ERISA Preemption: To Infinity and Beyond and Back Again? (A Historical Review of Supreme Court Jurisprudence)

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I. ERISA'S HISTORICAL BACKGROUND AND THE SCOPE OF ITS PREEMPTIVE

Scheme

After a decade long study, Congress enacted the Employee Retirement Income Security Act ("ERISA") in 1974 to protect employees, participants, and beneficiaries, from perceived abuses involving the mismanagement of funds accumulated to finance various types of employee benefit plans. ERISA has

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2. ERISA § 3(6), 29 U.S.C. § 1002(6) (1998), defines "employee" as "any individual employed by an employer."
3. ERISA § 3(7), 29 U.S.C. § 1002(7) (1998), defines "participant" as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit."
4. ERISA § 3(8), 29 U.S.C. § 1002(8) (1998), defines "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."
been described repeatedly by the Supreme Court as a “comprehensive and reticulated statute” with an “interlocking, interrelated, and interdependent remedial scheme.” This scheme contains elaborate and complex provisions for the regulation of employee pension plans and, to a lesser extent, employee welfare plans, e.g., plans providing health, disability, severance, and other miscellaneous, non-pension benefits.


8. ERISA § 3(2)(A), 29 U.S.C. § 1002(2)(A) (1998), defines “employee pension benefit plan” and “pension plan” as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—(i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.”

9. ERISA § 3(1), 29 U.S.C. § 1002(1) (1998), defines “employee welfare benefit plan” and “welfare plan” as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of the Labor Management Relations Act (other than pensions on retirement or death, and insurance to provide such pensions).” By referencing § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. § 186(c)(5), ERISA § 3(1) expands the definition of benefits covered by ERISA. Section 302(c)(5) of the LMRA was enacted as part of the Labor Management Relations Act or Taft-Hartley Act of 1947. See Pub. L. No. 80-101, 61 Stat. 136 (1947). In 1947, Congress imposed legal requirements on union-sponsored plans financed by employer contributions. Section 302 makes it illegal for an employer to provide anything of value to a representative of employees. One exception to this rule was for employer contributions to employee benefit plans meeting the conditions specified in Section 302(c)(5). See Employee Benefits Law 4 (BNA, 1991). Among the benefits potentially covered by ERISA because of the reference to benefits described in Section 302(c)(5) are: "medical
ERISA establishes intricate reporting and disclosure obligations for all plans, provides specific schedules for the vesting, accrual, and funding of pension benefits, and imposes significant standards of care, duties of loyalty, and other obligations on fiduciaries and plan administrators of all ERISA plans. Because of the "comprehensive and reticulated" nature of ERISA, the sponsor of an employee benefit plan is charged with many obligations, including determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, providing appropriate information to participants, and keeping appropriate records in order to comply with applicable reporting requirements.

When drafting ERISA, its congressional authors recognized that the most efficient way to meet these responsibilities was to establish a uniform, federal, administrative scheme, providing a set of standard procedures to guide administration of plans, processing of claims, and disbursement of benefits. This was particularly true in the case of plans covering employees or beneficiaries in many different states. If a uniform federal system were not devised, those plans might be required to keep records in some states but not in others; to make certain benefits available in some states but not in others; to process claims in a certain way in some states but not in others; and to comply with certain fiduciary standards in some states but not in others. Additionally, the inefficiencies in plan operation caused by such "patchwork" regulation might lead multi-state employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.

or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance; ... pooled vacation, holiday, severance or similar benefits, or defraying costs of apprenticeship or other training programs: ... scholarships for the benefit of employees, their families, and dependents for study at educational institutions ... child care centers for preschool and school age dependents of employees, or ... financial assistance for employee housing: ..." 29 U.S.C. § 186(c)(5-7) (1993).

14. ERISA § 3(16)(B), 29 U.S.C. § 1002(16)(B) (1998), defines “plan sponsor” as "(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan."
This need for a uniform, federal regulatory and administrative scheme prompted Congress to enact the broadest statutory preemption provision to date. Section 514(a) of ERISA provides, "[T]he provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ...." ERISA sections 514(c)(1) and 514(c)(2) define state laws as "[a]ll laws, decisions, rules, regulations, or other state actions having the effect of law, of any State" including "[a] State, any political subdivisions thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans ...." Thus, if ERISA preemption applies, state common law claims, state law statutes, state law remedies, and/or state regulations are displaced, and ERISA becomes controlling law.

Although Section 514(a) of ERISA broadly preempts state laws that relate to an employee benefit plan, that preemption is limited and qualified by a "saving clause," which states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." The saving clause is then limited by the "deemer clause," which in turn states that no employee benefit plan, with certain exceptions not relevant here, "shall 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." Although ERISA's preemption provision "[is] not a model of legislative drafting," the Supreme Court has steadfastly described it as "conspicuous for its breadth," "clearly expansive," with a "broad

scope,"^{26} and an "expansive sweep."^{27} Because of its intended expansive coverage, the boundaries of ERISA's preemptive reach have been the focus of considerable jurisprudential attention since the Supreme Court first addressed the issue in 1981. In fact, the Court has decided no less than sixteen ERISA preemption cases in the last seventeen years.^{28} According to the Court, the high number of ERISA preemption cases^{29} reflects the complex and comprehensive nature of the statute, the prevalence of pension and welfare plans in the national economy, and their importance to the financial security of the American workforce.^{30}

Most of the Supreme Court cases involve the proper scope of the "relate to" clause of the preemption provision, and the Court has struggled, particularly in its more recent decisions, with the inherent vagueness of that key statutory phrase. Some ERISA cases involve the question of conflict preemption—whether a state law is preempted because it conflicts with a specific portion of the ERISA statute. This article will survey and examine the sixteen ERISA preemption Supreme Court cases and attempt to identify evolving analyses and trends.

II. EARLY SUPREME COURT CASES: 1981-1992

The Court first construed ERISA's preemption provision in Alessi v. Raybestos-Manhattan, Inc.^{31} Defendants, two New Jersey employers, maintained ERISA covered pension plans. Both plans provided that an employee's retirement benefits would be offset or reduced by an amount equal to state workers' compensation awards. In 1977, the New Jersey Legislature amended

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30. Boggs, 117 S. Ct. at 1760.
its workers' compensation laws to expressly prohibit such pension plan offsets. Alleging violations of the state law, two suits were initiated in New Jersey state court. In both suits, plaintiffs were retired employees whose pension plan retirement benefits had been offset or reduced by their workers' compensation awards. The defendant companies removed the suits to federal court. There, both district court judges ruled that the pension offset provisions were invalid under New Jersey law, and concluded that Congress had not intended ERISA to preempt laws of this sort. The Third Circuit Court of Appeals consolidated the cases and reversed, finding, among other things, that the New Jersey statute forbidding offsets of pension benefits by the amount of workers' compensation awards could not withstand ERISA's general preemption provision.

After granting certiorari, a unanimous Supreme Court began its analysis by first acknowledging that, in enacting ERISA's preemption provision, Congress intended to depart from its previous legislation that envisioned the exercise of state regulation over pension funds and meant to establish pension plan regulation as an exclusive federal concern. The Court then noted that the ERISA preemption phrase “relate[s] to any employee benefit plan... gives rise to some confusion” where it is asserted to apply to a state law governing an area subject to the state's traditional police power, e.g., workers' compensation. Although acknowledging some “confusion,” the Court did not analyze the language of the preemption provision. Rather, it struck down the statute because the practice of offsetting pension benefits was permissible under federal law and the law of other states. Allowing the state statute to stand would have forced the employer to either structure all its benefit payments in accordance with New Jersey law or to adopt different payment formulae for employees inside and outside the state. Under those circumstances, the employer would be required to accommodate conflicting regulatory schemes in devising and operating a system for processing and paying benefits claims—precisely the burden ERISA preemption intended to avoid. The Alessi Court rejected New Jersey's claim that the state attempted to protect workers' compensation benefits, not regulate benefit plans. The Court maintained that ERISA's definition of a “state” as that “which purports to regulate directly or indirectly... employee benefit plans” made clear that even inadvertent state action bearing on private pension plans may encroach upon the area of exclusive federal concern.

32. Id. at 507-08, 101 S. Ct. at 1898. The New Jersey law at issue stated that “[t]he right of compensation granted by this chapter may be set off against disability pension benefits or payments but shall not be set off against employees' retirement pension benefits or payments.” N.J. Stat. Ann. § 34:15-29 (West Supp. 1980).
35. Buczynski v. General Motors Corp., 616 F.2d 1238 (3d Cir. 1980).
37. Id.
38. Id. at 524-25, 101 S. Ct. at 1907.
39. Id.
Although the Supreme Court did not address the meaning of the "relate to" phrase in *Alessi,* it confronted the subject again two years later in *Shaw v. Delta Airlines, Inc.* At issue was whether two New York laws—one prohibiting discrimination in employee benefit plans based on pregnancy and the other requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy—were preempted by ERISA. Delta Airlines and two other employers provided their employees with various ERISA-covered medical and disability benefit plans. These plans did not, however, provide benefits to employees disabled by pregnancy as required by the two New York laws. As a result, the three employers brought declaratory judgment actions against state agencies and officials alleging the laws were preempted by ERISA.

In a unanimous opinion, the Court analyzed whether the two laws "relate[d] to" an ERISA plan. Citing Black's Law Dictionary's definition of the term "relate," the Court held that a law relates to an employee benefit plan, in the normal sense of the phrase, "if it has a connection with or reference to" such a plan. Employing this definition, the Court held that the Human Rights Law, which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy, and the Disability Benefits Law, which required employers to pay employees specific benefits, clearly "relate[d] to" benefit plans. The Court held that the plain language of the preemption provision, the structure of ERISA, and its legislative history, all supported such a finding. The Court did, however, temper its broad "reference to or connection with" analysis, conceding "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."

The Court then considered the State's argument that the Human Rights Law was exempt from preemption under ERISA section 514(d), which states the preemption provision shall not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . ." Relying on this
exception, the State asserted that preemption of the Human Rights Law would impair and modify Title VII because it would change the means by which Title VII was enforced.\textsuperscript{52} Agreeing with the State, the Court observed that Title VII expressly preserved non-conflicting state laws.\textsuperscript{53} Further, the Court noted that when an employment practice prohibited by Title VII occurs in a state that prohibits the same practice, and the state has established an agency to enforce that prohibition, the EEOC refers the charge to the state agency for a determination.\textsuperscript{54} Given the interplay between federal and state employment laws, the Court reasoned:

If ERISA were interpreted to pre-empt the Human Rights Law entirely with respect to covered benefit plans, the State no longer could prohibit the challenged employment practice and the state agency no longer would be authorized to grant relief. The EEOC thus would be unable to refer the claim to the state agency. This would frustrate the goal of encouraging joint state/federal enforcement of Title VII; an employee’s only remedies for discrimination prohibited by Title VII in ERISA plans would be federal ones. Such a disruption of the enforcement scheme contemplated by Title VII would, in the words of § 514(d), “modify” and “impair” federal law.\textsuperscript{55}

The Court also noted Title VII was neutral on the subject of employment practices it did not prohibit. As such, the Court found that insofar as state laws prohibit employment practices that are lawful under Title VII, preemption would not “impair” Title VII within the meaning of Section 514(d). Accordingly, the Court held that the Human Rights Law was preempted with respect to ERISA benefit plans only to the extent that it prohibited practices that were lawful under federal law.\textsuperscript{56}

The Court next focused on the Disability Benefits Law. Although the Court held that the disability law “related to” an ERISA plan, it noted that section 514(a) of ERISA limited preemption to state laws that related to benefit plans “described in section 4(a)\textsuperscript{57} and not exempt under section

\textsuperscript{52} Shaw, 463 U.S. at 100-01, 103 S. Ct. at 2902.
\textsuperscript{53} Id. at 101, 103 S. Ct. at 2902. Section 708 of Title VII provides “Nothing in this title shall be deemed to exempt or relieve any person from any liability, duty, penalty, or punishment provided by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful employment practice under this title.” See 42 U.S.C. § 2000e-7 (1996).
\textsuperscript{54} Shaw, 463 U.S. at 101, 103 S. Ct. at 2902. The EEOC may not actively process any charges “before the expiration of sixty days after proceedings have been commenced under the State or local law, unless such proceedings have been earlier terminated.” 42 U.S.C. § 2000e-5(c) (1989).
\textsuperscript{55} Shaw, 463 U.S. at 102, 103 S. Ct. at 2902-03.
\textsuperscript{56} Id. at 103, 103 S. Ct. at 2903.
\textsuperscript{57} ERISA § 4(a), 29 U.S.C. § 1003(a) (1998), provides that the provisions of ERISA “shall apply to any employee benefit plan if it is established or maintained—(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization
Section 4(b)(3) exempts any employee benefit plan "maintained solely for the purpose of complying with applicable . . . disability insurance laws." Consequently, the Disability Benefits Law would not be preempted if the plans to which it related were exempt from ERISA under Section 4(b).

Answering that question, the Court recognized that Section 4(b)(3) excludes "plans," not portions of plans, from ERISA coverage. As such, the Court found that those portions of the employers' multi-benefit plans maintained to comply with the Disability Benefits Law were covered by ERISA and because of preemption could not be regulated by state law:

There is no reason to believe that Congress used the word "plan" in § 4(b) to refer to individual benefits offered by an employee benefit plan. To the contrary, § 4(b)(3)'s use of the word "solely" demonstrates that the purpose of the entire plan must be to comply with an applicable disability insurance law.60

The Court further observed:

The test is not one of the employer's motive—any employer could claim that it provided disability benefits altruistically, to attract good employees, or to increase employee productivity, as well as to obey state law—but whether the plan, as an administrative unit, provides only those benefits required by the applicable state law.61

Accordingly, the Court found that while a state may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. "If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply."62 Ultimately, although the Court held that the Disability Benefits Law was not preempted, the State of New York could not enforce its provisions through regulation of ERISA-covered benefits plans.63

Two years later, the Court decided Metropolitan Life Insurance Co. v. Massachusetts.64 In another unanimous opinion, the Court addressed, for the first time, ERISA's "saving" clause which exempts from preemption state laws

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60. Shaw, 463 U.S. at 107, 103 S. Ct. at 2905.
61. Id.
62. Id. at 108, 103 S. Ct. at 2906.
63. Id. at 109, 103 S. Ct. at 2906.
"which regulate insurance, banking, and securities." The Court considered the impact of ERISA preemption on a Massachusetts statute requiring certain minimum mental health care benefits be provided to Massachusetts residents insured under a general health policy or an employee health care plan. Following enactment of the statute, the Attorney General of Massachusetts filed a declaratory judgment action against certain insurers who failed to amend their insurance policies in compliance with the statute. Eventually, the case made its way to the Supreme Court.

At the outset, the Court held the statute related to an ERISA plan, thus placing it within the broad sweep of the preemption clause because it bore "indirectly but substantially" on all insured benefit plans by requiring the plans to purchase the benefits specified in the statute. The Court then turned to the state's argument that the statute was "saved" from preemption because it was a state law regulating insurance.

Beginning its analysis, the Court observed that, "while clear enough on their faces," the preemption and saving clauses are not models of legislative drafting, "for while the general pre-emption clause broadly pre-empts state law, the savings clause appears broadly to preserve States' lawmaking power over much of the same regulation." Notwithstanding this "statutory complexity," the Court maintained that, on its face, the statute was saved from preemption as a law "which regulates insurance" within the meaning of the saving clause because it regulated the terms of certain insurance contracts.

The Court's "common-sense" view of the statute was reinforced by the language of the "deemer clause," which states an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." The Court found that by excluding from the saving clause laws regulating insurance contracts applying directly to benefit plans, the deemer clause demonstrated Congress' intent to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause.

As part of its analysis, the Court rejected the insurers' argument that mandated-benefit laws are not traditional insurance laws. In support of this finding, the Court adopted the criteria of the McCarran-Ferguson Act to

67. Id. at 734, 105 S. Ct. at 2386.
70. Id. at 739-40, 105 S. Ct. at 2389.
71. Id.
73. Id. at 741, 105 S. Ct. 2389-90.
determine whether regulation regarding the substantive terms of insurance contracts fell squarely within the saving clause as laws "which regulate insurance." Those criteria were summarized as: (1) whether the practice has the effect of spreading risk among all insureds; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.75

Initially, the Court determined the statute regulated the spreading of risk because its intent was to effectuate legislative judgment that the risk of mental health care should be shared. Next, the Court found that mandated-benefit laws directly regulated an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder. The Court also reasoned that the third McCarran-Ferguson criterion was present because mandated-benefit statutes imposed requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.76 Concluding its analysis, the Court stated:

In short, the plain language of the saving clause, its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated-benefit laws such as § 47B are saved from pre-emption by the operation of the saving clause.77

The decision, the Court acknowledged, "result[ed] in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not."78 However, the Court maintained that "[b]y so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter."79

McCarran-Ferguson was to "ensure that the States would continue to have the ability to tax and regulate the business of insurance." Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 217-18, 99 S. Ct. 1067, 1076 (1979). The Act provides that "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation ... of such business." 15 U.S.C. § 1012(a) (1984 & Supp. 1998). According to the Metropolitan Life Court, "The ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." 417 U.S. at 744 n.21, 105 S. Ct. at 2391 n.21.

76. Id. at 743, 105 S. Ct. at 2391.
77. Id. at 744, 105 S. Ct. at 2391. The Court also pointed out that Massachusetts had never tried to enforce that portion of the statute pertaining directly to benefit plans, effectively conceding that such an application of the statute would be preempted by ERISA's preemption clause. Id. at 735, 105 S. Ct. at 2387 n.14.
78. Id. at 747, 105 S. Ct. at 2393.
79. Id.
Two terms later, the Court again construed the insurance saving clause and the "relate to" clause in *Pilot Life Insurance Co. v. Dedeaux.* There, plaintiff filed a diversity action in a Mississippi federal court challenging the termination of his disability benefits and asserting state law claims for tortious breach of contract, breach of fiduciary duty, and fraud in the inducement. Plaintiff's suit sought state law damages for failure to provide benefits under an insurance policy, general damages for mental and emotional distress, and punitive and exemplary damages. Plaintiff did not, however, assert any of the several causes of action available to him under ERISA. Eventually, defendant filed a motion for summary judgment asserting the plaintiff's claims were preempted. The district court granted defendant's summary judgment, but the Fifth Circuit reversed, relying on *Metropolitan Life.*

In its fourth consecutive unanimous preemption opinion, the Court held that because each state law claim was based on the alleged improper processing of a claim for benefits under an employee benefit plan, those claims indisputably related to an ERISA plan and thus were preempted. The Court then addressed the plaintiff's assertion that because the Mississippi law of bad faith (part of his tortious breach of contract claim) regulated insurers such as the defendant, it was saved from preemption. The Court observed that a common-sense understanding of the phrase "regulates insurance" meant that a law must not simply have an impact on the insurance industry, but "must be specifically directed toward that industry." Because the roots of the law of bad faith were firmly planted in the general principles of tort and contract law, and not limited to breach of an insurance contract, the Court determined the law did not regulate insurance within the meaning of the saving clause.

The Court also rejected the assertion that the law of bad faith met any of the McCarran-Ferguson Act criteria. In contrast to the mandated-benefits law in *Metropolitan Life,* the common law of bad faith did not define the terms of the relationship between the insurer and the insured. Rather, it declared only that, whatever terms were agreed upon in the insurance contract, a breach of that contract may, in certain circumstances, allow the policyholder to obtain punitive damages. Thus, the state common law of bad faith was therefore no more "integral" to the insurer-insured relationship than any state's general contract law was integral to a contract made in that state.

81. Id. at 43-44, 107 S. Ct. at 1551.
82. 770 F.2d 1311 (5th Cir. 1985).
84. 481 U.S. at 47-48, 107 S. Ct. at 1553.
85. Id. at 50, 107 S. Ct. at 1554.
86. Id.
88. 481 U.S. at 51, 107 S. Ct. at 1555.
Finally, the Court reasoned that Congress clearly expressed an intent that the civil enforcement provisions of ERISA be the exclusive vehicle for actions asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of Section 502(a) would pose an obstacle to the purposes and objectives of Congress. Accordingly, because of "the deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies," the Court concluded that plaintiff's state common law claims were preempted.90

The same day the Court decided Pilot Life it issued its opinion in Metropolitan Life Insurance Co. v. Taylor ("Taylor").91 There, the Court held that a state court suit that did not raise a federal claim within the four corners of the petition was removable to federal court.92 Taylor arose out of a suit filed in Michigan state court by an employee against his employer and the insurer of the employer's benefit plan for "compensatory damages for money contractually owed Plaintiff, compensation for mental anguish caused by breach of [his insurance] contract, as well as immediate re-implementation of all benefits and insurance coverages..."93 Plaintiff also asserted claims for wrongful termination of his employment and for wrongfully failing to promote him in retaliation for a prior workers' compensation claim. None of the claims raised by the plaintiff's state lawsuit, however, referred to ERISA or raised any other federal claims. Thus, pursuant to the "well-pleaded complaint" rule, the plaintiff's suit was not removable to federal court.94 Nonetheless, the defen-

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89. 29 U.S.C. § 1132(a)(1)(B) (1998). Under the civil enforcement provisions of Section 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary.

90. 481 U.S. at 52-54, 107 S. Ct. at 1555-57.


92. 481 U.S. at 60, 107 S. Ct. at 1544. By statute "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a) (1998). One category of cases over which the district courts have original jurisdiction are "federal question" cases; that is, those cases "arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331 (1986).

93. 418 U.S. at 61, 107 S. Ct. at 1545.

94. The well-pleaded complaint rule has been called "the basic principle marking the boundaries of the federal question jurisdiction of the federal district courts." Franchise Tax Bd. of Ca. v. Construction Laborers Vacation Trust for S. Ca., 463 U.S. 1, 9-12, 103 S. Ct. 2841, 2846-48 (1983). The rule was first set forth in Louisville & Nashville R.R. Co. v. Mottley, 211 U.S. 149, 152, 29 S. Ct. 42, 43 (1908), and provides that a cause of action arises under federal law only when issues of federal law appear on the face of the plaintiff's well-pleaded complaint. Thus, in Franchise Tax Bd., an ERISA preemption/removal case, the Court held that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the
dants removed the suit to federal court alleging federal question jurisdiction over the benefits claim by virtue of ERISA and pendent jurisdiction over the remaining claims. The District Court found the case properly removable and eventually granted the defendants' summary judgment on the merits. The Sixth Circuit Court of Appeals reversed on the ground that the District Court lacked removal jurisdiction. The Supreme Court granted certiorari.

The Supreme Court first held that under Pilot Life plaintiff's common law contract and tort claims "relate[d]" to a benefit plan and thus were preempted by ERISA. The Court also held the claims were not "saved" from preemption because the state claims were based upon common law, not laws regulating insurance. The Court observed that because this was a suit by a beneficiary to recover benefits from an ERISA plan, the claim fell squarely under Section 502(a)(1)(B) of ERISA, the exclusive federal cause of action for resolution of such disputes.

Turning to the removal issue, the Court explained that, under the "well-pleaded complaint rule," a cause of action arises under federal law only when the plaintiff's complaint raises issues of federal law within the four corners of the petition. The Court noted, however, that legislatively, Congress may so completely preempt a particular area, that any civil complaint, even one not citing federal law in the four corners of the petition, is removable because it is necessarily federal in character. The Court cited Section 301(a) of the Labor Management Relations Act, which provides that, "[s]uits for violation of contracts between and employer and a labor organization... may be brought in any district court in the United States having jurisdiction over the parties, without respect to the amount in controversy or without regard to the citizenship of the parties." Similarly, the jurisdiction clause of Section 502 of ERISA provides: "The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action." Relying on the close parallels between the two jurisdictional statutes, the Court concluded, "Congress has clearly manifested an

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defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case. Id. at 14, 103 S. Ct. at 2848.

96. Taylor, 481 U.S. at 61-62, 107 S. Ct. at 1545 (citing Taylor v. General Motors Corp., 763 F.2d 216 (6th Cir. 1985)).
97. Id. at 62, 107 S. Ct. at 1546.
98. Id. at 62-63, 107 S. Ct. at 1546.
99. Id. at 63-64, 107 S. Ct. at 1546. (citing Avco Corp. v. Machinist, 390 U.S. 557, 88 S. Ct. 1235 (1968) (other citations omitted)). Avco stands for the proposition that if a federal cause of action completely preempts a state cause of action, any complaint that comes within the scope of the federal cause of action necessarily "arises under" federal law. Franchise Tax Bd., 463 U.S. at 23-24, 103 S. Ct. at 2854.
intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." As such the Taylor petition, although purporting to raise only state law claims, was "federal in character" and removable to federal court.

The Court's third 1987 preemption case was Fort Halifax Packing Co. v. Coyne. This case was far more difficult for the Court to resolve than its predecessors, as reflected by the five-to-four decision, representing the first time the Court split on an ERISA preemption case. At issue was a Maine statute requiring employers with more than one hundred employees to provide a one-time severance payment to employees in the event of a plant closing. After the employer closed its plant and declined to pay severance benefits, employees and the Maine Director of the Bureau of Labor Standards filed suit against the employer. The employer argued the Maine statute was preempted because severance benefits are covered by ERISA and any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan.

Rejecting the employer's contentions, the majority explained that ERISA's preemption provision does not refer to state laws relating to "employee benefits," but rather to state laws relating to "employee benefit plans." Although the Court acknowledged that it had previously construed the phrase "relate to" expansively, it maintained: "Nothing in our case law, however, supports appellant's position that the word 'plan' should in effect be read out of the statute." The Court then noted that, under the statute, the employer assumed no responsibility to pay benefits on a regular basis, and thus faced no periodic demands on its assets that created a need for financial coordination and control. Rather, the employer's obligation was predicated on the occurrence of a single contingency that might never materialize. However, even to the extent that the obligation to make the severance payment did arise, satisfaction of that duty involved only one payment to employees at the time of plant closure.

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102. Taylor, 481 U.S. at 66, 107 S. Ct. at 1548. The Court also recognized that in its prior decision in Franchise Tax Bd., it suggested that a state action that was not only preempted by ERISA, but also came within the scope of ERISA's civil enforcement section (Section 502(a)), might fall within the *Avco* rule. *Id.* at 64, 107 S. Ct. at 1547.

103. 481 U.S. at 67, 107 S. Ct. at 1548. The concurring opinion by Justices Brennan and Marshall stressed the narrow nature of the Court's holding, emphasizing that the decision should not be interpreted as adopting a broad rule that any defense premised on congressional intent to preempt state law is sufficient to establish removal jurisdiction. *Id.* at 68, 107 S. Ct. at 1548.


107. 482 U.S. at 7, 107 S. Ct. at 2215.

108. *Id.* at 8, 107 S. Ct. at 2215 ("[T]he provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."

29 U.S.C. § 1144(a) (1998) (emphasis added)).

109. *Id.* at 8, 107 S. Ct. at 2216 (citations omitted).

110. *Id.* at 12, 107 S. Ct. at 2218.
The Court also held preemption of the Maine statute was inconsistent with congressional intent. The Court noted that in enacting ERISA, Congress was concerned with uniform federal regulation of employee benefit plans because such plans involved the ongoing administrative activity potentially subject to employer abuse. The Maine statute's requirement of a one-time lump-sum payment, triggered by a single event, required no on-going administrative scheme to meet the employer's obligation. As such, the Maine statute did not create the type activity subject to employer abuse that ERISA was designed to prevent and therefore was not preempted.\footnote{Id. at 16, 107 S. Ct. at 2220.}

The dissent criticized the majority for creating a loophole in ERISA's preemption statute by making preemption turn on the existence of an "administrative scheme"\footnote{Id. at 23, 107 S. Ct. at 2223-24.} and argued that requiring an administrative scheme as a prerequisite for ERISA preemption effectively allowed states to dictate a wide array of employee benefits to be provided by employers by simply characterizing them as "non-administrative." Such a requirement would in turn allow states to circumvent the intent of Congress to preempt all state laws that relate to employee benefit plans.\footnote{Id. at 23-25, 107 S. Ct. at 2224-25.}

The following term, the Court decided \textit{Mackey v. Lanier Collection Agency \\& Service.} There, a collection agency filed suit in state district court, obtained judgments against twenty-three welfare benefit plan participants, and then successfully instituted an action garnishing the participants' welfare plan benefits.\footnote{486 U.S. 825, 108 S. Ct. 2182 (1988).} The Georgia Court of Appeals reversed,\footnote{178 Ga. App. 467, 343 S.E.2d 492 (1986).} holding that a Georgia statute, barring the garnishment of funds or benefits of an employee benefit plan or program subject to ERISA, exempted plan benefits from garnishment.\footnote{486 U.S. at 827-88, 108 S. Ct. at 2184-25.} Reversing the appellate court, the Georgia Supreme Court stated that while it agreed with the appellate court that the statute barred the garnishment action, the statute was preempted by ERISA because it purported to regulate garnishment of ERISA funds and benefits.\footnote{256 Ga. 499, 350 S.E.2d 439 (1986).} The Georgia Supreme Court concluded that Congress did not bar garnishment of employee welfare benefits, even though employee pension benefits were protected by ERISA as non-alienable. Because the statute prohibited that which ERISA permitted, the Georgia Supreme Court held the statute was "in conflict with" the federal scheme, and therefore preempted. By the same token, however, the Georgia statute at issue barred the garnishment of "[funds or benefits of [an] ... employee benefit plan or program subject to ... [ERISA]." Ga. Code Ann. § 18-4-22.1 (1982).\footnote{Id. at 16, 107 S. Ct. at 2220.}

\footnote{Id. at 23-25, 107 S. Ct. at 2224-25.}Under ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1) (1998), "Each pension plan shall provide that benefits provided under [an ERISA plan] may not be assigned or alienated." No such protection exists under ERISA for welfare benefits.
Supreme Court concluded that the plan was subject to garnishment under the general state garnishment law. 120

Citing conflicting decisions among the courts on this issue, the Supreme Court granted certiorari. In a five-to-four opinion, the Court conceded at the outset that the Georgia statute in dispute related to an ERISA plan and was preempted because it expressly referred to—indeed, solely applied to—ERISA employee benefit plans. 121 The Court then addressed what it considered “the more complex question” of whether the entire Georgia garnishment procedure, which did not single out or refer to ERISA plans in any way, was preempted by ERISA. 122

The Court rejected the argument of the plan’s trustees that garnishment imposed administrative costs and burdens upon benefit plans. Rather, the Court concluded, the text and structure of ERISA’s preemption and enforcement provisions demonstrated that “Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits.” 123 In reaching its conclusion that Georgia’s general garnishment statutes were not preempted, the Court relied on two principal arguments.

First, the Court noted Congress contemplated that ERISA benefit plans could be sued under certain circumstances, i.e., pursuant to ERISA section 502(d)(2), 124 the civil enforcement statute, and for “run-of-the-mill state-law claims” such as unpaid rent, failure to pay creditors, or torts committed by an ERISA plan. 125 Because ERISA does not provide an enforcement mechanism for collecting judgments won in such suits, the Court reasoned that Congress must have intended that state law methods of collection remain undisturbed. 126

The Court’s second argument focused on congressional intent. The Court held that when Congress intended to preclude a particular method of state-law enforcement of judgments, or extend anti-alienation protection to a particular type of ERISA plan, it did so expressly. Citing ERISA section 206(d)(1), 127 barring the alienation or assignment of pension benefits provided for by ERISA benefit plans, the Court observed Congress did not enact any similar provision applicable to ERISA welfare benefit plans such as the one at issue in Mackey. The Court maintained that Congress’ silence concerning the attachment or garnishment of ERISA welfare plan benefits “acknowledged and accepted the

120. 486 U.S. at 828, 108 S. Ct. at 2185.
121. Id. at 829-30, 108 S. Ct. at 2185-86.
122. Id. at 830-31, 108 S. Ct. at 2186.
123. Id. at 831-32, 108 S. Ct. at 2186.
125. 486 U.S. at 832-33, 108 S. Ct. at 2186-87.
126. Id. at 833-34, 108 S. Ct. at 2187-88.
practice, rather than prohibit[ed] it." Accordingly, the majority concluded that ERISA preemption fell short of barring application of a general state garnishment statute to participants' benefits in the hands of an ERISA welfare benefit plan.

Four members of the Court dissented. The thrust of the dissent was the majority's failure to recognize the "substantial and onerous obligation" state garnishment laws would impose on employee benefit plans. For instance, the plan at issue would incur significant administrative burdens and costs to confirm the identity of each of the twenty-three plan participants in debt to the collection agency, calculate the participant's maximum entitlement from the fund for the period between the service date and the reply date of the summons of garnishment, determine the amount that each participant owed to respondent, and make payments into state court of the lesser of the amount owed to the collection agency and the participant's entitlement. The plan trustees would also be required to determine the validity and priority of garnishments and, if necessary, bear the costs of litigating these issues. Further, because the plan was a multi-employer plan with participants in several states, it was potentially subject to multiple garnishment orders under varying or conflicting state laws. Arguing these effects of garnishment laws on employee benefit plans were not too tenuous, remote, or peripheral, the dissent asserted that such laws should be preempted.

The Court's next ERISA preemption case, *Massachusetts v. Morash,* was another unanimous opinion. There, an employer was charged with criminal violation of a Massachusetts payment of wages statute for failing to pay unused vacation time to discharged employees. The employer moved to dismiss the charges on the ground that its vacation policy, paid out of general assets, was an "employee welfare benefit plan" under ERISA and that the state law prosecution was therefore preempted. The Supreme Court granted certiorari to resolve a split in the circuits on the issue of whether vacation pay benefits, paid from an employer's general assets, constituted a welfare benefit plan governed by ERISA.

The Court recognized that although the definition of "welfare benefit plan" included "any plan, fund, or program . . . maintained for the purpose of providing . . . vacation benefits," neither "plan, fund, or program" nor

129. *Id.* at 842, 108 S. Ct. at 2192.
130. *Id.* (citing Shaw v. Delta Airlines, Inc., 463 U.S. at 100 n.21, 103 S. Ct. at 2901 n.21).
132. Under the Massachusetts law at issue, an employer was required to pay a discharged employee his full wages, including holiday or vacation payments, on the date of discharge. Mass. Gen. Laws ch. 149, § 148 (1987).
134. *Id.* at 112, 109 S. Ct. at 1671.
"vacation benefits" was further defined. Nonetheless, the Court noted that Congress' primary goal in enacting ERISA was to prevent mismanagement of funds accumulated to finance employee benefits by establishing extensive reporting, disclosure, and fiduciary duty requirements. The Court held that because ordinary vacation payments are typically fixed, due at known times, and do not depend on contingencies outside the employee's control, payment of such benefits presented none of the risks ERISA was intended to address.\(^{136}\)

The Court also held that inclusion of routine vacation pay policies within ERISA would result in profound consequences for employers, courts, and employees. For example, ERISA coverage for routine vacation pay would require employers providing such benefits either to comply with ERISA's detailed reporting and disclosure requirements, or to discontinue the practice of compensating employees for unused vacation time. Additionally, if ERISA covered claims for vacation benefits, federal court jurisdiction would expand greatly, providing any employee with a vacation grievance a federal forum. Finally, because ERISA's vesting and funding requirements did not apply to welfare benefit plans,\(^{137}\) employees participating in vacation plans would receive less statutory protection if ERISA displaced existing extensive state regulation of vesting, funding, and participation rights for such benefits.\(^{138}\) For these reasons, the Court held that payments for unused vacation time to discharged employees by a single employer from its general assets did not constitute an ERISA plan and therefore were not preempted by ERISA.\(^{139}\)

In its next case, \textit{FMC Corp. v. Holliday},\(^{140}\) the Court again interpreted the saving and deemer clauses in deciding whether ERISA preempted a Pennsylvania anti-subrogation law, as applied to a self-funded welfare benefit plan. A plan beneficiary was involved in an automobile accident requiring extensive medical treatment paid for by the plan. The plan contained a clause requiring reimbursement of benefits if the participant recovered on a claim against a third party.\(^{141}\) The plan was self-funded, i.e., it did not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.\(^{142}\) After paying benefits, the plan asserted its subrogation right with respect to proceeds from the tort litigation.\(^{143}\) The beneficiary refused to reimburse the

\(^{136}\) 490 U.S. at 115, 109 S. Ct. at 1673.
\(^{137}\) ERISA §§ 201(1), 301(a); 29 U.S.C. §§ 1051(1), 1081(a) (1998).
\(^{138}\) 490 U.S. at 118-19, 109 S. Ct. at 1675.
\(^{139}\) Id. at 120-21, 109 S. Ct. at 1675-76.
\(^{141}\) Id. at 54, 111 S. Ct. at 405-06.
\(^{142}\) See supra notes 64-79 and accompanying text. In \textit{Metropolitan Life v. Massachusetts}, the Court acknowledged that its construction of the saving clause in certain preemption situations would leave insured plans open to indirect regulation while self-funded plans would not be so regulated. 471 U.S. 724, 747, 105 S. Ct. 2380, 2393 (1985).
\(^{143}\) The facts of this case were particularly egregious. As a result of the automobile accident, the plan beneficiary was seriously and permanently injured. At the time her tort suit was settled,
plan, relying upon Pennsylvania's anti-subrogation law which provided: "In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . payable under . . . any program, group contract or other arrangement for the payment of benefits."144

The plan brought a diversity action against the beneficiary seeking a declaratory judgment that it was entitled to reimbursement.145 Both the district court146 and the Third Circuit147 found that the anti-subrogation statute prohibited FMC's exercise of subrogation rights on the plan participant's claim against the driver. Noting that the Third Circuit's holding conflicted with decisions of other appellate courts that had construed ERISA's deemer clause to protect self-funded plans from all state insurance regulation, the Supreme Court granted certiorari.148

The Court initially recognized that, by its plain language, the anti-subrogation law "relate[d] to" an employee benefit plan.149 Next, the Court held that because the statute directly controlled the terms of insurance contracts by invalidating any subrogation provisions the contracts contained, the statute fell within the saving clause as a law regulating insurance.150 Turning its focus to the deemer clause, the Court held: "We view the language of the deemer clause . . . to be either coextensive with or broader, not narrower, than that of the saving clause." Applying this broad construction of the deemer clause, the Court concluded that, if a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the state may not regulate it.151 As a result, the anti-subrogation law was not saved from preemption because the state could not deem this self-funded plan to be an insurer.152

The dissent faulted the majority for drawing "a broad and illogical" distinction between self-insured plans and insured plans, arguing that had Congress intended this result, it could have stated simply that "all State laws are

resulting in recovery of $49,875.50, plus accrued interest, her medical expenses were $178,000.00 and the cost of future care was unknown. FMC Corp. v. Holliday, 885 F.2d 79, 80 (3d Cir. 1989).

145. 498 U.S. at 54-56, 111 S. Ct. at 406.
147. 889 F.2d 79 (3d Cir. 1989).
149. Id. at 58-60, 111 S. Ct. at 407-08.
150. Id. at 60-61, 111 S. Ct. at 409. The Court held the Pennsylvania law was subject to ERISA's insurance saving clause because the law directly controlled the terms of insurance contracts by invalidating subrogation provisions contained therein and because the law did not merely have an impact on the insurance industry, but was instead aimed at it.
151. Id. at 64-65, 111 S. Ct. at 411.
152. Id.
pre-empted insofar as they relate to any self-insured employee plan.” The dissent also took issue with the majority’s reading of the deemer clause “as merely reinjecting into the scope of ERISA’s pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.” Finally, the dissent maintained that no rational reason existed for permitting a self-funded plan to enforce a subrogation clause against an injured employee while depriving an insured plan the same right.

That same year, the Court issued its opinion in *Ingersoll-Rand Co. v. McClendon.* There, an employee brought a state law wrongful discharge claim alleging he was terminated four months before his pension vested in order to prevent his receipt of benefits. Eschewing any ERISA claims, plaintiff sought compensatory and punitive damages, as well as future lost wages under various state law tort and contract theories. The lower court ruled in the defendant’s favor on the basis that plaintiff was employed at-will. The Texas Supreme Court, however, reversed, and established a public policy exception to the employment at-will doctrine for the protection of employees’ pension plan interests.

Granting certiorari, the Supreme Court reversed. The Court held that, to succeed in this cause of action, plaintiff would have to prove “that the principal reason for his termination was the employer’s desire to avoid contributing to or paying benefits under the employee’s pension fund.” The Court maintained: “The existence of a pension plan is a critical factor in establishing liability under the State’s wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.” Accordingly, the Court held that the claims related to an ERISA plan and were preempted.

The Court also stated that, even if there were no express preemption in the case, the Texas cause of action would be preempted because the plaintiff’s wrongful discharge claim fell squarely within the ambit of ERISA section 510, which provides: “It shall be unlawful for any person to discharge . . . a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . . .” By its terms, Section 510 protects plan participants from termination motivated by an employer’s desire to prevent a pension from vesting.

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153. *Id.* at 65, 111 S. Ct. at 411.
154. *Id.* at 65-66, 111 S. Ct. at 411.
157. 779 S.W.2d 69 (Tex. 1989).
158. 498 U.S. at 135-36, 111 S. Ct. at 481.
159. *Id.* at 140, 111 S. Ct. at 483.
160. *Id.* (emphasis in the original).
161. *Id.*
162. *Id.* at 142, 111 S. Ct. at 484-85.
The Court observed that Congress viewed this section as a crucial part of ERISA because, without it, employers would be able to manipulate employment to circumvent the provision of promised benefits.\(^{164}\) As such, the Court concluded: "We have no doubt that this claim is prototypical of the kind Congress intended to cover under § 510."\(^{165}\) Because the Texas cause of action purported to provide a remedy for the violation of a right expressly guaranteed by, and exclusively enforced through, ERISA, the Court held that "due regard" for ERISA required preemption of the state law.\(^{166}\)

The Court's next case, *District of Columbia v. Greater Washington Board of Trade*,\(^{167}\) is regarded as the "high water mark" for ERISA preemption. There, the District of Columbia amended its workers' compensation laws and required employers providing health insurance to their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits.\(^{168}\) The Greater Washington Board of Trade, a nonprofit

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165. *Id.*

166. *Id.* at 145, 111 S. Ct. at 486. Also significant in *Ingersoll-Rand* is Justice O'Connor's dicta in the final paragraph of the opinion:

   The preceding discussion also responds to the Texas court's attempt to distinguish this case as one not within ERISA's purview . . . . [T]here is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek "pension benefits." It is clear that the relief requested here is well within the power of federal courts to provide.

Consequently, it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of pension benefits.

*Id.* at 145, 111 S. Ct. at 486 (emphasis added). The plaintiff in *Ingersoll-Rand* requested punitive and compensatory damages. Based on Justice O'Connor's comments, some plaintiffs argued that *Ingersoll-Rand* supported claims for *ex contractu* damages, including punitive damages, under ERISA. Several district courts accepted that argument. See, e.g., International Union, United Automobile, Aerospace and Agricultural Implement Workers v. Midland Steel Prods. Co., 771 F. Supp. 860, 863 (N.D. Ohio 1991); Blue Cross and Blue Shield v. Lewis, 753 F. Supp. 345 (N.D. Ala. 1990). However, the argument has been soundly rejected by appellate courts. For instance, the Eleventh Circuit, in holding that *extracontractual damages are not available under Section 502(a)(3), explicitly found that such a holding did not conflict with *Ingersoll-Rand*. In *McRae v. Seafarers' Welfare Plan*, 920 F.2d 819 (11th Cir. 1991), Judge John Minor Wisdom, sitting by designation, explained the *Ingersoll-Rand* dicta as follows:

   The Supreme Court was stating that federal law provides relief for ERISA actions other than those that seek to recover pension benefits, such as the plaintiff's cause of action for wrongful termination. The Supreme Court is not holding that the specific remedies this plaintiff had sought under state law are necessarily the remedies that will be afforded him should he be granted relief under ERISA § 502.

*Id.* at 821. See also *Harsch v. Eisenberg*, 956 F.2d 651, 660 (7th Cir. 1992) ("[W]e think the prudent course is to follow Judge Wisdom in his interpretation. We will continue to doubt the availability of *extracontractual damages under ERISA until a more plausible signal reaches us from above.").


corporation that provided health insurance coverage for its employees, filed suit to enjoin enforcement of the statute on the ground that the “equivalent” benefits requirement was preempted by ERISA.169 The district court granted the District of Columbia’s motion to dismiss, but the appellate court reversed.170

The Court held the statute specifically referred to welfare benefit plans regulated by ERISA and on that basis alone was preempted.171 The Court rejected the District of Columbia’s contention that the statute was exempt from preemption under Section 4(b) of ERISA,172 which exempts from ERISA coverage employee benefit plans “maintained solely for the purpose of complying with applicable workers’ compensation laws . . .”.173 The Court explained: “The exemptions from ERISA coverage . . . do not limit the pre-emptive sweep of [the preemption clause] once it is determined that the law in question relates to a covered plan.”174

Relying on Metropolitan Life Insurance Co. v. Massachusetts,175 the District of Columbia also argued ERISA’s preemption provision should be construed to require a two-step analysis: If the state law “related to” an ERISA-covered plan, it could still survive preemption if employers could comply with the law through separately administered plans exempt under Section 4(b). Rejecting that contention, the Court distinguished Metropolitan Life, stating that its previous decision only construed the scope of the saving clause’s safe harbor for state laws regulating insurance and did not purport to add any further gloss on the preemption provision.176 Ultimately, the Court simply reiterated that any state law imposing requirements by reference to employee benefit plans subject to ERISA “must yield to ERISA.”177

Disagreeing with the majority, the dissent appeared to foreshadow the Court’s future path when it stated:

Nothing in ERISA suggests an intent to supersede the State’s efforts to enact fair and complete remedies for work-related injuries; it is difficult to imagine how a State could measure an injured worker’s health benefits without referring to the specific health benefits that worker receives. Any State that wishes to effect the equitable goal of the

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169. 506 U.S. at 128, 113 S. Ct. at 582.
171. 506 U.S. at 130, 113 S. Ct. at 583.
173. 506 U.S. at 131, 113 S. Ct. at 584.
174. Id. (citing Alessi, 451 U.S. 504, 525, 101 S. Ct. 1895, 1907, (1981) ("It is of no moment that New Jersey intrudes indirectly, through a workers’ compensation law, rather than directly, through a statute called ‘pension regulation’").
176. 506 U.S. at 132, 113 S. Ct. at 585.
177. Id. at 132-33, 113 S. Ct. at 584.
District's statute will be forced by the Court's opinion to require a predetermined rate of health insurance coverage that bears no relation to the compensation package of each injured worker. The Court thereby requires workers' compensation laws to shed their most characteristic element: post-injury compensation based on each individual workers' pre-injury level of compensation.178

The dissent also maintained that, instead of mechanically repeating earlier dictionary definitions of the word "relate" as its only guide in an important and difficult area of statutory construction, the Court should pause to consider the wisdom of the basic rule disfavoring federal pre-emption of state laws, and the specific concerns identified in the legislative history as the basis for federal preemption.179 With preemption of the field, Congress rounded out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. However, because the statute at issue did not regulate "even one inch of the pre-empted field, and pose[d] no threat whatsoever of conflicting and inconsistent state regulation," the dissent asserted that by holding that the law was preempted, "the Court has already taken a step that Congress neither intended nor foresaw."180

III. A NEW LOOK AT PREEMPTION: SUPREME COURT CASES 1993-1997

In John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank,181 the Court was called upon to decide whether ERISA's fiduciary standards182 governed an insurance company's conduct in relation to certain annuity contracts.183 After determining the insurance company was a fiduciary, the Court addressed the insurer's argument that ERISA's fiduciary standards could not govern an insurer's administration of general account contracts because to do so would pose irreconcilable conflicts between state and federal regulatory regimes.184

The Court began its analysis by noting that ERISA requires fiduciaries to act "solely in the interest of the participants and beneficiaries and ... for the

178. Id. at 137-38, 113 S. Ct. at 587.
179. Id. at 138, 113 S. Ct. at 588.
180. Id.
182. The obligations of an ERISA fiduciary are described in ERISA section 4, 29 U.S.C. § 1104(a) (1998). A fiduciary must discharge its duties with respect to a plan "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries . . . ." A person is a fiduciary with respect to an employee benefit plan "to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . ." ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A) (1998).
183. 510 U.S. at 89, 114 S. Ct. at 521.
184. Id. at 97, 114 S. Ct. at 525.
exclusive purpose of... providing benefits to participants and beneficiaries.185 On the other hand, state law required an insurer “to consider the interests of all of its contractholders, creditors and shareholders” and to “maintain equity among its various constituencies.”186 The insurer contended ERISA must yield to state law because Congress reserved to the states primary responsibility for regulation of the insurance industry.187 In response, the Court conceded that the law at issue, because it concerned the management of the general account assets of an insurer, was saved from preemption because it regulated insurance. At the same time, however, the Court maintained:

[W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but “where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,” federal preemption occurs.188

In this preemption analysis, the John Hancock Court did not rely on Shaw’s189 “reference to or connection with” approach for determining whether a state law was preempted under ERISA. Rather, the Court emphasized “traditional preemption” standards, noting that state law is generally not displaced. This description of ERISA preemption signaled the first retreat from the Court’s prior expansive interpretations.

Two years later, in New York State Conference of Blue Cross v. Travelers Insurance Co. (“Travelers”),190 the Court held that a state law requiring hospitals to collect surcharges from patients covered by commercial insurers, but not from patients insured by Blue Cross/Blue Shield, was not preempted by ERISA. The Court noted that although the preemption provision is clearly expansive, the meaning of “relate to” must be limited by the objectives of the ERISA statute.191 Signaling a departure from prior preemption opinions, the Court observed:

If “relate to” were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for “[r]eally, universally, relations stop nowhere.” But that, of course, would be to read Congress’s words of limitation as mere sham, and to read the presumption against pre-emption out of the law

185. Id. at 97, 114 S. Ct. at 525 (citing ERISA § 494(a), 29 U.S.C. § 1104(a) (1998)).
186. Id.
187. Id. at 98, 114 S. Ct. at 525.
191. Id. at 655-56, 115 S. Ct. at 1677.
whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to construe the phrase “relate to” does not give us much help drawing the line here.  

Analyzing whether the statute related to ERISA plans, the Court held the statute did not have any “reference to” ERISA plans because it was indiscriminately imposed upon HMOs and patients, regardless of whether the commercial coverage or membership was secured by an ERISA plan, private purchase, or otherwise. Embarking next on the “connection with” test, the Court noted:

[T]his still leaves us to question whether the surcharge laws have a “connection with” the ERISA plans, and here an uncritical literalism is no more help than in trying to construe “relate to.” For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.

The Court then observed that, in enacting ERISA, Congress intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law. The goal, the Court said, “was to minimize the administrative and financial burden of complying with conflicting directives among states or between states and the federal government and to prevent the potential for conflict in substantive law.” However, “cost-uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those ‘conflicting directives’ from which Congress meant to insulate ERISA plans.”

The Court observed that although there was no evidence the surcharges would drive every health insurance consumer to Blue Cross, economically, the law made Blue Cross more attractive (or less unattractive) as an insurance alternative. As a result, the Court found the regulation did not “bind plan administrators to any particular choice” and had only an “indirect economic effect” on choices made by insurance purchasers of ERISA plans. The Court held the regulation was “no different from myriad state laws in areas traditionally subject to local regulation” and it was not the intent of Congress to preempt such

192.  *Id.* (internal citations omitted).
193.  *Id.*
194.  *Id.*
195.  *Id.* (citing *Ingersoll-Rand*, 498 U.S. at 142, 111 S. Ct. at 484).
196.  514 U.S. at 661-62, 115 S. Ct. at 1680 (citations omitted).
197.  *Id.* at 659, 115 S. Ct. at 1679.
Striking the balance between conflicting state and federal regulation, the Court stressed the importance of traditional state police powers:

While Congress's extension of preemption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like,"... nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern... 199

The Court did attempt to draw some boundaries where state law would run afoul of ERISA preemption. Respondents had argued that the New York law was preempted because, under Metropolitan Life,200 the challenged law mandated specific plan benefits and, as such, related to employee benefit plans. While holding that respondents' reading of Metropolitan Life was too broad, the Court noted there were limits to state regulation in this area:

In any event, Metropolitan Life can not carry the weight the commercial insurers would place on it. The New York surcharges do not impose the kind of substantive coverage requirement binding plan administrators that was at issue in Metropolitan Life. Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues. As they currently stand, the surcharges do not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage.201

The Court's evolving preemption analysis was further clarified in California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc. ("Dillingham").202 At issue was whether ERISA preempted a California "prevailing wage" statute that permitted public works contractors to pay less than prevailing journeyman wage to apprentices in approved apprenticeship programs. The Court noted:

To determine whether a state law has the forbidden connection, we look both to "the objectives of the ERISA statute as a guide to the scope of

198. Id. at 668, 115 S. Ct. at 1683.
199. Id. at 661-62, 115 S. Ct. at 1680 (internal citations omitted).
201. 514 U.S. at 663-64, 115 S. Ct. at 1681 (emphasis added).
the state law that Congress understood would survive," as well as to the nature of the effect of the state law on ERISA plans.\textsuperscript{203}

Relying on Mackey,\textsuperscript{204} Ingersoll-Rand,\textsuperscript{205} and Greater Washington Board of Trade,\textsuperscript{206} the Court clarified the "reference to" step in Shaw's "relate to" test. The Court found a "reference" exists where the state law specifically refers to ERISA plans, where it acts "immediately and exclusively upon ERISA plans," or where the existence of such plans "is essential to the law's operation."\textsuperscript{207} Noting that an apprenticeship program may be paid for out of an employer's general assets, so that an ERISA plan is not essential, the Court found that there was no "reference" to an ERISA plan in the prevailing wage statute.\textsuperscript{208}

Asserting that the prevailing wage statute at issue was "indistinguishable" from the surcharge statute in Travelers,\textsuperscript{209} the Court found there was no "connection" to an ERISA plan. In so holding, the Court relied upon three factors: (1) that wages paid on public work projects have long been subject to state regulation; (2) that such regulations are "quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like," and (3) that while the regulation provided, "some measure of economic incentive to comport with the state's requirements," other reasons existed for obtaining state sanctioning of an apprenticeship program.\textsuperscript{210}

Especially significant was the concurring opinion written by Justice Scalia, joined by Justice Ginsburg. Justice Scalia's concurrence characterized the level of Supreme Court activity in the ERISA preemption arena as "suggesting that our prior decisions have not succeeded in bringing clarity to the law."\textsuperscript{211} Furthermore, although he joined the Court's opinion in Dillingham, Scalia criticized its underlying rationale:

I join the Court's opinion today because it is a fair description of our prior case law, and a fair application of the more recent of that case law. Today's opinion is no more likely than our earlier ones, however, to bring clarity to this field—precisely because it does obeisance to all our prior cases, instead of acknowledging that the criteria set forth in some of them have in effect been abandoned.\textsuperscript{212}

\begin{enumerate}
\item[203.] 117 S. Ct. at 838 (citations omitted).
\item[207.] 117 S. Ct. at 838 (citations omitted).
\item[208.] 117 S. Ct. at 839.
\item[210.] 117 S. Ct. at 840-42.
\item[211.] 117 S. Ct. at 843.
\item[212.] \textit{Id.}
The concurrence asserted that applying the "relate to" provision according to its terms "was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else." Challenging the other members of the Court, Justice Scalia went on to state:

I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies—namely, the field of laws regulating "employee benefit plans . . . ." Our new approach to ERISA pre-emption is set forth in John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank: "we discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis." I think it accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption. Nothing more mysterious than that; and except as establishing that, "relates to" is irrelevant.

The implications of this concurring opinion are difficult to determine. The opinion states the Court is applying traditional concepts of "field" and "conflict" preemption in recent ERISA cases. The cases relied on indicate that state law can be preempted in either of two general ways. First, if Congress evidences an intent to occupy a given field, any state law falling within that field is preempted. Second, if Congress has not entirely displaced state regulation over the matter in question, state law is still preempted to the extent it actually conflicts with federal law, that is, when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress.

The Court's next 1997 case was De Buono v. NYSA-ILA Medical and Clinical Services Fund. The question before the Court was whether the "opaque" language in ERISA's preemption provision precluded New York from imposing a gross receipts tax on the income of medical centers operated by ERISA funds. The Court began its analysis by endorsing its prior approach

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213. Id.
214. Id. (citations omitted).
in Travelers and Dillingham that the "relate to" clause, while expansive, must have practical limits, and the normal presumption against preemption will only be overcome after examining the objectives Congress sought to achieve with ERISA.219

Following this approach, the Court observed that historically, the police powers of the states have included the regulation of health and safety. Although the state law at issue was a revenue raising measure, it operated in a field that has been traditionally occupied by the states because it targeted only the health care industry.220 As a result, the burden was on the parties challenging the statute to overcome "the starting presumption that Congress does not intend to supplant state law."221

Before dealing specifically with the New York law at issue, the majority distinguished prior decisions where the Court held preemption applied:

This is not a case in which New York has forbidden a method of calculating pension benefits that federal law permits,222 or required employers to provide certain benefits.223 Nor is it a case in which the existence of a pension plan is a critical element of a state law cause of action,224 or one in which the state statute contains provisions that expressly refer to ERISA or ERISA plans.225

Instead, the Court likened the statute to the one at issue in Travelers, i.e., one of a myriad state laws of general applicability that impose some burdens on the services at hospitals, residential health care facilities, and diagnostic and treatment centers. The assessments became a part of the State's general revenues.

219. 117 S. Ct. at 1751.
220. 117 S. Ct. at 1752 n.10.
221. 117 S. Ct. at 1752.
222. See, e.g., Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524-25, 101 S. Ct. 1895, 1907 (1981) ("Whatever the purpose or purposes of the New Jersey statute, we conclude that it "relate[s] to pension plans' governed by ERISA because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law.").
224. See, e.g., Ingersoll-Rand, 498 U.S. 133, 139-40, 111 S. Ct. 478, 483 ("We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan . . . . Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.").
225. Id. (citing Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 828-30, 108 S. Ct. 2182, 2184-86 (a provision that explicitly refers to ERISA in defining the scope of the state law's application is pre-empted); District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130-31, 113 S. Ct. 580, 583-84 (1992) ("Section 2(c)(2) of the District's Equity Amendment Act specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted.").
administration of ERISA plans but nevertheless do not "relate to" them within the meaning of preemption provision. The Court concluded: "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."

In its third and final 1997 preemption case, Boggs v. Boggs, the Court confronted "the intersection of ERISA pension law and state community property law." Isaac Boggs worked for South Central Bell from 1949 until his retirement in 1985. He and his first wife, Dorothy, were married when he began working for the company and they had three sons. When Dorothy died, she bequeathed one third of her estate in full ownership to her husband, and a lifetime usufruct in the remaining two thirds. She left her sons the naked ownership of the remaining two thirds, subject to Boggs' usufruct.

After the death of his first wife, Isaac Boggs married for the second time. When he retired in 1985, he received various benefits from his employer's retirement plans, including a lump-sum savings plan distribution, which was rolled over into an individual retirement account (IRA); shares of stock from the company's employee stock ownership plan (ESOP); and a monthly annuity payment.

When Isaac Boggs died, he was survived by his second wife and three children from his first marriage. A dispute arose between the survivors as to ownership of Isaac Boggs' employee benefits. The children sought to enforce the provisions of the first wife's will, which would have provided them two-thirds of her estate, including her community property interest in Boggs' employee benefits. Under ERISA, the second wife, as the surviving spouse,
was entitled to a survivor's annuity, and she had not waived her right to the survivor's annuity, nor had she consented to having the sons designated as the beneficiaries. Accordingly, she contested the validity of the first wife's will, and argued that the sons' claim was preempted by ERISA because it conflicted with ERISA's surviving spouse annuity and anti-alienation provisions.

The federal district court and the Fifth Circuit held that ERISA did not preempt Louisiana community property law. Noting a split between the Ninth and Fifth Circuits, and that the issue affected nine community property states with more than 80 million residents and over $1 trillion in ERISA qualified pension plans, the Supreme Court granted certiorari.

The Court stated at the outset:

We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects. We hold that there is a conflict, which suffices to resolve

asset. Hare v. Hodgins, 586 So. 2d 118, 122 (La. 1991). Thus, if one spouse receives benefits from a pension plan, he or she must account to the other spouse for this benefit which vests equally in both spouses from the instant of acquisition. Boggs v. Boggs, 82 F.3d 90, 96 (5th Cir. 1996). Additionally, Louisiana Civil Code article 890.1 now provides that "If a recurring payment is being made from a public or private pension or retirement plan, an annuity policy or plan, an individual retirement account, a Keogh plan, a simplified employee plan, or any other similar retirement plan, to one partner or to both partners of a marriage, and the payment constitutes community property, and one spouse dies, the surviving spouse shall enjoy a legal usufruct over any portion of the continuing recurring payment which was the deceased spouse's share of their community property, provided the source of the benefit is due to payments made by or on behalf of the survivor."

235. 117 S. Ct. at 1758. The surviving spouse annuity provision requires that every qualified joint and survivor annuity include an annuity payable to a non-participant surviving spouse. The survivor's annuity may not be waived by the participant, absent certain limited circumstances, unless the spouse consents in writing to the designation of another beneficiary, which designation cannot be changed without further spousal consent, witnessed by a plan representative or notary public. 117 S. Ct. at 1761 (citing 29 U.S.C. § 1055(d)(1) and (c)(2) (1998)).


238. Boggs v. Boggs, 82 F.3d 90 (5th Cir. 1996). In an opinion authored by Judge Wiener, six members of the Fifth Circuit vehemently dissented from the failure of the court to rehear the case en banc. 89 F.3d 1169 (5th Cir. 1996). Foreshadowing the Supreme Court's position, Judge Wiener argued that a testamentary transfer of an interest in undistributed retirement benefits frustrates ERISA's goals of securing national uniformity in pension plan administration and of ensuring that retirees and their dependents are the actual recipients of retirement income. Id. at 1176-78. Regarding uniformity, Judge Wiener observed that each community property state has its own unique set of specific rules affecting ownership and management of such property, including some notable differences from state to state. Further, all community property rules differ substantially from the concomitant rules of non-community states. As such, Judge Wiener maintained that allowing these disparate laws to trump ERISA could not help but have a materially adverse impact on plan administration: "Quite simply, ERISA's goal of uniformity would be unattainable if the ultimate enjoyment of ERISA plan benefits were left to the vicissitudes of the varying and disparate marital property laws of the several states, be they community or separate." Id. at 1177.

239. 117 S. Ct. at 1759-60.
the case. We need not inquire whether the statutory phrase “relate to” provides further and additional support for the pre-emption claim.240

Although it did not refer to DeBuono, Dillingham, or Travelers in its holding, the Court relied on “conventional conflict preemption principals” to preempt Louisiana state law.241 The Court then explained that the statutory object of the joint and survivor annuity provision was to ensure a stream of income to surviving spouses.242 As such, the Court concluded that ERISA would be undermined by allowing a predeceasing spouse, her heirs, and legatees to have a community property interest in the survivor’s annuity.243

IV. WHAT DOES IT ALL MEAN AND WHERE ARE WE HEADED?

While hinting at a new direction in preemption analysis in John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank,244 the Supreme Court was openly skeptical of the direction of ERISA preemption jurisprudence in New York State Conference of Blue Cross v. Travelers Insurance Co. (“Travelers”),245 when it stated that past case law was unhelpful to the process of examining New York’s surcharge law.246 Two years later, concurring in California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.,247 Justice Scalia candidly expressed his opinion that the Court’s earlier “relate to” jurisprudence was simply wrong and that the criteria set forth in those cases had been “abandoned.”

It is submitted that in surveying the Supreme Court’s preemption analysis, the test for preemption has changed from earlier efforts to read literally the clause “relate to” to a more pragmatic approach asking: “Is this the type of law Congress intended to preempt?” This new approach is coupled by an emphasis

240. 117 S. Ct. at 1760-61.
241. See also National Auto. Dealers and Assocs. Retirement Trust v. Arbeitman, 89 F.3d 496 (8th Cir. 1996), a case preceding Boggs with similar facts. There, first and second wives claimed the decedent’s pension plan benefits. The first wife argued that the second wife waived her claim for pension benefits by executing a prenuptial agreement. Id. at 498-99. The Eighth Circuit held, inter alia, the prenuptial agreement did not constitute a waiver of the second wife’s right to receive pension plan benefits. Id. at 500-01. The Court also held that the first wife’s state law equitable estoppel claim was preempted by ERISA because to enforce the state law claim was inconsistent with specific ERISA provisions and the terms of the decedent’s pension plan. Id. at 502.
242. 117 S. Ct. at 1761.
243. 117 S. Ct. at 1762.
244. See supra notes 181-189 and accompanying text.
245. See supra notes 190-201 and accompanying text.
246. The Court noted: “[W]e have to recognize that our prior attempt to construe the phrase ‘relate to’ does not give us much help drawing the line here.” Travelers, 514 U.S. 645, 655-56, 115 S. Ct. 1671, 1677 (1995).
247. See supra notes 211-214 and accompanying text.
on traditional State police powers. Some trends are emerging in the lower courts.

First, these trends have not altered traditional preemption analysis where a participant or beneficiary sues for benefits and asserts state law benefit claims. Most courts continue to hold ERISA preempts plan participants' state law fraud claims, wrongful death claims, and employment retaliation claims. However, when one of the parties to the suit is outside of the "traditional ERISA relationships," i.e. the employer, the plan, the plan fiduciaries, and the beneficiaries/participants, this factor weighs heavily against preemption. Some courts have declined to apply preemption where claims are asserted against an independent insurance agent for fraud in the sale of a policy or where claims are asserted against non-fiduciary third party administrators for breach of contract.

Following Dillingham, some courts have declined to preempt traditional state laws regulating employment and construction activities. In Operating Engineers Health and Welfare Trust Fund v. JWJ Contracting Co., certain ERISA trust funds sued under Arizona law to enforce an obligation to pay funds owed to the trusts by the employer's surety after the employer's bankruptcy. Focusing upon the surety's status as third party to the employer-trust fund and ERISA...
relationships generally, the court held that the state law was too tenuous, remote, or peripheral to apply preemption.256

In Trustees For Michigan Laborer's Health Care Fund v. Seaboard Surety Co.,257 the Sixth Circuit held that a state law requiring bonds to ensure payment of employee benefits was not preempted. The court noted a law requiring bonds to ensure payment was of general applicability and was not directed toward ERISA plans. It concluded the enforcement provisions of the state law affected only the bonding contract and did not affect the administration of ERISA trust funds. Implicit in its reasoning was the fact the defendant bond company was not a traditional ERISA entity.

However, in Plumbing Industry Board v. Howell Co., Inc.,258 the court considered whether ERISA preempted a law providing employee benefit plans with a lien against funds for a project when an employer failed to make payments. As opposed to the surety cases, the entity actually making the payments for the defaulting employer under the lien law was the general contractor. The Second Circuit concluded this state law was preempted because it directly conflicted with ERISA's specific delineation of the entities liable for benefits.

Two cases from the Ninth Circuit portend future problems for application of ERISA preemption. In Cisneros v. Unum Life Insurance Co.,259 at issue was the application of California's "Notice—Prejudice" rule. This state law provided that an insurance company could not deny benefits because it did not receive timely notice of a claim unless it could prove actual prejudice. The insurer refused to pay benefits because plaintiff failed to provide the insurance company with timely notice of her claim. There was no question that the application of the rule "related to" the ERISA plan. The only question was whether the rule was saved from ERISA preemption under the three criteria of the McCarran-Ferguson Act.260 Conceding that the state law did not satisfy all three criteria of the McCarran-Ferguson Act, the Ninth Circuit held the law was saved from preemption because it applied to the insurance industry and became an integral part of the relationship between the insurer and the insured. The practical effect of this case was to add the "Notice—Prejudice" rule as a term to all insured ERISA plans in California.

The Ninth Circuit revisited the notice rule in Ward v. Management Analysis Co. Employee Disability Benefit Plan.261 Here, as in Cisneros, plaintiff gave untimely notice of his claim to an insurance company. However, he argued that he gave timely notice to his employer, who served as an agent for the insurance company under California law. Contrary to California law, the terms of the plan

256. Id. at 679.
257. 137 F.3d 427 (6th Cir. 1998).
258. 126 F.3d 61 (2d Cir. 1997).
259. 134 F.3d 939 (9th Cir. 1998).
260. See supra notes 74-75, 84-85 and accompanying text.
261. 135 F.3d 1276 (9th Cir. 1998).
specifically and unequivocally stated that the employer was not the agent of the insurance company. The Ninth Circuit then held ERISA did not preempt California's agency law and held the employer was the insurer's agent, contrary to the unambiguous language of the plan.

In explaining its new test, the Ninth Circuit concluded that only two types of laws are now preempted: 1) laws that mandate employee benefit structures or their administration; and 2) laws that provide alternative enforcement mechanisms. Despite the fact that the application of California law resulted in rewriting the plan, the court concluded this state law did not mandate benefit plan structure or administration and did not provide alternate enforcement mechanisms. It is submitted that a state law invalidating an insured ERISA plan provision as to the procedure for submitting a proof of claim is a law mandating plan administration. Nevertheless, the Ninth Circuit has managed to rely upon the more recent Supreme Court ERISA holdings to narrow the early "relate to" test and enforce state law without preemption.

V. CONCLUSION

Justice Scalia concluded that the Supreme Court's prior decisions failed to bring clarity to ERISA preemption law. The abundance of case law each year analyzing ERISA preemption seems to support his conclusion. As the Supreme Court and the appellate courts continue to develop case law in this area, it is doubtful that the plethora of ERISA preemption cases will abate. Currently, preemption jurisprudence lacks consistency and uniformity, an essential goal of Congress in enacting ERISA. The plethora of preemption jurisprudence and the difficulties in attaining uniformity will continue because ERISA litigation will remain a significant part of the dockets of the federal courts. This trend toward continued expansion of ERISA litigation is fueled by American demographic trends. As the "Baby Boom" generation ages, there will be increased pressure placed upon ERISA retirement and welfare plans. Increased ERISA litigation activity will necessarily follow and force courts to grapple repeatedly with ERISA preemption. No matter what tests are ultimately adopted to define the "relate to" clause, the scope, variety, and sheer number of ERISA claims courts will address in the future will preclude clarity and uniformity in this area of law.

262. See supra notes 211-214 and accompanying text.