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

GLENN S. SMITH, and KATHY SMITH, Plaintiffs, v. THE PRUDENTIAL HEALTH CARE PLAN, INC., and TRUSTEES OF THE PENNSYLVANIA AUTOMOTIVE ASSOCIATION INSURANCE TRUST, Defendants.	Civil Action No. 97-891

Gawthrop, J. May , 1997

M E M O R A N D U M

Before the court is Defendant Prudential Health Care Plan, Inc's Rule 12(b)(6) Motion to Dismiss this Complaint alleging breach and negligent performance of a health insurance contract. Defendant removed this action from the Bucks County Court of Common Pleas, and now moves for its dismissal, on the grounds that the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq., preempts Plaintiffs' claims. Upon the following reasoning, I shall grant Defendant's Motion to Dismiss.

I. Background

Plaintiff Glenn S. Smith alleges that he had a health insurance contract with Defendant Prudential Health Care Plan, Inc. ("PruCare"), through its contract holder, Defendant Trustees

of the Pennsylvania Automotive Association Insurance Trust. This contract, the PruCare HMO Plan, is attached to the Complaint.

On January 18, 1995, Mr. Smith injured his leg in an automobile accident. He was told that he needed surgery to reduce his heel bone, and that without surgery the bone fragments would fuse, causing Mr. Smith permanent injury. Defendants, however, allegedly refused to approve the surgery. Surgical correction is no longer possible.

On January 7, 1997, Mr. Smith and his wife, Kathy Smith, filed a Complaint in the Bucks County Court of Common Pleas, alleging breach of contract, negligent performance of contract, and loss of consortium. PruCare removed this action and now moves for its dismissal on the grounds that it is preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq.

II. Standard of Review

A court should dismiss a complaint pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a cause of action only if it is clear that no relief could be granted under any set of facts consistent with the complaint's allegations. Hishon v. King & Spalding, 467 U.S. 69, 73 (1984). In deciding a Rule 12(b)(6) motion, a court must accept as true the facts pleaded in the complaint and will draw all reasonable inferences in the plaintiff's favor. See D.P. Enterprises, Inc. v. Bucks County Community College, 725 F.2d 943, 944 (3d Cir. 1984). At this

stage, a court may consider the complaint, exhibits attached to the complaint, matters of public record, and undisputedly authentic documents if the plaintiff's claims are based upon those documents. Pension Benefit Guar. Corp. v. White Consol. Indus., 998 F.2d 1192, 1196 (3d Cir. 1993), cert. denied, 510 U.S. 1042 (1994).

If the court considers material outside the pleadings, the court shall treat the motion to dismiss as one for summary judgment. Fed. R. Civ. P. 12(b). Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). Unless evidence in the record would permit a jury to return a verdict for the non-moving party, there are no issues for trial, and summary judgment becomes appropriate. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In considering a motion for summary judgment, a court does not resolve factual disputes or make credibility determinations, and must view facts and inferences in the light most favorable to the party opposing the motion. Siegel Transfer, Inc. v. Carrier Express, Inc., 54 F.3d 1125, 1127 (3d Cir. 1995). However, the party opposing the summary judgment motion must come forward with sufficient facts to show that there is a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317 (1986).

III. Discussion

ERISA applies to employee benefit plans established or maintained by employers engaged in commerce or in activities affecting commerce. 29 U.S.C. § 1003(a). If ERISA applies, it preempts any state-law claims which "relate to" the employee benefit plan. See 29 U.S.C. § 1144(a); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45 (1987).

A. The Existence of an Employee Benefit Plan

An essential prerequisite for preemption is the existence of an employee benefit plan. In this case, the parties dispute whether such a plan exists. Defendant maintains that ERISA governs the Pennsylvania Automotive Association ("PAA") Trust, a plan which purchases group insurance policies, including the PruCare HMO Plan. Plaintiffs counter that this plan does not fulfill the ERISA definition of an employee benefit plan. Because both parties have submitted material outside the pleadings, I shall treat Defendant's Motion to Dismiss as a motion for summary judgment under Fed. R. Civ. P. 56 on the issue of whether an ERISA-governed plan exists.[1]

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1. Although Plaintiffs have not submitted material directly addressing this issue, they have had an opportunity to respond to Defendant's contentions and they have submitted other material outside the pleadings. Further, the answer to the question of whether an ERISA plan exists is critical for determining the viability of Plaintiffs' claims and the proper forum for those claims.

Defendant has submitted evidence that the PAA is a non-profit trade association of automobile dealers. PAA members formed the PAA Trust in order to provide medical and other benefits to their employees, including Plaintiff Glenn Smith.[2] The PAA Insurance Trust's Agreement and Declaration of Trust ("Trust Agreement") outlines the structure of this Trust. Because the Trust was formed by more than two employers for the purpose of providing employee benefits, the Trust is a Multiple Employer Welfare Arrangement ("MEWA").[3] Defendant maintains that the PAA intended for ERISA to cover this MEWA. However, the mere intent to form a MEWA governed by ERISA does not guarantee that ERISA actually will apply: the MEWA still must satisfy the statutory requirements. See MDPhysicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d 178, 183 n. 7 (5th Cir.), cert. denied, 506 U.S. 861 (1992). ERISA governs only those MEWAs which it considers employee benefit plans.

ERISA defines an employee benefit plan as either a pension benefit plan or an employee welfare benefit plan. 29 U.S.C. § 1002(3). An employee welfare benefit plan ("EWBP"), by

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2. Mr. Smith is employed by Colonial Auto Body, which is owned either by Fred Beans Ford or Thompson Toyota. The precise identity of the owner is not material, because both dealers subscribe to the PAA Trust.

3. In relevant part, ERISA defines a MEWA as "an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing a [pension or welfare] benefit . . . to the employees or two or more employers . . . or to their beneficiaries . . . ." 29 U.S.C. § 1002(40)(A).

definition, requires (1) a plan, fund or program (2) established or maintained (3) by an employer, by an employee organization, or by both (4) for the purpose of providing benefits including medical, surgical, or hospital care or benefits in the event of sickness or accident (5) to participants or their beneficiaries. See Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc).[4] The existence of an EWBP is "`a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person.'" Deibler v. United Food & Commercial Workers' Local Union 23, 973 F.2d 206, 209 (3d Cir. 1992) (quoting Wickman v. Northwestern Nat'l Ins. Co., 908 F.2d 1077, 1082 (1st Cir. 1990)).

The first requirement for an EWBP is the existence of a plan, fund, or program. For a plan to exist, a reasonable person must be able to ascertain the intended benefits, the class of beneficiaries, the source of financing, and procedures for receiving benefits. Henglein v. Informal Plan for Plant Shutdown

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4. Specifically, the statute provides:

> The terms `employee welfare benefit plan' and `welfare plan' mean 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 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 . . . .

29 U.S.C. § 1002(1).

Benefits for Salaried Employees, 974 F.2d 391, 399 (3d Cir. 1992). The PruCare HMO Plan describes in detail the plan's intended medical benefits and the procedures for receiving those benefits. It notes that the plan covers full-time employees of PAA Trustees, and that the plan is financed by contributions from the employees. The Trust Agreement clarifies that PAA employers also contribute. Thus, the plan fulfills the first requirement for an EWBP.

The PruCare HMO Plan and the Trust Agreement also satisfy the fourth and fifth elements of an EWBP. These documents indicate that the Trust's purpose is to provide life insurance and health insurance as required by the fourth factor. These documents also meet the fifth requirement by showing that these benefits are to be provided to plan participants, namely, employees of PAA members who subscribe to the Trust.

The key dispute here is over the second and third elements, that is, whether an employer or employee organization established or maintains this plan. ERISA defines an employer as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). In this case, the PAA sponsored, established, and now maintains the plan at issue. Although it appears that the PAA, in so doing, may have acted directly as an employer, it did not do so as Plaintiff's

employer. The question then becomes whether it acted indirectly in the interest of Mr. Smith's employer.

To determine whether a MEWA is acting in the interest of its participating employers, courts first examine the involvement of those employers in the plan's establishment and administration. See, e.g., Atlantic Health Care Benefits Trust v. Foster, 809 F. Supp. 365, 372-73 (M.D. Pa. 1992) (citing MDPhysicians, 957 F.2d at 185), aff'd, 6 F.3d 778 (3d Cir. 1993), cert. denied, 510 U.S. 1043 (1994). In MDPhysicians, the court found that no ERISA plan existed where the subscribing employers neither established nor operated the plan. In that case, the plan's creator did not act indirectly for the subscribing employers but rather acted for its own profit. The court concluded that Congress never intended ERISA to cover a plan created by independent entrepreneurs who form and maintain an insurance plan without employers' input. Here, however, the Trust Agreement demonstrates that the participating employers established the trust as a non-profit plan for their employees' benefit. Further, these employers, through their chosen representatives, now administer the Trust. The employers thus established and now administer the plan.

The other factor for determining whether a MEWA acts in its employers' interest is whether the participating employers share a common economic interest which is unrelated to the provision of benefits. See, e.g., Atlantic Health Care Benefits Trust, 809 F. Supp. at 372-73 (citing Wisconsin Educ. Ass'n Ins.

Trust v. Iowa State Bd. of Public Instruction, 804 F.2d 1059, 1063 (8th Cir. 1986)). See also Moideen v. Gillespie, 55 F.3d 1478, 1481 (9th Cir. 1995) (noting that "the Department of Labor has interpreted section 1002(5) to encompass a requirement of a bona fide `organizational relationship' among the members other than a mere association for the purpose of qualifying for benefits"). In Moideen, the court found that ERISA did not cover a Trust open to any business with under 500 employees because common size was not a bona fide organizational relationship. By contrast, this plan restricts coverage to persons, organizations or corporations who are engaged in the automobile industry or related industries. Because the PAA Trust subscribers all belong to the auto industry, they share a common economic interest unrelated to the provision of insurance. Thus, the PAA Trust acts indirectly in the interests of its participating employers.

In short, the PAA Trust satisfies ERISA's definition of an employee welfare benefit plan.

B. ERISA Preemption

Having determined that an ERISA employee welfare benefit plan exists, the court now must determine whether ERISA preempts Plaintiffs' claims. As stated above, ERISA preempts any state-law claims which "relate to" an employee benefit plan. ERISA thus preempts most state law claims pertaining to employee

benefits,[5] including claims based in common-law contract and tort. See Pilot Life, 481 U.S. at 47. Generally, ERISA preempts complaints alleging improper processing of a claim for benefits. Id. More specifically, ERISA will preempt claims that an insurance company, providing services under an EWBP, improperly refused to pre-certify an employee's surgery. See Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298, 302-03 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994). The essence of Plaintiffs' contract claims is that PruCare refused to pre-approve surgery on Mr. Smith's heel bone. These claims arise from the administration of ERISA plan benefits, and thus relate to an ERISA plan. Similarly, Plaintiff Kathy Smith's loss of consortium claim depends upon the allegation that PruCare improperly administered plan benefits. Thus, this claim also relates to an ERISA plan. See Balush v. Independence Blue Cross, No. 96-7303, 1996 WL 741960 (E.D. Pa. Dec. 17, 1996) (finding that ERISA preempts loss of consortium claim which arises from an alleged failure to timely approve a necessary medical procedure). Because Plaintiffs' claims all relate to an ERISA plan, ERISA preempts these claims. I would note here the Eighth Circuit's apt comment:

> Other courts have speculated that Congress could not have foreseen the precertification review process when it enacted a preemption clause so broad that it relieves ERISA-regulated plans of most tort liability.

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5. Although ERISA exempts state laws regulating insurance, banking, or securities, see 29 U.S.C. § 1144(b)(2)(A), no such laws are at issue in this case.

> . . . Although this may well be true, modifications of ERISA in light of questionable modern insurance practices must be the job of Congress, not the courts.

Kuhl, 999 F.2d at 304. Thus, because ERISA as currently formulated preempts Plaintiffs' claims, those claims shall be dismissed.

Defendant PruCare contends that these claims should be dismissed with prejudice because Plaintiffs cannot state a claim against PruCare under ERISA. The only ERISA claim appearing on the face of Plaintiffs' complaint is one for the wrongful denial of benefits. A plan participant may bring a civil action for the wrongful denial of benefits under 29 U.S.C. § 1132(a)(1)(B), but such an action may be brought only against the plan itself or a plan fiduciary. See Curcio v. John Hancock Mut. Life. Ins. Co., 33 F.3d 226, 233 (3d Cir. 1994). ERISA broadly defines a fiduciary as one who exercises discretion over the plan's management, administration, or disposition of its assets, or who renders investment advice to the plan. 29 U.S.C. § 1002(21)(A). Given the record before me, it does not appear that PruCare is either a plan or a plan fiduciary. However, at this point in the proceedings, I am unwilling to conclude that Plaintiffs could state no claim against PruCare under ERISA. Thus, although I shall dismiss Plaintiffs' claims against PruCare, I shall grant Plaintiffs leave to amend their complaint.

An order follows.

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O R D E R

AND NOW, this day of May, 1997, upon the reasoning in the attached Memorandum, Defendant Prudential Health Care Plan Inc.'s Motion to Dismiss is GRANTED with leave to amend the complaint. Plaintiffs may file an amended complaint within thirty (30) days of entry of this Order.

BY THE COURT

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Robert S. Gawthrop, III, J.