

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DANIELLE CECCHANECCHIO)	
Plaintiff)	CIVIL ACTION
)	
v.)	No. 00-4925
)	
CONTINENTAL CASUALTY CO.)	
Defendant)	

MEMORANDUM

Padova, J. **January** , **2001**

Before the Court are Plaintiff Danielle Cecchanecchio’s Motion to Remand and Defendant Continental Casualty Company’s Motion to Dismiss. Both Motions are fully briefed and ripe for decision. For the reasons that follow, the Court denies Plaintiff’s Motion to Remand, grants Defendant’s Motion to Dismiss, and grants Plaintiff leave to file an Amended Complaint.

I. Background

Plaintiff Danielle Cecchanecchio worked as a pharmacist for the Kmart corporation beginning in July of 1994. As a benefit of the employment, Plaintiff elected to enroll in a long-term disability insurance policy. In September 1997, Plaintiff was diagnosed with a severe and acute urinary condition known as interstitial cystitis. She filed for and received benefits pursuant to her short-term disability coverage. She stopped working as a pharmacist and took on a light duty position in the Kmart pharmacy. Subsequently, her medical condition caused her to be unable to perform her duties, and she filed for long-term disability benefits. Her claims were denied.

Plaintiff filed the instant action against the Defendant Continental Casualty Company in the

Court of Common Pleas of Philadelphia County, asserting breach of contract and bad faith claims. Defendant filed notice of removal on September 28, 2000, and on October 3, 2000, moved to dismiss the Complaint on the basis the plan is covered by the Employment Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001, et seq., and that the claims are therefore preempted by federal law. Plaintiff filed a response claiming that the insurance plan is not covered by ERISA, and also moved separately to remand the action to state court.

II. Discussion

A. Plaintiff’s Motion to Remand

Under the federal removal statute, a “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 . . . to the district court of the United States.” 28 U.S.C.A. § 1441(a) (West 1994). Though ordinarily the well-pleaded complaint rule requires that a federal question be apparent on the face of a non-diversity complaint removed to federal court, there are certain areas of the law that Congress has so completely pre-empted that any civil claims raised in the area are necessarily federal in character. See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 67 (1987). A claim to recover benefits due under an ERISA employee benefit plan is one such claim. Id.; Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 354 (3d Cir. 1995). As the removing party, Continental Casualty Company bears the burden of establishing the propriety of removal, and thus of establishing that the insurance plan in question is an ERISA plan. See Dukes, 57 F.3d at 350. “The existence of an ERISA plan is a question of fact, to be answered in the light of all the surrounding circumstances from the point of view of a reasonable person.” Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1120 (9th Cir. 1998).

The parties dispute that the long-term disability insurance plan in which Plaintiff was enrolled is an ERISA plan. ERISA defines an “employee welfare benefit plan” as:

[A]ny plan, fund or program which was heretofore established or is hereafter established or maintained by an employer . . . 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, . . . medical, surgical, or hospital care or benefits . . .

29 U.S.C.A. § 1002(1) (West 1999). The Department of Labor has promulgated regulations, known as the Safe Harbor regulations, designed to clarify the definition of an employee welfare benefit plan.

Under the regulations, a plan is excluded from ERISA if:

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

29 C.F.R. § 2510.3-1(j) (1999). In order for the exemption to apply, all four criteria must be met.

United States v. Blood, 806 F.2d 1218, 1220-21 (4th Cir. 1986).

The only dispute here is with respect to the third criterion,¹ which provides that “the sole functions of the employer . . . with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees, . . . to collect premiums through payroll deductions . . . and to remit them to the insurer. 29 C.F.R. § 2510.3-1(j)(3). Courts have broadly

¹Defendant acknowledges that Kmart made no financial contributions to the plan, and that the benefit is a voluntary one. (Def.’s Resp. to Pl.’s Mot. for Rem. at 4.) Neither do the parties dispute the fourth criterion.

construed this language in light of the policy underlying the regulation generally. Byard v. Qualmed Plans for Health, Inc., 966 F. Supp. 354, 359 (E.D. Pa. 1997). “An employer will be said to have endorsed a program . . . if, in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercise control over it or made it appear to be part and parcel of the company’s own benefit package.” Johnson v. Watts Regulator Co., 63 F.3d 1129, 1135 (1st Cir. 1995). Neutrality is maintained if the employer performs only administrative tasks and eschews any role in drafting of the plan, working out its structural components, determining eligibility for coverage, interpreting policy language, investigating claims, allowing or disallowing claims, or handling litigation or negotiating settlements. Id. at 1136.

Defendant has submitted the following documents in support of its contention that the plan is an ERISA plan: (1) an affidavit from Ann M. Quaintance, Kmart’s Manager of Life & Disability Plans; (2) a copy of the Summary Plan Description distributed by Kmart to its employees; and (3) a copy of Kmart Corporation’s Master Welfare Benefit Plan description. These documents establish the following:

1. Kmart analyzed, examined, negotiated, and procured the type and style of insurance, and the benefits under the plan are only available to Kmart employees. (Ex. 1 ¶ 6.)
2. Kmart implemented changes to keep the plan affordable to its associates (employees). (Ex. 1A at 3.)
3. Kmart amended the program of insurance and reserved the right to terminate or amend the insurance coverage. (Ex. 1A at 20; Ex. 1B at 8.)²

²Article V of the Kmart Corporation Master Welfare Benefit Plan states:

Although the Company established the Plan with the intent to maintain it indefinitely, it can amend or terminate the Plan by written instrument at any time and for any reason. . . . Any amendment or termination of the Plan shall not adversely affect reimbursements to which Participants, beneficiaries and/or

4. Kmart tells its employees to contact it with any questions about coverage. (Ex. 1A at 6, 20-21; Ex. 1B at 5.)
5. Claim filing is handled through Kmart's Disability Claims Coordinator. (Ex. 1A at 18.)
6. Documents prepared by Kmart and distributed to the associates refer to employee "rights" under ERISA. (Ex. 1A at 22.)

The Court concludes that Defendant has made a sufficient showing to demonstrate that the plan does not meet the third prong of the Safe Harbor regulations, and that the plan is therefore an ERISA plan. The Plan Summary and Master Document describe the plan as a company plan, and the documents refer to the disability plan as the "Kmart Corporation Long Term Disability Income Plan," while making no reference to the Continental Casualty Company. Kmart also does more than advertise the program to its employees; it serves as the point of contact as the plan administrator, and, more importantly, handles the filing of complaints. Furthermore, Kmart explicitly retained the power to terminate the plan, thus suggesting actual control rather than simple administration to make the benefit available. Based on these documents and Kmart's actions, an objectively reasonable employee would conclude that Kmart had not merely facilitated the disability benefit program's availability, but had exercised control over it, and that the plan was part and parcel of the company's own benefit package and specifically endorsed by the employer. See Shiffler v. Equitable Life Assur. Soc., 663 F. Supp. 155, 161 (E.D. Pa. 1986).

Having concluded that the disability benefit plan in question is an ERISA plan, the Court must next examine the claims brought by Plaintiff and determine the extent to which said claims are

Covered Dependents were entitled under the terms of the Plan prior to the date of amendment or termination. Thereafter, none of the Participants, beneficiaries, Covered Dependents nor the Company shall have any liability or obligation to make any further contributions under the Plan.

(Ex. 1B at 8.)

preempted. The complete preemption doctrine applies to state law causes of action that fit within the scope of ERISA's civil enforcement provision contained in section 502.³ Metropolitan Life, 481 U.S. at 64-66; Dukes, 57 F.3d at 354-55. Complete preemption under ERISA section 502(a) is a jurisdictional concept. In re U.S. Healthcare, Inc., 193 F.3d 151, 160 (3d Cir. 1999). Only state law claims that are completely preempted and that fall within the scope of section 502 are removable and subject to dismissal in federal court. In re U.S. Healthcare, 193 F.3d at 160.

ERISA also provides for a second type of preemption, under section 514(a).⁴ Dukes, 57 F.3d at 355. Section 514(a) preemption, or express preemption, is a substantive concept that governs the applicable law, which does not by itself create removal jurisdiction. Id. It is important to distinguish

³ERISA is a federal statute designed to comprehensively regulate employee welfare benefit plans that "through the purchase of insurance or otherwise," provide medical care. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987). Section 502(a) of ERISA contains a civil enforcement mechanism which provides:

A civil action may be brought -

- (1) by a participant or beneficiary . . .
 - (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
- (2) by the Secretary, or be a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
- (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a) (West 1994). Section 1109 creates personal liability for breach of fiduciary duty. 29 U.S.C. § 1109(a) (West 1994).

⁴Section 514(a) states ERISA's preemptive effect as follows:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a) (1994).

between complete preemption, which governs the jurisdictional inquiry, and express preemption, which is a substantive concept. In re U.S. Healthcare, 193 F.3d at 160. With respect to state law claims that fall outside the scope of section 502, the district court lacks removal jurisdiction over such claims, even if they are preempted by section 514(a). Id. In such a case, the district court only has power to remand such claims to the state court. Id.

To consider whether the claims stated are completely preempted, the Court considers whether they “fall within the scope of” ERISA’s civil-enforcement provisions. Dukes, 57 F.3d at 355. The Third Circuit distinguishes between claims regarding the quantity and the quality of the benefits due under a plan. In re U.S. Healthcare, 193 F.3d at 161-63. Quantity of care claims are those that involve the defendant’s failure to provide or pay for certain benefits, or statements that a certain treatment is a benefit due under an employee benefit plan. Id. at 162. Quality of care claims are those that seek to hold a defendant liable for its role as the arranger of medical treatment whether in terms of its decisions about the treatment of individual plaintiffs or adoption of certain treatment policies. In re U.S. Healthcare at 162-63. Only the former, quantity claims, are completely preempted under ERISA section 502(a). Id. at 162. Claims about the quality of provided service are not completely pre-empted.; the district court lacks removal jurisdiction over such claims. Id. at 162-63.

Here, all but at least two of the claims are completely pre-empted. Count One, which brings a breach of contract claim, seeks “to recover benefits due to him under the terms of his plan, . . . [and] to enforce his rights under the terms of the plan.” 29 U.S.C. §1132(a)(1)(B); see Kolb v. Livengrin Foundation, Inc., Civil Action No. 92-1703, 1992 U.S. Dist. LEXIS 17172, at *12 (E.D. Pa. Nov. 9, 1992). Count Three, which brings a declaratory relief claim, is also completely preempted. See Norris v. Continental Casualty Co., CIVIL ACTION No. 00-1723, 2000 U.S. Dist. LEXIS 9163, at

*4 (E.D. Pa. June 29, 2000). Because two of the claims are completely preempted, removal is proper, and the Court has jurisdiction over the claims.⁵ The Court therefore denies Plaintiff's Motion to Remand.

B. Defendant's Motion to Dismiss

Having determined that removal is proper, the Court grants Defendant's Motion to Dismiss all three counts of the Complaint. As discussed above, Counts I and III are completely pre-empted, and therefore must be dismissed. See Norris, 2000 U.S. Dist. LEXIS 9163, at *3 (dismissing claims subject to complete preemption). Count II, which brings a bad faith claim under Pennsylvania law, is subject to express pre-emption under §514(a). See Asprino v. Blue Cross & Blue Shield Ass'n, Civil Action 96-7788, 1997 U.S. Dist. LEXIS 6708, at *4 (E.D. Pa. May 7, 1997). It is therefore dismissed with prejudice.

The Court, however, grants Plaintiff leave to file an Amended Complaint bringing claims for relief pursuant to the ERISA statute.

An appropriate Order follows.

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⁵The Court has supplemental jurisdiction over Count II. See Davis v. SmithKline Beecham Clinical Labs., Inc., 993 F. Supp. 897, 899 (E.D. Pa. 1998).

CONTINENTAL CASUALTY CO.)
Defendant)

ORDER

AND NOW, this day of January, 2001, upon consideration of Plaintiff Danielle Cecchanecchio's Motion to Remand (Doc. No. 4), and any responses thereto, **IT IS HEREBY ORDERED** that said Motion is **DENIED. IT IS FURTHER ORDERED** that:

1. Upon consideration of Defendant Continental Casualty Company's Motion to Dismiss Plaintiff's Complaint (Doc. No. 2), and any responses thereto, Defendant's Motion is **GRANTED**, and Counts I, II, and III of Plaintiff's Complaint are **DISMISSED**.
2. Plaintiff is granted leave to file an Amended Complaint. Such Amended Complaint shall be filed on or before February 19, 2001.

BY THE COURT:

John R. Padova, J.