EMPLOYMENT LAW

by John Harper and Nancy L. Patterson***

I. INTRODUCTION

The Employee Retirement Income Security Act (ERISA)[1] has increasingly become a source of litigation and analysis in recent years. The Fifth Circuit continues to address a myriad of complex issues related to this statute each year. The following article highlights the Fifth Circuit Court's most significant decisions over the last twelve months.

II. THE PREEMPTIVE SCOPE OF ERISA

A. *Overview - Sections 1144 and 1132*

Since the United States Supreme Court's decisions in *Pilot Life Insurance Co. v. Dedeaux*[2] and *Metropolitan Life Insurance Co. v.*

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1. 29 U.S.C. §§ 1001-1461 (1988).
2. 481 U.S. 41 (1987).

Taylor,[3] state law benefit claims against insured employee welfare benefit plans or their insurers are preempted by ERISA. This preemption stems from two ERISA provisions. First, is the general preemption provision found in 29 U.S.C. section 1144.[4] Second, the jurisdictional grant and remedial provisions of section 1132 have been held to be exclusive.[5]

The Supreme Court recently reiterated the broad sweep of ERISA preemption and the exclusivity of section 1132 remedies in its review of a Texas Supreme Court decision. In *Ingersoll-Rand Co. v. McClendon*,[6] a discharged employee sued his former employer alleging his discharge was wrongful under various state law tort and contract theories.[7] McClendon further alleged that the reason for his termination was the company's desire to preclude him from vesting in his pension fund.[8] The state trial court granted the employer's motion for summary judgment holding that McClendon's termination was lawful because he was an "at-will" employee.[9] The court of appeals affirmed.[10] The Texas Supreme Court reversed the lower courts and created a new public policy exception to the long standing employment-at-will doctrine.[11] Under this exception, recovery would be allowed if the employee could 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."[12]

The company appealed to the United States Supreme Court which rejected the Texas Supreme Court's decision and held that the

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3. 481 U.S. 58 (1987).

4. The general preemption provision may be summarized as follows: 29 U.S.C. section 1144(a) broadly preempts all state laws related to an ERISA plan and Section 1144(b)(2)(A) saves from preemption state laws which regulate the business of insurance, banking or securities. 29 U.S.C. § 1144(a) (1988). This clause is often referred to as the "savings" clause. Section 1114(b)(2)(B) states that an ERISA plan shall not be deemed to be an insurance company for the purposes of the savings clause. 29 U.S.C. § 1144(b)(2)(B) (1988). The savings clause has been held to relate solely to state laws which regulate the "business of insurance" as covered by the McCarran-Ferguson Act, 15 U.S.C. section 1101 (1988). 29 U.S.C. § 1144(b)(2)(B) (1988).

5. *See* 29 U.S.C. § 1132 (1988).

6. 111 S. Ct. 478 (1990).

7. *Id.* at 481.

8. *Id.*

9. *Id.*

10. *Id.*

11. *See id. See also*, Sabine Pilots Serv., Inc. v. Hauck, 687 S.W.2d 733 (Tex. 1985) (holding that the Texas Supreme Court is free to judicially create exceptions to the judicially created doctrine of employment-at-will).

12. McClendon v. Ingersoll-Rand Co., 779 S.W.2d 69, 71 (Tex. 1990).

employee's claims were preempted by both section 1144(a) and section 1132 of ERISA.[13] Quoting *FMC Corp. v. Holliday*,[14] the Court stated that the "preemption clause is conspicuous for its breadth" and its language is "deliberately expansive."[15] The Court reasoned that in order for an employee to prevail under the Texas decision, she "must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment."[16] The Court further stated that "[b]ecause the court's inquiry must be directed to the plan, this judicially created cause of action 'relate[s] to' an ERISA plan."[17] The Court then added that "[e]ven if there were no express preemption, . . . the Texas cause of action would be pre-empted because it conflicts directly with" section 510 of ERISA.[18] Section 510 specifically protects plan participants from termination or discrimination caused by an employer's desire to prevent a pension from vesting.[19] In so ruling, the Court made it abundantly clear that claims "related to" an ERISA plan, involving claims for benefits thereunder and falling within ERISA's section 1132 remedial provisions, are preempted without reference to the explicit preemptive provisions of section 1144.[20]

B. Specific Decisions Involving Preemption

1. Claims for Benefits

The Fifth Circuit has been faced with preemption questions in several settings during the survey period. In *Gahn v. Allstate Life Insurance Co.*,[21] the employee brought suit against her health group insurer challenging the cancellation of her policy after she was

13. Ingersoll-Rand Co. v. McClendon, 111 S. Ct. 478, 483 (1990).
14. 111 S. Ct. 403 (1990).
15. 111 S. Ct. at 482.
16. *Id.* at 483.
17. *Id.*
18. *Id.* at 484-85.
19. *Id.* at 485.
20. The next step in this arena involves the savings clause in 29 U.S.C. section 1144(b)(2)(A). If a claim predicated on state insurance law is made and falls within section 1132, what happens to the state insurance law remedy? The Texas Supreme Court has held that state law remedies are preempted. Cathey v. Metropolitan Life Ins. Co., 805 S.W.2d 387, 391 (Tex. 1990), *cert. denied*, 111 S. Ct. 2855 (1991).
21. 926 F.2d 1449 (5th Cir. Mar. 1991).

diagnosed with liver cancer.[22] She alleged a cause of action under the Louisiana "abuse of rights" doctrine, a civil law concept which precludes a party from abusing a right given by contract.[23] After reviewing the factors developed under the McCarran-Ferguson Act for determining whether a law regulates the "business of insurance",[24] the court found that the "abuse of rights" doctrine is "not confined to the insurance industry but is a law of general application."[25] Thus, it is preempted by ERISA to the extent an insured attempts to use the doctrine "to defeat the contractual right of an insurance company to cancel an employee benefit plan."[26]

The plaintiff's second claim in *Gahn* was brought pursuant to section 22.213(B)(7) of the Louisiana Insurance Code.[27] This provision sets out the conditions that an insurer must meet before it may cancel an insurance policy.[28] The court found that the statute "regulates insurance" and thus, is not preempted by ERISA.[29]

In *Brock v. Primedica, Inc.*,[30] a group health plan participant and her husband brought suit seeking benefits from the insurer and plan administrator.[31] The plaintiffs also alleged claims under Louisiana state law for mental anguish and emotional distress.[32] The court of appeals affirmed the dismissal of these claims stating that they were based upon "common law of general application that is not a

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22. *Id.* at 1450-51.

23. *Id.* at 1451.

24. Three criteria have been developed for determining whether a law regulates the "business of insurance": "[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id.* at 1453 (citing Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743 (1985)).

25. 926 F.2d at 1451.

26. *Id.*

27. *Id. See* LA. REV. STAT. ANN. § 22.213(B)(7) (West Supp. 1990).

28. *See* LA. REV. STAT. ANN. § 22.213(B)(7).

29. *See* 926 F.2d 1454. *See also* Cramer v. Association Life Ins. Co., 569 So. 2d 533, 538-41 (La. 1990) (distinguishing between section 22.657 which is preempted by ERISA and section 22.213(B)(7) which is not preempted by ERISA), *cert. denied*, 111 S. Ct. 1391 (1991); Soniat v. Travelers Ins. Co., 538 So. 2d 210, 215 (La. 1989) (holding that ERISA does not preempt § 22.213(B)(7) and is in the nature of a mandated benefit law "saved" from preemption.).

30. 904 F.2d 295 (5th Cir. June 1990).

31. *Id.* at 296.

32. *Id.* at 297.

law regulating insurance."[33] Accordingly, the claims fell within ERISA's broad preemptive scope.[34]

Similarly, in *Pitts v. American Security Life Insurance Co.*,[35] the plaintiff's claims for exemplary damages under Mississippi law permitting such damages for bad faith breach of contract were found to be preempted.[36] However, the court also held that Mississippi's law of "vesting," which states that a right to benefits vests upon the occurrence of the injury giving rise to the medical care expenses and cannot be cancelled, was applicable.[37] In this regard, it must be noted that the issue was *not* argued and the statute was conceded to be applicable if the underlying policy was found to be voidable rather than void due to misrepresentations.[38] The authors' opinion is that the issue is still open.[39]

In *Barrientos v. Reliance Standard Life Insurance Co.*,[40] the wife of a deceased employee who had been covered under his employer's group life insurance plan brought suit alleging the death benefits had been wrongfully paid to the deceased's brother.[41] The plaintiff alleged claims under the Texas Deceptive Trade Practices Act[42] and the Texas Insurance Code,[43] as well as state common law claims for fraud and breach of the duty of good faith and fair dealing.[44]

The defendant insurance company removed the case to federal court and promptly filed for dismissal under Rule 12(b)(6), arguing that all of plaintiff's claims were preempted by ERISA.[45] The district court dismissed the suit.[46] The Fifth Circuit Court of Appeals affirmed, holding that the parenthetical phrase in ERISA's deemer clause of section 1144(b)(2)(B) stating that "other than a plan estab-

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33. *Id.* (citing Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62 (1987)).
34. 904 F.2d at 297.
35. 931 F.2d 351 (5th Cir. May 1991).
36. *See id.* at 357-58. *See also In Re* Gulf Pension Litig., 764 F. Supp. 1149, 1214 (S.D. Tex. 1991) (promissory estoppel claim preempted by ERISA).
37. 931 F.2d at 355. *See* Brown v. Blue Cross Blue Shield, Inc., 427 So. 2d 139 (Miss. 1983).
38. *See* 931 F.2d at 356.
39. *See supra* notes 13-20 and accompanying text.
40. 911 F.2d 1115 (5th Cir. Sept. 1990).
41. *See id.* at 1116.
42. TEX. BUS. & COMM. CODE ANN. §§ 17.41-17.93 (Vernon 1987).
43. TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon 1981).
44. 911 F.2d at 1116.
45. *Id.*
46. *Id.*

lished primarily for the purpose of providing death benefits" did not prevent preemption of the plaintiff's state law claims.[47] Rather, the phrase only removed group life plans from the restrictions of the deemer clause.[48] A state law claim being applied to a death benefit plan is still subject to preemption if it "relates to" the plan and is not otherwise "saved" from preemption.[49] The court stopped short of determining whether the claims raised by the plaintiff were actually preempted as this ultimate question was not presented in the appeal.[50]

2. *Other Preemptive Issues*

In *E-Systems, Inc. v. Pogue*,[51] the sponsors of certain employee welfare benefit plans filed separate actions, seeking declaration that ERISA preempted the Texas Administrative Services Tax Act (ASTA).[52] Under the 1987 Texas law, a two and one-half percent annual tax was imposed on each person "receiving any form of administrative or service fee, consideration, payment, premium, fund, reimbursement, or compensation" for providing a service for various types of employee welfare benefit plans.[53] According to ASTA's definitions, the terms "administrative" or "service" fees would include sums contributed by beneficiaries of the plans.[54]

Both E-Systems, Inc. and LaQuinta Motor Inns, Inc. had established and sponsored ERISA-covered self-insured, self-administered employee welfare benefit plans which received some limited contribution from plan participants.[55] The State of Texas demanded tax payments under ASTA, which were paid by the sponsors under protest.[56] Upon review of ASTA's provisions, the court found that ASTA "relates to" the ERISA plans and was therefore preempted.[57] Specifically, the court noted:

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47. *Id.* at 1118.

48. *See id.*

49. *Id.* Consider the analysis here in conjunction with the issue discussed earlier, regarding state laws purporting to "vest" health benefit coverage. *See supra* notes 29-39 and accompanying text

50. *See id.*

51. 929 F.2d 1100 (5th Cir. May 1991), *cert. denied sub nom.* Barnes v. E-Systems, Inc., 112 S. Ct. 585 (1991). (consolidated with LaQuinta Motor Inns, Inc. v. Reynolds).

52. *Id.* at 1102. *See* TEX. INS. CODE ANN., art. 4.11A, §§ 1-13 (Vernon Supp. 1991).

53. TEX. INS. CODE ANN. art. 4.11A § 1.

54. *Id.* §§ 3(2)(A) & (B).

55. 929 F.2d at 1102.

56. *Id.*

57. *Id.*

> The tax is calculated as, *inter alia*, a percentage of all claims paid and disbursements made by the plans each year. The payment is one year removed thus reducing future assets and the capability of the plans to pay benefits. The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation.[58]

The court thus enjoined enforcement of ASTA and directed the State of Texas to refund the taxes paid.[59]

3. Does the Claim Relate to a Plan?

ERISA does not preempt claims which only have a remote connection with an ERISA-covered plan.[60] This was illustrated in *Memorial Hospital System v. Northbrook Life Insurance Co.*,[61] where a hospital sued an employer and the insurer of the employer's ERISA-covered group health plan after the insurer denied certain claims.[62] Under the employer's plan, an employee's insurance coverage was not effective until the thirty-first day of employment.[63] Unfortunately, a family member of a new employee became ill prior to the thirty-first day and was admitted to the hospital.[64] At the time of admission, the hospital contacted the insurance company whose employee verified coverage.[65] Based on the insurance company's representation, the hospital rendered services valued at over $100,000.[66] However, after the patient left the hospital, the insurer denied coverage under the terms of the policy.[67] The hospital ultimately sued the insurer under article 21.21 of the Texas Insurance Code.[68]

After a thorough review of ERISA's intended purpose, the court held that one of the hospital's state law claims against the insurer was not preempted.[69] The court found that since the putative bene-

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58. *Id.* at 1103.
59. *See id.* at 1104.
60. *See infra* Part III (discussing whether there is an ERISA plan to which the claim relates).
61. 904 F.2d 236 (5th Cir. June 1990).
62. *Id.* at 238.
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.*
68. *Id. See also* TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon 1981).
69. 904 F.2d at 239. The claim predicated upon the hospital's status as assignee of the putative plan beneficiary was preempted by ERISA. *See id.*

ficiary was not a covered plan participant, this claim did not relate to the group health plan.[70] Thus, the hospital's claim as a third-party health care provider was "independent of the plan's actual obligations under the terms of the insurance policy and in no way seeks to modify those obligations."[71] Rather, the hospital was merely seeking reimbursement for services it would not have provided but for the negligent misrepresentation of the insurer's employee.[72]

C. *Jurisdictional Issues*

The Fifth Circuit considered a somewhat unique situation involving the issue of ERISA preemption in *Total Plan Services, Inc. v. Texas Retailers Association*.[73] In *Total Plan Services*, a suit was filed in Texas state court seeking resolution of several fiduciary claims involving a multiple employer insurance trust (the TRA Trust) established by the Texas Retailers Association (TRA).[74] The suit alleged state law causes of action for breach of contract, equitable estoppel, unfair insurance practices, deceptive trade practices, breach of the duty of good faith and fair dealing, tortious interference with contractual relations and gross negligence.[75]

The defendants filed motions for summary judgment contending that the TRA Trust and its fiduciaries were governed by ERISA and, thus, the suit could only be brought in federal court.[76] The state court denied the motions and ruled that the state court claims were not preempted by ERISA.[77] In response, the defendants filed a suit in federal district court asking that the state court proceedings be enjoined and seeking a declaratory judgment that the claims were preempted by ERISA.[78]

The Fifth Circuit subsequently affirmed the federal district court's dismissal of the action for failure to state a claim.[79] The court relied on the Federal Anti-Injunction Act[80] which generally prohibits a

70. *Id.* at 250.
71. *Id.*
72. *Id.*
73. 925 F.2d 142 (5th Cir. Mar. 1991).
74. *Id.* at 143.
75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.* at 146.
80. 28 U.S.C. § 2283 (1988).

federal court from issuing injunctions to prevent a state court proceeding.[81] The court held that the "appropriate authority to decide the scope of the ERISA preemption issue in *this* case was the state court, where the action initially was filed and where this issue initially was presented and ruled upon."[82]

The plaintiff in *Slaughter v. AT&T Information Systems, Inc.*[83] brought an action in state court against her former employer and union alleging that her termination involved a breach of contract.[84] Specifically, the plaintiff contended she was entitled to termination pay under an established company plan.[85] The employer and union removed the case to federal court where the plaintiff's claim was dismissed due to limitations.[86] During the pendency of the plaintiff's appeal, she filed a second action in state court alleging the denial of benefits, termination pay, under an ERISA plan.[87] The employer was granted summary judgment based on the res judicata effect of the first ruling in federal court, and, again, the plaintiff appealed.[88]

In a somewhat confusing argument, the plaintiff asserted on appeal that exclusive jurisdiction of her ERISA claim rested in federal court.[89] The plaintiff claimed that she failed to amend her petition in the first action to allege ERISA following the removal to federal court because she wished to "preserve her right to remand."[90] As a result, she concluded that "because she could not have asserted her ERISA claims [in the first case] and because the two cases involve different issues and standards of proof, res judicata [did] not [apply]."[91]

The Fifth Circuit held that the plaintiff's decision not to bring the ERISA claim in her original action was "a tactical decision."[92] The ERISA claim should have been urged in the first action.[93] If the

81. *See id.*
82. 925 F.2d at 146 (emphasis in original).
83. 905 F.2d 92 (5th Cir. July 1990).
84. *Id.* at 93.
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*
89. *See id.*
90. *Id.*
91. *Id.*
92. *Id.* at 94.
93. *See id.*

plaintiff was concerned about preserving her right to remand, she should have filed a conditional motion to amend her claims subject to remand.[94] The lesson here is clear: When confronted with an ERISA governed claim, a plaintiff must seek to amend to assert the ERISA claim in case it is found to apply.[95]

III. THE EXISTENCE OF AN ERISA PLAN

A. Establishment of a Plan

ERISA's definition of an "employee welfare benefit plan" is found at title 29, section 1002(1) of the United States Code.[96] The issue of whether an employer has established an ERISA plan is a question of fact.[97] One of the most notable decisions rendered by the Fifth Circuit during the survey period involved this very issue and shed light on an earlier decision of the court.

In *Memorial Hospital System v. Northbrook Life Insurance Co.*,[98] the court explained its earlier and often cited decision in *Taggart Corp. v. Life & Health Benefits Administration.*[99] *Taggart* involved a claim by a corporation and its sole employee that a multiple employer trust (MET) was an ERISA plan.[100] The corporation had subscribed to the MET in order to purchase group health insurance for the employee and his family.[101] The employee, who was the owner of the company, later sued the MET under ERISA in connection with certain benefits allegedly owed.[102] The court dismissed the case, finding that the MET was not an ERISA plan and, further, stating that the "bare purchase of insurance" may not exclusively establish the existence of an ERISA plan.[103]

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94. *See id.*

95. Another example is found in *Cathey v. Metropolitan Life Ins. Co.*, 805 S.W.2d 387 (Tex. 1990), *cert. denied*, 111 S. Ct. 2855 (1991), where the plaintiffs expressly declined to amend to assert an ERISA claim after the trial court had held ERISA preempted their state law claims.

96. 29 U.S.C. § 1002(1) (1988). The issue seldom arises as to the existence of a pension plan. *See id.* at § 1002(2).

97. *See* Gahn v. Allstate Life Ins. Co., 926 F.2d 1449, 1451 (5th Cir. Mar. 1991).

98. 904 F.2d 236 (5th Cir. June 1990).

99. 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981).

100. *Id.* at 1210.

101. *Id.*

102. *Id.*

103. *Id.* at 1211.

The employer in the *Memorial Hospital* case, Noffs, Inc. (Noffs), had provided life and health insurance to its employees through a MET underwritten by Northbrook Life Insurance Company (Northbrook).[104] Noffs purchased the policy and made premium payments directly to Northbrook.[105] Noff's employees contributed one-half of the monthly premiums through payroll deductions, while the company paid the other half.[106]

In finding that Noffs had indeed established an ERISA plan, the *Memorial Hospital* court expressly adopted the rationale of the Eleventh Circuit in *Donovan v. Dillingham*.[107] Thus, an ERISA plan is established "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."[108]

The court rejected the plaintiff's argument that only a "bare purchase" of group health insurance was involved, and recognized that it is a common practice to provide health benefits through an insurance policy.[109] Further, ERISA expressly encompasses such a practice in its definition of an "employee welfare benefit plan."[110] The evidence established that the Noffs secured the insurance for the purpose of covering its employees and that the policy set forth the details of the benefits and conditions relating to coverage, including the procedure for filing a proof of claim.[111] The evidence further established that Noffs paid one-half of the monthly cost of employee coverage.[112]

In distinguishing *Taggart*, the *Memorial Hospital* court explained that *Taggart* involved the issue of whether the multiple employer trust (MET) insuring the sole employee was an ERISA plan.[113] The employer in *Memorial Hospital*, however, was providing coverage

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104. 904 F.2d at 238.

105. *See id.*

106. *Id.* at 241. These actions took the plan outside the Department of Labor's "safe harbor" regulations, 29 C.F.R. section 2510.3-1(j) (1987), which detail permissible actions which do not establish an ERISA plan. *See* 904 F.2d at 241 n.6. According to the court, the determination of whether the safe harbor regulations apply is the first step in the analysis. *Id.*

107. *Id.* at 242. *See also* Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (en banc).

108. 904 F.2d at 240 (citing Donovan v. Dillingham, 688 F.2d 1367, 1373).

109. *Id.* at 242.

110. *Id.* at 240 (citing 29 U.S.C. § 1002(1) (1988)).

111. *Id.* at 241.

112. *Id.*

113. *Id.* at 241-42.

for all its employees.[114] The court stated, "[t]here is, thus, an employer-employee-plan relationship that was lacking in *Taggart*."[115] Further, agreeing with *Donovan*, the court held that the purchase of insurance, although not conclusive evidence, is "substantial evidence" of the establishment of an ERISA plan, and the fact that a MET is involved did not alter the analysis.[116] The court found that "the fact that Noff's administrative functions under the policy are minimal is perfectly in keeping with its intent that Northbrook [the insurer would] administer the plan as well as insure it."[117]

In *Kidder v. H & B Marine, Inc.*,[118] the employer purchased a group health insurance policy to cover its employees.[119] When employee Kidder was later terminated, company officials told him that he was not eligible for continuation of group coverage, but was eligible for a conversion policy.[120] Kidder purchased the conversion policy which provided less coverage than the group plan.[121] Kidder's wife subsequently incurred substantial medical expenses, only some of which were covered by the conversion policy.[122] Kidder eventually sued his former employer, as well as the insurance company, under the Comprehensive Omnibus Budget Reconciliation Act (COBRA) for failing to provide him with continuation coverage.[123] Kidder sought just over $23,000 in damages which represented the difference between the benefits received under the conversion policy and the benefits that would have been received under the group policy.[124]

The court first determined that the employer had established an ERISA plan. Relying on *Memorial Hospital*, the court stated that the company's "payment of premiums on behalf of its employees is 'substantial evidence that a plan, fund, or program [was] established.' "[125] The court then determined that the employer was subject

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114. *Id.* at 243.
115. *Id.* (as distinguished from Taggart's employee-MET, or even employer-MET, relationship).
116. *Id.* at 242.
117. *Id.* at 243.
118. 932 F.2d 347 (5th Cir. Apr. 1991).
119. *Id.* at 349.
120. *Id.* at 350.
121. *Id.*
122. *Id.*
123. *Id.* at 348-49.
124. *Id.* at 350.
125. *Id.* at 353.

to the provisions of COBRA and had failed to properly notify Kidder under that statute of his rights concerning continuation benefits as required by COBRA.[126] The company was found solely liable for the damages to the Kidders.[127]

B. Governmental Plans Under ERISA

In *Shirley v. Maxicare Texas, Inc.*,[128] the court held that the health insurance plan established by a Texas public school district was a "governmental plan" within the meaning of ERISA section 1002(32).[129] Accordingly, the plan was outside the scope of ERISA pursuant to section 1003(b).[130]

IV. The Scope of Review

The United States Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch*[131] outlined the proper scope of judicial review regarding benefit determinations by ERISA fiduciaries. Emphasizing established principles of trust law, the Court held that "a denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[132] If the fiduciary has discretionary authority, a court should properly apply an abuse of discretion standard when reviewing any alleged wrongful benefit denial.[133]

The Fifth Circuit has had the opportunity to apply the *Bruch* decision in two situations during the survey period. In *Morales v. Pan American Life Insurance Co.*,[134] several former employees of a Pan American division in Louisiana brought suit after the division

126. *Id.* at 355.
127. *Id.* at 357. The district court had found that the insurer also bore responsibility. *Id.*
128. 921 F.2d 565 (5th Cir. Jan. 1991).
129. *Id.* at 567.
130. *Id.* In so ruling, the court aligned itself with rulings from the Second and Ninth Circuits. *See* Silvera v. Mutual Life Ins. Co., 884 F.2d 423, 425 (9th Cir. 1989), Roy v. Teachers Ins. and Annuity Ass'n, 878 F.2d 47, 50 (2d Cir. 1989).
131. 489 U.S. 101 (1989).
132. *Id.* at 115.
133. *Id.*
134. 914 F.2d 83 (5th Cir. Oct. 1990).

was disbanded and their pension plan terminated.[135] Under the terms of the pension plan, employees with less than ten years service were considered non-vested and received no benefits.[136] Vested employees, which were those with more than ten years service, were entitled to payment of their accrued pension benefits through a deferred annuity contract payable at age sixty-five or, if their accrued benefit had a present value under $5,000, they had the option of receiving their pension benefits in a lump sum payment.[137]

Following termination of the pension plan, the Pan American Pension Committee voted to offer a lump sum benefit to vested participants whose accrued benefits had a present value of less than $20,000.[138] Morales alleged that this decision limiting the lump sum payment option to only certain participants based on their level of accrued benefits was arbitrary and capricious, thus entitling him to remedies under section 1132(a) of ERISA.[139]

Citing the *Bruch* decision, the *Morales* court held that the Pension Committee's actions "should be reviewed under an abuse of discretion standard."[140] This was because the plan documents expressly granted the committee discretion to construe the plan, to determine eligibility, to authorize disbursements, to compute the amount and form of benefits and to perform other duties related to the plan.[141] The committee's actions were upheld with the court reiterating that "ERISA does not require that participants in a plan be offered a lump-sum payment option."[142]

In *Cathey v. The Dow Chemical Co. Medical Care Program*,[143] a group health plan participant sought reinstatement of certain canceled home nursing benefits and a determination of rights to future benefits.[144] The plaintiff was a retiree of Dow whose wife had become severely disabled due to multiple sclerosis.[145] Mrs. Cathey received

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135. *Id.* at 84.
136. *Id.* at 86.
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.* at 88.
141. *Id.*
142. *Id.* (citing Pompano v. Michael Schiavone & Sons, Inc., 680 F.2d 911, 914 (2d Cir. 1982), *cert. denied*, 459 U.S. 1039 (1982)).
143. 907 F.2d 554 (5th Cir. Aug. 1990).
144. *Id.* at 555.
145. *Id.*

home nursing care for eight hours daily for almost two years.[146] The Dow program's claims fiduciary, Metropolitan Life Insurance Company, had challenged the necessity of the nursing care on several occasions.[147] During this period, Mrs. Cathey's physician had prescribed around-the-clock nursing services.[148] The nursing benefits were ultimately terminated completely by the Dow program in 1985 "under the theory that her newly elected coverage plan excludes 'custodial' care and that the nature of her nursing services were 'predominantly custodial.' "[149]

In their suit against the Dow program, the Catheys' alleged that the termination of benefits was abusive and unauthorized by the terms of the coverage.[150] The court first determined that the language of the coverage plan did not contain an express grant of discretion.[151] Therefore, the fiduciary's actions were reviewed de novo.[152] The court then found that the terms of the plan did actually exclude all custodial nursing care but provided for certain, limited home visits.[153] Thus, the fiduciary was "not free to reject, in total, claims where a portion of the nursing services is noncustodial" and otherwise covered under the plan.[154] Thus, to the extent the Dow program provided for fifty annual home nursing visits, the Catheys were found to be "due the measure of noncustodial nursing services provided during such visits."[155]

V. Federal Common Law

The intent of Congress in passing ERISA was for the courts to develop a body of federal common law governing employee benefit

146. *Id.*

147. *Id.* at 556.

148. *Id.*

149. *Id.* at 555. The election of the new plan was voluntary by the plaintiffs, presumptively due to the higher lifetime maximum benefits. *See id.* at 557.

150. *Id.* at 556.

151. *Id.* at 560. The court's rationale is troubling. A general grant of power as highlighted in footnote six of the opinion is found lacking not because it is not broad enough, but because it was contained in the appointment provision specifying the administrator was to serve until a successor was appointed. *See id.* at 559 n.6.

152. *Id.* at 560. In this regard, even when a plan grants discretion so as to bring the arbitrary and capricious standard into play, it is probable that the application of this standard is "a range rather than a point," based on factors such as the self interest of the fiduciary. Brown v. Blue Cross and Blue Shield of Ala., Inc., 898 F.2d 1556, 1564 (11th Cir. 1990) (quoting Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052 (7th Cir. 1987)). *See* Dennard v. Richards Group, Inc., 681 F.2d 306, 314 (5th Cir. 1982).

153. 907 F.2d at 561.

154. *Id.*

155. *Id.*

plans. In *Pitts v. American Security Life Insurance Co.*,[156] the Fifth Circuit did just that. Gregory Pitts was an employee of a small, family operated Louisiana plumbing company, Universal.[157] In 1985, due to financial woes, Universal merged with another small company, McKenzie, Inc., owned by the same family.[158] Universal then assumed the group health insurance policy which had covered McKenzie's employees which required the company to have a minimum of ten employees.[159] Since the newly formed company did not meet this requirement, some individuals not employed by the company were listed on the forms submitted to the insurer.[160] Pitts was listed and was actually employed by the company.[161]

Pitts was injured in an accident in January 1986 and submitted several claims for medical expenses which were promptly paid.[162] American Security did, however, notify the company that it intended to increase the premiums.[163] As a result, Universal decided to seek less expensive coverage; however, the new policy would not include Pitts.[164] Pitts' father, therefore, agreed to pay the entire amount of any increase in order to keep the policy in effect, but after a short period of time, Pitts' father could no longer afford the premiums.[165] American Security terminated the policy in June 1987 and extended benefits to Pitts for three months under the policy terms.[166]

After giving notice of termination, American Security cashed five premium checks it had been holding in order to recover some of its losses under the policy.[167] Near the end of the three month extended benefit period, Pitts filed suit seeking an injunction preventing termination of the policy.[168] Pitts argued that he was vested in the benefits under the policy.[169] American Security argued that

156. 931 F.2d 351 (5th Cir. May 1991).
157. *Id.* at 353.
158. *Id.*
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.* at 354.
163. *Id.*
164. *Id.*
165. *Id.*
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.* Pitts claimed vestment under a Mississippi state law doctrine. *Id. See* Brown v. Blue Cross Blue Shield, Inc., 427 So. 2d 139, 141 (Miss. 1983).

due to the material misrepresentations made by the company as to the number of covered employees, the policy was void.[170]

On appeal, the court held the policy was voidable, not void.[171] The Fifth Circuit noted the existence of evidence which showed American Security should have had reason to know that Universal "was probably not fulfilling the requirements of the policy."[172] American Security's cashing of the premium checks with this knowledge, and without reservation, was held to be a waiver.[173] The court went on to state that Pitts was entitled to continued benefits because

> (1) Pitts had a reasonable expectation of continued benefits; (2) the entitlement to benefits vested at the time of the injury, which was before American Security decided to cancel the policy; (3) the total disability resulting from the accident precluded Pitts from obtaining other coverage; and (4) Pitts was innocent of any wrongdoing.[174]

Finally, the *Pitts* court reiterated the five factors which should be considered when making a determination of whether to award attorneys' fees under section 502(g) of ERISA:

> (1) the degree of the opposing party's culpability or bad faith; (2) the ability of the opposing party to satisfy an award of attorney's fees; (3) whether an award of attorneys' fees would deter other persons who will be acting under similar circumstances; (4) whether the party seeking attorneys' fees sought to benefit all participants in an ERISA plan or to resolve a significant legal question under ERISA; and (5) the relative merits of the parties' positions.[175]

Simmons v. Willcox[176] presented the court with an entirely different set of issues. In that case, a discharged employee sought information from her former employer regarding the status of her accrued pension benefits under the company's employee benefit plan.[177] The company referred her to the plan administrator which provided her with requested information on several occasions and a represen-

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170. 931 F.2d at 355.
171. *Id.*
172. *Id.* at 356.
173. *Id.* at 357.
174. *Id.* at 356. The defendant conceded that if the policy was not void, the Mississippi law of vesting was applicable. *Id.*
175. *Id.* at 358 (citing Ironworkers Local No. 272 v. Bowen, 624 F.2d 1255, 1266 (5th Cir. 1980)).
176. 911 F.2d 1077 (5th Cir. Sept. 1990).
177. *Id.* at 1079.

tative of the administrator met with Simmons to discuss her options under the plan.[178]

In November 1987, Simmons received from the administrator forms on which to file a claim for benefits but did not file such a claim.[179] Instead, she sued her former employer for terminating her because of her age and sex in order to prevent her from vesting in her pension plan.[180] Simmons also alleged that her employer and the plan administrator had "breached their fiduciary duties under ERISA by denying her access to information regarding her benefits."[181]

The court of appeals upheld the district court's grant of summary judgment finding that benefits information had not been withheld; rather, the record revealed that "the defendants were quite forthcoming and cooperative."[182] Furthermore, Simmons had failed to exhaust her administrative remedies by requesting the benefits.[183] The court stated that "until she does so, [she has] no cause of action for denial of ERISA benefits" or breach of fiduciary duty.[184]

VI. Pension Fund Issues

Koch Industries, Inc. v. Sun Co., Inc.,[185] involved Koch's purchase of a Sun oil refinery in Corpus Christi, Texas.[186] As a result of the purchase, over five hundred Sun employees became employees of Koch.[187] Koch and Sun agreed to establish a special pension plan, known as the "Suntide Plan," for these employees in an effort to protect their pension benefits.[188] The plan was adopted by Sun under the acquisition agreement immediately prior to the closing date and Koch assumed the plan as of the closing date.[189] As a part of the agreement, Sun would fund the plan by transferring to it "assets equal to the present value of the benefits expected to be paid to the employees as they became eligible."[190] Sun also agreed to transfer an

178. *Id.*
179. *Id.*
180. *Id.*
181. *Id.*
182. *Id.* at 1081.
183. *Id.*
184. *Id.*
185. 918 F.2d 1203 (5th Cir. Dec. 1990).
186. *Id.* at 1205.
187. *Id.*
188. *Id.*
189. *Id.*
190. *Id.* at 1205-06.

additional amount "sufficient to fund increases in retirement benefits based on assumed annual cost of living increases for the employees of just under 7%."[191]

Sun made the necessary calculations, which were checked by Koch, and then transferred the funds in two separate payments, which were accepted by Koch.[192] Shortly thereafter, Koch notified Sun of a "deficiency in the payments by virtue of Sun's failure to pay 'interest' on the funds from the closing date until the dates of transfer."[193] Sun denied the obligation to make any additional payments for the interest amount and Koch sued for approximately $360,000.[194]

Koch alleged that section 208 of ERISA[195] was violated by Sun's refusal to make the interest payment.[196] This claim was flatly rejected by the court of appeals.[197] Section 208 provides that (1) employers may not in a merger, consolidation or transfer of a pension plan decrease liabilities of the plan, and (2) employers who transfer liability must also transfer sufficient plan assets to pay previously promised benefits as they come due.[198] The trial testimony of Sun's actuary showed clearly that the amount actually transferred by Sun was well above that needed to satisfy the requirements of section 208.[199] Given this evidence, the court found for Sun on this pension issue.[200]

VII. CONCLUSION

ERISA litigation has mushroomed in the past few years. This year's survey has segregated ERISA as a separate topic. Based upon the number of cases and myriad of issues involved under this statute, continued heavy court involvement is anticipated. Congressional tinkering, or worse, has occurred almost every year. Today's decisions may well be tomorrow's history rather than precedent. Whatever

191. *Id.* at 1206.
192. *Id.*
193. *Id.*
194. *Id.*
195. 29 U.S.C. § 1058 (1988).
196. 918 F.2d at 1206.
197. *Id.* at 1206-07.
198. *Id.* at 1207.
199. *Id.*
200. 918 F.2d at 1206-07.

Congressional action occurs, cases currently in the appellate process[201] will provide ample grist for next year's Survey.

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201. For example, cases involving the change in a plan to limit benefits for AIDS related illnesses and applied to current AIDS victims is facing the court. The court will also likely face the issue of ERISA application to a benefit plan providing similar benefits to the Texas Workers Compensation law of a nonsubscriber.