

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

EARL H. BROWN : CIVIL ACTION
 :
 v. :
 :
 THE PAUL REVERE LIFE INSURANCE :
 COMPANY : NO. 01-1931

MEMORANDUM AND ORDER

Norma L. Shapiro, S.J.

May 20, 2002

Dr. Earl Brown ("Brown"), filing this action for breach of an insurance contract and for bad faith under 42 Pa. Cons. Stat. Ann. § 8371, asserts that defendant Paul Revere Life Insurance Company ("Paul Revere") has wrongfully refused to pay him proceeds of a disability insurance policy. Brown claims to have developed post-traumatic stress disorder from the practice of emergency medicine; Paul Revere contends he is not eligible for lifetime disability benefits for his inability to practice medicine.

Paul Revere argues that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1002, et seq., preempts Brown's state law claims. Paul Revere's Motion to Apply ERISA was denied because there were disputed issues of material fact.¹ On March 18 and 25, 2002, a bench trial was held to resolve these disputed facts. A judgment for Paul Revere would require Brown to replead his complaint under ERISA's civil enforcement provisions; a judgment for Brown would allow his state law causes of action to be tried to a jury.

After a review of the record and the briefs, the court now

¹The court, with the parties' consent, construed the Motion as one for summary judgment. Paul Revere has also moved for summary judgment on plaintiff's state law causes of action, and has moved in limine to exclude evidence at a jury trial. See infra p. 17 n. 8.

makes the following findings of fact and conclusions of law.

I. FINDINGS OF FACT

1. Brown is a board-certified emergency room physician.

2. In June, 1984, Brown and three other physicians formed a professional corporation, Lower Merion Emergency Medical Associates, P.C. ("LMEMA"). Brown served as LMEMA's President. Mary Murphy ("Murphy") served as LMEMA's Treasurer. Lloyd Feigenbaum ("Feigenbaum") and Robert Fine ("Fine") were shareholders. Tr. March 18, 2002, at 12, 52, 79.

3. LMEMA's source of income was a contract with Lankenau Hospital to provide emergency room care at that hospital. Id. at 39.

4. In 1986, LMEMA hired a financial advisor to explain how the corporation could provide benefits to its employees. Tr. March 18, 2002, at 13.

5. According to this advisor, if LMEMA paid for certain benefits, such as disability insurance, the individual's later collection of those benefits would be tax-free. Id. at 14-15.²

6. LMEMA created a structure to pay for employee benefits to take advantage of these purported tax consequences:

A. LMEMA kept the salary of each of its shareholders/employees low enough to have surplus money available on a regular basis. Id. at 32.

B. Murphy divided this "bonus" money equally between

²To the extent that Murphy correctly remembered the advisor's position, it was not a correct statement of the law.

the four shareholders. Id.

- C. Before paying a shareholder his or her share, Murphy deducted payments the corporation had made on the employee's behalf (hereinafter "bonus deductions"). These bonus deductions included: continuing medical education; reimbursement for the cost of conferences and publications; professional dues; costs for examinations; parking fees; disability insurance; and medical insurance. Id. at 33.
- D. LMEMA did not require any employee to purchase insurance, remit dues, or receive parking reimbursement. Id. at 33. Murphy, for example, did not ask LMEMA to pay for her disability insurance with bonus deductions. She received correspondingly larger bonuses from LMEMA. Id.
- E. LMEMA treated each bonus deduction as a corporate expense, and did not report the deductions as employee income on W-2 forms. Id. at 31-32.
- F. Disability insurance was paid for out of each employee's pretax income. Id. at 31.

7. After 1991, when Fine left LMEMA, the bonus distribution changed to give preference to more senior doctors, but the overall structure remained the same. Id. at 26-27. At all times, bonuses were proportional to the shares each employee owned in the corporation. Id. at 27.

8. Murphy stated that LMEMA treated "bonus deductions" as the property of the individual shareholders. Id. at 43; cf. id. at 24 ("bonus money" part of wages owed shareholders); id. at 70 (testimony of Brown that bonus money "was mine"). This testimony was contradicted by the LMEMA's practice. Murphy, testifying about LMEMA's profit and loss statement for 1997-1998 (D. Ex. 5), stated that she had included a refund on the accrued interest of Feigenbaum's Northwestern Mutual Insurance policy as partnership income in the year the amount was refunded. Id. at 22. On cross-

examination, Murphy claimed this tax treatment was a mistake: "it really was [Feigenbaum's] refund..." Id. at 43. She admitted that each of LMEMA's remaining shareholders had been paid a share of Feigenbaum's "refund." Id. at 43-44. On balance, Murphy's testimony that LMEMA had a consistent policy of treating the bonus distributions as employee property was not altogether credible.

9. In 1986, during or after the shareholders' meeting with the financial planner, Brown presented LMEMA with his bill for a preexisting Paul Revere disability insurance policy to take advantage of the tax savings offered by the corporate payment system. Id. at 56, 70.

10. In June, 1986, Paul Revere issued Brown the insurance policy at issue here. Pl's Ex. 7 (the "Policy"). The Policy included total disability "own occupation" coverage: Brown contends that if he is unable to work as an emergency medical physician, he is entitled to receive disability benefits. Id. at 71. One other shareholder, Fine, bought a similar disability policy. Id. at 57; Dep. of Arakelian at 7. Any other LMEMA shareholder was eligible to purchase insurance through Paul Revere. Id. at 57.

11. On June 24, 1986, Brown's insurance agent, Clark Colburn ("Colburn"), filled out most of the application for the Policy that Brown signed. Id. at 72. No LMEMA or Paul Revere employee helped Brown fill out his application. Id. at 73.

12. The Policy's application provides a contradictory account of how the premiums were to be paid:

- A. In section "M: Premium Information," boxes in subsection 3, labeled "Paid by: Proposed Insured," and "Notices to: Residence" have been checked as

opposed to employer and business alternatives. Pl's. Ex. 7, at addendum 7.

- B. But in section N ("Corrections and Amendments (For Home Office Use Only)), someone has written, in different handwriting, "M4-Employer Pay." M4 refers to "Check Pay Method", and is not relevant to issues of purchaser identity.
- C. In practice, LMEMA paid for the Policy through Brown's bonus deductions. Id. at 70; see also supra, Finding of Fact #6 (discussing the bonus payment system); D. Ex. 2 (bills sent to LMEMA by Paul Revere). The bills were paid on a LMEMA checking account, and signed by its Treasurer. Id. at 17. The effective date of the Policy paid for by LMEMA was October 15, 1986. Id. at 18. There is no evidence that LMEMA contributed any money to the Policy premiums apart from that paid from Brown's share of the bonuses.

13. Brown did not treat LMEMA payments of Policy premiums as income for tax purposes. Id. at 31.

14. Sandra Arakelian, a billing supervisor managing the Policy's implementation, testified that the Policy was less expensive than it would have been if Brown had obtained it without LMEMA's intervention:

- A. Paul Revere treated the Policy as an "employee security plan" ("ESP"). Paul Revere makes ESPs available to employers who wish to insure multiple employees. Under an ESP, the employer is sent one bill listing the premiums owed for all employees, with a premium discount to each policyholder. Both Brown and Fine bought Paul Revere ESPs in 1986. Brown's policy premiums were discounted by fifteen percent (15%) because the Policy was an ESP. Dep. of Arakelian at 6-8.
- B. Brown continues to pay a discounted premium: in 2002, the Policy's actual premium was \$4,004.99 annually, while the premium without a discount would have been \$4,676.46. Id. at 11-12.

15. Arakelian's testimony was partially credible. She

stated that Paul Revere usually requires three or more insured employees before treating an employee's policy as an ESP, id. at 21-22, but admitted that all that is required for an employer sponsored policy is that an employer is responsible for "receiving the billing and paying the premium." Id. at 38. She was unable to testify if Brown had received the 15% discount when he purchased additional insurance after 1986. Id. at 26-27. She was unable to explain how Brown's insurance premium is now calculated. Id. at 49. Brown testified that he was unable to calculate the discount he received. Id. at 65, 67-68.

16. The evidence established: (1) Paul Revere discounted the premiums for the Policy by 15% at the beginning of its term; (2) this discount was unavailable to individuals but was available to Brown because the premiums were billed to and paid by his employer; (3) later increases in the premium may or may not have been discounted; (4) all that was required to obtain a Paul Revere discount was payment by an employer (Paul Revere did not inquire about the source of funds).

17. Paul Revere sent all information about the Policy, including opportunities to change coverage, directly to Brown at his home address. Id. at 74. LMEMA was not involved with decisions Brown made to purchase additional benefits. Id. at 75.

18. In 1992, Fine left LMEMA, and took his insurance coverage with him. Id. at 36, D. Ex. 2. LMEMA paid no premiums on Fine's insurance policy after he left the corporation. Id. Murphy, writing to Paul Revere concerning the list bill, informed the insurer that "Robert Fine is no longer employed by [LMEMA]. Please bill him directly at [his home address.]" Id.

19. In 1997, Lanckenau terminated LMEMA's contract. Id. at

39. Because its income stream had diminished, the shareholders decided to stop paying insurance premiums through employee bonus deductions. Id. at 39.

20. Brown paid the premiums himself after April 14, 1997. Id. at 38, 67, 76. There was no increase in the premium. Id. at 69. LMEMA has no contact with Paul Revere concerning the Policy. Id. at 78.

21. LMEMA filed a certified final tax return on June 30, 2000. Id. at 41. In 2000, it also filed an affidavit certifying it was going out of existence. Id.; P. Ex. 59. However, the Secretary of State's records state that LMEMA is still a duly incorporated and subsisting corporation in Pennsylvania. Id. at 10; D. Ex. 1. Brown is still LMEMA's president. Id. at 79.

II. **DISCUSSION**³

A. JURISDICTION

Plaintiff asserts diversity jurisdiction under 28 U.S.C. § 1332. Paul Revere, a Massachusetts corporation, and Brown, a Pennsylvania citizen, are diverse, and there is the statutory requisite amount in controversy.

Paul Revere contends that ERISA preempts Paul Revere's state law causes of action, and that federal question jurisdiction exists under 28 U.S.C. § 1331. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (defining ERISA preemption).

Either way, this court has subject matter jurisdiction. Paul Revere does not contest personal jurisdiction. If plaintiff's

³Any facts in the Discussion section not found in the Facts section are incorporated by reference therein.

state law claims are preempted, venue is proper under 28 U.S.C. § 1391(b)(2). If not, venue is proper under 28 U.S.C. § 1391(a)(2).

B. ERISA PREEMPTION

Congress enacted ERISA to protect participants in employee benefit plans. See 29 U.S.C. § 1001(a) & (b). To assure uniform treatment, Congress provided that where a plan is covered by ERISA, all state laws relating to the plan are preempted. Id. at § 1144(a); see Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138-39 (1990). Preemption serves the Congressional goal of minimizing burdens on plan administrators and reducing costs for beneficiaries. See Egelhoff v. Egelhoff, 532 U.S. 141, 150 (2001). However, preemption is an affirmative defense, and the burden is on the defendant to assert its application to any given plan.

The ERISA statute defines a covered Policy as:

Any plan, fund or program which was . . . 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

29 U.S.C. § 1002(1).

Courts have observed this definition is "nearly tautological," Demars v. Cigna Corp., 173 F.3d 443, 445 (1st Cir. 1999): a plan is an employee benefit plan (governed by ERISA) if it was established or maintained by an employer to benefit employees.

"[T]he 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." Credit Managers Ass'n

v. Kennesaw Life & Accident Ins. Co., 809 F.2d 617, 625 (9th Cir. 1987).

The issues are: (1) whether the Policy, on its face, is governed by ERISA; (2) if so, whether the "safe harbor" regulations, 29 C.F.R. § 2510.3-1(j), nevertheless defeat preemption; and (3) whether anything after the Policy's formation changed its status. See Waks v. Empire Blue Cross/Blue Shield, 263 F.3d 872 (9th Cir. 2001) (addressing issue of "conversion").⁴

1. Brown's Policy, on its Face, is Governed by ERISA.

Disability insurance is governed by ERISA if it is provided by "any plan, fund, or program ... established or maintained by an employer ... for purpose of providing for its participants ... benefits" 29 U.S.C. § 1002(1). The Policy satisfies this statutory definition.

The Policy is a "plan" because "from the surrounding circumstances a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." Smith v. Hartford Ins. Group, 6 F.3d 131, 136 (3d Cir. 1993). A reasonable person could

⁴This approach (addressing the general rule before inquiring about the "safe harbor") makes logical sense, even if varies the order and content of the test provided by the leading case authority. Cf. Thompson v. American Home Assur. Co., 95 F.3d 429, 434-35 (6th Cir. 1996) (asking: (1) does safe harbor apply; (2) is there an ERISA "plan" and (3) was the plan established or maintained to benefit employees). The safe harbor is intended to clarify the statutory language; its language is exclusionary and restrictive. Cf. Peckham v. Gem State Mut., 964 F.2d 1043, 1049 n. 10 (10th Cir. 1992) (fact that safe harbor does not apply does not mean that ERISA does apply); McNeil v. Time Ins. Co., 205 F.3d 179, 190 (5th Cir. 2000) (a plan can not be governed by ERISA if all the safe harbor "exclusions" apply). Applying the safe harbor first exaggerates the importance of its exclusionary clauses. It is better to first ask the general question, does this plan appear to be governed by ERISA, and only then determine if the exclusion applies.

ascertain: (1) the Policy intended to provide disability benefits; (2) the class of beneficiaries was employees of LMEMA; (3) pre-tax payments to Paul Revere by LMEMA were the source of the Policy premiums; and (4) benefits were to be paid directly to the insured.

LMEMA established or maintained this plan to benefit its employees. Its shareholders decided that it should offer pre-tax insurance premiums in 1986. Such insurance premiums bought the Policy at issue and replaced a policy formerly issued to Brown as an individual. The new Policy, complete with a discount only available to employees, was one of the benefits the Corporation offered its employees once its income was sufficiently stable. The purchase of insurance by an employer is strong, if not conclusive, evidence that the employer has established or maintained the plan under ERISA. See Madonia v. Blue Cross & Blue Shield, 11 F.3d 444 (4th Cir. 1993) (conclusive evidence); Randol v. Mid-West Nat'l Life Ins. Co., 987 F.2d 1547 (11th Cir. 1993) (where employer deducted from paycheck and contributed \$75 toward each premium payment, employer had maintained policy); Brundage-Peterson v. Compicare Health Services Ins. Corp., 877 F.2d 509, 511 (7th Cir. 1989) (where the employer arranged and paid for insurance, ERISA plan created); cf. Gaylor v. John Hancock Mut. Life Ins. Co., 112 F.3d 460, 464 (10th Cir. 1997) (mere purchase of insurance not conclusive, but is evidence that employer has expressed an intention to provide long term benefits). LMEMA paid the insurance premiums through its employees' bonus deductions until it was unable to do so in 1997. This bonus deduction structure enabled LMEMA employees to obtain insurance coverage at lowered cost (through tax benefits and discounts).

ERISA applies on the face of the Policy because it is a part of a well-defined plan, established by LMEMA to provide benefits to its employees.

2. The Safe Harbor Regulation Does Not Apply.

The safe harbor provision, 29 C.F.R. § 2510.3-1(j), states that: "[f]or purposes of title I of the Act and this chapter, the terms 'employee welfare benefit plan' and 'welfare plan' shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:

(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 services actually rendered in connection with payroll deductions or dues checkoffs."

The parties agree that the safe harbor regulation is relevant,⁵ participation in the program was voluntary (safe harbor 2), and LMEMA did not receive consideration for the provision of insurance to employees (safe harbor 4). The provisions of the safe harbor in dispute are: (1) whether the "contribution" was made by LMEMA; and (3) whether LMEMA "endorsed" the policy.

⁵For the first time at oral argument, Brown's counsel contended that the Policy was not a "group policy" because it was issued to Brown as an individual. However, the Policy is clearly of the "group-type;" it was treated by Paul Revere as an ESP, usually available to groups of three or more. Multiple policies were billed together to LMEMA monthly.

a. LMEMA Made a "Contribution" Precluding Application of the Safe Harbor Provision.

The meaning of "no contributions are made by an employer" has not been decided by the Court of Appeals for the Third Circuit.

Brown analogizes LMEMA's bonus deduction payment system to paycheck withholding. Paycheck withholding is not an employer contribution under 29 C.F.R. § 2510.3-1(j)'s exclusionary definition.⁶ Paul Revere argues that Brown did not declare the bonus deductions as income, so he can not now claim that he, rather than LMEMA, paid for the Policy. Cf. Morris v. Paul Revere, 986 F. Supp. 872 (D.N.J. 1997) (Orlofsky, J.).

In Morris, the plaintiff, a chiropractor and co-owner of a small business, argued 29 C.F.R. § 2510.3-1(j)(a) precluded preemption. Like here, the business paid the policy's premiums, and the plaintiff did not declare them as income. Morris, protesting that he had instructed his accountant to declare the premium payments as income and had since filed amended returns, asked the court to read an employee's "intent" into the contribution provision.

In his well-reasoned opinion, Judge Orlofsky held that "contribution" should be given its clear meaning: if an employer pays for a premium, then it has contributed. To determine whether an employer has paid, the court considered the behavior of the parties at the time of the payment, not later, self-serving allegations: if the employee did not report the premium payments as income, and avoided income tax on the premiums, he could not

⁶See Rubin v. Guardian Life Ins. Co. of Am., 174 F. Supp. 2d 1111 (D. Or. 2001) (paying premiums through payroll deductions did not preclude plan from falling within safe harbor); see also Thompson, 95 F.3d at 435 (where employer withheld contributions from paychecks, the parties both "admitted" that safe harbor criterion (1) was satisfied); cf. 29 C.F.R. § 2510.3-1(j)(3) (safe harbor applies when premium payments are no more than "payroll deductions" or a "dues checkoff").

later claim the premiums for ERISA purposes. Id. at 880-81. Individuals must live with the consequences of their tax filings. Logically, if an employee treats a premium as taxable income, he has represented the premium amount was his payment. If not, then he has represented the premium amount was paid by his employer rather than by him. Brown is estopped by his contemporaneous tax returns from claiming that he paid the premiums for the Policy. Just as the plaintiff in Morris, Brown can not rely on later averments about his intent regarding these premiums.

Judge Orlofsky's opinion does not totally dispose of the inquiry about "contribution" here. Morris involved the payment of premiums out of the general funds of the corporation. See Morris, 986 F. Supp. at 875-76; see also Randol, 987 F.2d 1547 (employer maintained policy when it contributed \$75 toward each premium payment out of general corporate funds). But here, LMEMA paid premiums from each individual shareholder's allocation of corporate profits (akin to dividends). These bonuses were regularly distributed, and LMEMA's Treasurer testified that it was a "mistake" to return an excess premium to corporate funds instead of to the individual shareholder. Cf. supra Finding of Fact #8. According to Brown, the LMEMA bonus deduction system was nothing more than payroll deduction in a different form.

Brown's argument fails in part because of his contemporaneous tax returns: the bonus deductions were not his in the same way mere deductions from salary would have been. But even if LMEMA's bonus deductions were equivalent to payroll deductions, the advantages of the bonus system distinguish Brown's Policy from one excluded from ERISA by 29 C.F.R. § 2510.3-1(j)(1). LMEMA contributed to the Policy by enabling payments from pre-tax income and by allowing Brown discounted premiums as an employee of the corporation. Where an employer provides its employees benefits they can not receive as individuals, it has contributed to an

ERISA plan. See Kuehl v. Provident Life & Accident Ins. Co., 2000 U.S. Dist. LEXIS 21625, *10 (E.D. Wis. Apr. 20, 2000) (contribution exists where 10% discount available only to employees in group plans); WEBSTER'S NEW WORLD DICTIONARY 303 (1988) (defining "contribute to" as a having a "share in bringing about a result[;] ... be partly responsible for"); cf. 26 CFR § 54.4980B-2 (in determining eligibility for continuation coverage statute (COBRA), Treasury Regulation states: "a group health plan is maintained by an employer ... even if the employer ... does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization.");⁷ but see Rubin, 174 F. Supp. 2d at 1117 (no contribution where premiums were discounted because of aggregations). The 15% discount was available to Brown only because he bought insurance together with other employees of LMEMA. The tax benefit he took advantage of was available only because LMEMA organized the bonus payment system as it did. But for Brown's status as a LMEMA employee, the premium payments on the Policy would have been higher in absolute terms and would have been payable with taxable income. Although it is true that Brown's share of bonus money would ultimately have been his, this does not make premium payments from "bonus deductions" protected like "payroll deductions" under 29 C.F.R. § 2510.3(j)(1).

The safe harbor's first exclusionary definition, 29 C.F.R. §

⁷This regulation could be read against Paul Revere. It suggests that simply receiving benefits at lower cost does not equal an employer contribution. But it is not advisable to parse the difference between the COBRA and ERISA regulations as if they were the statutes at issue. Both regulations address the meaning of "established or maintained by an employer." If an employee's ability to buy a policy at a discount rate by virtue of his employment status suffices to "maintain" a policy under the COBRA regulation, it should also create an employer contribution under the safe harbor.

2510.3-1(j)(1), does not apply because LMEMA made a "contribution" to the Policy by providing Brown a benefit he could not have received as a non-employee.

(b) Endorsement by LMEMA is Irrelevant in View of its Contribution.

Because the "no contribution" requirement is not met, it is unnecessary to resolve if, from a reasonable third party's perspective, LMEMA endorsed the Policy. See Thompson, 95 F.3d at 435 (all four criteria must be met); Johnson v. Watts Regulator Co., 63 F.3d 1129, 1137 (1st Cir. 1995) (endorsement analyzed from reasonable third party's perspective).

(3) Nothing Happened After the Policy's Formation to Change its Status.

Brown, noting that he paid the premiums on his policy after LMEMA dissolved, argues that ERISA can not apply when there is no employer to administer the plan. He contends the Policy was converted even though there was no express conversion right.

According to the records of the Secretary of State, LMEMA is still a legal entity. The principals of LMEMA contend they have completed all the formalities required to dissolve the corporation. But, it is not necessary to decide if LMEMA is really a defunct corporation.

Some cases have held that a policy once governed by ERISA may be "converted" to a non-ERISA policy if an employee who has left a company explicitly exercises a contractual right to "convert" to an individual plan. See Waks, 263 F.3d 872 (absent an employer-employee relationship, conversion doctrine excepts policy from ERISA); Demars, 173 F.3d 443 (applying ERISA to converted policy would create "all-too-distant" relationship between the plan and

the insurance claim); see also Chami v. Provident & Accident Ins. Co., 2002 U.S. Dist Lexis 2528 (N.D. Ind. February 5, 2002) (following Demars and Waks); Mimbs v. Commercial Life Ins. Co., 818 F. Supp. 1556 (S.D. Ga. 1993) (converted policies not subject to ERISA); but see Massachusetts Cas. Ins. Co. v. Reynolds, 113 F.3d 1450 (6th Cir. 1997) (ERISA still applies when partner continued coverage under individual plan after leaving partnership); Painter v. Golden Rule Ins. Co., 121 F.3d 436 (8th Cir. 1997) (ERISA governs policy converted from group to individual coverage). This "conversion doctrine" has not yet been adopted by the Court of Appeals for the Third Circuit, nor by any court in this district.

Even if conversion rights were recognized, no court has ruled that a plaintiff who does not convert, but simply continues to pay as an individual when his employer becomes defunct, has removed his policy from ERISA coverage. Waks stated that ERISA preemption after conversion would be "an absurd result because there is no ERISA plan and no administrator." Waks, 263 F.3d at 876, citing Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 16 (1987) ("It would make no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate."). But Waks did not rest on this ground, and distinguished earlier cases where an employee had not elected to convert.

If a policy could be converted absent a contractual right and without any evidence the individual notified his insurer that he was no longer employed, a purpose of ERISA preemption would be undermined. One rationale for preemption is to lower administrative costs: forcing an insurer to know the insured's employment status would increase costs and burden beneficiaries. The burden must be on Brown to prove that he elected to convert by informing Paul Revere that LMEMA was defunct; he was best placed to know this alleged fact. Cf. G. CALABRESI, THE COST OF ACCIDENTS 140-44 (1970) (liability should be placed on the party who avoids

costs at least expense). Brown provided no evidence satisfying this burden; he continues to receive discounts available only to groups of individuals.

Brown may not avoid preemption as if the Policy had been converted because he never informed Paul Revere that LMEMA had allegedly ceased operations and he was no longer a LMEMA employee.

III. CONCLUSIONS OF LAW

1. The Policy was established or maintained to provide benefits to LMEMA employees; it is governed by ERISA.

2. The safe harbor regulation does not apply because LMEMA contributed to the Policy's purchase by providing Brown with the ability to obtain discounted premiums and pay those premiums with pre-tax income. Brown is estopped from arguing that he paid the premiums personally.

3. Brown never informed Paul Revere that LMEMA had ceased operations and he was no longer employed by LMEMA, so his Policy has not been converted to an individual, non-ERISA, policy.

4. Brown's state law causes of action are preempted by ERISA and must be dismissed, but Brown may amend his complaint to restate his claims under ERISA.⁸

5. An appropriate Order follows.

⁸Because no jury trial will follow, Paul Revere's pending Motion for Summary Judgment on Brown's state law claims and Motion in Limine are moot and will be denied.

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

EARL H. BROWN : CIVIL ACTION
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 THE PAUL REVERE LIFE INSURANCE :
 COMPANY : NO. 01-1931

JUDGMENT

AND NOW, this 20th day of May, 2002, on consideration of defendant's seventh affirmative defense, the parties' briefs, and the evidence established at trial on March 18 and 25, 2002, it is **ORDERED** that:

1. This action is governed by ERISA. Plaintiff's state law claims are **PREEMPTED** and **JUDGMENT IS ENTERED** against plaintiff Earl H. Brown and for defendant Paul Revere Insurance Company on plaintiff's Amended Complaint, without prejudice to filing a Second Amended Complaint.

2. Plaintiff shall have until June 4, 2002, to file a Second Amended Complaint expressly framing any or all of his preempted state law causes of action as claims within ERISA's civil enforcement provision, 29 U.S.C. § 1132. Defendant shall have twenty (20) days after service of such amended complaint to move, answer, or otherwise plead.

3. Paul Revere's Motion for Summary Judgment (erroneously docketed twice as #31 and #34) on plaintiff's state law causes of action is **DENIED AS MOOT**.

4. Defendant's Motion in Limine Regarding the Characterization of Plaintiff's Occupation (erroneously docketed twice as #30 and #33) is **DENIED AS MOOT**.

Norma L. Shapiro, S.J.