Recent Developments in Avoiding ERISA Preemption: Part I

David G. Wirtes, Jr.
Mobile, Alabama

This article presents plaintiffs' attorneys with practical tips for avoiding the consequences of preemption by ERISA. Many otherwise viable insurance fraud and bad-faith cases have been gutted by this Act, often to the surprise of the attorney, always to the dismay of the client. Part I contains a step-by-step method for analyzing whether preemption may be avoided. Also provided is a brief survey of preemption cases which concern several important topical issues. Part II (to be published in TDJ's September/October issue) will contain discovery techniques you can use to steer your way clear of ERISA's reach.

A several-step method may be used for evaluating whether ERISA preemption can be avoided in the employee welfare benefit plan context. The analysis proceeds step by step as follows:

STEP I: STATUTORY EXCEPTIONS

The first major step in your analysis is to determine whether your purported plan meets one of the statutory exceptions to ERISA coverage. Look to 29 U.S.C. § 1003, the section entitled "Coverage," to determine whether any of these five statutory exceptions are applicable. For example, is your "plan" a "*governmental plan*"? ERISA excepts from coverage governmental plans under 29 U.S.C. § 1003(b)(1):

> (b) The provisions of this title shall not apply to any employee benefit plan if
>
> (1) Such plan is a governmental plan as defined in 29 U.S.C. § 1002(32).

An example of a case analyzing whether a governmental plan exists is *Harbor Ins. Co. v. Blackwelder*, 554 So. 2d 329 (Ala.), *cert. denied*, 110 S. Ct. 2209 (1990). In *Blackwelder*, a committee was formed from members of Alabama's junior, community, and technical colleges to solicit insurance. The court held this committee was not an agency or instrumentality of the state of Alabama nor of any political division of the state and therefore the plan did not meet the governmental exception.

***David G. Wirtes, Jr.** is an attorney with the law firm of Cunningham, Bounds, Yance, Crowder & Brown in Mobile, Alabama.*

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You should compare *Silvera v. Mutual Life Ins. Co.*, 884 F.2d 452 (9th Cir. 1989), where the court found a group health policy purchased by a city was a governmental plan and therefore exempt from ERISA. Similarly, compare *Longoria v. Cearley*, 796 F. Supp. 997 (W.D. Tex. 1992), for its discussion of why community agencies' plans are *not* governmental plans.

> *The first steps of your analysis require you to determine whether you meet any of the statutory exceptions.*

The next statutorily excepted plans are found at 29 U.S.C. § 1003(b)(2) and (3):

> (2) Such plan is a church plan as defined at 29 U.S.C. § 1002(33).
>
> (3) Such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.

For a discussion of church plans, *see American Association of Christian Schools Voluntary Employees Beneficiary Ass'n Welfare Plan Trust by Janney v. U.S.*, 850 F.2d 1510 11th Cir. 1988); *cf. Jones v. Raiser Foundation*, 1992 WL 52522 (D.D.C., February 26, 1992).

Examples of cases construing the workers' compensation/disability insurance exception are *Fears v. Luedke*, 739 F. Supp. 327 (E.D. Tex. 1990), and *Richardson v. Lahood & Association, Inc.*, 571 So. 2d 1082 (Ala. 1990).

The next statutory exception is when:

> (4) Such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresidential aliens.

An example of this statutory exception is found in *Pistick v. Potash Corp. of Saskatchewan Sales Ltd.*, 698 F. Supp. 131 (S.D. Ohio 1988). In *Pistick*, the court found that because the plan was controlled by a wholly owned Canadian corporation, it was maintained outside the United States. Further, the court held that since less than 30 of the 1,668 covered employees were U.S. citizens, the plan was substantially for the benefit of nonresident aliens. Accordingly, the court found the case not subject to ERISA preemption.

The final statutorily excepted type of plan:

> (5) Is an excess benefit plan as defined at 29 U.S.C. § 1002(36) and is unfunded.

So, the first steps of your analysis require you to determine whether you meet any of the statutory exceptions.

STEP II: REGULATORY EXCEPTIONS

The next step is to look at the type of benefits at issue. The law concerning ERISA welfare benefit plans purports to provide redress for claims concerning medical, surgical, sickness, accident, disability, or death benefits. According to the Department of Labor's regulations, there are many types of employment benefits which are specifically excluded from coverage under the Act. Some examples are temporary disability pay, vacation pay, active military duty pay, and overtime; other excluded benefits include dining allowances and on-premises facilities for recreation, strike funds, memorial funds, and employee discounts for purchases of articles sold by the employer. You can find these exceptions and many more in the Department of Labor's regulations at 29 C.F.R. § 2510.3-1.

The most important of these regulatory exceptions to coverage in the insurance context are found at 29 C.F.R. § 2510.3-1(j). Simply stated, if your facts meet these four regulatory criteria, then even if the insurance concerns health, disability, or life insurance benefits, you still fall outside the scope of ERISA preemption. The four criteria are:

> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check-offs, and to remit them to the insurer; and,
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check-offs.

These regulations provide a "safe harbor" of employee welfare benefit plan cases which, despite concerning conventional health and disability insurance plans, still fall outside the scope of ERISA preemption. Numerous cases from the circuit courts and district courts have been reported which recognize the regulations as a safe harbor. A good example is the case of *Brundage-Peterson v. CompCare Health Svs. Ins. Corp.*, 811 F.2d 509 (7th Cir. 1989), where the court noted that, pursuant to these regulations, an employer could engage in such steps as distributing advertising brochures from insurance providers, or answering questions of its employees concerning insurance, or even deducting the insurance premiums from its employees' paychecks and remitting them to the insurers, without thereby creating an ERISA plan. Other important cases construing these regulations include *MDPhysicians & Assoc's, Inc. v. State Bd. of Ins.*, 957 F.2d 178 (5th Cir. 1992); *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991); *Kidder v. H&B Marine, Inc.*, 932 F.2d 347 (5th Cir. 1991); *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991); and *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990). These and other recent cases clearly hold that a failure to meet any one or more of the regulatory criteria does not mean that, *ipso facto*, an ERISA plan *is present*. Instead, the cases suggest that one must look to all the surrounding circumstances to determine whether the employer had an intention to provide benefits to its employees and whether the employer administratively participated to some meaningful degree in establishing and maintaining the purported plan. This is discussed in more detail below.

If your claim is not excepted from coverage by the statutes or regulations, you must next look at the statutory definition of *employee welfare benefit plan* and dissect it. In other words, satisfy yourself that each and every element of the statutory definition is met. If no statutory *employee welfare benefit plan* is implicated by your facts, then ERISA can be avoided.

STEP III: DISSECT ELEMENTS

The definition of *employee welfare benefit plan* is found at 29 U.S.C. § 1002(1):

> [A]ny plan, fund, or program . . . established or maintained by an employer or an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purposes of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, hospital care or benefits, or benefits in the event of sickness, accident, disability or death.

Determine first whether any plan, fund, or program exists. Determine next whether this plan, fund, or program is established or maintained by an employer or an employee organization. Third, determine whether the plan, fund, or program was established or is maintained for the purposes of providing for its participants or their beneficiaries medical, surgical, sickness, accident, disability, or death benefits.

If your claim is not excepted from coverage by the statutes or regulations, you must next look at the statutory definition of "employee welfare benefit plan" and dissect it.

The most important determination under this first three-step analysis is deciding whether a plan exists. The U.S. Supreme Court has made it very clear that ERISA is concerned with regulation of employee welfare benefit *plans* and not just employee welfare benefits. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Supreme Court stated:

> Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation. It is for this reason Congress preempted state laws relating to plans rather than simply to benefits.

Id. at 10–11.

How does the attorney ascertain whether a plan exists? There is no easy answer to this question. Guidance is found in a decision from the Eleventh Circuit known as *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982). In *Donovan*, the court provided general guidelines for helping with this determination. *See Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991) (*Donovan* proscribed general guidelines). The court stated that an employee welfare benefit plan, fund, or program exists if:

> [f]rom the surrounding circumstances a reasonable person can ascertain the intended benefits, a

> class of beneficiaries, the source of financing and procedures for receiving benefits.

Id. at 1373. However, *Donovan* stopped short of saying that these four factors were dispositive of the issue. Numerous cases are reported which reflect judicial struggling with this question. Some cases, like *Hansen v. Continental Investors Ins. Co.*, 940 F.2d 971 (5th Cir. 1991), say the *Donovan* test isn't enough. Just because it is a plan, it isn't necessarily an ERISA plan. *Hansen* requires examination of whether the employer has meaningful administrative involvement with the establishment and ongoing maintenance of the putative plan. *Id.* at 977–78. *Cf. Randol v. Mid-West Life Ins. Co.*, ___ F.2d ___ (11th Cir. 1993) (employer need not have any administrative involvement to constitute an ERISA plan).

Multiple-employer trusts and multiple-employer welfare arrangements have repeatedly been found to not themselves constitute ERISA "plans" because of the absence of employer involvement.

Determination of whether a plan exists is a question of fact. *Glasser v. Amalgamated Workers Union Local 88*, 806 F.2d 1539 (11th Cir. 1986), *reh'g denied*, 813 F.2d 411 (11th Cir. 1987) and *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991). The *Donovan* decision makes clear that failure to comply with the regulations requiring a written plan instrument and regular reporting to the Department of Labor does not necessarily foreclose ERISA coverage. On the other hand, *Donovan* points out that pamphlets or papers including language that the plan is an ERISA plan are indicative of a plan's existence. *Williams v. Wright* holds that a plan can exist even if it consists of only one participant and even if it is funded from the general assets of the employer. Purchase by an employer of a group plan of insurance for employees is substantial evidence of the existence of a plan under *Donovan*. Remember though, under *Ft. Halifax, supra*, there must be something more than a simple decision to extend benefits to employees.

Thus, you should analyze whether the parties intended to create or participate in a plan, whether the employer participates in the administration of any benefits under the purported plan, whether there is any ongoing involvement by the employer with such things as processing claim forms, making premium deductions or payments to insureds, and maintaining trust accounts for plan assets, and whether anyone within the employer's organization has been specifically designated as the person responsible for establishing or maintaining the purported plan.

The next question to resolve is whether the plan was established or maintained by the employer or an employee organization. This should be a relatively straightforward assessment. But, it provides another avenue for avoiding preemption. Multiple-employer trusts and multiple-employer welfare arrangements have repeatedly been found to not themselves constitute ERISA "plans" because of the absence of employer involvement. *See Taggart Corp. v. Life & Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030, 101 S. Ct. 1739, 68 L. Ed. 2d 225 (1981). The focus must always be upon the employer's or employee organization's actual involvement in such things as purchasing group policies, subscribing to memberships for coverage, contributing in whole or part to premium payments, and undertaking administrative and fiduciary responsibilities to the plan's participants.

STEP IV: CHOICE OF REMEDY

The next step in the analysis is to determine whether the remedy you seek under your circumstances is otherwise provided by federal law. ERISA specifically exempts from preemption "any law of the United States . . . or any rule or regulation issued under any such law." Specifically, 29 U.S.C. § 1144(d) provides:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.

So, theoretically, if your claim involves, say, age discrimination, which might be actionable under the Age Discrimination in Employment Act, you should not be concerned with ERISA preemption of that type of claim.

STEP V: THE "RELATES TO" TEST

The next step in your determination about whether ERISA preemption can be avoided depends upon an analysis of the Act's preemption clause. 29 U.S.C. § 1144(a) provides:

> The provisions of this subchapter shall . . . supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

The Act defines "state" as any state or local government entity:

> [w]hich purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this sub-chapter.

The Act defines "state law" as:

> All laws, decisions, rules, regulations, or other State action having the effect of law.

Thus, the sole statutory test is whether your claim under a state law *relates to* an employee welfare benefit plan. The determination of whether your claim relates to an employee benefit plan is often very difficult. Both the U.S. Supreme Court and the Eleventh Circuit Court of Appeals have taken very expansive views of the "relates to" language. For example, in *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549 (1987), the U.S. Supreme Court held Mississippi state breach of contract, breach of fiduciary duty, and fraud claims preempted when they involved an insurer's wrongful administration of an employee benefit plan which resulted in termination of an employee's disability benefits. The Supreme Court spoke of the expansive sweep of the preemption clause. In *Dedeaux*, the Supreme Court reiterated its prior holding that "the phrase 'relate to' is to be given its broad common-sense meaning, such that a state law 'relates to' a benefit plan 'in the normal sense of the phrase, if it has connection with or reference to such a plan.'" *Dedeaux*, 107 S. Ct. at 1553 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2389 (1985)); *Shaw v. Delta Airlines*, 103 S. Ct. 2890, 2900 (1983).

Despite the broad and expansive language, the "relates to" test can generally be broken down into three simple assessments:

- first, if your situation concerns a direct claim for pension plan benefits or employee welfare plan benefits which were provided as part of an employee benefit plan, your claim will obviously be found related to the plan and deemed preempted;
- second, where the existence of your state law claim, whatever type it might be, depends upon the existence of an employee welfare benefit plan to be actionable, it will be found to be preempted by the Act; and,
- third, where your state claims would constitute a cause of action of the same type as those enumerated at 29 U.S.C. §§ 1132 and 1140, then your claim will be deemed related to an employee welfare benefit plan as a matter of law and thus preempted.

Ultimately, the tests appear to be whether the claim directly or indirectly interferes with an employee welfare benefit plan's administration, or whether the claim seeks benefits from such plan.

You should note, though, that the U.S. Supreme Court has warned against any literal interpretation of the preemption clause. In *Shaw v. Delta Airlines, Inc.*, 103 S. Ct. 2890 at 2901, n.21 (1983), the Court stated:

> Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law "relates to" the plan.

Ultimately, the tests appear to be whether the claim directly or indirectly interferes with an employee welfare benefit plan's administration, or whether the claim seeks benefits from such plan. For example, in *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S. Ct. 2211 (1987), the Supreme Court rejected an ERISA preemption claim where a Maine statute required employers to provide a one-time severance payment to employees in the event of a plant closing. The Court characterized this state law as affecting only employee benefits and not employee benefit plans. The court denoted that its policy concern was the exclusive federal regulation of plan administration. "Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patch-work scheme of regulations." As this statute did not affect the administration of an employee welfare benefit plan, the court was quick to find no preemption by the Act. *Mackey v. Lanier Collections Agency & Service*, 108 S. Ct. 2182 (1988), is essentially to the same effect as *Ft. Halifax*.

The Eleventh Circuit has likewise noted that some state law claims are too tenuously related to employee welfare benefit plans to justify preemption. In *Clark v. Coats & Clark, Inc.*, 865 F.2d 1237

(11th Cir. 1989), an employee's claim for intentional infliction of emotional distress was not preempted even where the underlying conduct could have formed a basis for a wrongful discharge claim under ERISA. 29 U.S.C. § 1140 (regarding interference with protected rights).

Some laws which are traditionally thought to have regulated insurance are not "saved" from preemption because they do not meet the test as defined in Pilot Life.

Furthermore, in *Howard v. Parisian, Inc.*, 807 F.2d 1560 (11th Cir. 1987), the plaintiff raised state court claims for bad faith and intentional infliction of emotional distress when he was denied insurance coverage under an employee welfare benefit plan. The plaintiff had actually been terminated from his employment, but his complaint raised only the issue of his entitlement to the health care benefits. The Eleventh Circuit held that the claims were related to the administration of the plan and therefore preempted by ERISA. But the decision provides a very clear caveat on the "relates to" language:

> Admittedly some state laws affect employee benefit plans too tenuously to be characterized fairly as relating to employee benefit plans. . . . Nor are state laws preempted merely because they have an economic impact on employee benefit plans. . . . However, if a state law claim arises out of the administration of benefits under a plan, the claim is preempted.

807 F.2d at 1564.

STEP VI: SAVINGS CLAUSE

The final steps in your analysis require that you look to the *savings clause* and the *deemer clause* of the Act to determine whether your state law claim might be saved from preemption. The savings clause, found at 29 U.S.C. § 1144(b)(2)(A), excludes from preemption:

> [a]ny law of any State which regulates insurance, banking or securities.

In other words, the savings clause specifically allows state laws that regulate insurance to continue to regulate insurance undisturbed. The test for determining whether a state law falls within the savings clause was set forth in *Pilot Life v. Dedeaux*, 481 U.S. 41, 48–49 (1987), as follows:

> First, we took what guidance was available from a common-sense view of the language of the savings clause itself. Second, we made use of the case law interpreting the phrase, business of insurance, under the McCarron-Ferguson Act, . . . in interpreting the savings clause. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarron-Ferguson Act:
>
> First, whether the practice has the effect of transforming or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Thus, for a law to be saved under the savings clause and to avoid preemption, three major factors must be considered. First, the law must fit within the common-sense meaning of the term "regulates insurance." Second, the law must fit within all the three criteria used to determine if a practice is considered the "business of inurance" under the McCarron-Ferguson Act; namely, (a) whether the practice has the effect of transferring or spreading a policyholder's risk, (b) whether the practice is an integral part of the policy relationship between the insurer and the insured, and (c) whether the practice is limited to entities within the insurance industry. Last, the test of congressional intent that ERISA's civil enforcement scheme be exclusive must be taken into consideration.

It is not always clear what laws "regulate insurance." Some laws which are traditionally thought to have regulated insurance are not "saved" from preemption because they do not meet the test as defined in *Pilot Life*. For example, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Supreme Court held that a state law which mandated specific mental health benefits be extended to Massachusetts residents who were covered by general health insurance policies was saved from preemption under the savings clause. However, in *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988), a Florida statute allowing a civil action for wrongful death benefits was held preempted and not saved under the savings clause. In *Belasco v. W.R.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), Alabama's bad faith law was likewise deemed preempted and not saved under the savings clause.

STEP VII: DEEMER CLAUSE

The final test is whether the deemer clause, 29 U.S.C. § 1144(b)(2)(B), has any effect on a state law claim which might have been saved by the savings clause. The deemer clause limits the savings clause by providing that no employee benefit plan or trust:

> [s]hall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

When dealing with group health, disability, life, or other ERISA-covered insurance plans funded by an insurance company through a policy or otherwise, the deemer clause is of no significance. However, when dealing with employers who have self-funded plans, the deemer clause can pose problems.

Under the savings clause, a law which regulates insurance is saved from preemption. Thus, these laws can remain intact and continue regulating insurance companies. But the deemer clause specifically excepts from state regulations self-funded ERISA employee welfare benefit plans, as such plans shall not be deemed insurance companies and therefore cannot be subject to insurance regulations. The recent decision from the U.S. Supreme Court in *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990), provides guidance in analyzing this paradox.

The foregoing step-by-step method of analysis should not be considered as cast in stone. Tinker with the method to suit your needs. Use the steps to help analyze ahead of time how best to seek an appropriate remedy for your client.

RECENT DEVELOPMENTS

By going through the various steps of the tests for determining whether ERISA preemption will affect any given set of facts, we've covered several of the recent U.S. Supreme Court and Eleventh Circuit Court of Appeals decisions which govern these determinations. We next turn to specific topics where preemption determinations have had significant consequences.

Fraud in the Inducement

In reviewing the step-by-step process for evaluating whether ERISA preemption will occur, we've talked about the "relates to" language of the preemption clause. Again, the test is whether your state law claim relates to the administration of an employee welfare benefit plan.

Many are erroneously under the impression that *Pilot Life v. Dedeaux* conclusively held that any claim for fraud will be preempted as it relates to a plan. This is just not true. *Pilot Life* merely held a claim for fraud in connection with *the administration of benefits* was preempted. *Pilot Life* did not foreclose a claim for fraud in the inducement to become a plan member or beneficiary under a plan.

Many are erroneously under the impression that Pilot Life v. Dedeaux *conclusively held that any claim for fraud will be preempted as it relates to a plan. This is just not true.*

This point was very clearly made by Justice Shores' majority opinion in *HealthAmerica v. Menton*, 551 So. 2d 235 (Ala.), *cert. denied*, 110 S. Ct. 1166 (1990), *reh'g denied*, 110 S. Ct. 1840 (1990). In *HealthAmerica*, Justice Shores distinguished *Pilot Life* with the following:

> Although the complaint in *Pilot Life* contained a count for "fraud in the inducement", the opinion makes it unmistakably clear that the only claims he pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan.
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> ....
>
> In this case, Menton does not claim improper processing of a claim, nor any benefits under the terms of the plan. To the contrary, he claims he was fraudulently induced to drop his existing coverage by misrepresentations made by the defendants to him prior to his becoming a member of the HealthAmerica plan.

The *HealthAmerica* decision was followed by *Harbor Ins. Co. v. Blackwelder*, 554 So. 2d 329 (Ala.), *cert. denied sub. nom., Blackwelder v. Life & Health Servs., Inc.*, 110 S. Ct. 2209 (1990). In *Blackwelder*, eligible employees could make a choice of one of two plans. One of the plans was provided by Central Bank. The other plan, called the L&H plan, was underfunded. The employees who chose the

underfunded L&H plan claimed that because of misrepresentations that the plan was "fully funded," they were fraudulently induced into the plan.

The Alabama Supreme Court noted the plaintiffs' damages were caused by misrepresentations and promises of benefits they were induced to accept. The court distinguished these damages from damages which might have arisen from a claim for fraudulent administration of the plan or nonpayment of claims by the plan. Since the alleged fraudulent activity was not sufficiently related to administration of the plan, the state court fraud-in-the-inducement claim was not deemed preempted.

There has to be some value to the fact that certiorari was denied in both *HealthAmerica* and *Blackwelder*. Nonetheless, the Eleventh Circuit Court of Appeals in *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), found that a claim for fraudulent inducement under Alabama state law was preempted. The Farlows filed suit in an Alabama state court against the plan and its administrator, raising three state law causes of action, including fraudulent misrepresentation, negligence, and violation of Alabama's twisting statute. The defendants removed to federal court, alleging ERISA preemption, and they simultaneously moved to strike the state law claims and to strike the Farlows' demand for a jury trial. The Farlows moved to remand the action to state court, arguing that ERISA did not preempt their state law claims. Judge Lynne of the Northern District granted the defendants' motion to strike the state law claims and then certified his order as final under § 54(b).

The Eleventh Circuit affirmed the district court's grant of the motion to strike the state law claims. The Eleventh Circuit reasoned as follows:

> The Farlows' complaint alleges that (the plan's agent) negligently failed to disclose that the plan did not provide maternity and pregnancy coverage and fraudulently misrepresented that the plan's coverage was coextensive with the plaintiffs' former plan coverage.
>
> The conduct alleged in these claims is not only contemporaneous with the plan's refusal to pay benefits, but the alleged conduct is intertwined with the refusal to pay benefits. Thus, finding the Farlows' state law claims not wholly remote in content from the plan, we reject the Farlows' contention that simply because their claims involve misconduct in the sale and implementation of the plan, their claims do not relate to the plan.

Importantly in *Farlow*, the status of the plan as an ERISA plan was not seriously disputed. Plus, plaintiff sued the plan and its administrator. Distinction should be made when plaintiff sues only a sales agent or an insurer which are not participants of the putative plan.

In *Mullenix v. Aetna Life & Cas. Ins. Co.*, 912 F.2d 1406, at 1412–13 n.7 (11th Cir. 1990), the court specifically rejected the reasoning from the Alabama Supreme Court's decision in *HealthAmerica*. The Eleventh Circuit wrote:

> Appellant has also directed our attention to the recent decision of the Alabama Supreme Court in *HealthAmerica*. Plaintiff there dropped his health insurance and enrolled in a new plan which failed to cover his dependent's medical expenses despite representations to that affect. Plaintiff then filed suit against the new insurer and its agent pleading a common law action for fraud and misrepresentation, but no claim was filed under ERISA. The state court held that a claim for fraud in the inducement did not "relate to" an employee benefit plan and was therefore not preempted by ERISA. The court further held that the Alabama "twisting statute" is a law specifically related to the insurance industry and that it was therefore "saved" from preemption. In so ruling, the court acknowledged that this court had previously ruled on a question in *Farlow*, but the Alabama Supreme Court was "unconvinced that Congress intended this result".
>
> Eleventh Circuit law controls in this instance and we do not find the *HealthAmerica* case persuasive with respect to the state claims in this case.

In an unpublished opinion, *Byrne v. Crance*, No. 90-7574 (11th Cir., May 13, 1991), the court again adopted the *Farlow* rationale:

> In this appeal we are asked to determine whether the district court correctly found that *Farlow* controlled and required the dismissal of plaintiff Byrne's state law claim for fraud in the inducement in connection with alleged misrepresentations which caused him to switch insurance policies under his employer's health insurance plan.

The court concluded that *Farlow* controlled and affirmed the dismissal of the state law claims. In another unpublished opinion, *Avery v. Crance*, No. 91-7313 (11th Cir., March 31, 1992), the court again embraced *Farlow* in affirming a dismissal of a fraud-in-the-inducement claim. Still other Eleventh Circuit opinions appear to have rejected plaintiffs'

fraud-in-the-inducement claims. *Cf. Sanson v. General Motors Corp.*, 966 F.2d 618 (11th Cir. 1992) (fraud in the inducement to forego pension benefits); *First National Life Ins. Co. v. Sunshine-Junior Food Stores, Inc.*, 960 F.2d 1546 (11th Cir. 1992) (fraud in provision of insurance benefits and claims handling).

Yet at least three district court judges in Alabama have found that fraud-in-the-inducement cases are not related to plans sufficiently to warrant preemption.

In *Martin v. Pate*, 749 F. Supp. 242 (S.D. Ala. 1990) (Butler, J.), *aff'd on other grounds*, 934 F.2d 1265 (11th Cir. 1991), the plaintiff, Mr. Martin, was an officer of a trucking company. Mr. Martin called Woodruff, an insurance agent, to secure low-cost insurance coverage. Woodruff arranged a meeting between Martin and another insurance agent, Pate. Pate was an independent agent working for Continental Investors Life. Continental Investors Life underwrote the American Life Styles Protection & Security Trust's insurance. The two insurance agents, Woodruff and Pate, traveled together to meet Martin. During their travel, Woodruff related to Pate that their potential insured had recently undergone a checkup regarding his heart for which there had been a $600 payment to a physician. In actuality, Martin had undergone a heart catheterization that disclosed triple-vessel coronary disease. Nonetheless, Pate wrote coverage through the trust and Continental Investors Life Company. When Martin later underwent bypass surgery, the insurer refused to pay, claiming that Martin had made misrepresentations regarding his heart condition in the original application for insurance.

Judge Butler found plaintiff's claim for fraud in the inducement not preempted. He distinguished the *Pilot Life* decision with a single sentence:

> This court does not view Martin's fraud claim as based on improper processing of his claim for benefits and thus *Pilot Life* is not controlling.

Id. at 245.

Judge Butler reasoned Martin was not making a claim as a beneficiary under a plan. Rather, Martin was claiming he was fraudulently induced to become a beneficiary under the plan. Judge Butler concluded that "the better reasoned and more persuasive" (*id.* at 246) authorities held that claims for fraud in the inducement were not preempted. Judge Butler specifically rejected the *Farlow* opinion's rationale by relying on the *Clark v. Coats & Clark* decision from the Eleventh Circuit. The court stated:

> A close reading of *Clark* reveals that the court actually held that a state law claim is not preempted where it alleges "conduct which was proximate (or even concurrent) in time to the alleged ERISA violation, but wholly remote in content." Applying *Clark* to the case at bar, this court views the conduct giving rise to Martin's fraud claim, i.e., the alleged misrepresentations by defendants regarding coverage under the policy and the alleged ERISA violation, i.e., failing to pay benefits due to be paid, as wholly remote in content and thus the fraud claim is not preempted.

Id. at 247.

Judge Butler has remanded another fraud-in-the-inducement case to state court following the *Martin* rationale in *Austin v. McDonald*, U.S.D.C. Case No. 91-1036-B-M, order dated March 13, 1992. Judge Richard Vollmer has rendered two opinions which trace *Martin* in remanding fraud-in-the-inducement cases. *Workman v. Wright*, U.S.D.C. Case No. 92-0066-RV-M, order dated October 6, 1992, and *Walker v. MILICO*, U.S.D.C. Case No. 92-0217-RV-S, order dated November 3, 1992 (*Walker* remains pending in the district court upon the insurer's request for reconsideration.) Judge Acker, in the Northern District, recognizes the viability of fraud-in-the-inducement claims. *See Bryant v. Blue Cross & Blue Shield of Alabama*, 751 F. Supp. 968 (N.D. Ala. 1990); *Wright v. Sterling Investors Life Ins. Co.*, 747 F. Supp. 653 (N. D. Ala. 1990); and *Davis v. American General Group Ins. Co.*, 732 F. Supp. 1132 (N. D. Ala. 1990).

Still another Alabama district court judge *rejects* the theory that fraud-in-the-inducement claims fall outside ERISA. *See Beal v. Jefferson Pilot Life Ins. Co.*, 798 F. Supp. 673 (S.D. Ala. 1992) (Howard, J.).

Alabama's Twisting Statute

The twisting statute is found at Alabama Code § 27-126. The statute reads:

> No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading, incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy.

There has been much recent litigation on the issue of whether the twisting statute affords a private cause of action. The Alabama Supreme Court in *HealthAmerica, supra,* suggested *in dicta* that there is a private right of action under the statute. However, the *Farlow* decision, while talking about the twisting statute, never really decided whether a private right of action existed. The Eleventh Circuit's more recent decision in *Mullenix* recites in a footnote that the *Farlow* decision had the effect of finding that no private right of action existed.

Cases brought under the twisting statute, just like those alleging fraud in the inducement, will apparently live or die depending upon which judge is drawn.

In *Butler v. Fringe Benefits Plans, Inc.,* 701 F. Supp. 807 (N.D. Ala. 1990), Judge Acker indicates a cause of action under the twisting statute is not sufficiently related to administration of a plan to warrant preemption. Judge Acker also seems to indicate that even if there were a sufficient nexus between the conduct and administration of the plan, the cause of action would be saved under the savings clause.

However, Judge Vollmer in the Southern District has recently released two opinions, *Garris v. Pioneer Life Ins. Co. of Illinois,* 768 F. Supp. 335 (S.D. Ala. 1991), and *Bryant v. Commonwealth Life Ins. Co.,* 767 F. Supp. 1120 (S.D. Ala. 1991), which expressly conclude that the twisting statute does not afford a private right of action. These decisions discuss *Farlow, Mullenix,* and *HealthAmerica,* but they do not refer to any degree to Judge Acker's decision in *Butler v. Fringe Benefits Plans.* On the issues of whether the twisting statute affords a private right of action, whether twisting conduct is sufficiently related to administration of a welfare benefit plan, and whether the twisting statute would be saved under the savings clause as a law that regulates insurance, all will apparently have to be resolved by the U.S. Supreme Court.

Cases brought under the twisting statute, just like those alleging fraud in the inducement, will apparently live or die depending upon which judge is drawn. Bear in mind that an order of remand under 28 U.S.C. § 1447(d) is nonreviewable by the district court upon reconsideration or by the appellate court by direct appeal, mandamus or otherwise. So long as the district judge remands the case on the basis of a lack of jurisdiction, you will find yourself in the friendlier environment of the state court system. See *Harris v. Blue Cross/Blue Shield of Alabama, Inc.,* 951 F.2d 325 (11th Cir. 1992) (if district court remands because court lacks subject matter jurisdiction, remand order is not subject to review by appeal, mandamus or otherwise).

Interference with Protected Rights

There is a recent decision from the Alabama Supreme Court which warrants attention on the issue of *interference with protected rights.* The decision is important because the Alabama Supreme Court expressly and unequivocally concludes that even when a case is deemed preempted by ERISA and the relief to be afforded is the statutory relief provided by the Act, extracontractual and punitive damages are available in the appropriate circumstances and the aggrieved plaintiff has a right to a trial by jury on his or her claims.

The decision of *Haywood v. Russell Corp.,* 584 So. 2d 1291 (Ala. 1991) (again authored by Justice Shores), eliminates any lingering doubt which might have been created through the U.S. Supreme Court's decision in *Ingersoll-Rand Co. v. McLendon,* 111 S. Ct. 478 (1990). *Haywood* concerns an employee's claim that she had been injured on the job. She filed a workers' compensation claim which was rejected by her employer. She then filed a claim for sickness and accident benefits through her employer-provided disability plan. The insurance processing clerk wrote a note to Ms. Haywood that she would have to change her sickness and accident benefits claim form to reflect that her injury did not arise from an on-the-job accident, or else she couldn't get her disability benefits. Ms. Haywood refused to put this false information on the form. Ms. Haywood eventually received her disability payments.

The Alabama Supreme Court had no difficulty in finding that the claim was preempted by ERISA. The court looked to 29 U.S.C. § 1140, a statute which proscribes interference with protected rights under employee welfare benefit plans. The statute reads as follows:

> It shall be unlawful for any person to discharge, find, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employment benefit plan, or for the purpose of interfering with the attainment of any right to which such participant may become entitled under this plan. It shall be

> unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter. The provisions of 29 U.S.C. § 1132 shall be applicable in the enforcement of this section.

So, the Alabama Supreme Court found that a remedy was afforded to Ms. Haywood under the Act and that this scenario was exactly the same as that which had been decided in the *Ingersoll-Rand* decision. The court then remanded the case so that Ms. Haywood could attempt to amend her pleadings and state a claim for relief under the Act.

The import of the decision is that the Alabama Supreme Court took the *Ingersoll-Rand* decision one step further and discussed the types of damages recoverable. Justice Shores wrote:

> The Supreme Court, in *Ingersoll-Rand*, has now specifically held that the courts are authorized to award damages, both extracontractual, and even punitive, where the facts support them, even though they are not specifically provided for in ERISA. In doing so, it simply correctly carries out the intent of Congress in passing ERISA. State courts, with concurrent jurisdiction of ERISA actions, likewise possess such authority.
>
> These statutory causes of action bear a striking resemblance to the common law actions they replaced. In specifically authorizing the courts to develop remedies not specifically provided for in ERISA, the Supreme Court now recognizes the possibility of recovery of tort-like damages in ERISA cases. We agree with the observation of Judge Acker in *Blue Cross & Blue Shield of Alabama v. Lewis*, 753 F.Supp. 345 (N.D. Ala. 1990), that this leads inexorably to the right of trial by jury in these ERISA cases.

The employer's application for rehearing in *Haywood* was unanimously rejected. The essence of this application was that the state court did not have concurrent jurisdiction to hear or decide a 29 U.S.C. § 1140 type of claim. This case remains pending in the Circuit Court for Tallapoosa County before Judge Dale Segrest. This case will likely end up in the U.S. Supreme Court before it's finished.

Subrogation

Everyone is aware of the decision from the Alabama Supreme Court in *Powell v. Blue Cross & Blue Shield of Alabama*, 581 So. 2d 772 (Ala. 1990), where the court recognized the full recovery rule in subrogation cases. There are a couple of recent decisions that impact on the applicability of *Powell* to subrogation claims where ERISA plans are involved.

In *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990), the U.S. Supreme Court held that ERISA preempts state laws of subrogation when the ERISA plan is self-funded. Case law like the *Powell* decision obviously meets the statutory definition of state law. So, in the context of subrogation claims made by self-insured ERISA plans, *Powell* appears to have no application. On the other hand, insured plans would still be subject to state regulation, and therefore the *Powell* rule would still apply.

A decision from the Eighth Circuit, *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), rejected a request for development of a federal common law approach and instead indicates that the letter of the contract will be enforced. The Fourth Circuit in *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990), has created a common law unjust enrichment rule. This rule essentially holds that an injured plaintiff will not be allowed to avoid the consequences of a subrogation claim, because to allow this double recovery would be to unjustly enrich the injured plaintiff.

In the Northern District of Alabama, Judge Acker decided in *Blue Cross & Blue Shield of Alabama v. Lewis*, 754 F. Supp. 849 (N.D. Ala. 1991), that *Powell* applies to an insured health care plan's subrogation claim under ERISA.

In an unpublished decision from the Southern District, Judge Howard decided that *FMC Corp. v. Holliday* precluded application of *Powell* when a self-funded or self-insured plan made a claim for subrogation. Specifically, in *Blue Cross & Blue Shield of Alabama v. Jackson Academy*, U.S.D.C. Case No. 90-0807-H-M, Judge Howard wrote the following:

> Alabama law provides that the insurer is not entitled to subrogation unless or until the insured has been made whole for his loss (citing, *Powell*). The defendant contends that, under *Powell*, Blue Cross is not entitled to subrogation until it has shown that the injured plaintiff has been made whole.
>
> However, the law established in *Powell* is preempted because the employee benefit plan was self-funded or self-insured. In *FMC Corp. v. Holliday*, the Supreme Court held that state anti-subrogation laws were preempted by ERISA when the employee benefit plan is self-funded:

> "Self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relates to' the plans. State laws directed toward the plans are preempted. . . . On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation."
>
> Because *Powell* curtails Blue Cross's claimed right of subrogation, it has a connection with the employee benefit plan. Any state law prohibiting employers from structuring their employee benefit plans in a manner that requires reimbursement in the event of recovery from a third party creates a conflict with [a contractual right to subrogation with the employee benefit plan]. Thus, the common law in *Powell* clearly "relates to" the employee benefit plan. *Baxter v. Lynn*, 886 F.2d 182, 185 (8th Cir. 1989). With *Powell* preempted, interpretation of the purported subrogation clause becomes a matter of federal law.

Because of the confusion in this area, the lesson to be learned is that you must determine whether your client's medical bills are paid by a self-insured or insured welfare benefit plan before you can decide if *Powell* has any application to your circumstances.

Attorney as Fiduciary to an ERISA Plan

Every employee benefit plan subject to ERISA is required to provide for "one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." *McNeese v. Health Plan Mktg.*, 647 F. Supp. 981, 984 (N.D. Ala. 1986), quoting 29 U.S.C. § 1102(a)(1). The Act defines fiduciaries by the extent persons exercise discretionary authority or discretionary control or render investment advice for consideration. 29 U.S.C. § 1002(21)(A). The Act also statutorily imposes numerous duties upon persons who qualify as fiduciaries to the plan. *See* 29 U.S.C. § 1104(a)(1). These duties include loyalty, acting with due care, skill, prudence and diligence, diversification of investments, and conforming to the written requirements of the plan. *Id.* Moreover, fiduciaries are statutorily prohibited from engaging in specified transactions. 29 U.S.C. § 1106. These include engaging in transactions involving the plan and certain parties in interest, dealing with assets of the plan toward his or her own interests, receiving consideration from persons with interests in the plan, and others. *Id.*

In *Chapman v. Klemick*, 750 F. Supp. 520 (S.D. Fla. 1990), a personal injury plaintiff's attorney was found by the court to be a fiduciary to his client's ERISA plan, and he was therefore subject to acting as a fiduciary when resolving the ERISA plan's subrogation claim against his client.

The lesson to be learned is that you must determine whether your client's medical bills are paid by a self-insured or insured welfare benefit plan before you can decide if Powell *has any application to your circumstances.*

The attorney recovered $25,000 from a third-party tortfeasor. The attorney's client had received $28,000 in medical expense reimbursements from his ERISA plan. The attorney had actual knowledge of the ERISA plan's subrogation claim. Nevertheless, the attorney apparently thought of himself as the judge and jury in deciding whether his client had been made whole, as he disbursed the $25,000 he recovered from the tortfeasor to his client and to himself as attorney's fees.

The district court agreed with the ERISA plan's claim that the attorney was in a fiduciary relationship with the plan as regards the subrogation claim. So the district court ordered the attorney to pay the subrogation claim in full out of his pocket. Then, to add a little icing on the cake, the district court ordered the attorney to pay the ERISA plan's attorney's fees in the amount of $28,000 as punishment for his breach of fiduciary duties.

This decision, while notable, is not without precedent. In *Donovan v. Daugherty*, 550 F. Supp. 390 (S.D. Ala. 1982), an attorney, not a fiduciary to a plan, was nonetheless found liable for sanctioning violations of the prohibited transactions rules by the plan's actual fiduciaries.

For a thorough discussion of "local" case law concerning fiduciary duties, *see* Note, *Fiduciary Duties Under ERISA: Interpretations Within the Eleventh Circuit*, 19 Cumberland L.R. 131 (1988).

Development of Federal Common Law

In *Kanne v. Connecticut General Life Ins. Co.*, the late Judge Robert Vance called for the creation of a federal common law to fill in the gaps between the remedies afforded by the Act and the myriad situations which could not have been foreseen or provided for by congressional drafters. When *Ingersoll-Rand v. McLendon*, 111 S. Ct. 478 (1990),

was released, anticipation was heightened that the Supreme Court had expressly sanctioned such an approach. Recently, though, the Eleventh Circuit slammed this door shut with a resounding thud.

In *Sanson v. General Motors Corp.*, 966 F.2d 618 (11th Cir. 1992), the plaintiff, Sanson, was allegedly told that employees at GM's Lakewood assembly plant were not eligible for enhanced benefits under a special retirement plan. Sanson retired accepting ordinary benefits. Shortly after Sanson's retirement, GM offered the enhanced retirement benefits to eligible Lakewood employees. Sanson requested that his benefits be modified accordingly but his request was denied.

Sanson sued in state court, alleging he took early retirement in reliance on GM's fraudulent representations. The Eleventh Circuit held that Sanson's claims were preempted by ERISA and affirmed the district court's grant of summary judgment in favor of GM. Most important, despite acknowledging that Sanson was left with no recourse for being allegedly defrauded out of pension benefits, the court stated:

> In the face of clear precedent to the contrary from the Supreme Court, the Eleventh Circuit, and other circuits, this court cannot create a federal common law of remedies for the benefit of the plaintiff on the sole authority of [a congressional report]. *McRae*, 920 F.2d at 823; see generally *Connor v. Aerovox, Inc.*, 730 F.2d 835, 841 (1st Cir. 1984), cert. denied, 470 U.S. 1050, 105 S.Ct. 1747, 84 L.Ed.2d 812 (1985) ("once Congress has addressed a national concern, court's fundamental commitment to separation of powers precludes it from scrutinizing the sufficiency of [that] solution").

Id. at 622–23. Judge Butler wrote a searching dissent wherein he argued that:

> [t]he combination of the majority's holding—that Sanson's state cause of action is preempted by ERISA even while ERISA denies him any alternative remedy—is dissappointingly pernicious to the very goals and desires that motivated Congress to enact pension laws in the first place.

Id. at 625.

So, it seems that at least in the Eleventh Circuit, the development of a federal common law faces as many obstacles as do fraud-in-the-inducement cases. Yet, in other circuits, a federal common law is developing case by case. *Cf. Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990), *cert. denied*, 111 S. Ct. 512 (1990) (unjust enrichment).

Promissory Estoppel

In *Psychiatric Institute of Washington, D.C. v. Connecticut General Life Ins.*, 780 F. Supp. 24 (D.D.C. 1992), the supposed insured assigned his benefits rights to plaintiff Psychiatric Institute. The plan's administrator orally assured the Institute that coverage was available. In fact, the insured's coverage had actually terminated prior to treatment. The district court found Psychiatric Institute's claim preempted by ERISA. Most important, the court found that the federal common law of ERISA supported a promissory estoppel theory based on the oral representations of the administrator.

It seems that at least in the Eleventh Circuit, the development of a federal common law faces as many obstacles as do fraud-in-the-inducement cases. Yet, in other circuits, a federal common law is developing case by case.

In *Swint v. Protective Life Ins. Co.*, 779 F. Supp. 532 (S.D. Ala. 1991), a participant in an employee welfare benefit plan brought an ERISA and COBRA action after the plan stopped paying benefits to the participant's stepson. The participant asserted that Protective Life should be estopped and/or deemed to have waived its right to deny coverage due to its failure to make an adequate and timely inquiry into the stepson's eligibility for dependent coverage and due to its own conduct and ultimately terminating the coverage. *Id.* at 536. Judge Richard Vollmer conducted a bench trial and issued an order finding liability against the plan. Part of Judge Vollmer's rationale was that Protective Life was estopped from denying liability under the plan or the COBRA amendments to the plan:

> The doctrine of equitable estoppel generally is applicable in actions brought pursuant to ERISA, including the COBRA amendments thereto. *See, National Companies Health Benefit Plan v. St. Joseph's Hospital*, 929 F.2d 1558 (11th Cir. 1991). To prevail on a claim for equitable estoppel under federal common law, the plaintiff must prove that:
>
> "(1) The party to be estopped misrepresented material facts;

"(2) The party to be estopped was aware of the true facts;

"(3) The party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it;

"(4) The party asserting the estoppel did not know, nor should it have known, the true facts; and,

"(5) The party asserting the estoppel reasonably and detrimentally relied on the misrepresentation." *Id.* at 1572.

Plaintiffs have satisfied that burden in this cause.

Id. at 559.

Certainly Judge Vollmer's opinion in *Swint* appears at odds with the Eleventh Circuit's rejection of any federal common law for fraud in *Sanson, supra*. Nevertheless, Judge Vollmer's opinion in *Swint* is important reading—the case comprehensively discusses the topic of ERISA preemption and includes numerous citations to other cases concerning estoppel and other topical issues.