)(B). The Court held that defendant could not give plaintiff 502(a)(1)(B) standing by waiving the anti-assignment provision; Second Circuit precedent holds that “A party . . . cannot waive a defect in a federal court’s subject matter jurisdiction.”

**Progressive Healthcare Sols. LLC v. United Healthcare Servs., 2018 U.S. Dist. LEXIS 21963 (W.D. Lou. 2018).** Defendant-insurer removed to federal court a claim by a provider based upon an alleged authorization to go ahead with medical service delivered by the insurer, arguing that it was completely preempted by ERISA. The District Court rejected this argument, finding that because the claim was allegedly based upon an independent contractual duty established during the alleged authorization process, not under the terms of the ERISA plan itself, the cause of action was based upon an independent duty outside of ERISA, and was therefore not preempted.

**Cape Regional Medical Center v. CIGNA Health and Life Ins. Co., 2018 WL 2980386 (D. N.J. June 14, 2018).** Cape Medical, as assignee, sought reimbursement of allegedly underpaid benefits from Cigna Health for emergency medical services provided to individuals who were beneficiaries of Defendant’s health benefits plan governed by ERISA. Dismissing the action, the District Court ruled that Plaintiff’s a claim for violation of N.J. Admin. Code §11.4-37 was preempted by ERISA because Plaintiff’s right to recover depends entirely on the interpretation of terms and provision of the ERISA plan, and thus could have been brought pursuant to ERISA § 502(a).

**Advanced Orthopedics and Sports Medicine Institute v. Empire Blue Cross Blue Shield, 2018 WL 2758221 (D. New Jersey, June 7, 2018).** Plaintiff, an out of network healthcare provider, brought suit to recover certain payments incurred from a medical procedure that was performed on the patient insured under an employee health insurance plan administered by Empire. The Complaint alleged breach of contract, promissory estoppel, account stated, fraudulent inducement, and various violations of the New Jersey administrative regulations. The district court dismissed Plaintiff’s complaint finding that the claims were preempted by ERISA § 514(a) insofar as each related to an employee benefit plan. The district court rejected Plaintiff’s assertion that the claims were based upon an “independent” preauthorization agreement, stating that Plaintiff asserted “quintessential ERISA claims” in its reimbursement dispute as they all required reference to an ERISA plan and resolution depended entirely on the terms and provisions of the plan.

Associates, an out-of-network health care provider, brought suit in state court to recover certain payments incurred from a medical procedure performed on an insured under the Fund’s employee health insurance plan administered by Defendant Horizon. The case was removed to federal court on the basis of ERISA’s complete preemption doctrine. In dismissing Plaintiff’s common law claims arising from Defendant’s failure to fully reimburse Plaintiff for the medical procedure, the District Court ruled that Plaintiff’s common law claims were preempted by ERISA § 514 because each one implicates the Plan’s terms and thus “relates” to the ERISA plan. The District Court rejected Plaintiff’s argument that the claims were not preempted because they relate solely to an independent preauthorization agreement, stating that the agreement authorizes the provider to perform the procedure but does not govern payment for the procedure.

*Reva, Inc. v. United Healthcare Insurance Company*, 2018 U.S. Dist. LEXIS 112955 (S.D. Fla. June 11, 2018). Plaintiff Reva filed suit against Defendants insurers in state court alleging that as a provider of emergency ambulance services, it provided services to individuals insured by Defendants and was “grossly underpaid” in violation of Florida law. Plaintiff asserted common law claims for unjust enrichment, quantum meruit, and statutory violations. Defendants removed the case to federal court on the grounds of ERISA’s complete preemption doctrine. Plaintiff filed a motion to remand arguing, among other things, that its claims do not fall within ERISA’s scope because they are rate of payment claims. Plaintiff argued that its dispute is about the rate of payment rather than a right of payment. The District Court agreed with Plaintiff and issued an order remanding the case to state court. The District Court stated that it found the Plaintiff’s claims were not preempted by ERISA because Plaintiff was not challenging a denial of coverage for certain services not covered by the plans but rather disputed the amount it was paid, that is, that it was not paid enough.

*North Jersey Spine Group, LLC v. Blue Cross and Blue Shield of Massachusetts, Inc.*, 2018 U.S. Dist. LEXIS 76537, 2018 WL 2095174 (D. N.J. May 7, 2018). Plaintiffs North Jersey Spine Group, LLC and Dr. Garrick Cox, out-of-network and non-participating healthcare providers, filed common law claims of unjust enrichment, quantum meruit, promissory estoppel, and negligent misrepresentation arising from Plaintiff’s performing surgery on patient insured by Defendant. Plaintiff received pre-authorization for the procedure and was denied payment on grounds the procedure was not medically necessary. After Defendants removed the action to federal court Plaintiffs moved to remand the case to state court, arguing that the matter was not completely preempted. In remanding the case, the District Court found that Plaintiffs did not have a valid assignment of benefits and Plaintiff’s claims stemmed from Defendants’ pre-authorization of medical services. As such, Plaintiffs had an independent legal basis for their claim.

*E. Coast Advanced Plastic Surgery v. Horizon Blue Cross Blue Shield of N.J.*, 2018 U.S. Dist. LEXIS 199891, (D.N.J. Nov. 26, 2018). Plaintiff, an out-of-network provider, sued Defendant for full payment of services after Plaintiff provided medically-necessary surgery to Patient covered under a self-insured plan administered by Defendant. Plaintiff alleged that Defendant knew it was an out of network provider, but told Plaintiff prior authorization was not necessary for coverage. The court considered whether ERISA preempted Plaintiff’s state law claims of breach of contract, promissory estoppel, account stated, and fraudulent inducement, and could be construed as claims for benefits. The court rejected Defendant’s argument that ERISA preempts the claims because the amount of reimbursement pursuant to an oral contract was the essence of the dispute, rather
than whether the plan provided certain coverage. The court remanded the case back to New Jersey state court on grounds that ERISA does not preempt the claims.

**N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc., 2018 U.S. Dist. LEXIS 211272 (D.N.J. Dec. 14, 2018).** Plaintiff, a medical provider, entered an agreement with MultiPlan to join their network of medical providers in reliance on MultiPlan’s promise that Plaintiff would be reimbursed at 80% of Plaintiff’s billed charges. The agreement required Plaintiff to provide medical services to a patient after he or she displayed an insurance card with MultiPlan’s logo or after a patient arrived for medically necessary emergency services. Then, Plaintiff would submit invoices to the Defendants (including medical insurers). Defendants either underpaid, or failed to pay. Thus, Plaintiff sued, alleging fourteen claims that include conspiracy, breach of good faith and fair dealing, etc. Two Defendants removed the case to federal court, and alleged three reasons for ERISA preemption: (1) the claims would require the court to determine whether Plaintiff’s claims constitute covered services eligible for reimbursement; (2) Plaintiff failed to alleged an independent duty upon which makes Plaintiff’s services eligible for reimbursement; and (3) two claims would require the court to apply and interpret ERISA plan documents. The court relied on the *Davila* test to grant Plaintiff’s motion to remand the case to state court on grounds that Plaintiff’s claims failed both prongs of the test. The court reasoned that although Plaintiff received valid assignment of ERISA rights from fifteen of the eighteen representative patients, the essence of Plaintiff’s claims is whether Defendants are entitled to reimburse Plaintiff at the 80% rate, not whether Plaintiff is entitled to a right to payment. Furthermore, the alleged independent duty supporting Plaintiff’s claim arose from the logo on the patients’ insurance cards, in compliance with the Agreement between Plaintiff and MultiPlan, not from a duty to pay pursuant to Defendants’ ERISA benefit plans. Therefore, Plaintiff’s claims failed both prongs of the *Davila* test.

3. **Medical Malpractice Cases**

E. **Severance Pay**

F. **Wrongful Discharge Claims**

1. **Common Law Claims**

**Spangler v. E. Ky. Power Coop., Inc., 2018 U.S. Dist. LEXIS 206122 (E.D. Ky. Dec. 6, 2018).** Defendant employed both Plaintiff and her husband as employees. Plaintiff sought assistance from Defendant’s human resources employees and General Counsel to obtain death benefits after her husband died. Plaintiff sued Defendant, claiming wrongful termination after Defendant’s employees allegedly harassed her in meetings held to discuss the death benefits. Defendant filed a motion to dismiss, noting that ERISA preempts Plaintiff’s wrongful termination claim. The court noted that plaintiffs must generally rely on public policy from well-established legislative enactment to support a wrongful termination claim in an at-will employee situation. Here, Plaintiff relied on ERISA § 510 to establish the public policy underlying her wrongful termination claim. She alleged that her termination stemmed from Defendant’s interference with protected ERISA rights. The court granted Defendant’s motion to dismiss on grounds that ERISA preempts
Plaintiff’s claims because the Act provides both the public policy underlying Plaintiff’s wrongful termination claim, and the available remedies.

Thompson v. Reliant Care Mgmt. Co., 2018 U.S. Dist. LEXIS 204849 (E.D. Mo. Dec. 4, 2018). Plaintiff alleged that he executed an employment agreement with Defendant containing several employment termination provisions. Defendant instructed Plaintiff to ensure that Defendant’s facilities complied with state regulations. However, Defendant terminated Plaintiff’s employment shortly after this request due to Plaintiff’s alleged unprofessionalism. Plaintiff sued Defendant and alleged multiple claims, including: (1) breach of contract for termination without cause and failure to pay money and benefits owed under the Agreement, and (2) retaliation under Missouri Human Rights Act for reporting sexual harassment. Defendant removed the case to federal court, and argued that ERISA preempted both claims. On Plaintiff’s motion to remand, the court considered whether the breach of contract claim related to an employee benefits plan, and whether Plaintiff’s retaliation claim arose under ERISA § 510. The court held that Plaintiff’s claims fail to raise a federal question. First, benefits sought under Plaintiff’s breach of contract claim do not constitute benefits that require an ongoing administrative scheme. Instead, simple or mechanical determinations could calculate Plaintiff’s benefits. Furthermore, Plaintiff’s retaliation claim did not arise under ERISA § 510 because Plaintiff did not alleged that Defendant terminated him to interfere with his attainment of ERISA rights. Instead, Plaintiff alleged that Defendant’s reasons for terminating his employment were pretextual, and that the true purpose was to avoid paying money and benefits owed pursuant to the employment agreement. Therefore, the court granted Plaintiff’s motion to remand the case to Missouri state court.

2. Employment Discrimination Laws

Davis v. Con-Way Freight, Inc., 715 Fed. Appx. 805, 2018 U.S. App. LEXIS 7400, 2018 WL 1443623. Plaintiff claimed he was fired because of the cost of providing him health care benefits. The Ninth Circuit noted that the claim was preempted. As it explained, “[W]e have held that where the plaintiff’s claim or theory alleged that the employer terminated the employee to avoid paying benefits or sought to prevent the discharged employee from obtaining benefits, ERISA preempted the claim.”

Soto v. Int’l Paper Co., 2018 U.S. Dist. LEXIS 193491 (C.D. Cal. Nov. 13, 2018). Plaintiff, a truck driver, alleged that his employer has a policy of terminating employees on the cusp of reaching 55 to avoid paying early retirement benefits, and that his supervisor began reprimanding soon after he turned 54. In addition, Plaintiff was involved in a car accident while driving his employer’s vehicle a few months before reaching 55. Defendant subjected Plaintiff to a drug screening, which Plaintiff alleged was done to use the accident as pretext. Plaintiff sued his employer under California’s age discrimination law after Defendant allegedly fired Plaintiff a month before his 55th birthday. Plaintiff alleged multiple cause of action, including age discrimination. The court noted that Plaintiff failed to allege facts to suggest Defendant terminated him because of his age, instead of avoiding early retirement benefit obligations. Thus, the court found that ERISA preempts Plaintiff’s age discrimination because the facts suggest employer terminated Plaintiff to avoid paying early retirement benefits in violation of ERISA § 510.

Gates v. Morris, 2018 U.S. Dist. LEXIS 52732 (S.D. W. Va. Mar. 29, 2018). Plaintiff, who had an ERISA medical plan, alleged that he took a medical leave with the promise that he would be
able to return to his job afterwards. After attempting to return to work, Plaintiff was told that his position had been terminated. Plaintiff brought state law claims as well as ERISA claims against his employer and plan. The court ruled that the state law claims were all preempted because they pertained to Defendants’ performance of duties pertaining to an ERISA plan.

_Fonseca v. Hewlett-Packard Co._, No. 3:18-cv-00071, 2018 U.S. Dist. LEXIS 151330 (S.D. Cal. Aug. 31, 2018). Plaintiff-former employee filed suit against Defendant-former employer in state court based on his wrongful termination on the basis of age related to Defendant’s workforce reduction plan. Defendant removed the case to federal court on the basis of complete pre-emption under ERISA § 502(a). Plaintiff filed a motion to remand. The court granted Plaintiff’s motion finding that contrary to Defendant’s contentions, the workforce reduction plan was not an ERISA plan. The court explained that Defendant could not satisfy the first prong of the _Davila_ test to establish ERISA pre-emption because Plaintiff was not seeking to enforce or obtain any relief on the basis of ERISA or an ERISA plan, so he could not have brought his claims under ERISA § 502(a).

_Catoggio v. Sheet Metal Workers Int'l Ass'n, Local 25, AFL-CIO_, No. 17-11674, 2018 U.S. Dist. LEXIS 156729 (D.N.J. Sept. 13, 2018). After the case was removed to federal court, Plaintiff-employee sought remand for a variety of state law claims brought against Defendants-employer and union for his wrongful termination. Plaintiff’s claims included, but were not limited to, workers compensation discrimination, disability discrimination, and retaliation. Defendant-employer argued that Plaintiff’s state law claims were completely pre-empted by ERISA because the apprenticeship program Plaintiff participated in was an ERISA plan. The court disagreed and granted Plaintiff’s motion. The court explained that “Plaintiff’s request for damages is strictly associated with the discriminatory and retaliatory conduct engaged in by Defendants, and appears to be separate from recovering, enforcing, or clarifying benefits under an ERISA plan.” _Id._ at *11. The court further explained that “assuming _arguendo_ Plaintiff could have potentially brought this case under ERISA, the Court finds that there are clear independent legal duties under New Jersey state law that are implicated by Defendants’ alleged conduct.” _Id._ at *12.

G. Fraud and Misrepresentation Claims

_Del Castillo v. Community Child Care Council of Santa Clara County_, 2018 WL 2357698, 2018 EB Cases 185, 380 (N.D. Calif., May 24, 2018). Plaintiffs are current or former employees of Defendant 4Cs, a non-profit organization that sponsored a pension plan. 4Cs began converting Plaintiffs’ vested retirement account balances into life annuity contracts after having plaintiffs sign documents that were purported to be enrollment applications for the 4Cs retirement plans but in reality were binding contracts agreeing to the conversion. Plaintiffs alleged ERISA violations as well as common law claims for breach of contract, fraud in the inducement and conversion. In issuing a dismissal order the district court held that plaintiffs’ common law claims were preempted by ERISA insofar as all related to plan assets, i.e., the life annuity contracts, all depended on the existence of an ERISA-covered plan to demonstrate damages and relate to the administration of an employee benefit plan covered by ERISA.

_Waters v. AIG Claims, Inc._, 2018 WL 2986213, 2018 EB Cases 210,402 (M.D. Ala. June 14, 2018). District Court adopts Magistrate Judge’s order denying Plaintiffs’ leave to amend to add
state law claims of outrage, breach of contract, fraud and civil conspiracy on the ground that such claims would be futile because they relate to the administration of a claim and therefore are preempted by ERISA. Defendants’ actions denying Plaintiffs’ recovery as beneficiaries under two life insurance policies were “intertwined with the refusal to pay benefits” in that the basis for denial was the intoxication exclusion of the policies.

_TBM Consulting Group, Inc. v. Lubbock National Bank_, 2018 WL 2448446, 2018 EB Cases 192,617 (E.D. N.C. May 31, 2018). Plaintiffs assert negligent misrepresentation claim against trustee fiduciary arising from insufficient and incorrect valuation of ESOP shares. Plaintiff claimed that defendant acting as a plan fiduciary induced it to take out an inflated bank loan to its detriment. The District Court found that the negligent misrepresentation claim was preempted by ERISA insofar as the conduct of a fiduciary acting in its fiduciary capacity were the underlying acts that supported Plaintiffs’ claim. Claim dismissed.

I. Circumstances Where State Law Claims Are Often Found Preempted

_Purvis v. Lutheran Homes of S.C., Inc.,_ 2018 U.S. Dist. LEXIS 35042, 2018 WL 1156428. Plaintiff sued her employer in state court for breach of contract, detrimental reliance, and bad faith failure to pay insurance. The Court held that plaintiff’s claims did not exist without reference to Defendant’s ‘A Guide to Your Benefits,’ which appeared to be an ERISA benefit plan. Therefore, the claims were preempted.

_Bd. of Trs. v. Bright St., LLC_, No. 3:16-cv-481, 2018 U.S. Dist. LEXIS 162031 (S.D. Ohio Sep. 20, 2018). In this multiemployer pension fund withdrawal liability case, the court granted Plaintiff-trustees and funds’ motion for judgment on the pleadings under Fed. R. Civ. P. 12(c) in relation to Defendant-successor employer’s counterclaims for fraud, negligent misrepresentation, conspiracy, and abuse of process. Defendant’s counterclaims were mostly based on Plaintiff’s alleged failure to inform them of the withdrawal liability and financial state of the funds. Plaintiff’s motion was granted by the court, based in part on the court’s finding that the state law counterclaims were expressly pre-empted by ERISA § 514(a).

_Hocheiser v. Liberty Mut. Ins. Co.,_ 2018 U.S. Dist. LEXIS 47870, 2018 WL 1446409. Plaintiff sued in federal court after defendant, the plan administrator, discontinued Plaintiff’s long-term disability benefits. In addition to ERISA claims, Plaintiff brought state law claims for breach of contract, bad faith, negligence, and the New Jersey Unfair Claim Settlement Practices Act. The court found that “claims alleging breach of contract, bad faith, or negligence in connection with the denial of benefits under an ERISA-covered plan are preempted under ERISA, because those claims are premised on the existence of the plan.” Also, the NJUCSPA claim was preempted because it pertained to the plan: “Absent the existence of the Plan, Plaintiff’s cause of action for violation of the New Jersey Unfair Claim Settlement Practices Act would cease to exist.”

the case to federal court asserting complete preemption under ERISA. In denying Plaintiff’s motion for remand the District Court ruled that Plaintiff asked only for reimbursement under an employee benefit plan. As such, his breach of contract claim “relates to” his plan because the contractual rights on which he brings suit arise directly and exclusively from the terms of the plan.

Lawrence v. Randolph Hosp., Inc., 2018 U.S. Dist. LEXIS 49259, 2018 WL 1478039. Plaintiff brought a state law action alleging that her employer’s HR department falsified documents in an attempt to avoid plan liability for plaintiff’s medical bills. The court held that plaintiff’s claims “are all to recover benefits under ERISA-governed plans. And . . . resolving her claim . . . necessitates interpretation of ERISA-governed employee benefit plans. Thus, her claims are completely preempted by § 502.”

Wilson v. Chagrin Valley Steel Erectors, Inc., 2018 U.S. Dist. LEXIS 50769, 2018 WL 1512906. Plaintiffs were trustees for ERISA plans between the Defendant employer and Defendant’s employee participants. The plans changed position on the calculation of payments due by the employer. When the employer failed to pay the increased amount, plaintiffs filed suit under ERISA. Defendants countersued under state law for breach of contract based on the argument that plan participants had known about the employer’s calculation method for years and had audited and approved this methods. The court held that “federal courts may not apply common law theories to alter the express terms of written benefit plans.” Therefore, any contract which might have been created outside of the ERISA plan documents itself was void, and the counterclaim was preempted.

2. Circumstances Where Preemption Is Less Likely

Weddle v. Life Insurance Company of North America, 2018 U.S. Dist. LEXIS 88241 (D. Mass. May 10, 2018). Plaintiff Weddle brought suit against Defendant Life Insurance Company of North America for terminating her long-term disability benefits. Count III of her complaint alleged intentional infliction of emotional distress. Defendant insurer argued this claim was preempted by ERISA because the claim arose directly out of the handling and administration of the Plaintiff’s ERISA claim. The District Court stated that if adjudicating the claim would not require the court to evaluate or interpret the terms of the ERISA plan, or to determine whether the benefits were improperly terminated under the plan, the claim would not be preempted by ERISA. Finding that Count III failed to state a valid claim for intentional infliction of emotional distress, the District Court granted dismissal.

Sky Toxicology, Ltd. v. UnitedHealthcare Ins. Co., No. 5-16-CV-01094-FB-RBF, 2018 U.S. Dist. LEXIS 150245 (W.D. Tex. Sept. 4, 2018). Plaintiffs-toxicology labs sued Defendants-insurers after Defendants’ prior suit against them was dismissed from federal court for lack of jurisdiction. Defendants asserted multiple state law counterclaims against Plaintiffs “based on alleged misrepresentations and omissions committed” in Plaintiffs’ submission of claims to Defendants “for unnecessary and expensive out-of-network toxicology services.” Id. at *4-6. Plaintiffs moved for dismissal of the counterclaims under Fed R. Civ. P. 12(b)(1), 12(b)(6), and 12(b)(7) based on both express and complete ERISA pre-emption. The court denied Plaintiffs’ motion. In regard to express pre-emption under ERISA § 514(a), the court explained that there is a distinction “between state law claims based on representations about the scope of plan coverage and ones involving a dispute over actual plan interpretation or application,” and that only the latter
are usually found to be pre-empted. *Id.* at *13. The court further determined that Defendants’ state law counterclaims “do not appear to turn on or necessarily implicate any dispute over the interpretation or application of plan terms,” but primarily “appear[] to relate to the Labs’ alleged fraudulent or negligent misrepresentations.” *Id.* at *16-17. The court stated that “no part of the ERISA statutory framework regulates the accuracy of information supplied by plan participants or their assignees,” and Plaintiffs “have failed to prove that holding a third-party provider here responsible for alleged fraudulent misrepresentations and omissions under Texas law affects a relationship regulated by ERISA.” *Id.* at *18-19. In regard to complete pre-emption under ERISA § 502(a), the court also found that Defendants’ counterclaim failed the second prong of the Davila test because “these claims are premised on a legal duty – sounding in tort – distinct from a duty under the plans.” *Id.* at *22.

**Rojas v. Cigna Health & Life Ins. Co.,** No. 14-CV-6368, 2018 U.S. Dist. LEXIS 169726 (S.D.N.Y. Sept. 28, 2018). This case was originally filed by Plaintiffs—medical providers against Defendant-insurer for reimbursement of medical services rendered to Defendant’s insureds. Defendant filed four counterclaims against Plaintiff for fraud, unjust enrichment, money had and received, and breach of contract. Defendant sought to re-coup what had already been paid to Plaintiffs for other medical services that were allegedly over-billed and marked-up, and thus “paid ‘in error.’” *Id.* at *7. Plaintiffs moved for summary judgment pursuant to Fed. R. Civ. P. 56(a) on Defendant’s counterclaims based on ERISA pre-emption grounds. After dismissing Defendant’s unjust enrichment and money had and received counterclaims for other reasons, the court determined that Defendant’s breach of contract and fraud counterclaims were not expressly pre-empted by ERISA § 514(a) because “[t]he existence of any ERISA plan here serves only as a backdrop; it is effectively the context for ‘garden variety fraud.’” *Id.* at *39 (citations omitted). The court also found that the remaining counterclaims failed both prongs of the Davila test for complete pre-emption under ERISA § 502(a) because Defendant was not a beneficiary or participant, and thereby could not bring a claim under ERISA § 502(a)(1)(B); and the counterclaims, along with Defendant’s service agreement with Plaintiffs, implicated other independent legal duties, including the duty to provide truthful claim submissions.

**Regents of Univ. of California v. Triple S Steel Holdings Inc.,** No. SACV161408DOCFFMX, 2018 WL 3831010 (C.D. Cal. July 2, 2018). Plaintiff provided medical care on several occasions to a participant of the Triple S Steel Holdings, Inc. Health Plan. Before doing so, plaintiff contacted the plan’s claims administrator, Group & Pension Administrators, Inc., each time to ensure coverage. Each time, GPA confirmed coverage. The plan nonetheless failed to pay the full medical bills plaintiff submitted, so plaintiff sued in state court on a theory of quantum meruit. After Defendant removed the case to federal court, the court held that Plaintiff’s quantum-meruit claim was not preempted, because the alleged misrepresentations did not arise from the plan’s terms and did not impact the relationship between the Defendants and the plan participant.

**Texas Oral & Facial Surgery, PA v. United Healthcare Dental Inc.,** No. 4:18-CV-0944, 2018 WL 3105114 (S.D. Tex. June 25, 2018). Plaintiff Texas Oral and Facial Surgery provides oral-surgery services in Texas. Shell Oil Company provides its employees dental insurance through an ERISA plan; the plan provides insurance through United Healthcare Dental, Inc. Plaintiff alleged that Shell informed both plaintiff and Shell employees that the dental plan covered 100% of any cutting procedures. Plaintiff also alleged that United told plaintiff the same thing. After plaintiff
performed surgery for plan participants and beneficiaries, United denied total coverage. Plaintiff sued Shell for negligent misrepresentation and United for fraud and breach of contract. The court held that plaintiff’s claims were not preempted by ERISA, because the claims were premised on representations that were independent of the plan’s terms.

H. Common Law and Statutory Regulation of Health Coverage and Delivery of Medical Services

1. Introduction

2. Mandated Benefits Cases

3. State Surcharge Regimes

4. Regulation of Provider Groups: Any Willing Provider Legislation

5. Third-Party Administrator Licensing Statutes

6. Medical Malpractice and Related Claims
   a. The Pegram and Davila Decisions
   b. The Effect of Aetna Health Inc. v. Davila
   c. Prior Case Law

7. State Law Claims by Health Care Providers

_Hansen v. Grp. Health Coop., 902 F.3d 1051 (9th Cir. 2018)._ Plaintiff-mental health providers filed suit against Defendant-insurer in state court for violation of Washington’s Consumer Protection Act, Wash. Rev. Code § 19.86.020, after Defendant adopted the Milliman Care Guidelines for evaluating mental healthcare coverage. Plaintiffs further claimed that the guidelines were biased against mental healthcare and used by Defendant to deny such services in violation of the Washington Mental Health Parity Act, Wash. Rev. Code § 48.44.341. Defendant removed the case to federal court, after which the district court dismissed some claims and remanded the remainder to state court. The Ninth Circuit reversed and remanded the entire dispute back to state court. The circuit court reasoned that Plaintiffs’ claims were not completely pre-empted by ERISA § 502(a) because they did not satisfy the second prong of the _Davila_ test because Plaintiffs’ “claims for unfair and deceptive business practices are based on independent duties beyond those imposed by three of their patients’ ERISA plans.” _Id._ at 1060. The court further explained that “[t]he relevant inquiry [] focuses on the origin of the duty, not its relationship with health plans.” _Id._

_Davita Inc. v. St. Joseph’s/Candler Health Sys., 2018 U.S. Dist. LEXIS 50760, 2018 WL 1513317._ Plaintiff, a health care provider, sued defendant in state court for failure to pay contractual rates. Defendant removed on the basis that plaintiff had assignments which allowed it to sue under ERISA, and Plaintiffs moved to remand. The Court ruled that ERISA did not preempt the state claim because “The Eleventh Circuit Court of Appeals has recognized that a healthcare provider may end up with either an assigned ERISA claim and an independent state law claim, or
both. Under these circumstances, an assignment of benefits is irrelevant if the healthcare provider has alleged only an independent state law claim. . . . Plaintiff has carefully crafted its complaint to allege only a state law claim based on Defendant’s purported breach of the agreement to provide medical services to Defendant’s insureds. At no point in the complaint does Plaintiff either mention ERISA or base any allegation on a claim that an insured may have against Defendant.”

I. Domestic Relations Laws

*Smith v. Iron Workers Dist. Council of S. Ohio & Vicinity Pension Tr.*, 329 F. Supp. 3d 647, 666 (N.D. Ind. 2018). In 2013, Garland Smith retired and elected to receive the life-annuity-payment option from his ERISA retirement plan. In 2016, Garland and plaintiff Deborah Smith divorced. Afterwards, Deborah obtained a domestic relations order entitling her (and, potentially, her beneficiaries upon death) to 40% of Garland’s monthly payments. When the plan determined the order was not qualified under ERISA, Deborah sued, alleging an ERISA claim and a state-law conversion claim. The court first concluded the order was ERISA-qualified. The parties disputed whether the conversion claim was preempted based on 29 U.S.C. § 1144(b)(7), which excepts QDROs from ERISA preemption. The court nonetheless held that plaintiff’s claim was preempted, because at its core, the dispute amounted to a claim for wrongfully withheld benefits from an ERISA plan.

*Vlahos v. Alight Sols. Benefit Payment Servs., LLC*, No. 17-CV-12505-ADB, 2018 WL 3764262 (D. Mass. Aug. 8, 2018). When plaintiff filed for divorce from Mark Vlahos in May 2013, Vlahos’s ERISA-covered 401(k) retirement plan had a $125,000 account balance. Over a year later, the account balance was $25,000, due to Vlahos taking withdrawals from it. Plaintiff sued, asserting various state-law claims against the plan fiduciaries for not protecting her interest in the retirement account. On removal to federal court, the court held that Plaintiff’s claims were connected to ERISA, as Plaintiff’s relationship with defendants was established exclusively by the retirement plan. And the QDRO exception to ERISA preemption did not apply, as plaintiff did not submit a domestic relations order to the court for review. Even if plaintiff had, her claims would still be preempted, as they involved improper plan administration, not claims arising from the QDRO itself. Thus the court held that ERISA preempted Plaintiff’s state claims.

*Dalton v. Dalton*, 551 S.W.3d 126, 138 (Tex. 2018). An Oklahoma court entered a separation agreement between Bart and Carol Dalton that established a level of spousal support and granted Carol 50% of Bart’s interest in his ERISA retirement plans. Later, Bart filed for divorce in Texas court. Before entering a divorce decree, the Texas court determined Bart was in arrears regarding his support obligations. To address it, the court entered a qualified domestic relations order assigning Carol an additional interest in Bart’s retirement plans. When the court later issued a divorce decree, it incorporated the Oklahoma court order. Bart’s failure to pay support continued, so the Texas court issued a second QDRO assigning Carol additional interests in Bart’s retirement accounts. Bart appealed, arguing that the post-divorce order assigning Carol more benefits was illegal. The Texas Supreme Court held that Bart’s claim was not preempted, because “ERISA does not strip a state’s power to determine how it will govern divorce and support issues in its borders.” And because no state law permitted the trial court to change the original decree’s division of property through a post-decree QDRO, ERISA did not apply, and the trial court lacked authority to enter the order at issue.
1. Pre–Retirement Equity Act Cases

2. Post–Retirement Equity Act Cases

a. Testamentary Powers Under ERISA

b. Beneficiary Designations Under ERISA

**Premera Blue Cross v. Winz, 2018 WL 2010573, 2018 EB Cases 152,494 (W.D. Washington, April 30, 2018).** In an interpleader action decedent Gerald Winz’s mother and sister seek recovery of pension equity plan and 401(k) plan benefits pursuant to deceased’s designation of beneficiary forms and by operation of the plan provisions which automatically revoke a spousal designation as beneficiary upon entry of a divorce decree. Gerald Winz’s ex-spouse sought recovery of additional retirement benefits on the basis of Washington state law governing the intentional nondisclosure of community property. In granting summary judgment for the deceased’s mother and sister, the District Court ruled that ERISA preempted any attempt to assign retirement benefits to anyone other than to the designated beneficiary under the ERISA-covered retirement plans. The District Court cited with approval caselaw which established that “a state law cannot invalidate an ERISA plan beneficiary designation by mandating distribution to another person.”

**Estate of Covello v. Nordstrom, Inc., 2018 U.S. Dist. LEXIS 185832 (W.D. Wash. Oct. 30, 2018).** Plaintiff sued Defendant Nordstrom after Defendant distributed a deceased participant’s Section 401(k) plan account balance to the named beneficiary, rather than the estate. Defendant removed the case to federal court and filed a motion to dismiss on grounds that ERISA preempts Plaintiff’s claim pursuant to Washington’s Trust and Estate Dispute Resolution Act. Plaintiff argued that ERISA’s preemption provisions were inapplicable to Washington’s laws governing wills. In its analysis, the court noted that Plaintiff failed to cite authority for its argument, and provided numerous cases in which courts have found that ERISA preempts state probate laws typically used to determine the proper beneficiary under an ERISA plan. Therefore, the court held that ERISA preempts Plaintiff’s claims to recover benefits under the plan.

**Flinn v. Minn. Life. Ins. Co., 2018 U.S. Dist. LEXIS 193809 (D. Mass. No. 14, 2018).** Plaintiff’s deceased wife had a life insurance plan through her employer. The decedent did not designate a beneficiary under the Plan, but the Plan’s terms indicated that Plaintiff was the “preference beneficiary.” Instead, the Insurer paid the benefits to the decedent’s sister. Plaintiff sued Defendant for failing to pay the benefits to him as the preferred beneficiary. The court held that ERISA does not completely preempted Plaintiff’s claims because Plaintiff alleged that the Insurer violated state law obligations to transfer benefits to him, not to recover benefits. The court also held that ERISA § 514 does not expressly preempt Plaintiff’s claims because he does not seek relief that would affect the administration of employee benefit plans, nor would the relief require all plan administrators to follow a particular standard when distributing benefits. Therefore, the court ultimately held that it lacks federal question jurisdiction.

**Christopoulos v. Trout, No. 15 CV 3466, 2018 U.S. Dist. LEXIS 162716 (N.D. Ill. Sept. 24, 2018).** A man passed away, designating 19 beneficiaries in his group life insurance policy, but not including his two minor children. The children’s mother filed suit as the Plaintiff against Defendant-insurer on her children’s behalf in state court. Defendant removed the case to federal
court and deposited (interpleaded) the insurance funds with the court. Approximately two years prior, divorce proceedings had been initiated in state court, but never finalized. As part of those proceedings, the judge ordered that the two minor children be listed as irrevocable beneficiaries of the man’s group life insurance policy, but that never happened. The divorce proceedings were dismissed upon the man’s death and never finalized. Nonetheless, a motion was filed in state court to clarify whether that court’s prior order regarding the life insurance policy was a “Qualified Domestic Relations Order” (“QDRO”) under ERISA. That state court answered in the affirmative. Based on such, Plaintiff filed a motion for summary judgment pursuant to Fed. R. Civ. P. 56(a) in the federal court proceedings requesting that the court order the life insurance proceeds to be split between her two children as required by the QDRO. Despite finding that the life insurance policy was governed by ERISA, which would ordinarily require that state laws cannot invalidate ERISA beneficiary designations, the court found that the exception to ERISA pre-emption under § 514(a) for QDROs was applicable. The court cited ERISA §§ 206(d)(3)(A) and 514(b)(7), along with the Seventh Circuit’s decision in Blue v. UAL Corp., 160 F.3d 383, 385 (7th Cir. 1998), which held that compliance with QDROs was obligatory for ERISA plan administrators. The court also noted that “Blue teaches that a state appellate court is the place to litigate a QDRO’s validity under state law.” Id. at *21. The court granted Plaintiff’s motion.

J. State Wage Payment and Collection Statutes, Prevailing Wage Laws, and Apprenticeship Statutes

1. Wage Payment and Collection

**Kelley v. Hein**, No. 1:17-cv-06636, 2018 U.S. Dist. LEXIS 149909 (N.D. Ill. Sept. 4, 2018). Plaintiffs—welfare benefit fund and union sued Defendants—officers for alleged payments due under ERISA § 502(a)(3) and the Illinois Wage Payment and Collection Act, 820 ILCS 115/1 et seq. The court found that the latter claim was likely completely pre-empted by ERISA § 502(a) because the second prong of the Davila test had been met, i.e., there was no independent legal duty for Defendants to make the contributions to the fund apart from the ERISA statute. The court also found that Plaintiffs lacked standing to claim wage theft, beyond what was owed to the fund, because Plaintiffs would not “have standing to complain of wage-theft injuries suffered by individual employees.” Id. at *11-12.

2. Prevailing Wage and Apprenticeship Laws

K. State Tax Laws

L. State Escheat and Unclaimed Property Laws

**Scudder v. Colgate Palmolive Co.**, No. 16-7433, 2018 U.S. Dist. LEXIS 149592 (D.N.J. Aug. 31, 2018). Plaintiff—State Treasurer brought suit against Defendant—employer under the New Jersey Uniform Unclaimed Property Act, N.J.S.A. 46:30B-1-109. Defendant removed the case to federal court, and subsequently moved to dismiss it entirely pursuant to Fed. R. Civ. P. 12(b)(6) on the basis that Plaintiff’s claims were completely pre-empted by ERISA § 502(a). Relying on Gobeille, the court granted Defendant’s motion because “Plaintiff’s audit contains an impermissible ‘relation to’ and ‘connection with’ an ERISA-regulated plan by virtue of the audit requesting production of documents and data related to allegedly unclaimed benefit payments.
under a benefit plan undeniably governed by ERISA” *Id.* at *12.