National Multiple Sclerosis Society's Law Day
May 01, 2001
By Frank N. Darras and David T. Bamberger

What is ERISA and how can you avoid it?

I. What is ERISA

ERISA is a federal regulatory scheme enacted in 1974 in an effort to control fiduciary looting of company or union pension plans which left thousands of retired Americans stripped of the pension benefits they had accumulated after decades of work. [29 U.S.C. section 1001; Massachusetts v. Morash (1989) 490 U.S. 107, 115, 109 S.Ct. 1668, 1673]. Although originally enacted to prevent pension plan abuses, ERISA also applies to all employee benefit "plans", including health care coverage benefits, even when there is no formal "plan" established and even when the health care benefits are provided through the purchase of a group insurance policy [Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549].

II. What State Laws Are Preempted When ERISA Applies?

The preemption clause under ERISA provides that all state laws which "relate to" an employee benefit plan are preempted [29 U.S.C. section 1144]. The Supreme Court has traditionally interpreted that "relate to" language very broadly [see Ingersoll-Rand Co. v. McLendon, 498 U.S. 133, 139, 111 S.Ct. 478, 483], although more recent cases suggest that the Court is pulling back from that broad preemption [See New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (1995) 514 U.S. 218, 115 U.S. 1671 (concluding that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course")]. Under 29 U.S.C. section 1144, all state laws are preempted, except those regulating insurance. And, incredibly, even California Insurance Code section 790.03 (dealing with unfair insurance practices) has been found to not be a law regulating insurance under ERISA's savings clause. [Marshall v. Bankers Life & Cas. (1992) 2 Cal.4th 1045, 10 Cal.Rptr.2d 72].
However, the United States Supreme Court's recent decision in UNUM Life Insurance Co. v. Ward (1999) 119 S.Ct. 1380, 143 L.Ed.2d 462 is highly encouraging. In Ward, the Supreme Court considered California's notice-prejudice rule, which generally bars an insurer from denying coverage based on the insured's delay in submitting notice of claim (or violation of any general cooperation requirement in the policy) unless the insurer was prejudiced thereby. The Court held that the notice-prejudice rule is a " law . . . which regulates insurance" and is therefore saved from preemption by ERISA.

III. What Remedies Are Available If ERISA Applies?

Determination of whether an action is subject to ERISA preemption is critical because of the limited remedies available under ERISA [29 U.S.C. 1132]. The courts almost universally conclude that remedies in connection with an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered [Mass. Mut. Life Ins. Co. v. Russell (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; Mertens v. Hewitt Assoc. (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069].

However, one line of cases has held that damages are properly recoverable under ERISA based on language in the U.S. Supreme Court's opinion in Ingersoll-Rand. In that case, an employee sought compensatory and punitive damages for his employer's tortious termination of his employment just before his plan benefits would

have vested [498 U.S. at 136, 111 S.Ct. at 481]. The Supreme Court stated that "[I]t is clear that the relief requested here is well within the power of federal courts to provide" 498 U.S. at 145, 111 S.Ct. at 486].

This language was authored by Justice O'Connor, the same Justice who only three years earlier penned the landmark case of Pilot Life. Based on Ingersoll-Rand, some courts have concluded that consequential and punitive damages are meant to be recoverable under ERISA.1 At present, however, that is far from the majority view.

IV. What is the Standard of Review Where ERISA Applies?

As if ERISA's restrictions on remedies weren't onerous enough, insurers in ERISA cases are also arguing that their decisions to deny benefits are entitled to deference from the court, and thus that an insured can't even recover policy benefits unless he can somehow prove that the insurer's decision to deny those benefits was arbitrary and capricious.
In that regard, any court evaluating a claim subject to ERISA must first decide what standard of review should be applied to the benefit determination by the ERISA administrator. [Snow v. Standard Life Ins. Co. (9th Cir 1996) 87 F.3d 327, 330]. The choice of the standard of review often determines the outcome of the litigation. If the court adopts the "de novo" standard of review, it will reevaluate and reweigh the evidence available to the administrator and independently determine whether the insured is disabled.

But if the court applies the highly deferential "abuse of discretion" standard of review, the only issue before the court is whether the insurer's decision to deny benefits was arbitrary and capricious. Under that standard, the court will typically uphold the insurer's denial as long as the insurer can point to some rational justification for its decision, even if the overwhelming weight of the evidence favors the insured. Where a deferential standard of review is applied, the insurer's determination will be overturned only if it was clearly erroneous or conflicts with the plain language of the plan [Saffle v. Sierra Pacific Power Co. (9th Cir. 1996) 85 F.3d 455, 458; Williamson v. UNUM Life Insurance Co. of America (C.D. CA 1996) 943 F.Supp. 1226].2

Fortunately, under the Supreme Court's mandate in Firestone Tire & Rubber Co. v. Bruch 1989) 489 U.S. 101, 115, 109 S.Ct. 948, 956-957, 103 L.Ed.2d 80, a court reviewing the determinations of an ERISA administrator must conduct a de novo review unless the plan explicitly grants the administrator discretionary authority to interpret plan language or make benefit determinations. Whether a plan administrator has discretionary authority, and is thus entitled to deferential judicial review, must be determined from the plan language. Id. That discretion cannot be implied from the language of the plan; it must be express. [Orozco v. United Airlines, Inc. (9th Cir. 1989) 887 F.2d 949, 952; Cathey v. Dow Chemical Co. Medical Care Program (5th Cir. 1990) 907 F.2d 554, 559; Moon v. American Home Assur. Co. (11th Cir. 1989) 888 F.2d 86, 88].

And the grant of discretionary authority cannot be qualified or ambiguous. Deferential review is appropriate only where discretion was "unambiguously retained" by the administrator. Bogue v. Ampex Corp. (9th Cir. 1992) 976 F.2d 1319, 1325. Based thereon, in Kearney v. Standard Insurance Company (9th Cir. 1999) 175 F.3d 1084, the Ninth Circuit found that an insurer was not entitled to deferential review where a group disability policy provided that:

"Subject to all the terms of the group policy, Standard will pay the LTD benefit described in Part 8 upon receipt of satisfactory written proof that you have become disabled while insured under the group policy."
In Kearney, the insurer argued that the term "satisfactory written proof" was sufficient to trigger the abuse of discretion standard of review. But the Ninth Circuit concluded that there were "at least three fair readings of the phrase with quite different consequences". [Id. at 1090], and thus that the carrier had not 'unambiguously retained' discretion" [Id.]. Accordingly, the Court held that the plaintiff's claim should be reviewed de novo. [Id.].

V. What Evidence Can Be Considered at a De Novo ERISA Trial?

Even where a court applies a de novo standard of review to an ERISA administrator's benefit determination, there is no guarantee that the court will consider evidence outside the administrative record compiled by the administrator. For example, although the Second Circuit typically "accept[s] without discussion a district court's consideration on de novo review of evidence not presented to the plan administrator" [Masella v. Blue Cross & Blue Shield of Connecticut (2nd Cir. 1991) 936 F.2d 98, 104], the Ninth Circuit generally accepts evidence beyond the administrative record only "when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review" [Kearney v. Standard Insurance Company (9th Cir. 1999) 175 F.3d 1084, 1090]. The Ninth Circuit is especially reluctant to consider extrinsic evidence that "could as easily have been submitted to the administrator"[Id. at 1091]3 before it made its claim decision.

But even in circuits where extrinsic evidence is admitted only if it is "necessary" for an adequate de novo review, the courts are finding such necessity with increasing frequency. For example, the circumstances under which the Fourth Circuit will consider evidence outside the administrative record include the following:

"[C]laims that require consideration of complex medical questions or issues regarding the credibility of medical experts";

"[T]he availability of very limited administrative review procedures with little or no evidentiary record";

"[T]he necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts";

"[I]nstances where the payor and the administrator are the same entity and the court is concerned about impartiality";

"[C]laims which would have been insurance contract claims prior to ERISA"; and

"{C]ircumstances in which there is additional evidence that the claimant could not have presented in the administrative process".
Quesinberry v. Life Ins. Co. of North America (4th Cir. 1992) 987 F.2d 1017, 1027.4 The Quesinberry court emphasized that "[t]his list of factors is not exhaustive" and is "merely a guide for district courts faced with motions to introduce evidence not presented to the plan administrator" [Id.].

VI. What Are Some of the Ways to Escape ERISA Preemption?

To assess whether a policy is subject to ERISA preemption, it must first be determined whether there is "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 . . . benefits in the event of sickness, accident, disability, death or unemployment . . ." [29 U.S.C. section 1002(1)].

The insurer has the burden of proving the facts necessary to establish the existence of an ERISA "plan". Kanne v. Connecticut General Life Insurance Co. (9th Cir. 1988) 867 F.2d 489, 492, n. 2, cert. denied, 492 U.S. 906 (1989); see also Zavora v. Paul Revere Life Ins. Co. (9th Cir. 1998) 145 F.3d 1118, 1120, n.2. As a practical matter, though, most courts will determine that a benefit is part of an ERISA "plan" if the benefit is provided through employment.

That does not mean, however, that there are no potential ways to circumvent ERISA. Here are a few:

An independent contractor is not an "employee" and is therefore not subject to ERISA preemption [Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992); Barnhart v. New York Life (9th Cir. 1998) 141 F.3d 1310.5

A government employee or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

Employees of churches or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)]. Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee. See 29 C.F.R. sections 2510.3-3(b) and (c); Kennedy v. Allied Mutual Ins. Co. (9th Cir. 1991) 952 F.2d 262; Meredith v. Time Insurance Co. (5th Cir. 1993) 980 F.2d 352. In Robertson v. Alexander Grant & Co. (5th Cir. 1986) 798 F.2d 868, the Court relied on those regulations in "[f]inding ERISA inapplicable to plans covering only partners". Similarly, in Meredith v. Time Insurance Co. (5th Cir. 1993) 980 F.2d 352, the court held that "an insurance plan purchased by a sole proprietor, covering only herself and her spouse, [does not] constitute . . . an 'employee welfare benefit plan' as that term is defined in ERISA".6 Further, in Fugarino v. Hartford Life & Acc. Ins. Co. (6th Cir. 1992) 969 F.2d 178, the Court held that a business owner is exempt from ERISA, stating that "a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA". And in Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102, 1104, the Court stated that "in order to establish an ERISA employee welfare benefit plan, the plan must provide benefits to at least one employee,7 not including an employee who is also the owner of the business in question", and thus that ERISA does not apply where "the disability insurance policies at issue were for the sole interest and benefit of the plaintiff, and not his employees".

Some courts have suggested that a plan is not "established or maintained" by an employer [29 U.S.C. section 1002(1)] unless the employer intended to create an ERISA plan.8 Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively participated in the design and operation of the plan, directly controlled the day-to-day operation of the plan, exercised substantial discretion over the plan, and/or established a separate administrative scheme to manage the plan.9 Still others have found that the "established or maintained" requirement may not be met despite significant employer involvement in the administration of the plan.10 Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.11 And a few others have held that the "is maintained" requirement implies that the plan must be in current operation,12 and thus that ERISA does not apply where the former employer has sold his business and stopped contributing to the plan13 or has gone bankrupt and ceased any involvement in the plan.14

Plans that fall under the Department of Labor's "safe harbor" regulations [29 C.F.R. 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;15 (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;16 (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; and (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations. See Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129.

In addition, there is a recent indication by the United States Supreme Court that it will be receptive to arguments against ERISA preemption. In UNUM Life Insurance Co. of America v. Ward (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States - on whose brief the Court had based its ruling in Pilot Life17 that ERISA is the exclusive remedy for state law causes of action

for bad faith - had changed its position on that issue. Although the Court concluded in Ward that it "need not address the Solicitor General's current argument" because Ward was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in Pilot Life.

And the federal district courts concur. During the past 18 months, district court judges in Colorado,18 Oklahoma19 and Alabama20 have relied on Ward in ruling that ERISA does not preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 U.S.C § 1144(B)(2)(A)] so as to avoid preemption). Conversely, Colorado, Oklahoma and Alabama limit the cause of action to the insurance industry21 - and so does California.
More specifically, the California Supreme Court has repeatedly held that claims for tortious breach of the implied covenant of good faith and fair dealing (i.e., bad faith) can only be brought in cases involving insurance contracts. For example, the Court held in Foley v. Interactive Data Corp. (1988) 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 that it is only "in the context of insurance contracts where . . . breach of the implied covenant will provide the basis for an action in tort". And the Court recently reiterated that "compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies" and that "at present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [Cates Construction Inc. v. Talbot Partners (1999) 21 Cal.4th 28, 43, 86 Cal.Rptr.2d 855].

Thus, unlike the Mississippi law construed in Pilot Life (which allowed tortious bad faith claims in a variety of contexts and therefore did not "regulate insurance"), California's bad faith tort is only available in the insurance arena. For that reason, California's bad faith law should be found to "regulate insurance" and therefore be "saved" from ERISA preemption.

VII. What is the Impact of the Sole Owner of a Disability Policy Providing Other Benefits to Employees?

An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which did cover employees.

For example, in Bellisario v. Lone Star Life Ins. (CD Cal. 1994) 871 F.Supp. 374, a company provided group health insurance to its employees. The company also purchased a disability policy providing coverage to the company president. But when the disability policy was purchased, the company president and the insurance company executed a memorandum of agreement which specifically provided that the disability policy was "part of a formal Wage Continuation plan" for the benefit of the company president. [Id. at 375]. That fact was the primary basis for the trial court's conclusion that the disability policy constituted an employee benefit subject to ERISA. [Id. at 378-379]. In contrast, where there is noevidence of any such agreement that the disability policy is part of a "wage continuation plan", ERISA should not preempt.
Similarly, in Peterson v. American Life & Health Insurance (9th Cir. 1995) 48 F.3d 404, the company purchased a short-term health insurance policy ("Policy No. 1") which covered the company's partners (including the plaintiff) and the company's employee. The company later purchased a long-term policy ("Policy No. 2") which covered one partner and the employee, but not the remaining partner - the plaintiff in the case - because he failed a physical examination required by the second insurer. However, the plaintiff remained insured under Policy No. 1 - which had included the employee at the time the policy incepted, but now covered only the plaintiff.

When the plaintiff's claims for heart bypass surgery were denied under Policy No. 1, the plaintiff sued. The Ninth Circuit concluded that the policy was subject to ERISA, despite the fact that the plaintiff was the sole beneficiary of the policy at the time of the surgery. But the basis for that ruling was that the policy had originally been purchased as one component of the company's ERISA plan - as evidenced by the fact that the employee was originally included on that policy - and the policy retained that status despite the fact that the policy later had no employee participants..

Indeed, that very distinction was recently drawn in Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159 , a case in which the court found that no ERISA "plan" existed. In addition to distinguishing Peterson because it involved health coverage rather than disability coverage, Stanton distinguished Peterson on the ground that it "implicitly found that the firm's other policies in existence at the time of the disputed coverage were an ERISA plan and that [Policy No. 1] fit into that overall program" [Id. at 1165].

The Peterson case also was distinguished earlier this year in LaVenture v. Prudential Ins. Co. of America (9th Cir. 2001) 237 F.3d 1042, an extremely helpful decision by the Ninth Circuit. In LaVenture, a pair of business owners purchased a disability policy covering only them. They later provided their employees with health insurance subject to ERISA. The Ninth Circuit held that a disability claim by one of the business owners was not preempted by ERISA. The Court concluded that "a disability policy, not originally covered by ERISA, is (not) converted into an ERISA plan merely because a company offers its employees unrelated health insurance coverage" [Id. at1044-1045]. In so holding, the Ninth Circuit distinguished its earlier decision in Peterson on the ground that in that case the two policies were initially established with the intent to create one benefit plan.
A similar - and very favorable - opinion was recently issued by the Eleventh Circuit in Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102. The Slamen court was faced with a dentist who purchased a disability policy covering only himself and health and life insurance policies covering both himself and his employees. The Court held that the disability policy was not an ERISA plan because it only covered the dentist. Rejecting Bellisario and Peterson, the Court found that the disability policy was not converted into an ERISA plan merely because the dentist also provided ERISA benefits (i.e., the health and life insurance policies) to his employees. The Court was "not persuaded by Paul Revere's argument that ERISA . . . applies here because Slamen had in place other insurance for his employees", and concluded that "[n]on-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits".

Equally helpful is Rand v. The Equitable Life Assur. Society of the U.S. (E.D.N.Y. 1999) 49 F.Supp.2d 111, wherein the plaintiff was a partner who purchased various disability and BOE policies. In addition, his partnership provided a group health insurance policy for all its employees. The Court held that "the plaintiff's disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance".

1. See Weems v. Jefferson-Pilot Life Ins. Co., Inc. (Ala. 1995) 663 So.2d 905, 911, Haywood v. Russell Corp. (Ala. 1991) 584 So.2d 1291, East v. Long (N.D. Ala. 1992) 785 F.Supp. 941, 944; International Union, United Auto., Aerospace & Agricultural Implement Workers v. Midland Steel Prods. Co. (N.D. Ohio 1991) 771 F.Supp. 860, and Lawrence v. Jackson Mack Sales, Inc. (S.D. Miss. 1992) 837 F.Supp. 771.

2. Additionally, certain courts have held that it is an abuse of discretion to refuse to give appropriate weight to treating physicians' reports, since those reports are entitled to greater weight than those by non-examining doctors and consultants. See Dodson v. Woodmen of the World Life Ins. Society (8th Cir. 1997) 109 F.3d 436, 439 and Donaho v. FMC Corp. (8th Cir. 1996) 74 F.3d 894, 901.

3. Similarly, the Fourth Circuit indicates that extrinsic evidence may be considered where "there is additional

evidence that the claimant could not have presented in the administrative process" [Quesinberry v. Life Ins. Co. of North America (4th Cir. 1992) 987 F.2d 1017, 1027].
4. The Fourth Circuit's decision in Quesinberry was endorsed by the Ninth Circuit in Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan (9th Cir. 1995) 46 F.3d 938, Kearney v. Standard Insurance Company (9th Cir.1999) 175 F.3d 1084, and Tremain v. Bell Industries, Inc. (9th Cir. 1999) 196 F.3d 970

5. However, if the independent contractor obtains insurance benefits through the same group plan that covers employees of the company, the court may determine that he is a "participant" and that his claims are preempted [See Harper v. American Chambers Life Ins. Co. (9th Cir. 1990) 89 F.2d 1432, 1434].

6. And this result does not change simply because the sole proprietor is incorporated and pays the premiums through his professional corporation. In Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102, 1106, n. 4, the court rejected the insurer's argument that the disability policy was preempted by ERISA because the premiums were paid by the dentist's professional corporation rather than the dentist as an individual. The Court reasoned that the professional corporation was wholly owned by the dentist, that he could not be considered an employee of the corporation he owned, and that the insurer would still "have to show that an employee other than [the dentist] received benefits under the disability insurance policy" in order to trigger ERISA. This holding was cited with approval in Rand v. The Equitable Life Assur. Society of the U.S. (E.D.N.Y. 1999) 49 F.Supp.2d 111.

7. Similarly, in Donovan v. Dillingham (11th Cir. 1982) 688 F.2d 1367, 1371, the court held that a "plan . . . falls within [the] ambit of ERISA only if the plan . . . covers ERISA participants because of their employee status in an employment relationship."

8. See Kanne v. Connecticut General Life Ins. Co. (9th Cir. 1988) 867 F.2d 489, 493; Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159; Hansen v. Continental Ins. Co. (5th Cir. 1991) 940 F.2d 971, 978.

9. See Hansen, 940 F.2d at 978; Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1134; Elco Mechanical Contractors. Inc. v. Builders Supply Assoc. of West Virginia (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; Taggart Corp. v. Life and Health Benefits Administration, Inc. (5th Cir. 1980) 617 F.2d 1208, 1210; and Sindelar v. Canada Transport, Inc. (Neb. 1994) 520 N.W.2d 203, 207.

10. See Zavora v. Paul Revere Life Ins. Co. (9th Cir. 1998) 145 F.3d 1118, 1121; du Mortier v. Massachusetts General Life Ins. Co., supra (C.D. Cal. 1992) 805 F.Supp. 816, 821; Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson, supra, 63 F.3d 1129.

11. See du Mortier and Johnson, supra.

12. See Stanton, supra, (S.D. Cal. 1999) 37 F.Supp.2d 1159

13. Loudermilch v. The New England Mutual Life Ins. Co. (S.D. Ala. 1996) 942 F.Supp. 1434.

14. Mizrahi v. Provident Life and Accident Ins. Co. (S.D. Fla. 1998) 994 F.Supp. 1452.

15. "Endorsement of a program requires more than merely recommending it". Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1136.

16. The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See Hrabe v. Paul

Revere Life Insurance Company (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

17. Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549.

18. Hall v. UNUM Life Ins. Co. of America, U.S. District Court for the District of Colorado, Case No. 97-M-1828, November 1, 1999 Order by Chief Judge Richard S. Matsch Granting Motion For Leave To File Amended And Supplemental Complaint Adding Third Claim For Relief. Note that although the unpublished order did not expressly reference the Supreme Court's decision in Ward, the order was issued in response to a motion (for leave to file an amended and supplemental complaint) that had been based solely on Ward.

19. Lewis v. Aetna U.S. Healthcare, Inc. (N.D. Ok. 1999), No. 99-CV-104-H(M).

20. Hill v. Blue Cross Blue Shield of Alabama (N.D. Ala. 2000) 117 F.Supp.2d 1209.

21. For example, in Oklahoma the tort of bad faith is "specific to the insurance industry" [Lewis, 78 F.Supp.2d at 1215], "applie[s] exclusively to contracts between insurance companies and their insureds" [Id. at 1212] and "has never been extended beyond the insurance area" [Id. at 1208]. Similarly, "the only targets for the tort of bad faith in Alabama are insurance companies" [Hill, 117 F.Supp.2d at 1212].