STATE OF MICHIGAN

COURT OF APPEALS

CLAYTON GROUP SERVICES, INC., f/k/a CLAYTON ENVIRONMENTAL CONSULTANTS,

Plaintiff-Appellant,

v

FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, GROUP PERKS, INC., and ROBERT SCHECHTER & ASSOCIATES,

Defendants-Appellees.

UNPUBLISHED
July 26, 2002

No. 226491
Oakland Circuit Court
LC No. 99-015795-CK

Before: Jansen, P.J., and Holbrook, Jr. and Griffin, JJ.

PER CURIAM.

Plaintiff appeals as of right from the trial court's orders granting summary disposition in favor of defendants under MCR 2.116(C)(10), ruling that plaintiff's claims are preempted by the Employee Retirement Income Security Act (ERISA), 29 USC 1001 *et seq*. We affirm.

I

Plaintiff is an environmental safety consulting company, with its offices located in the city of Novi. Defendant First Allmerica Financial Life Insurance Company (First Allmerica) had issued a group health insurance policy (the plan) to plaintiff on January 1, 1997. Defendants Group Perks, Inc., and Robert Schechter & Associates (Group Perks/Schechter) are insurance agencies that have acted as an agent for plaintiff with regard to its various insurance, financial, and employee benefits matters. The plan, by its terms, provides benefits "pursuant to an employee welfare benefit plan or plans within the meaning of ERISA." Plaintiff is the plan sponsor and administrator and First Allmerica is a co-administrator.

In 1997, there was an unusually large claims history made under the plan, and plaintiff's premiums for 1998 would have been substantially higher. Because of the anticipated increase in the premiums, plaintiff consulted with Peter Mendler, an insurance agent with Group Perks/Schechter. The discussion centered around changing health coverage from the First Allmerica plan to various Health Maintenance Organizations (HMO). Because plaintiff has employees throughout the country, it would not have been possible to enroll all the employees in

an HMO before termination of the plan with First Allmerica. Therefore, it was necessary to leave some employees on the First Allmerica plan until an HMO plan could be effectuated for them.

Plaintiff was concerned about the impact on the premiums by leaving some employees on the First Allmerica plan. Consequently, Mendler contacted Joseph Graham, a sales manager for First Allmerica. Under the terms of the plan, set forth in rider number one, plaintiff was required to pay a monthly fixed cost and to pay a variable cost that depended on the claims filed by plaintiff's employees and was capped by a cumulative monthly claim limit to First Allmerica. Because of the time lapse inherent in paying medical claims, the plan provided that the cumulative monthly claim limit is determined from the number of employees insured three months earlier. Graham, however, assertedly informed Mendler that the maximum premium would be based on the number of employees covered under the plan for that month. According to plaintiff, Mendler was assured that plaintiff would be charged only for the employees who remained on the First Allmerica plan and Mendler reported this to plaintiff.

Based on this information from Mendler, plaintiff moved the majority of its employees to health insurance policies with HMOs in February 1998. First Allmerica, however, continued to charge premiums reflecting coverage for the employees who had been moved to the HMOs based on the three-month lag as set forth in the rider. Plaintiff then requested that First Allmerica refund what plaintiff claimed was an over charge of $113,304.78. First Allmerica refused to reimburse any amount to plaintiff. Plaintiff subsequently filed suit against First Allmerica and Group Perks/Schechter, alleging claims of misrepresentation, breach of contract, and negligence.

After the completion of discovery, First Allmerica moved for summary disposition, contending that plaintiff's claims were preempted by ERISA. The trial court agreed, finding that this dispute involved rights and obligations under an employee benefit plan covered by ERISA. GroupPerks/Schechter subsequently moved for summary disposition as well, and the trial court also granted that motion. The trial court again found that plaintiff's claims relate to an ERISA plan, and the claims were preempted by ERISA.

II

We review de novo the trial court's ruling regarding defendants' motions for summary disposition under MCR 2.116(C)(10). *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). Likewise, we review de novo the trial court's ruling regarding the applicability of ERISA preemption as a question of law. *Woodworker's Supply, Inc v Principal Mut Life Ins Co*, 170 F3d 985, 989 (CA 10, 1999).

III

With these general principles in mind, we first address plaintiff's claims of misrepresentation and breach of contract against First Allmerica. We begin by noting that before preemption will be found, there must be a state law involved, there must be an employee benefit plan, and the state law must relate to the employee benefit plan. *Airparts Co, Inc v Custom Benefit Services of Austin, Inc*, 28 F3d 1062, 1064 (CA 10, 1994). Here, there is clearly a state law involved, that being common law claims of misrepresentation and breach of contract. See,

e.g., *Ingersoll-Rand Co v McClendon*, 498 US 133, 138-139; 111 S Ct 478; 112 L Ed 2d 474 (1990) (common law claim of wrongful discharge constitutes a state law claim). Further, this case implicates an employee benefit plan because the terms of the plan clearly state that it is intended to provide benefits pursuant to an employee welfare benefit plan within the meaning of ERISA and the rider describing the terms of the premiums specifically states that it is attached to and made a part of the plan.

The central question is whether plaintiff's state law claims against First Allmerica "relate to" the employee benefit plan. 29 USC 1144(a). As the court in *Airparts* stated, perhaps even understated, "[t]here is no simple test for determining when a law 'relates to' a plan." *Id.* at 1064, quoting *Nat'l Elevator Industry, Inc v Calhoon*, 957 F2d 1555, 1558 (CA 10, 1992). The United States Supreme Court has held that a state law "relate[s] to" an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v Delta Air Lines, Inc*, 463 US 85, 96-97; 103 S Ct 2890; 77 L Ed 2d 490 (1983). More specifically, a state law refers to a plan and will be preempted where: (1) the state law imposes requirements by reference to an ERISA covered program; (2) the state law acts immediately and exclusively on ERISA plans; or (3) the existence of an ERISA plan is essential to the state law's operation. *California Division of Labor Standards Enforcement v Dillingham Construction, N A, Inc*, 519 US 316, 324-325; 117 S Ct 832; 136 L Ed 2d 791 (1997); *Wilson v Zoellner*, 114 F3d 713, 716 (CA 8, 1997).

Here, we must conclude that plaintiff's breach of contract claim against First Allmerica is premised on the existence of an ERISA plan. *Ingersoll-Rand, supra* at 140. Specifically, plaintiff alleges that First Allmerica (a co-administrator of the plan) breached the plan when it failed to give thirty-one days' notice of a rate increase as required by the plan.[1] Clearly, this cause of action arises out of the group health insurance plan, that is, the existence of the plan is a critical factor in establishing liability for breach of contract. *Id.* at 139-140. Without the plan, there can be no breach. Therefore, plaintiff's breach of contract claim against First Allmerica is preempted by ERISA because this claim refers to the plan.

While the misrepresentation claim against First Allmerica does not necessarily refer to the plan, see *Wilson, supra* at 717 (state common-law tort of negligent misrepresentation does not contain a reference to ERISA), we find that the misrepresentation claim is connected with the plan such that it is preempted. To determine whether a state law claim has a forbidden connection with the plan, the courts look to the objective of ERISA as a guide to the scope of state law that Congress understood would survive and to the nature and effect of the state law on ERISA plans. *Dillingham, supra* at 325. A state law has a prohibited connection with the plan where: (1) the state law mandates employee benefit structures or their administration; or (2) the state law provides alternative enforcement mechanisms. *New York State Conference of Blue Cross & Blue Shield Plans v Travelers Ins Co*, 514 US 645, 658; 115 S Ct 1671; 131 L Ed 2d 695 (1995).

Plaintiff alleges that First Allmerica misrepresented the terms of the plan when Graham, First Allmerica's sales manager, told Mendler that the premiums would be based on the number

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[1] This notice requirement is contained in rider number one, which, as we have stated, is made a part of the plan by its terms.

of employees insured under the plan beginning on the first day of each month, rather than on the third preceding month as the plan specified. Here, we note that plaintiff is an ERISA entity because it is both the employer and the administrator of the plan. First Allmerica is also an ERISA entity because it is the issuer of the plan and a co-administrator. See *Airparts, supra* at 1065 (the principal ERISA entities are the employer, the plan, the plan fiduciaries, and the beneficiaries).[2] The misrepresentation claim involves ERISA entities and the amount of premiums to be made to the plan. The misrepresentation claim, therefore, relates to the plan because it arises out of the administration of the plan. In particular, ERISA requires all employee benefit plans to "specify the basis on which payments are made to and from the plan," 29 USC 1102(b)(4), and the fiduciary (First Allmerica) shall administer the plan "in accordance with the documents and instruments governing the plan," 29 USC 1104(a)(1)(D). See also, *Egelhoff v Egelhoff*, 532 US 141; 121 S Ct 1322; 149 L Ed 2d 264, 271 (2001). Therefore, plaintiff's misrepresentation claim against First Allmerica is preempted by ERISA because it is connected with the plan where the claim arises out of the administration of the plan.

Accordingly, the trial court did not err in granting summary disposition in favor of First Allmerica because plaintiff's claims are preempted by ERISA where the claims relate to the plan.

IV

Later, the circuit court granted summary disposition in favor of defendants Group Perks/Schechter on the basis that because plaintiff's claims against First Allmerica were preempted by the ERISA, plaintiff's claims against Group Perks/Schechter were also preempted because they relied on the same set of facts. The Honorable Steven N. Andrews reasoned:

> Clearly, Plaintiff's claims [against Group Perks/Schechter] relate to an ERISA plan. Plaintiff's allegations concern the proper calculation of ERISA plan premiums, and Defendants' alleged statements regarding the calculation of plan premiums. Here, in entertaining the merits of plaintiff's negligence and misrepresentation claims, the Court would be required to calculate the policy premiums that would have been owed under a plan administered by Allmerica or by plans administered by the various HMOs. Plaintiff's claims are sufficiently related to the subject matter regulated by ERISA to be preempted.

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[2] First Allmerica constitutes a "fiduciary" of the plan as that term is broadly defined in ERISA:

> [A] person is a fiduciary 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. [29 USC 1002(21)(A).]

We agree with the circuit court. Indeed, plaintiff's claims against Group Perks/Schechter in count III of its complaint were substantially similar to its claims against First Allmerica in count I. Where the claims against First Allmerica alleged that First Allmerica had "made negligent misrepresentations in regard to the Group Policy" which were "egregious, arbitrary, and indifferent to its insured, the Plaintiff," plaintiff's claims against Group Perks/Schechter alleged that Group Perks/Schechter were "negligent and unskillful *in failing to properly interpret the Group Policy of defendant Allmerica*, to the detriment of the plaintiff." (Emphasis added.) Essentially, plaintiff's complaint relies on the same facts regarding all defendants – the interpretation and representation of First Allmerica's policy language by First Allmerica and Group Perks/Schechter – and claims negligence or misrepresentation on the part of First Allmerica or Group Perks/Schechter or both. Because the claims rely on the same facts, in order to prevail in this action plaintiff had to prove that either (1) the employee benefit plan offered by defendant was modified before plaintiff switched its employees from that plan to another or (2) that the provision – requiring that premiums in any given month were based on the number of employees enrolled in the plan three months before that date – was misrepresented by defendants. However, either of these possibilities would require an interpretation of the ERISA plan. Accordingly, the lower court correctly found preemption and granted summary disposition in favor of Group Perks/Schechter.

V

Plaintiff also argues that the trial court erred in refusing to allow it to amend its complaint. MCR 2.116(I)(5) provides:

> If the grounds asserted are based on subrule (C)(8), (9), or (10), the court shall give the parties an opportunity to amend their pleadings as provided by MCR 2.118, unless the evidence then before the court shows that amendment would not be justified.

In our view, allowing plaintiff to amend its complaint would be futile because under the ERISA's statutory scheme, the federal courts have exclusive jurisdiction over plaintiff's claims. A trial court need not grant leave to amend a complaint when the amendment would be futile. *Jenks v Brown*, 219 Mich App 415, 420; 557 NW2d 114 (1996). 29 USC 1132(e) provides that

> Except 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, fiduciary, or any person referred to in section 1021(f)(1) of this title. 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.

Plaintiff's claims do not fall within one of the exceptions to the grant of exclusive jurisdiction in the federal courts. Subsection (a)(1)(B) allows participants or plan beneficiaries "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 USC 1132(a)(1)(B). However, plaintiff is not a participant or beneficiary of the plan. 29 USC 1002(7), (8). Indeed, in its proposed amended complaint, plaintiff avers that it is suing "in [its] capacity as a fiduciary

within the meaning of ERISA." Thus, first exception to the exclusive jurisdiction mandate in the ERISA is not available to plaintiff. The other exception is also not applicable to plaintiff. Section (1)(B)(7) allows a state to "to enforce compliance with a qualified medical child support order." 29 USC 1132(a)(1)(B)(7). That is not the situation in the case at bar. Therefore, the federal courts are vested with exclusive subject-matter jurisdiction of this matter and any motion to amend plaintiff's complaint would have been futile. The lower court did not err when it denied plaintiff's motion to amend.

Affirmed.

/s/ Donald E. Holbrook, Jr.
/s/ Richard Allen Griffin