Recent Developments in Avoiding ERISA Preemption: Part II—Discovery

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This is the second article of a two-part series presenting plaintiffs' attorneys with practical tips for avoiding the consequences of preemption by ERISA. Part II contains discovery techniques you can use to steer your way clear of ERISA's reach.

This article, the second of two parts, provides examples of discovery devices that should help you work your way through the ERISA preemption thicket.

REQUESTS FOR ADMISSIONS

Insurers must act quickly under the removal statutes.[1] Aggressive defense attorneys may be apt to err on the side of caution by removing the case first and worrying about sustaining their burden of proof on ERISA issues later.

No technique works better at forcing the controversy to a timely and resolute end than the use of thorough and sifting requests for admissions. File these immediately upon receipt of the removal papers. You will quickly narrow and refine the question of preemption to a few factual issues which may then be addressed through depositions. Most important, through aggressive and prompt action, you may force the defendants into committing to positions through their responses, which, upon further reflection, they may regret later.

First consider whether you can use requests for admissions to establish that your case falls within the safe harbor regulations promulgated by the Department of Labor.[2] Consider the following examples:

Please admit:

1. That plaintiff's (employer) (employee organization) made no contributions to the putative "plan" within the meaning of 29 C.F.R. § 2510.3-1(j).
2. That participation in the putative "plan" was completely voluntary for (employees) (members), including (plaintiff) within the meaning of 29 C.F.R. § 2510.3-1(j);

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3. That the plaintiff's (employer) (employee organization) did not endorse any plan within the meaning of 29 C.F.R. § 2510.3-1(j);
4. That the plaintiff's (employer) (employee organization) did not receive any consideration or payments for any administration of any plan within the meaning of 29 C.F.R. § 2510.3-1(j).

Remember, if your facts meet each of the four safe harbor criteria, the claim is excluded from the definitions of "employee welfare benefit plans" and "benefit plans" as a matter of law. Furthermore, recent case law suggests that meeting just some of the safe harbor criteria is enough to then require judicial scrutiny of more than merely the *Donovan v. Dillingham* factors.[3] For example, in *Hansen v. Continental Ins. Co.*,[4] the court held that just because a "plan" exists does not necessarily mean that the plan is an "ERISA plan." The court must also examine the intent of the employer—it must be shown that the employer had "a purpose to provide benefits to its employees" and there must be some meaningful degree of participation by the employer in the creation or administration of the plan.[5]

So, next focus your requests for admissions on proving or disproving common statutory elements of ERISA plans. Structure your requests so that you can make out a strong argument that the employer's participation was minimal or nonexistent:

Please admit:

5. That there was no trustee for any alleged ERISA "plan" (within the meaning of 29 U.S.C. § 1103);
6. That there was no trust for any alleged ERISA "plan" (within the meaning of 29 U.S.C. § 1103);
7. That the (employer) (employee organization) maintained no trust funds for any alleged ERISA "plan" (within the meaning of 29 U.S.C. § 1103);
8. That there was no "plan sponsor" for any alleged ERISA "plan" (within the meaning of 29 U.S.C. § 1002(16)(B));
9. That there was no administrator for any alleged ERISA "plan" (within the meaning of 29 U.S.C. § 1002(16)(A));
10. That no one employed at (employer) (employee organization) was designated as any administrator for the putative "plan";
11. That none of the (employees) (members) had any administrative responsibilities toward the putative "plan";
12. That none of (employer's) (employee organization's) officers or employees were considered fiduciaries to the "plan" (within the meaning of 29 U.S.C. § 1002(14)(A));
13. That none of (employer's) (employee organization's) officers or employees had any fiduciary duties to the putative "plan" (within the meaning of 29 U.S.C. § 1104);

Recent case law suggests that meeting just some of the safe harbor criteria is enough to then require judicial scrutiny of more than merely the Donovan v. Dillingham *factors.*

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14. That there is no document purporting to establish or maintain any "plan" prepared by the (employer) (employee organization);
15. That there is no written instrument purporting to establish or maintain any "plan" prepared by the (employer) (employee organization) which provides for one or more named fiduciaries to jointly or severally have authority to control and manage the operation and administration of the "plan" (within the meaning of 29 U.S.C. § 1102);
16. That there is no written instrument which provides a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of 29 U.S.C. § 1001, *et seq.* (within the meaning of 29 U.S.C. § 1102(2)(b)(1));
17. That there is no written instrument purporting to establish or maintain any "plan" which specifies procedures for providing adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant (within the meaning of 29 U.S.C. § 1133(1));
18. That there is no written instrument purporting to establish or maintain any "plan" which sets forth in writing procedures which afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim (within the meaning of 29 U.S.C. § 1133(2));

19. That no fiduciary to this purported "plan" is bonded (within the meaning of 29 U.S.C. § 1112);
20. That there is no summary plan description for this purported "plan" (within the meaning of 29 U.S.C. § 1022(a)(1));
21. That neither the plaintiff nor any other participant in the purported "plan" has been provided with a copy of a summary plan description (within the meaning of 29 U.S.C. § 1022(a)(1));
22. That the purported summary plan description does not conform with the requirements for style, format, and content required by the regulations (within the meaning of 29 C.F.R. § 2520.102-1, 2, and 3);
23. That no reports, financial statements, or other documents were ever filed by (employer) (employee organization) with the Secretary of Labor (within the meaning of 29 U.S.C. § 1023);
24. That no reports, financial statements, or other documents were ever filed by (employer) (employee organization) with the Secretary of the Treasury (under Internal Revenue Code §§ 6057–6059);
25. That the (employer) (employee organization) did not maintain a copy of the Department of Labor's interpretative bulletin relating to the ERISA Guidelines and the Special Reliance Procedure (within the meaning of 29 C.F.R. § 2509.75-10).

Because the employer's intent appears to be gaining importance in the context of judicial scrutiny of whether the putative "plan" is actually an ERISA plan, your requests for admissions should also focus on the circumstances surrounding the original purchase of or subscription to the insuring agreement.

Please admit:

26. That (plaintiff) did personally apply for the purchase of this insurance;
27. That (employer) (employee organization) did not complete or submit any (participating employer's) (participating employee organization's) application;
28. That (salesperson-agent) never spoke with any of (employer's) (employee organization's) executive officers or managers at any time concerning the sale/subscription to the insurance;
29. That it was not a condition of the sale/subscription to this insurance that plaintiff's co-employees purchased and/or subscribed to this insurance;
30. That it was not a condition of the sale/subscription to this insurance that plaintiff's (employer) (employee organization) purchase and/or subscribe to this insurance;
31. That the only underwriting criteria all involved with acceptance or rejection of plaintiff's application were health/risk-rating criteria;
32. That (salesperson/agent) knew nothing of ERISA at the time of this sale;
33. That (salesperson/agent) had received no education or training from (insurer) (multiple-employer trust) regarding ERISA;
34. That (salesperson/agent) made no oral representations regarding ERISA or of any consequences of this sale (subscription) to insurance being deemed an ERISA "employee welfare benefit plan" at the time of any communications with (plaintiff) (employer) (employee organization);
35. That "ERISA" is not mentioned anywhere in any of the sales brochures, policy applications, or policy documents shown or delivered to (plaintiff) (plaintiff's co-employees) (employer) (employee organization);
36. That (employer) (employee organization) had no intention to establish or maintain any employee welfare benefit plan (within the meaning of 29 U.S.C. § 1001, *et seq.*);
37. That (insurer) (multiple-employer trust) (multiple-employer welfare arrangement) never intended to comply with nor in fact complied with any laws or regulations governing implementation or maintenance of employee welfare benefit plans within the meaning of ERISA;
38. That (insurer) (multiple-employer trust) (multiple-employer welfare arrangement) purposefully intended to avoid and in fact avoided compliance with the statutory and regulatory requirements for implementation and maintenance of ERISA employee welfare benefit plans in the course of marketing and selling the insurance made the basis of this litigation.

INTERROGATORIES

You should insist on receipt of answers to interrogatories before taking any Rule 30(b)(6) depositions of the insurer's, employer's, and plan's representatives. Taking 30(b)(6) depositions of

well-rehearsed professionals without knowing ahead of time what factual issues exist can be disastrous. Narrow the issues. Learn what defendants are relying upon as they develop their record evidence toward sustaining their burden of proof on the ERISA preemption defense. Use the answers to these interrogatories when carefully thinking through your series of potent leading questions for the depositions.

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1. Please state with specificity how the insurance from which the plaintiff's claims arise is an employee welfare benefit plan regulated by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1002(3).

(A) In your answer to this interrogatory, pleae state with specificity the following:

(1) How an "employee welfare benefit plan" was "established or maintained" by any employer.

(2) How an "employee welfare benefit plan" was "established or maintained" by any employee organization.

2. Describe each and every act or event undertaken or participated in by (employer) (employee organization) to establish and/or maintain an employee welfare benefit plan.

(A) Please state with specificity any and all responsibilities (employer) (employee organization) had for administration of the purported employee welfare plan.

3. Please list all communications of which defendant is aware (whether written or verbal) between plaintiff's (employer) (employee organization) and the alleged employee welfare plan sponsor, plan trustee, plan administrator, plan fiduciary, and/or the defendant, which confirm, memorialize, or otherwise recognize the existence of an ERISA "plan" and/or the (employer's) (employee organization's) responsibilities under the plan.

4. Has (employer) (employee organization) made any contributions to the alleged employee welfare benefit plan within the meaning of 29 C.F.R. § 2510.3-1(j)?

(A) If so, please itemize all such contributions.

5. To your knowledge, is participation in the employee welfare benefit plan completely voluntary for participants of this purported plan within the meaning of 29 C.F.R. § 2510.3-1(j)?

(A) If participation is not completely voluntary for participants, then please state each and every fact upon which you rely in making this contention.

6. Has (employer) (employee organization) ever endorsed this purported employee welfare benefit plan?

(A) If so, please state with specificity each and every time, event, and instance that (employer) (employee organization) endorsed the employee welfare benefit plan; and, please provide photocopies of any writings which confirm, memorialize, or otherwise represent any such endorsement.

7. Does (employer) (employee organization) receive any money or consideration in connection with the administration of this purported employee welfare benefit plan?

(A) If so, please state with specificity the purpose or purposes for which it receives money or other consideration; and

(B) Please state with specificity each instance during the past two (2) calendar years when it received such cash or other consideration and the purpose thereof.

8. Does (employer) (employee organization) collect premiums through payroll deductions of its employees for the employee welfare benefit plan?

(A) If so, please state with specificity how any such deductions are calculated;

(B) how they are accounted for by the plan;

(C) how funds or monies deducted are transmitted for deposit to or with this plan; and

(D) how any such deductions are remitted to the plan.

9. Who is or are the sponsor(s) for this purported employee welfare benefit plan?

(A) Please state such person's(s') name, address, and telephone number and;

(B) Please state how this person(s) was so designated.

10. Who is or are the administrator(s) for this purported employee welfare benefit plan?

(A) Please state such person's(s') name, address, and telephone number and;

(B) Please state how this person(s) was so designated.

11. Who is or are the trustee(s) for this purported employee welfare benefit plan?

(A) Please state such person's(s') name, address, and telephone number and;

(B) Please state how this person(s) was so designated.

12. Who is or are the fiduciary(ies) for this purported employee welfare benefit plan?

(A) Please state such person's(s) name, address and telephone number and;

(B) Please state how this person(s) was so designated.

13. Please state whether any annual reports and/or financial statements of this purported employee welfare benefit plan were ever provided to:

(A) the plaintiff herein; or,

(B) (employer) (employee organization); or,

(C) any other employees of (employer) (employee organization); or,

(D) the Department of Labor; or,

(E) the Department of Treasury; or,

(F) the Pension Benefit Guaranty Association.

14. If any answer to the preceding interrogatory was in the affirmative, please provide a true and correct copy of any such annual report and/or financial statement, identifying the date, place, and purpose of provision of such report or statement.

15. Were any plan brochures submitted to the plaintiff (employer) (employee organization) prior to the purchase of the insurance which contained language expressing that insurance coverage was being provided under an employee welfare benefit plan within the meaning of ERISA?

(A) If so, please provide a description of any such brochure, and attach a true and correct copy of such brochure to your answers hereto.

16. Did any policy of insurance (certificate of coverage) issued to the plaintiff (employer) (employee organization) contain any language indicating that the insurance was being provided under an employee welfare benefit plan within the meaning of ERISA?

(A) If so, please attach a specimen copy of any such policy to your answers to these interrogatories and highlight with a colored marker any and all such language.

17. Please describe what steps, if any, were taken by (employer) (employee organization) (insurer) (multiple-employer trust) (multiple-employer welfare arrangement) to ensure that the employment benefit(s) at issue in this lawsuit were part of an employee welfare benefit plan (employee pension benefit plan) subject to ERISA, 29 U.S.C. § 1001, *et seq*.

(A) For each event so identified, please state the name, address, telephone number, and title or role of each person involved; and,

(B) Describe the circumstances which resulted in such step(s) being taken.

18. Describe with specificity (salesperson's/agent's) training and education concerning ERISA.

19. Describe with specificity the circumstances surrounding (salesperson's/agent's) sale and marketing of this insurance to:

(A) the plaintiff herein;

(B) plaintiff's coemployees, if any; and,

(C) (employer) (employee organization).

20. Was it (employer's) (employee organization's) intention to establish or maintain an employee welfare benefit plan?

(A) If so, state with specificity each and every act, event, or occurrence done or participated in by (employer) (employee organization) which supports your affirmative response to this interrogatory.

Very often because of airline scheduling or other reasons, you simply won't have time to digest and comprehend the documents if you see them for the first time when the deponent is sitting across the table from you.

REQUESTS FOR PRODUCTION

File comprehensive requests for production early in the discovery phase rather than duces tecum requests attached to deposition notices. These cases can be document intensive. Very often because of airline scheduling or other reasons, you simply won't have time to digest and comprehend the documents if you see them for the first time when the deponent is sitting across the table from you. The lesson is simple: get the documents first.

Please produce:

1. Each and every file which in any way pertains to the incident made the basis of this suit, including any and all correspondence, notes, memoranda, summary plan descriptions,

declarations of trust, applications for coverage, subscription agreements, policies of insurance, certificates of coverage, claim forms, written statements, medical records, medical reports, or other documents of any description whatsoever maintained by the defendant, its employees and/or agents, and any of its offices, whether at the home office, claims office, underwriting office, or any regional or local office of the said defendant. Plaintiff respectfully requests the defendant to note from which office each file produced in response to this request originated.

2. Any and all correspondence, notes, memoranda, printed handouts, brochures, training instructions, training manuals, reference manuals, employee guidelines, underwriting criteria, course material, or any other documents of any description whatsoever used in the training of those persons who sold or otherwise marketed the insurance made the basis of plaintiff's complaint.
3. Any reports, financial statements, or other documents produced and/or delivered to the United States Department of Labor, the United States Department of Treasury, or the Pension Benefit Guaranty Association pursuant to any statutory and/or regulatory obligations under the Employers Retirement Income Security Act of 1974.
4. Each and every claims file, including any and all correspondence, memoranda, claims forms, claims reviews, written statements, claims-handling policies and/or procedures, or other documents of any description whatsoever, maintained by the defendant in any of its claims offices, whether at the home office or any regional local office for the said defendant, relating in any manner to claims filed by or on behalf of plaintiffs or plaintiff. Plaintiff respectfully requests the defendant to note from which office each claims file produced in response to this request originated.
5. Each and every underwriting file, including any and all correspondence, memoranda, forms, written statements, participating employers' applications, participating employee applications, underwriting criteria, administration guidelines, underwriting evaluations criteria, trust agreements, summary plan descriptions, master plan descriptions, and any other documents of any description whatsoever, maintained by the defendant, its agents and/or employees in any of its offices, whether at the home office or any regional office, relating in any manner to the insurance made the basis of plaintiff's complaint. Plaintiff respectfully requests the defendant to note from which office each underwriting file produced in response to this request originated.
6. All medical records, medical reports, or other documents of any description whatsoever concerning the care and/or treatment of plaintiff.
7. For each document you fail or refuse to produce based in whole or in part upon an objection that such document or documents are protected from disclosure by the attorney-client privilege or the work-product doctrine, please produce a list containing the following:

   (A) a description of each such document;
   (B) the location of each such document;
   (C) the author or maker of each such document;
   (D) the addressee or recipient of each such document;
   (E) the date each such document was made or created;
   (F) the nature of each such document; and,
   (G) the basis for your objection to production.

DEPOSITIONS

At least four witnesses must be examined in every ERISA preemption case. These are the salesperson or agent who sold or marketed the insurance, a Rule 30(b)(6) designee from the underwriting department, a Rule 30(b)(6) designee from the claims department, and the administrator of the putative plan. Whether you use requests for production early in the discovery period or opt for attaching duces tecum requests to deposition notices, you must ultimately gain access to every material and relevant document you can.

The depositions of these witnesses should be used to show wholesale noncompliance with the requirements of ERISA's statutes and regulations. Emphasis should be placed on the employer's lack of any knowledge of the ramifications of having "established or maintained" an "employee welfare benefit plan." These factors can be established through showing that the agent knew nothing of ERISA at the time of the sale and that the agent accordingly didn't explain to any purchasers what

any requirements (or consequences) of ERISA might be. Similarly, you will likely encounter underwriting and claims personnel who know nothing of the statute and who are easily perplexed by the statutory lingo.

All told, plaintiff's discovery should be geared toward showing that ERISA is most often an "afterthought." ERISA is involved typically for the first time when the insurer or employer receives the summons and complaint in your lawsuit. Well-schooled defense attorneys see a causal nexus with employment and the *Donovan*[6] light bulb flashes in their minds.

At least until we receive additional clarification from the U.S. Supreme Court—or until the Eleventh Circuit has a significant change of heart—plaintiffs' lawyers must continue with aggressive litigation of these issues. While *Taggart*[7] remains binding precedent in this circuit, plaintiffs still have a slim life line to hang onto. But *Taggart*, like *Hansen* and the other few bastions of civility in this area of the law, require exhaustive evidentiary showings to overcome the clear judicial predispositions toward findings of preemption by ERISA.

CONCLUSION

Working through ERISA preemption cases is a lot of work—but there is a lot at stake. Hopefully, the materials provided herein will help you work your way through the thicket.

ENDNOTES

[1]28 U.S.C. § 1446(b) provides:

> The notice of removal of a civil action or proceeding shall be filed within thirty (30) days after the receipt by the defendant, through service or otherwise, of a copy of the initial pleading setting forth the claim for relief upon which such action or proceeding is based, or within thirty days after the service of summons upon the defendant if such initial pleading has then been filed in court and is not required to be served on the defendant, whichever period is shorter.
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> If the case stated by the initial pleading is not removable, a notice of removal may be filed within thirty days after receipt by the defendant, through service or otherwise, of a copy of an amended pleading, motion, order, or other paper from which it may first be ascertained that the case is one which is or has become removable, except that a case may not be removed on the basis of jurisdiction conferred by Section 1332 of this title more than one year after commencement of the action.

[2]29 C.F.R. 2510.3-1(j).

[3]Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982) (*en banc*) (a "'plan, fund or program' under ERISA implies the existence of intended benefits, intended beneficiaries, a source of financing, and procedure to apply for and collect benefits.").

[4]Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991); *cf.* MDPhysicians & Associates, Inc. v. State Bd. of Insurance, 957 F.2d 178 (5th Cir. 1992); Longoria v. Cearley, 796 F. Supp. 997 (W.D. Tex. 1992).

[5]*Id.* at 977–78.

[6]The *Donovan* four-factors test is truly of very little guidance. Any provision of a benefit can be shown to meet the tests. For example, giving Mom flowers on Mother's Day each year meets the *Donovan* criteria. The intended beneficiary is Mom, the benefits are flowers, the source of financing is your credit card, and the procedure for receiving benefits is the FTD man. Can Mom sue you next year under ERISA if you forget the flowers?

[7]Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030, 68 L. Ed. 2d 225, 101 S. Ct. 1739 (1981). In *Bonner v. City of Prichard*, 661 F.2d 1206 (11th Cir. 1981) (*en banc*), the Eleventh Circuit Court of Appeals adopted as binding precedent the decisions of the former Fifth Circuit, decided prior to October 1, 1981.