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**IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE**
**TWENTIETH JUDICIAL DISTRICT, DAVIDSON COUNTY**

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| **RISK SOLUTIONS CAPTIVE, INC., ("Captive") and HEALTH COST SOLUTIONS ("HCS"),** | ) | |
| **Plaintiffs,** | ) | |
| **vs.** | ) | **No. 16-0583-BC** |
| **EVERS CONSTRUCTION COMPANY INC. ("Evers"),** | ) | |
| **Defendant.** | ) | |

**MEMORANDUM AND ORDER: (1) DENYING DEFENDANT'S MOTION TO DISMISS AND (2) SETTING DEADLINES FOR PLAINTIFFS' SUMMARY JUDGMENT MOTION**

This lawsuit was filed by an insurance company, Risk Solutions Captive, Inc. ("Captive"), to recover $72,496.87 that it characterizes as premium payments the Defendant allegedly owes related to medical care benefits for Defendant's employees. The other Plaintiff in the lawsuit, Health Cost Solutions ("HCS"), is the claims administrator for the parties' arrangement who collected the premium from the Defendant and processed the claims and paid the benefits.

The lawsuit arises from a Participation Agreement the Plaintiffs entered into with the Defendant for one year beginning April 1, 2014, which was renewed for an additional year beginning April 1, 2015. Under the terms of the Participation Agreement the risk for payment of the Defendant's employee medical benefits was transferred to Plaintiff

Captive. The Plaintiffs assert that the Defendant's claims ultimately came in substantially in excess of the anticipated dollar amount the premium payments were based upon. More premium is owed, the Plaintiffs assert, based upon the actual claims.

The Defendant denies it owes additional payments asserting that it made all of the Employer Contributions required of it under the Participation Agreement. Additionally, the Defendant disputes the Plaintiffs' construction of the parties' agreement, including allocation of the Defendant's contribution, after deducting a fixed premium to another insuror.

Also, the Defendant has filed a Counterclaim asserting that the alleged refusal of the Plaintiff Administrator HCS to pay claims unless the additional premium is paid to Plaintiff Captive constitutes a misdirection of Plan assets, conversion and breach of fiduciary duty. The Defendant seeks an accounting of all sums received and disbursed, and for an order requiring the Plaintiffs to process, administer and pay all outstanding covered claims or, alternatively, for an order requiring the Plaintiffs to return any and all remaining Plan assets with any income generated.

The somewhat complicating aspects of the case are that Plaintiff Captive asserts it is a Protected Cell Captive Insurance Company under the provisions of Tennessee Code Annotated sections 56-13-101 *et seq*. and that it provided medical stop loss insurance to the Defendant for its employees medical care claims. As described by the Plaintiffs, "In the medical stop loss arena, captive insurance companies have characteristics similar to self-insurance employers. However, the main difference is that self-insured employers

pay claims from their own assets, whereas captive insurance companies are separate corporations that receive premiums and pay claims like any other insurance company."

Filed in June of 2016, the lawsuit was on a track of narratives filed to educate the Court on this niche area of insurance law on captive cells, and discovery was exchanged to lead up to summary judgment. At that point a preliminary issue emerged: whether this Court has jurisdiction to decide the case. Presently before the Court is the motion of the Defendant to dismiss pursuant to Tennessee Rule of Civil Procedure 12.02(1) for lack of subject matter jurisdiction due to federal preemption under the Employment Retirement Income Security Act ("ERISA") of 1974.

The determinative issue on Defendant's motion to dismiss is whether the Complaint fits the criteria contained in 29 U.S.C. § 1132(a)(3), as asserted by the Defendant, for which federal courts retain exclusive jurisdiction; or, as asserted by the Plaintiffs, whether the Complaint constitutes a purely state law claim that merely relates to an ERISA plan for which this Court has concurrent jurisdiction with federal courts.

After studying the statute and case law to understand the kinds of averments in complaints which are covered by 29 U.S.C. § 1132(a)(3) and applying that to the Complaint in this case, the Court concludes as a matter of law that the gravamen of the Complaint is a state law breach of contract claim for compensatory damages of $72,496.87 and that the Plaintiffs have sued for compensatory damages under a legal duty independent of ERISA or the plan terms. Under these circumstances, the lawsuit

does not come within the provisions of 29 U.S.C. § 1132(a)(3) of complete preemption of the federal courts and this Court has subject matter jurisdiction to decide the case.

It is therefore ORDERED that Defendant's *Motion To Dismiss* for lack of subject matter jurisdiction is denied.

It is further ORDERED that this case shall return to the plan provided in the February 21, 2017 Order of proceeding with the Plaintiffs filing for summary judgment, and that August 25, 2017 is the deadline for Plaintiffs to file their motion for summary judgment. Defendant's response deadline is September 29, 2017. Plaintiffs' reply, if any, is due October 10, 2017. Oral argument shall be conducted at 11:00 a.m., October 20, 2017. Setting a summary judgment deadline for the Plaintiffs is without prejudice to the Defendant to invoke the procedure under Tennessee Civil Procedure Rule 56.07 in response to the motion.

Contained below are the authorities and analysis on which the Defendant's motion to dismiss is denied.

## Parties' Positions

In support of its *Motion To Dismiss*, the Defendant argues that "this is a case between ERISA fiduciaries, therefore, and is governed by 29 U.S.C. § 1132(a)(3), for which jurisdiction is exclusive to the federal courts under 29 U.S.C. § 1132(e)(1) and (f)." *Motion To Dismiss*, p. 3 (May 5, 2017). The Defendant argues that the Plaintiffs'

characterization of their Complaint as a state law cause of action is irrelevant because the relief requested by the Plaintiffs would constitute a "Prohibited Transaction" within the meaning of ERISA:

> The relief demanded by Plaintiffs, in and of itself, constitutes a "Prohibited Transaction" within the meaning of [ERISA].
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> ****
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> Even assuming that the contracts can be read to support Plaintiffs' position, because the payments demanded would produce no benefits whatsoever for the participants and beneficiaries of the Plan, the only purpose to be served by those payments is to penalize the Plan for taking its business elsewhere. As such, the relief demanded in the Complaint, if ordered by this Court, would convert the underlying agreements into a "Prohibited Transaction" under ERISA and the regulations promulgated thereunder.
> Whether the Court looks to the basis for Plaintiffs' Complaint (and the remedy they seek) or to Evers' defenses and counterclaims, adjudication under ERISA is unavoidable. Because this Court is without the subject matter jurisdiction to hear the case or even dismiss it with prejudice, the Complaint must be dismissed without prejudice with leave to refile in a forum of appropriate jurisdiction.
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> Plaintiffs' characterization of their claims as sounding solely in state law is insufficient to avoid scrutiny under ERISA. In this case, Plan fiduciaries are at issue with each other over whether additional contributions to the Plan are required (or even permissible by law) and, if such contributions are required and permissible, the disposition of Plan assets. This is precisely the type of claim Congress chose to remove from the jurisdiction of state courts.

*Motion To Dismiss*, pp. 1-2; 4 (May 5, 2017).

In opposition to the *Motion to Dismiss*, the Plaintiffs argue that simply because the Complaint "relates to an ERISA Plan does not serve to convert the state law claim to a federal cause of action."

> The Complaint sets forth a state law claim for breach of contract. The Complaint does not invoke federal law. This Court may address the issues raised in the Complaint. The Defendant raises ERISA issues and then contends this Court has no subject matter jurisdiction over the lawsuit. First, this Court does not lose its jurisdiction over state law issues by the Defendant raising federal issues. Second, this Court has concurrent jurisdiction to address federal issues including ERISA issues. Third, the only ERISA field that completely preempts state law involves actions by beneficiaries for benefits which is not involved in this lawsuit. And, Fourth, even where complete [preemption] is involved, state courts retain concurrent jurisdiction.

*Plaintiffs Response To Defendant's Motion To Dismiss*, pp. 8-9 (May 16, 2017).

## Analysis

It is undisputed by the parties that the Complaint involves an employee welfare benefit plan that is subject to and governed by ERISA. *Plaintiffs Response To Defendant's Motion To Dismiss*, p. 2 (May 16, 2017) ("This lawsuit involves medical care benefits provided by Defendant Employer pursuant to an employee welfare benefit plan subject to ERISA."); Motion To Dismiss, p. 1 (May 5, 2017) ("The Parties have stipulated that the Evers Medical Benefits Plan is governed by ERISA.").

As noted above, the determinative issue in this case is whether the Complaint fits the criteria contained in 29 U.S.C. § 1132(a)(3), as asserted by the Defendant, for which federal courts retain exclusive jurisdiction; or, as asserted by the Plaintiffs, whether the

Complaint constitutes a purely state law claim that merely relates to an ERISA plan for which this Court has concurrent jurisdiction with federal courts.

The civil action and enforcement statute under ERISA is 29 U.S.C.A. § 1132(a). It identifies the individuals or entities who may bring a civil action under the Act, quoted as follows.

> A civil action may be brought—
>
> (1) by a participant or beneficiary--
>
> > (A) for the relief provided for in subsection (c) of this section, or
> >
> > (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 by 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;

Neither subsections (1) and (2) apply to this case because without dispute the Plaintiffs are not participants or beneficiaries to fit within (a)(1), and, as to (a)(2), relief under section 1109 is not being sought. The pertinent part is subsection (3) of 29 U.S.C. § 1132(a).

The significance of 29 U.S.C. § 1132(a)(3) to this case is that if a civil action is brought under that section, federal courts retain exclusive jurisdiction over the action, and it can not be brought in a state court because state court's lack subject matter jurisdiction

to hear this type of case. This is found in 29 U.S.C. § 1132 (e)(1) which provides that "[e]xcept for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have *exclusive jurisdiction* of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have *concurrent jurisdiction* of actions under paragraphs (1)(B) and (7) of subsection (a) of this section." (emphasis added). Case law also makes this point clear.

> Complete preemption is "a doctrine only a judge could love," *Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073, 1075 (7th Cir.1992), and one only judges could confusingly name. More productively thought of as a jurisdictional rather than a preemptive rule, complete preemption amounts to an exception to the well-pleaded complaint rule that converts a state-law claim that could have been brought under § 1132 into a federal claim, *Aetna Health Inc.*, 542 U.S. at 209, 124 S.Ct. 2488, and makes the recharacterized claims removable to federal court, *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 67, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). Section 1132 creates ERISA's civil action, permitting claims by a beneficiary "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." 29 U.S.C. § 1132(a)(1)(B). Complete preemption applies when a plaintiff dresses up a claim for benefits under a pension plan in state-law clothing because ERISA has "so fill[ed] every nook and cranny" of the area "that it is not possible to frame a complaint under state law." *Bartholet*, 953 F.2d at 1075. Put another way, "a complaint reciting that the claim depends on the common law of contracts is *really* based on [ERISA] if the contract in question is a pension plan. Congress has blotted out (almost) all state law on the subject of pensions, so a complaint about pensions rests on federal law no matter what label its author attaches." *Id.*

*Loffredo v. Daimler AG*, 500 F. App'x 491, 495 (6th Cir. 2012). *See also HCA Health Servs. of Tennessee, Inc. v. Bluecross Blueshield of Tennessee, Inc.*, No. M201401869COAR9CV, 2016 WL 3357180, at *8 (Tenn. Ct. App. June 9, 2016) ("However, state courts are not vested with jurisdiction to hear a cause of action brought

pursuant to section 1132(a)(3)."); *Aflac, Inc. v. Bloom*, 948 F. Supp. 2d 1374, 1381 (M.D. Ga. 2013) ("Unlike § 502(a)(1)(B) claims, claims asserted under § 502(a)(3) must be brought exclusively in federal court. 29 U.S.C. § 1132(e)(1)."); *Elec. Energy, Inc. v. Lambert*, 757 F. Supp. 2d 765, 773 (W.D. Tenn. 2010) ("Furthermore, ERISA grants the district courts of the United States the exclusive jurisdiction over suits brought by plan fiduciaries pursuant to 29 U.S.C. § 1132(a)(3)(B)(ii).").

Thus, the Court must examine the criteria contained above in the text of 29 U.S.C. § 1132(a)(3) to determine if this case comes within the exclusive federal court jurisdiction. Those criteria are

— whether the Plaintiffs are fiduciaries,

— whether the case fits the two-part test designed by the United States Supreme Court, and

— whether the relief sought is equitable or legal.

Each of these criterion is analyzed below based upon the allegations and averments in the Complaint as required by case law.

> On December 5, 2011, Strayhorn filed a counterclaim against Plaintiffs, alleging the Funds' (unnamed) trustees breached a fiduciary duty by hiring the "unqualified" Strayhorn and failing to provide her with any training, supervision, guidance, or oversight. (ECF No. 4 at 2–3.) Although it is unclear under which law Strayhorn asserts this counterclaim, even if the Court were to construe the counterclaim as being asserted pursuant to ERISA, it would not confer subject-matter jurisdiction on the Court because under the well-pleaded complaint rule, federal jurisdiction cannot rest upon a counterclaim. *Vaden v. Discover Bank*, 556 U.S. 49, 60, 129 S.Ct. 1262, 173 L.Ed.2d 206 (2009) (citing *Holmes Grp., Inc. v. Vornado Air Circulation Systems, Inc.*, 535 U.S. 826, 832, 122 S.Ct. 1889, 153 L.Ed.2d 13 (2002)).

*Dist. Council 1707 Local 389 Home Care Employees' Pension & Health & Welfare Funds v. Strayhorn*, 2013 WL 1223362, at *6 (S.D.N.Y. Mar. 25, 2013)

The Plaintiffs Are "Fiduciaries" As Defined By The Statute

The Court concludes from the allegations of the Complaint that the Plaintiffs do qualify as "fiduciaries" as that term is used in 29 U.S.C. § 1132(a)(3).

The term "fiduciary" is defined in the statute as:

> [A] person[1]…with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title."

29 U.S.C. § 1002(21)(A) (West 2017); see also *Byars v. Greenway*, No. 14-1181, 2014 WL 7335694, at *5 (W.D. Tenn. Dec. 19, 2014) ("To qualify as a fiduciary, a person must be 'specifically named as [a] fiduciar[y] by the benefit plan' or 'exercise [ ] discretionary control or authority over a plan's management, administration, or assets." *Chiera v. John Hancock Mut. Life Ins. Co.,* 3 F. App'x 384, 389 (6th Cir.2001) (citation omitted). An individual who merely performs 'perfunctory, ministerial function[s]' is not a fiduciary. *Hamilton v. Carell,* 243 F.3d 992, 999 (6th Cir.2001)."); *St. Francis Hosp. & Med. Ctr. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 776 F. Supp. 659, 661–62 (D. Conn. 1991) ("'Whether or not an individual or entity is an ERISA fiduciary must be determined by *662 focusing on the function performed, rather than on the title held.'

[1] Under 29 U.S.C.A. § 1002(9), the term person means "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization."

*Blatt v. Marshall & Lassman,* 812 F.2d 810 (2d Cir.1987). 'An entity need not have absolute discretion with respect to a benefit plan in order to be considered a fiduciary.... [R]ather, fiduciary status exists with respect to any activity enumerated in the statute over which the entity exercises discretion or control.' *Id.*")

Applying the above definition to the Complaint, the Court sees that the text in Paragraph 3 of Article II – Duties of Plan Administrator and Paragraph 2 of Article III – Duties of Claims Administrator of the *Claims Administration Agreement* states that Plaintiff HCS is solely performing "ministerial" functions and is not intended to be a "fiduciary" of the plan and it shall not provide any services to the Defendant that would require the use of discretion. Paragraph 3 of Article II – Duties of Plan Administrator of the *Claims Administration Agreement* and Paragraph 2 of Article III – Duties of Claims Administrator state in pertinent part:

> 3. Interpretation of the benefits, terms and conditions of the Plan and eligibility of employees and dependents for coverage and benefits under the Plan shall be the sole responsibility of [the Defendant]. [The Defendant] agrees that the administration services to be provided pursuant to this Agreement under the direction of such interpretation and policies of [the Defendant] are of a ministerial nature and are not intended to make [Plaintiff Health Cost Solutions] a fiduciary, plan administrator or sponsor with respect to the Plan.
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> 2. [Plaintiff Health Cost Solutions] shall not provide any services under this Agreement that would require the use of its discretion. All issues requiring discretion shall be resolved by [the Defendant].

Nevertheless, the Court finds that the pleadings contain allegations that the respective duties of both of the Plaintiffs come within the definition of fiduciary as

defined by 29 U.S.C. § 1002(21)(A). The Defendant's characterization of the facts averred in the pleadings that "[i]n the ordinary course of business under the Plan, HCS had and exercised discretionary authority over the Plan Assets deposited with its affiliate Captive, when it made determinations regarding whether Plan coverage extended to a given claim for medical equipment and services and whether other prerequisites (such as applicable deductibles) had been met before using Plan Assets to pay for those covered expenses," *Defendant's ERISA Analysis*, p. 3 (Mar. 31, 2017), is not disputed by the Plaintiffs. Under case law, these facts establish that the Plaintiffs are fiduciaries under federal law interpreting 29 U.S.C. § 1002(21)(A). *See, e.g., United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1357 (S.D. Fla. 2014) ("An insurance company with discretionary responsibility over the award of benefits under an employee benefits plan is considered to operate as a "fiduciary" within the meaning of this ERISA definition, *Wachtel v. Health Net, Inc.*, 482 F.3d 225 (3d Cir.2007), and in its role as fiduciary may "obtain appropriate equitable relief [under 502] to enforce any provisions ... of the terms of the plan." *Metropolitan Life Ins. Co. v. Price*, 501 F.3d 271 (3d Cir.2007).").

Accordingly, the first of the three criteria for application of 29 U.S.C. § 1132(a)(3) has been established in this case from the face of the Complaint.

Plaintiffs' Complaint Fails To Meet Two-Pronged "Complete" Preemption Test

The next issue is whether the Complaint fits within the U.S. Supreme Court's two-part test for complete preemption under ERISA's civil enforcement section 29 U.S.C. § 1132(a)(3) such that exclusive jurisdiction is in the federal courts.

> The Supreme Court has articulated a two-prong test to determine whether a claim is completely preempted under § 1132(a) of ERISA. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004). A claim is completely preempted when it satisfies both prongs of the following test:
>
> > (1) the plaintiff complains about the denial of benefits to which he is entitled only because of the terms of an ERISA-regulated employee benefit plan; and (2) the plaintiff does not allege the violation of any legal duty (state or federal) independent of ERISA or the plan terms.
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> *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 613 (6th Cir. 2013) (quoting *Davila*, 542 U.S. at 210, 124 S.Ct. 2488). The state-law claims in *Davila* involved insurance plans failing to exercise ordinary care when the plans denied coverage for certain medical procedures. *Davila*, 542 U.S. at 204–05, 124 S.Ct. 2488. Those claims involved "pure eligibility decisions" and were preempted by ERISA. *Id*. at 221, 124 S.Ct. 2488.

*Hackney v. AllMed Healthcare Mgmt. Inc.*, No. 16-5651, 2017 WL 656752, at *2 (6th Cir. Feb. 17, 2017).

In applying the foregoing legal standard to the record in this case, the Court concludes that the necessary requirements are not met to completely preempt the Plaintiffs' lawsuit under section 1132(a)(3).

As it relates to the requirements that the Complaint allege the denial of benefits to which the fiduciary is entitled only because of the terms of an ERISA-regulated employee benefit plan and that the claim does not allege the violation of any legal duty

(state or federal) independent of ERISA or the plan terms, neither of these two requirements are met. The allegations in the Complaint seek recovery for "premiums" owed under two separate contracts – the Participation Agreement and the Claims Administration Agreement.

These contracts are distinct agreements separate and apart from the ERISA plan and contain independent legal duties unrelated to the purpose and function of the ERISA plan. While the two contracts reference the ERISA plan and govern administration of the ERISA plan, the dispute, according to the Complaint, does not involve a claim or denial of benefits under the ERISA plan. The claim, according to the Plaintiffs, is for recovery of alleged "premiums" that it claims are due and owing under the Participation Agreement – not the ERISA plan. *See, e.g., Loffredo v. Daimler AG*, 500 F. App'x 491, 495 (6th Cir. 2012) ("Put another way, "a complaint reciting that the claim depends on the common law of contracts is *really* based on [ERISA] if the contract in question is a pension plan.").

According to the Complaint, the only connection between the ERISA Plan and the alleged "premiums" owed is that the "premiums" are calculated based on information that is derived from the ERISA plan. The information from the ERISA plan that the Plaintiffs allege determines the monthly premiums paid by the Defendant is what the Participation Agreement refers to as the "Participant's Claims Factors" as detailed in Schedule 1 of the Participation Agreement. These "claims factors" were dependent, varied and fluctuated over time as enrollees were added to or deleted from the list of ERISA plan participants from time to time. Despite being variable from month-to-month depending on enrollment

in the ERISA plan, it appears that the "claims factors" were used simply as one numeral in a mathematical calculation to determine monthly premium, not something that directly affected the granting or denial of benefits to the any beneficiary under the ERISA plan.

This interpretation is supported by the Answer And Counterclaim in which the Defendant described how the "claims factors" played into the calculation of "premiums" owed to the Plaintiffs.

> The Participation Agreement provided for and described a mechanism whereby Evers should enjoy the benefits of self-insuring its medical benefits expense up to a specified cap of $10,000.00 per enrollee (less any applicable deductible amount required to be paid by the enrollees under the coverage option selected by the enrollee, which in this case is either Plan A at $2,000.00 per year or Plan B at $5,000.00 per year). Although some enrollees will exceed their deductibles and the $10,000.000 self-insurance liability cap, most will not. In fact, some enrollees will not even meet their deductible limit that is a prerequisite to liability under the Evers medical benefit plan. In a self-insurance setting, any enrollee who does not meet their deductible or reach the $10,000.00 self-insurance limit represents a savings to the self-insurer over the cost of traditional fixed premium health care benefit plans available in the open market. In order for the $10,000.00 liability limit to be effective protection for Evers as the Plan Sponsor and self-insurer, the Participation Agreement provided for an additional two tiers of third-party insurance coverage: (a) liability for covered medical expenses from $10,000.00 to $100,000.00 were to be covered by Captive; and (b) liability for covered medical expenses over $100,000.00 were allocated to Gerber Life Insurance C9ompany under a traditional fixed premium health insurance policy with a $100,000.00 per enrollee deductible. The unit cost to Evers on a monthly basis varied over time as enrollees were added to or deleted from the list of plan participants from time to time. Changes in the participant list were reported to the Claims Administrator, Health Care Solutions ("HCS"), in the ordinary course of business and reflected in the monthly invoices sent to and paid by Evers.
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> [T]he "Captive Premium" is defined as 50 percent (50%) of the "Participant's Claims Factors." The Participant's Claims Factors" constitute an estimation of Evers' self-insurance liability that is prepaid each month to

> the Claims Administrator together with the Gerber premium and the various administrative charges (the "Evers Contribution"). Under the Participation Agreement, the Claims Administrator divides the Evers Contribution after the appropriate deductions for the Gerber premiums and the administrative charges, into equal halves and distributes one half to the "Participant Cell", the fund from which the Evers self-insured claims are to be paid, and the other half to Captive as "premium" for the first layer of coverage above the $10,000.00 self-insurance limit and the risk it assumes for any shortfall in the funds available at the Participant (Evers) Cell level.
>
> Therefore under the Participation Agreement, the "premium" that Captive is entitled to recover is the difference between the funds it received under the distribution provisions of the Participation Agreement and the amounts it was required to pay out in medical benefits.

*Answer And Counterclaim*, ¶ 6 (July 13, 2016).

The above statement of how the "premiums" are calculated is, for the most part, consistent with the Plaintiffs' characterization of the use and effect of the "claims factors" in calculating the monthly premiums owed to the Plaintiffs.

> 12. The Defendant pays a premium to participate in the Insurance Arrangement. The premium is paid monthly. The premium consists of the sum of several costs. Some of the costs varied among the employees depending upon their chosen plan and their type of coverage – single, employee + spouse, employee + child(ren), or family.
>
> 13. The premium is divided into two categories: (1) *fixed costs*, and (2) *claims factors*. The fixed costs are the same for the two (2) policies. The fixed costs are the same for each employee participant. The fixed costs are: the premium for the Specific Excess Loss Coverage - $100,000 deductible provided by Gerber; the Aggregate Stop Loss premium and termination liability option – 35% of aggregate deductible at termination; administrative fee; case management; disease management; PPO fee including utilization review and pre-cert; COBRA fee; Captive fee; and broker fee. Of the fixed costs, only the Specific Excess Loss Coverage varies depending upon the type of coverage – single, employee + spouse, employee + child(ren), or family.
>
> 14. The total of the claims factors is the calculation of anticipated claims. These are broken down by types of coverage: single, employee + spouse,

> employee + child(ren), or family. The aggregate claim factors are the claim factors calculated monthly based upon the participating employees. 50% of the claims factors is paid to the Participant Cell and 50% is paid for the Captive Coverage. The 50% paid to the Participant Cell goes to cover the claim of employees for $10,000 or less for the year.
>
> 15. The aggregate claims factors are listed as *maximum aggregate factors* and *expected aggregate factors*. The expected aggregate factors are 80% of the maximum aggregate factors. The maximum aggregate factors are the most that the Defendant is required to pay for claims factors regardless of the amount of claims of employees. 50% of the expected aggregate factors is the amount that is anticipated that Defendant will be required to pay in order to cover the employees' claims of $10,000 or less for the year.

*Plaintiffs' Educational Narrat*ive, pp. 5-6 (Nov. 1, 2016).

The text of the parties' Agreements also shows the independent and distinct legal duties of the Participation Agreement and Claims Administration Agreement versus ERISA employee welfare benefit plan:

> WHEREAS, the Participant is an employer that provides medical care benefits (the "Benefits") to its employees pursuant to an "employee welfare benefit plan" within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"); and
>
> WHEREAS, the Participant has entered into a Claims Administration Agreement with the Administrator, for the purpose of providing claims administration and other services to the Participant in connection with such provision of medical care benefits to the Employer's employees pursuant to ERISA; and
>
> WHEREAS, the Participant desires to transfer a portion of its risk for the provision of such Benefits to the Captive; and
>
> WHEREAS, the Participant intends to pay to the Administrator (i) a premium amount for insurance coverage to be provided by the Captive (the "Captive Premium"); (ii) a premium amount for specific and aggregate medical stop loss insurance coverage (the "Carrier Premium") to be purchased from Gerber Life Insurance Company (the "Carrier") (collectively, the Captive Premium and the Carrier Premium amounts being referred to herein as the "Premium"), and (iii) the self-funded aggregate

> claim factors (the "Participant's Claims Factors") to be paid to the Captive on behalf of the Participant Cell as set forth below, and the Administrator shall collect such amounts on behalf of the Carrier, the Captive and the Participant Cell;

*Stipulation of Documents*, Item 16, Participation Agreement as of April 1, 2015, p. 1 (Oct. 14, 2016).

Thus, both the Participation Agreement and the Claims Administration Agreement at issue in the Complaint govern a relationship between the parties that contains legal duties that are independent and separate of ERISA or the ERISA plan terms. The two agreements provided the Defendant with a legal mechanism to accomplish self-insurance through a relationship with a protected cell captive insurance company. While the terms of the agreements necessarily reference and relate to the ERISA medical benefits plan entered into between the Defendant and its employees, the Plaintiffs' Complaint seeks recovery for an independent legal duty owed to the Plaintiffs by the Defendant that is separate and apart from the ERISA medical benefits plan.[2] The Plaintiffs' claim does not

[2]In somewhat analogous circumstances, the United States District Court for the Western District of Tennessee in *Byars v. Greenway* granted the Plaintiff's motion to remand the lawsuit back to state court because the Plaintiff's state law tort claim for negligence was not completely preempted. In making this ruling, the Court recognized that while the Plaintiff's claim referred to and mentioned the ERISA plan, that does not automatically convert a purely independent state law claim for damages to a claim for benefits under an ERISA plan such that complete preemption mandates federal court jurisdiction.

> A state-law tort claim is "within the scope of § 1132(a)(1)(B)" when "(1) the plaintiff complains about the denial of benefits to which [s]he is entitled only because of the terms of an ERISA-regulated employee benefit plan; and (2) the plaintiff does not allege the violation of any legal duty (state or federal) independent of ERISA or the plan terms." *Gardner*, 715 F.3d at 613 (quoting *Davila*, 542 U.S. at 210) (internal quotation marks and alterations omitted). For complete preemption to occur, "both prongs of the test [must be] satisfied." *Id.* (quoting *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 947 (9th Cir.2009)). Phrased differently, if Plaintiff, " 'at some point in time, could have brought h[er] claim under ERISA' and 'there is no other independent legal duty that is implicated by [Defendants'] actions,' " complete preemption exists. *Loffredo v. Daimler AG*, 500 F. App'x 491, 501 (6th Cir.2012) (quoting *Davila*, 542 U.S. at 210).

seek any recovery or claim involving the denial or recover of benefits under the ERISA medical benefits plan. Rather, the allegations in the Plaintiffs' Complaint are claims for an unpaid premium invoice that the Plaintiffs assert is due and owing under the terms of the Participation Agreement and Claims Administration Agreement.

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> [The Plaintiff's] action, however, does not satisfy this test. She does not seek to be reinstated as a beneficiary or for payment of previously accrued benefits out of plan funds. (*See* D.E. 1–2.) Rather, she seeks monetary damages from [the Defendant] for alleged negligence in the notarization process and from [the Defendant] under agency principles. (*Id.*) She does not attempt to "recover benefits" or to "enforce" or "clarify ... rights" under the plan; thus her allegations do not fall under § 1132. Complete preemption does not occur every time a complaint mentions an ERISA plan. *Wright v.. Gen. Motors Corp.,* 262 F.3d 610, 615 (6th Cir.2001). Where a plaintiff includes plan benefits as "simply a reference to specific, ascertainable damages she claims to have suffered as a proximate result of" a defendant's tortious conduct, complete preemption under § 1132 does not apply. *Id.* If those damages "would be payable from [the defendants'] own assets" rather than from the plan, the argument against complete preemption becomes even stronger. *Gardner,* 715 F.3d at 614 (citation omitted). In this case, [the Plaintiff] does not allege that there are "benefits to which [s]he is entitled." *Id.* at 613 (citation omitted). Benefits are only relevant here as a measure of damages, and any recovery would come from Defendants' assets. Therefore, ERISA does not completely preempt Plaintiff's state law cause of action.[2]
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> > [FN 2.] In *Gardner,* the Sixth Circuit also analyzed whether the duty alleged to have been breached was independent of the plan. *See id.* at 614–15. Defendants correctly point out that ERISA, and perhaps the plan itself, required Plaintiff's signature on the Single Life Annuity Form to be "witnessed by a plan representative or a notary public." 29 U.S.C. § 1055. Whether [the Defendant's] duty under Tennessee law to act reasonably in notarizing the document, *see Peltz v. Peltz,* No. M199902299COAR3CV, 2000 WL 1532996, at *2 (Tenn.Ct.App. Oct. 18, 2000), is independent of the plan presents a close issue, but it is one this Court need not resolve. Because [the Plaintiff] does not allege that she is entitled to benefits to be paid from the plan, and because, as described below, the relief she seeks was never available under § 1132, whether the duty is independent is no longer at issue. *See Gardner,* 715 F.3d at 613 ("By its plain terms, [t]he two-prong[ed] test of *Davila* is in the conjunctive. A state-law cause of action is preempted by § [1132](a)(1)(B) only if both prongs of the test are satisfied." (alterations in original) (internal quotation marks omitted) (citation omitted)).

*Byars v. Greenway*, No. 14-1181, 2014 WL 7335694, at *4 (W.D. Tenn. Dec. 19, 2014)

The pleadings, therefore, establish that this lawsuit is not completely preempted because it fails to meet the two-pronged test stated by the Sixth Circuit in *Hackney v. AllMed Healthcare Mgmt. Inc.*, No. 16-5651, 2017 WL 656752, at *2 (6th Cir. Feb. 17, 2017).

No Equitable Relief Alleged As Required By 29 U.S.C. § 1132(a)(3)

Even assuming, however, that the Plaintiffs' claim could somehow fit within the two-pronged test of *Hackney v. AllMed Healthcare Mgmt. Inc.*, the Complaint would still not be completely preempted because it fails to allege appropriate "equitable relief" as required by 29 U.S.C. § 1132(a)(3).

For a claim to be completely preempted under 29 U.S.C. § 1132(a)(3), the claim by the fiduciary must seek (1) to enjoin any act or practice which violates any provision of the ERISA statute or the terms of the plan, or (2) to obtain other appropriate equitable relief either to redress such violations or to enforce any provisions of the ERISA statute or the terms of the plan. *Vanderbilt Univ. ex rel. Vanderbilt Univ. Health Ben. Plan v. Pesak*, No. 3:08-CV-1132, 2011 WL 4001115, at *4 (M.D. Tenn. Sept. 8, 2011) ("Section 502(a)(3) authorizes a plan fiduciary to bring suit to '(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)(3).").

Whether the relief sought in the Complaint qualifies as "equitable relief" under section 1132(a)(3) depends on the scope of relief requested in the Complaint.

> The forms of equitable relief available under § 502(a)(3) are limited to "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution)." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993). The Supreme Court has made it clear that "not all relief falling under the rubric of restitution [was] available in equity." *Great–West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 212, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002). Historically, the *Knudson* Court explained, restitution could be an equitable or legal remedy, and whether the remedy was equitable or legal depended on the basis for the claim and the relief sought. *Id.* at 213. Restitution was an equitable remedy when the plaintiff sought relief in the form of a constructive trust or an equitable lien upon "particular funds or property in the defendant's possession." *Id.* But when the plaintiff merely sought to impose personal liability upon the defendant to pay a sum of money—not to restore particular funds or property in the defendant's possession—the plaintiff assumed the status of a general creditor, and the restitutionary remedy he or she sought was legal rather than equitable. *Id.* at 213–14.
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> The [United States Supreme Court in *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 126 S. Ct. 1869, 164 L. Ed. 2d 612 (2006)] noted that the mere fact that the plan fiduciary alleged a breach of contract did not preclude it from maintaining a valid § 502(a)(3) claim. "ERISA provides for equitable remedies to *enforce plan terms,* so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make § 502(a)(3)(B)(ii) an empty promise." *Id.* at 363. Ultimately, *Sereboff* stands for the proposition that an ERISA plan fiduciary pursues "appropriate equitable relief" within the meaning of § 502(a)(3) when it seeks enforcement of the plan's reimbursement provision that identifies a particular fund and the share of that fund to which the plan is entitled, and that fund or a portion of it is within the possession and control of the beneficiary.

*Vanderbilt Univ. ex rel. Vanderbilt Univ. Health Ben. Plan v. Pesak*, No. 3:08-CV-1132, 2011 WL 4001115, at *4-5 (M.D. Tenn. Sept. 8, 2011); *see also Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 383 (6th Cir.), *cert. denied*, 136 S. Ct. 480, 193 L. Ed. 2d 350

(2015) ("We barred the "repackaging" of the claim because [the Plaintiff] had an adequate remedy to recover benefits under § 1132(a)(1)(B) and recovery of compensatory damages would not constitute "other appropriate equitable relief" under § 1132(a)(3). *Id.* at 615–16."); *Cent. States, Se. & Sw. Areas Health & Welfare Fund ex rel. Bunte v. Health Special Risk, Inc.*, 756 F.3d 356, 360 (5th Cir. 2014) ("As the Plan fiduciary, [the Plaintiff] is entitled to bring an action to 'enforce ... the terms of the plan.' However, the text of ERISA makes it clear that the relief sought must be 'appropriate equitable relief,' not legal relief. Ever since its decision in *Mertens v. Hewitt Associates*, 508 U.S. 248, 256, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), the Supreme Court has repeatedly defined 'appropriate equitable relief' as 'those categories of relief that were *typically* available in equity.' Equitable relief is contrasted with 'legal relief,' which constitutes claims seeking 'nothing other than compensatory damages.' The classic form of purely legal relief is money damages."); *Reeds v. Walker*, 2006 OK 43, ¶ 19, 157 P.3d 100, 110–11 ("By its express terms, § 502(a)(3) authorizes suits for equitable relief only. Construing this language in *Great–West Life Insurance Company v. Knudson*, the United States Supreme Court held that § 502(a)(3) does not 'authorize' a claim for legal relief. Because NAICO is seeking in this case quintessentially legal relief—to impose personal liability on defendants for money damages for breach of contract—its claim is clearly 'not authorized' by the federal statute upon which defendants rely for complete preemption.").

In addition to the foregoing federal court analysis, the Court located a Tennessee case addressing the scope of "equitable relief" under section 1132(a)(3). In *Hamrick's*,

*Inc. v. Roy*, the Court of Appeals, in denying a motion to dismiss for lack of subject matter jurisdiction, concluded that a breach of contract claim seeking only compensatory damages was not completely preempted under ERISA because it did not qualify as "equitable relief" under section 1132(a)(3). 115 S.W.3d 468, 474–76 (Tenn. Ct. App. 2002). For that reason, the Court in *Hamrick* concluded that the federal court did not have exclusive jurisdiction over the claim and the Tennessee state court retained subject matter jurisdiction over the case.

> We first address Defendants' argument that the Trial Court lacked subject matter jurisdiction over Plaintiff's claim. According to Defendants, federal courts have exclusive subject matter jurisdiction over claims by plan fiduciaries seeking reimbursement for sums paid to a plan participant. Defendants base this argument on 29 U.S.C. § 1132(a)(3) and § 1132(e)(1)….
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> According to Defendants, Plaintiff's claim is made pursuant to 29 U.S.C. § 1132(a)(3), and, therefore, must be filed in federal district court pursuant to 29 U.S.C. § 1132(e). Plaintiff argues its subrogation claim is not a cause of action classified as an ERISA claim for purposes of determining subject matter jurisdiction. In resolving this issue, it is important to note in this appeal Defendants challenge only the Trial Court's subject matter jurisdiction to hear the claim. Defendants do not assert other defenses which may or may not be available, such as federal preemption. We will, therefore, limit our resolution of this first issue to the very specific question presented for review, i.e., whether the Trial Court had subject matter jurisdiction over Plaintiff's claim. We conclude it did.
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> On January 8, 2002, the United States Supreme Court issued a 5–4 decision in *Great–West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002). Great West Life and Annuity Insurance Company ("Great West") sued Janette and Eric Knudson to enforce a reimbursement provision of a plan subject to ERISA. The specific issue presented for review was "whether § 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, 29 U.S.C. § 1132(a)(3) (1994 ed.), authorizes this action by petitioners to enforce a reimbursement

provision of an ERISA plan." 122 S.Ct. at 711. The Supreme Court concluded it did not. Janette Knudson was rendered a quadriplegic after an automobile accident. Great West filed a lawsuit in federal district court seeking injunctive and declaratory relief to enforce the reimbursement agreement and obtain from the settlement proceeds $411,157.11, all of which, except for $75,000.00, it had paid towards Knudson's medical bills resulting from the accident. In resolving the issue presented for review, the Supreme Court focused heavily on the language in § 1132(a)(3) which authorizes a plan fiduciary to bring an action "to enjoin any act or practice which violates ... the terms of the plan, or (B) to obtain *other appropriate equitable relief*...." (emphasis added). The Supreme Court then analyzed whether Great West's cause of action was properly classified as "equitable" relief. According to the Supreme Court, what Great West sought was, in essence:

> to impose personal liability on respondents for a contractual obligation to pay money—relief that was not typically available in equity. "A claim for money due and owing under a contract is 'quintessentially an action at law.' " *Wal–Mart Stores, Inc. v. Wells,* 213 F.3d 398, 401 (C.A.7 2000) (Posner, J.). "Almost invariably ... suits seeking (whether by judgment, injunction, or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for 'money damages,' as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of legal duty." *Bowen v. Massachusetts,* 487 U.S. 879, 918–919, 108 S.Ct. 2722, 101 L.Ed.2d 749 (1988) (SCALIA, J., dissenting). And "money damages are, of course, the classic form of *legal* relief." *Mertens, supra,* [508 U.S.] at 255, 113 S.Ct. 2063.

*Great–West,* 122 S.Ct. at 712–13. After reviewing applicable precedent regarding what was historically considered equitable relief versus legal relief, the Supreme Court concluded the relief sought by Great West was properly deemed legal relief, and because "petitioners are seeking legal relief—the imposition of personal liability on respondents for a contractual obligation to pay money—§ 502(a)(3)[, 29 U.S.C. § 1132(a)(3) ] does not authorize this action." 122 S.Ct. at 719.

The relief sought by Plaintiff in this case is quite similar to the relief sought in *Great West.* Specifically, Plaintiff is seeking to impose personal liability on Defendants for a contractual obligation to pay money. Pursuant to *Great West,* this is not an action authorized by 29 U.S.C. § 1132(a)(3) because it

> does not involve equitable relief. It necessarily follows that the jurisdictional limitation found in § 1132(e) limiting jurisdiction to the federal courts does not come into play. Because the jurisdictional limitation in § 1132(e) is not applicable, we conclude the Trial Court had subject matter jurisdiction over Plaintiff's claim.

115 S.W.3d 468, 474–76 (Tenn. Ct. App. 2002) (footnotes omitted).

Applying this law to the pleadings, the Court sees that the Plaintiffs' 4-page Complaint seeks "to recover premium owed by [the Defendant] under its contracts with the Plaintiffs" and "[t]hat the Plaintiffs be awarded a judgment against the Defendant for $72,496.87 plus prejudgment and post judgment interest." *Complaint*, pp. 1, 4 (June 7, 2017). In seeking this type of relief, the Plaintiffs are clearly seeking compensatory damages – not equitable relief or to address a violation of the ERISA statute or an ERISA plan. Because no equitable relief is sought and the Plaintiffs are simply seeking to impose personal liability on the Defendant for a contractual obligation to pay money, the complete preemption of section 1132(a)(3) does not apply. In this regard, this case is similar to *Hamrick's, Inc. v. Roy*, and the Court's analysis regarding complete preemption and subject matter jurisdiction when the only claim was for money damages:

> The relief sought by Plaintiff in this case is quite similar to the relief sought in *Great West.* Specifically, Plaintiff is seeking to impose personal liability on Defendants for a contractual obligation to pay money. Pursuant to *Great West*, this is not an action authorized by 29 U.S.C. § 1132(a)(3) because it does not involve equitable relief. It necessarily follows that the jurisdictional limitation found in § 1132(e) limiting jurisdiction to the federal courts does not come into play. Because the jurisdictional limitation in § 1132(e) is not applicable, we conclude the Trial Court had subject matter jurisdiction over Plaintiff's claim.

115 S.W.3d 468, 474–76 (Tenn. Ct. App. 2002) (footnote omitted).

Based upon the foregoing analysis and authorities, the Defendant's motion to dismiss for complete federal preemption is denied.

*s/ Ellen Hobbs Lyle*
ELLEN HOBBS LYLE
CHANCELLOR
BUSINESS COURT DOCKET
PILOT PROJECT

cc by U.S. Mail, email, or efiling as applicable to:

William B. Hubbard
Robyn E. Smith
Daniel H. Puryear
Thomas T. Pennington