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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

ACHEM INDUSTRY AMERICA, INC., Petitioner, v. THE SUPERIOR COURT OF LOS ANGELES COUNTY, Respondent; LIN OUYANG, Real Party in Interest.	B282801 (Los Angeles County Super. Ct. No. BC556293)

ORIGINAL PROCEEDINGS in mandate. Richard L. Fruin, Judge. Petition granted.

Law Offices of Ray Hsu and Ray Hsu for Petitioner.

No appearance for Respondent.

Lin Ouyang, in pro. per., for Real Party in Interest.

In the underlying action, real party in interest Lin Ouyang asserted claims for fraud and breach of contract against petitioner Achem Industry America, Inc. (Achem), her former employer, alleging that Achem improperly allowed her employment-based health insurance coverage to lapse when she took a leave of absence from her employment. Achem filed a motion for summary judgment or adjudication, contending the claims were preempted under the Employment Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.) (ERISA). After the trial court denied the motion, Achem sought relief from that ruling by writ of mandate. We conclude there are no triable issues of fact whether the claims are subject to ERISA preemption. Accordingly, we grant the petition for writ of mandate.

FACTUAL AND PROCEDURAL BACKGROUND

In August 2014, Ouyang initiated the underlying action. Her second amended complaint (SAC), filed June 11, 2015, contains claims for fraud, breach of contract, and wrongful termination in violation of public policy, along with claims under the California Fair Employment and Housing Act (Gov. Code, § 12900 et seq.) and the Labor Code. Pertinent here are the SAC's claims for fraud (fifth cause of action) and breach of contract (sixth cause of action), which were based on allegations that after Ouyang began an unpaid leave in January 2011, Achem improperly failed to pay the premiums for her health insurance, which she obtained through Achem's group health insurance plan.

In October 2016, the trial court granted judgment on the pleadings with respect to the SAC's claims, with the exception of the fraud and breach of contract claims described above. In February 2017, Achem sought summary judgment or adjudication on those remaining claims, contending, inter alia, that they were subject to preemption under ERISA. The trial court denied Achem's motion in its entirety, concluding that there were triable issues regarding the application of ERISA preemption.

On May 30, 2017, Achem filed its petition for writ of mandate or peremptory writ. We issued an alternative writ of mandate and imposed a temporary stay.

DISCUSSION

Achem contends the trial court erred in denying summary judgment. As explained below, we agree.

A. *Standard of Review*

"An order denying a motion for summary adjudication may be reviewed by way of a petition for writ of mandate. [Citation.] Where the trial court's denial of a motion for summary judgment will result in trial on non-actionable claims, a writ of mandate will issue. [Citations.] Likewise, a writ of mandate may issue to prevent trial of non-actionable claims after the erroneous denial of a motion for summary adjudication. [¶] Since a motion for summary judgment or summary adjudication 'involves pure matters of law,' we review a ruling on the motion de novo to determine

whether the moving and opposing papers show a triable issue of material fact. [Citations.] Thus, the appellate court need not defer to the trial court's decision. "'We are not bound by the trial court's stated reasons, if any, supporting its ruling; we review the ruling, not its rationale.'" [Citations.]" (*Travelers Casualty & Surety Co. v. Superior Court* (1998) 63 Cal.App.4th 1440, 1450.)[1]

B. *Governing Principles*

"ERISA is a comprehensive federal law designed to promote the interests of employees and their beneficiaries in employee pension and benefit plans. [Citation.] As a part of this integrated regulatory system, Congress enacted various safeguards to preclude abuse and to secure the rights and expectations that ERISA brought into being. [Citations.]

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[1] Ouyang asserted numerous objections to Achem's evidentiary showing. Because the trial court did not expressly rule on the objections, we presume them to have been overruled. (*Reid v. Google, Inc.* (2010) 50 Cal.4th 512, 534.) As Ouyang has not resurrected her objections before us, we examine the trial court's rulings in light of the entire body of evidence submitted in connection with Achem's motion for summary judgment or adjudication.

On a related matter, we note that the exhibits supporting Achem's petition include evidence not submitted to the trial court in connection with Achem's motion for summary judgment or adjudication. We decline to examine that evidence, as our review of a writ petition is limited to the record before the trial court. (*Spaccia v. Superior Court* (2012) 209 Cal.App.4th 93, 96, fn. 2 & 97.)

Prominent among these safeguards is an expansive preemption provision, found at section 514 of ERISA (29 U.S.C. § 1144 . . . [citations].)" (*Marshall v. Bankers Life & Casualty Co.* (1992) 2 Cal.4th 1045, 1050-1051 (*Marshall*).) That provision "is conspicuous for its breadth, establishing as an area of exclusive federal concern the subject of every State law that 'relates to' an employee benefit plan governed by ERISA. [Citation.]" (*Id.* at p. 1051.) The provision encompasses "state law claims" -- that is, causes of action predicated on state law -- meeting the criteria for preemption stated in the provision. (See *Morris B. Silver M.D., Inc., v. International Longshore & Warehouse etc.* (2016) 2 Cal.App.5th 793, 801 (*Morris B. Silver M.D.*).) Ordinarily, "[t]he consequences of ERISA preemption are significant for plaintiffs. ERISA limits plan participants and beneficiaries . . . to causes of action for recovery of policy benefits only. [Citation.]" (*Hollingshead v. Matsen* (1995) 34 Cal.App.4th 525, 532 (*Hollingshead*).)

Generally, section 514 of ERISA creates "an affirmative defense to a plaintiff's state law cause of action that entirely bars the claim; that is, the particular claim involved cannot be pursued in either state or federal court." (*Morris B. Silver M.D.*, *supra*, 2 Cal.App.5th at p. 799.) In order to demonstrate that a claim is subject to ERISA preemption, a defendant employer must show (1) that it established "'an employee welfare benefit plan'" within the meaning of ERISA, and (2) that the claim appropriately ""relates to"" the plan. (*Hollingshead*, *supra*, 34

Cal.App.4th at pp. 533, 539-540.) The defendant has the burden of demonstrating the facts necessary to establish ERISA preemption. (*Marshall*, *supra*, 2 Cal.4th at p. 1052.) That defense need not be alleged in the answer, and may be raised for the first time by a motion for summary judgment.

Under ERISA, the term "'employee welfare benefit plan'" means "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise" specified benefits, including "medical, surgical, or hospital care or benefits, or benefits in the event of sickness [or] disability . . . ." (29 U.S.C. § 1002(1).) Although the existence of an ERISA plan is ordinarily a question of fact, that question may resolved as a matter of law on summary judgment when the pertinent facts are undisputed. (See *Hollingshead*, *supra*, 34 Cal.App.4th at pp. 533-539.)

Whether a state law claim relates to an ERISA plan depends on the extent to which the claim implicates matters subject to ERISA.[2] As explained in *Pacific Airmotive Corp.*

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[2] Generally, under ERISA, "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." (*Shaw v. Delta Air Lines* (1983) 463 U.S. 85, 97.) However, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." (*Id.* at p. 100, fn. 21; see *New York State Conference of Blue Cross & Blue*
(*Fn. continued on the next page.*)

v. First Interstate Bank (1986) 178 Cal.App.3d 1130, 1138-1139, four factors influence whether ERISA preempts a state law claim: "(1) the extent to which the law in question relates to an area traditionally within a state's domain [citations]; (2) the extent to which the law directly or indirectly impinges on the terms and conditions of an employee benefit plan [citations]; (3) the extent to which the relief sought is incompatible with ERISA [citations]; and (4) the extent to which the rights the plaintiff seeks to enforce arise under an employee benefit plan. [Citations.]" Whether a state law claim relates to an ERISA plan may be resolved on summary judgment. (*Provience v. Valley Clerks Trust Fund* (1984) 163 Cal.App.3d 249, 258-259 (*Provience*).)

Courts have concluded that ERISA preempts a wide variety of state law claims by employees relating to ERISA plan benefits, including claims against employers predicated on the improper denial or processing of plan benefits. (*Simon Levi Co. v. Dun & Bradstreet Pension Services, Inc.* (1997) 55 Cal.App.4th 496, 502 [discussing cases]; *Morris B. Silver M.D.*, *supra*, 2 Cal.App.5th at p. 801 [discussing cases].) In *Metropolitan Life Ins. Co. v. Taylor* (1987) 481 U.S. 58, 61, an employee was enrolled in his employer-provided ERISA plan, which paid disability benefits. After

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Shield Plans v. Travelers Ins. Co. (1995) 514 U.S. 645, 655 ["If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then . . . preemption would never run its course"].)

suffering injuries in a car accident and undergoing a divorce, the employee took a leave of absence from work and received benefits under the plan. (*Id.* at pp. 60-61.) At the employer's request, the employee submitted to examinations by a psychiatrist and physician, who found that he was not disabled. (*Id.* at p. 61.) When the employee refused to return to work, his employer terminated his employment. (*Ibid.*) The employee sued his employer and the plan's insurer, asserting claims for wrongful termination and breach of contract, seeking compensatory damages for "'money contractually owed . . . , as well as immediate reimplementation of all benefits and insurance coverages . . . .'" (*Id.* at p. 61.) The United States Supreme Court concluded that the employee's common law contract and tort claims were subject to ERISA preemption. (*Id.* at p. 62.)

In *Drummond v. McDonald Corp.* (1985) 167 Cal.App.3d 428, 430, the plaintiff was enrolled in employer-provided health care and long-term disability benefit plans subject to ERISA. The plaintiff asserted claims against the employer for breach of the covenant of good faith and fair dealing, fraud, and intentional infliction of emotional distress, alleging that after she took a medical leave of absence, the employer improperly delayed the payment of disability benefits and refused to "convert" the plaintiff's group insurance to individual insurance. The appellate court held that the claims were subject to ERISA preemption. (*Drummond, supra,* at pp. 430, 432-434.)

B. *Ouyang's Demurrer to the Petition*

At the outset, we examine Ouyang's contention that Achem's petition must be dismissed due to formal defects. "A proceeding in mandamus is . . . subject to the general rules of pleading applicable to civil actions. [Citation.]" (*Chapman v. Superior Court* (2005) 130 Cal.App.4th 261, 271 (*Chapman*).) For that reason, "it is necessary for the petition to allege specific facts showing entitlement to relief. . . . If such facts are not alleged, the petition is subject to general demurrer [citation] or the court is justified in denying the petition out of hand." (*Gong v. City of Fremont* (1967) 250 Cal.App.2d 568, 573.)[3]

Here, Ouyang's return demurs to Achem's petition as fatally defective, arguing that it "does not consist [of] a petition setting out the ultimate fact allegations and issues," and that "the allegation of reversible error . . . is not supported by the [trial] court's order." We disagree. Although we do not condone Achem's failure to include within the petition a separate section in the form of a pleading, the petition adequately sets forth the factual allegations and issues. The petition describes the procedural history of the action, identifies the SAC's

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[3] We note that California Rules of Court, rule 8.486 sets forth other requirements, including that a petition for mandamus identify the real party in interest, contain a verification, and be accompanied by a memorandum of points and authorities and adequate record. Ouyang does not argue that Achem's petition fails to satisfy those requirements.

allegations potentially supporting ERISA preemption of the claims for fraud and breach of contract, and sets forth the trial court's ruling on the motion for summary motion or adjudication. We further observe that although Ouyang characterizes the petition as "uncertain," she has submitted two briefs (her return and a brief designated a "petition for rehearing" regarding the alternative writ) that include argument (with citation to legal authority) in support of the trial court's ruling. Accordingly, we overrule the demurrer. (*Chapman*, *supra*, 130 Cal.App.4th at pp. 271-272 [overruling demurrer to petition lacking "a traditional statement of facts" because petitioner's other submission identified the relevant facts and real party in interest addressed key issue in two briefs].)

C. *SAC's Claims for Fraud and Breach of Contract*

In assessing the denial of summary judgment, we look first to Ouyang's allegations in the SAC, which frame the issues pertinent to a motion for summary judgment or adjudication. (*Bostrom v. County of San Bernardino* (1995) 35 Cal.App.4th 1654, 1662 [""[I]t is [the complaint's] allegations to which the motion must respond by establishing . . . there is no factual basis for relief on any theory reasonably contemplated by the opponent's pleading. [Citation.]""].)

The SAC alleges the following facts: From January 2011 to November 2013, Ouyang was on an unpaid leave from her employment with Achem. When Ouyang started

the unpaid leave, she had Health Maintenance Organization (HMO) health insurance through Achem's group health insurance plan with premiums paid by Achem at no cost to her. During the unpaid leave, Achem never notified her that her health insurance coverage had been discontinued or directed her attention to her option for coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. §§ 1161 et seq.) (COBRA). Instead, in September 2011, Achem sent Ouyang a notice stating that it would provide HMO health insurance to its California employees at no cost to the employees. Ouyang submitted a timely enrollment form to Achem, which sent her an insurance card with an effective date of October 1, 2011.

In January 2012, Achem, through its human resource agency ADP [T]otal [S]ource (ADP), again notified Ouyang that she was eligible to register for coverage through Achem's group medical insurance plan at no charge to her. Upon receiving the notice, Ouyang contacted ADP, which confirmed that she was an employee of Achem on unpaid leave and that Achem would pay the premiums for her HMO health insurance, at no cost to her. ADP provided Ouyang with instructions how to register for Achem's group insurance plan. After complying with the instructions, Ouyang received an insurance card with an effective date of February 1, 2012.

In June 2012, when Ouyang sought medical services, she discovered that Achem had not paid the premiums for

her health insurance. As a result, she was obliged to personally pay for the medical services. Ouyang contacted ADP and inquired regarding coverage under COBRA. ADP told Ouyang that she was eligible for employer-sponsored health insurance coverage but ineligible for COBRA coverage, and advised her to enroll in Achem's group health insurance plan when it opened for registration. In or after June 2013, Ouyang registered in Achem's group health insurance plan and received an insurance card.

In November 2013, when Ouyang left her employment with Achem, she received neither notification that her insurance terminated nor notice of her COBRA rights. She contacted ADP, which told her that she was not eligible for coverage under COBRA. As a result, Ouyang lost the option to continue her employer-provide coverage under COBRA. In May 2014, she suffered injuries in a car accident, and incurred medical expenses exceeding $3,870 due to lack of health insurance.

Notwithstanding the SAC's references to ADP, Ouyang's claims target Achem, as the SAC alleges that Achem "was in sole control of the administration and maintenance of [Ouyang's] medical insurance benefits." The fraud claim relies on allegations that Achem knowingly made false representations to Ouyang regarding the payment of her insurance premiums and her ineligibility for COBRA coverage. According to the SAC, Achem made no payments for Ouyang's health insurance as early as February 2012, falsely stated that it continued

to make the payments in order to "get a lower premium[] rate by keeping [Ouyang] out of [Achem's] group health plan," and misrepresented her eligibility for COBRA rights in order to cover up its "false promises." The breach of contract claim alleges that Ouyang, by submitting enrollment forms to Achem, "entered a written agreement" under which Achem "would provide medical coverage to [her] and make premium payments to [her] HMO medical insurance plan . . . while [she] remained an employee . . . ." Both claims sought damages, including economic losses exceeding $3,870.

D. *Achem's Motion for Summary Judgment or Adjudication*

Achem sought summary adjudication on Ouyang's claims on several grounds, including that the claims, as alleged in the SAC, were subject to ERISA preemption. Achem's motion also asserted that each claim failed on the merits, although it did not identify that purported failure as a separate ground for summary adjudication.

In an effort to show the claims were meritless, Achem maintained that in view of the allegations in the SAC, ADP -- rather than Achem -- was responsible for the misrepresentations that Ouyang attributed to Achem. Pointing to the SAC, Achem argued: "[O]nly ADP . . . made the misrepresentation[s] to [Ouyang regarding] her health insurance eligibility. . . . [Achem] did not make any

representations to [Ouyang] regarding her health insurance eligibility."

Achem also offered evidence challenging certain allegations underlying the claims. Achem contended that Ouyang's unpaid leave was valid for only 12 weeks, and that she never intended to return to work. In support of the latter contention, Achem submitted a declaration that Ouyang filed in connection with another motion, in which she stated: "I stopped working at Achem . . . since January 2011." Furthermore, in order to show that no written agreement required Achem to provide health insurance to employees who had stopped working, and that Ouyang knew that Achem paid for her insurance only when she worked full time or part time, Achem presented an excerpt from its employee handbook, which states: "While on an unpaid leave of absence, in most instances, the employee must make arrangements for direct payment of . . . health insurance . . . ."

E. *Ouyang's Opposition*

Ouyang opposed summary adjudication on her claims, asserting that Achem failed to show that her alleged agreement with Achem regarding her health benefits while on leave constituted an "employee welfare benefit plan," within the meaning of ERISA. Her principal contention was that the alleged agreement was an "individual agreement" outside the scope of ERISA, notwithstanding the SAC's allegations that she sought a

benefit offered generally to employees under Achem's group health insurance plan, and that she entered into the agreement by completing enrollment forms for that plan. In support of that contention, she relied on the excerpt from Achem's employee handbook, arguing that it established a triable issue whether her agreement with Achem while on unpaid leave was "not part of [Achem's] employee welfare benefit plan." She also pointed to Achem's responses to special interrogatories, which stated (1) that in 2011, Achem did not offer group health insurance to any employee not working full time and not on a valid leave, and (2) that from 2012 to 2104, Achem relied on ADP to make arrangements for terminating coverage for any such employee. In the alternative, Ouyang argued that Achem failed to carry its initial burden on summary judgment of showing that Achem's group health insurance plan, as alleged in the SAC, constituted an ERISA plan.

Ouyang also offered evidence to support certain allegations in the SAC. Ouyang submitted Achem's notice to employees dated September 19, 2011 -- a copy of which was also attached to the SAC -- which described the terms of Achem's group health insurance plan, including the availability of HMO health insurance coverage at no cost to employees. Additionally, Ouyang presented copies of health insurance cards issued to her in and after October 2011, as well as Achem's answer to the SAC, which

acknowledged that Achem paid her health insurance premiums for a period after she began her unpaid leave.

F. *Trial Court's Ruling*

At the hearing on Achem's motion, the trial court characterized Ouyang's claims as predicated on a promise -- namely, "[W]hile you're on your leave, you'll have insurance coverage" -- and remarked, "[I]t might be a jury question as to whether [that promise] is related to an ERISA claim. But [Ouyang] doesn't plead [an] ERISA claim; she claims breach of an oral promise."

Following the hearing, the trial court denied Achem's motion in its entirety. With respect to both claims, the court concluded there were triable issues, "including but not limited" to whether the claims related to an ERISA plan, whether ADP acted as Achem's agent in entering into an agreement with Ouyang to pay for her benefits, and whether Achem ratified that agreement by making some payments. The court further stated: "[Ouyang's] evidence, if credited by the trier of fact, is sufficient to establish that any agreement by [Achem] to provide health benefits to [Ouyang] . . . was outside of [Achem's] agreement to provide coverage for her while she was working."

G. *Analysis*

We conclude that summary adjudication was improperly denied on each of Ouyang's claims. Generally, when a defendant seeks summary adjudication of a claim on

the basis of ERISA preemption and additionally, on the ground that the claim lacks merit, the issue of ERISA preemption presents a threshold determination properly resolved prior to the merit-based challenge. (*Provience*, *supra*, 163 Cal.App.3d at pp. 258-259 & fn. 6.) For that reason, the focus of our inquiry is on the existence of triable issues relevant to ERISA preemption. As explained below, there are no such issues.

1. *Existence of ERISA Plan*

We begin with whether Achem demonstrated the existence of "an employee welfare benefit plan" within the meaning of ERISA. In *Marshall*, our Supreme Court explained that when an employer, in seeking to provide its employees with health care benefits, "purchases a group insurance policy, contributes toward premiums and remits them to the insurer, and retains authority to terminate the policy or change its terms," the employer "has 'established or maintained' an ERISA plan regardless of whether it also processes claims or otherwise administers the policy." (*Marshall*, *supra*, 2 Cal.4th at pp. 1054, fn. 3, 1057.) Applying those criteria, the court concluded that an employer's conduct in buying a group health insurance policy, paying the entire cost of the premiums for its employees, submitting enrollment forms to a third party administrator, and changing insurance providers when necessary "demonstrated beyond peradventure" that the

employer established an ERISA plan. (*Marshall, supra,* at p. 1056.)

Here, the SAC's factual allegations, coupled with the evidence submitted by Ouyang, establish that Achem's group insurance plan constituted an ERISA plan. As explained in *Foxborough v. Van Atta* (1994) 26 Cal.App.4th 217, 222, fn. 3, in seeking summary judgment, "a defendant may rely on the complaint's factual allegations, which constitute judicial admissions. [Citations.] Such admissions are conclusive concessions of the truth of a matter and effectively remove it from the issues." Furthermore, we may review all the evidence submitted by the parties to determine whether Achem carried its initial burden of showing the existence of an ERISA plan. (*Villa v. McFerren* (1995) 35 Cal.App.4th 733, 750-751.)

The SAC expressly alleges that Achem purchased group health insurance through which it provided employees with HMO health insurance at no cost to the employees. Furthermore, attached to the SAC was a copy of Achem's September 19, 2011 notice to employees, which Ouyang also submitted with her opposition to Achem's motion. As the notice states that Achem had changed its health insurance provider and that employees would receive a new enrollment packet, the notice establishes Achem's authority over the group health insurance plan.

We further observe that although Achem's motion suggested that ADP -- rather than Achem -- was responsible for the misconduct Ouyang attributed to Achem, the record

demonstrates no triable issue whether Achem exercised sufficient control over the plan to foreclose its status as an ERISA plan. A plan may fall within the scope of ERISA even though the employer relies on a third party administrator. (*Marshall*, *supra*, 2 Cal.4th at p. 1057.) Here, the evidence submitted in connection with the motion shows that from 2012 to 2014, Achem employed ADP to manage its plan, and relied on ADP to make proper arrangements to terminate an employee's enrollment in the plan. As explained in *Marshall*, such delegation of administration tasks "is a common feature" of ERISA plans. (*Marshall,* at p. 1057.) In sum, there are no triable issues whether Achem established an ERISA plan.

2. *Claims Relate to the ERISA Plan*

We turn to whether Achem demonstrated that the SAC's claims for fraud and breach of contract relate to Achem's ERISA plan. Those claims are predicated on allegations that after Ouyang began her unpaid leave, Achem -- acting through ADP -- repeatedly told her that she continued to be eligible for HMO health insurance at no cost to her through Achem's group insurance plan, that she applied for the insurance as instructed, that at some point Achem stopped paying for her insurance, and that Achem did not provide timely notification of her COBRA rights, thus resulting in her failure to exercise those rights. Each claim seeks an award of damages, including $3,870 in

medical expenses she allegedly incurred for want of health insurance.

In view of these allegations, the claims are subject to ERISA preemption. Each claim alleges the existence of a right that -- according to the SAC -- was offered generally to Achem's employees, namely, the provision of HMO health insurance at no cost to an employee. Because that right implicated the economic value of the health insurance benefits offered under Achem's ERISA plan, it was a benefit of that plan. (*Magliulo v. Metropolitan Line Ins. Co.* (S.D.N.Y. 2002) 208 F.R.D. 55, 58 [right to health insurance at reduced price was benefit of ERISA plan]; see *Heffner v. Blue Cross and Blue Shield of Alabama, Inc.* (11th Cir. 2006) 443 F.3d 1330, 1338 [deductible-free insurance coverage was benefit of ERISA plan].) The fraud claim also alleges a failure to provide notification of COBRA rights, which renders the claim subject to ERISA preemption. (*Tingey v. Pixley-Richards West, Inc.* (9th Cir. 1992) 953 F.2d 1124, 1132-1133 [ERISA preempted state law claims alleging improper loss of COBRA rights].)

Before the trial court and in this writ proceeding, Ouyang has contended there are triable issues whether her claims relate exclusively to a promise or contract Achem made with respect to Ouyang as an individual, not to Achem's ERISA plan. In support of this contention, she points to the excerpt from Achem's employee manual, which states that "in most instances," an employee on unpaid leave must pay directly for health insurance.

Ouyang argues that the manual raises a triable issue whether her claims relate solely to "an individual benefit" outside the scope of ERISA.

Ouyang's contention fails, as it relies on a new theory of liability not pleaded in the SAC that is inconsistent with the SAC's allegations. "Under settled summary judgment standards, we are limited to assessing those theories alleged in the [SAC]. [Citations.] "'The burden of a defendant moving for summary judgment only requires that he or she negate plaintiff's theories of liability *as alleged in the complaint.* A 'moving party need not ". . . refute liability on some theoretical possibility not included in the pleadings." [Citation.]' . . . "'[A] motion for summary judgment must be directed to the *issues raised by the pleadings.* The [papers] filed in response to a defendant's motion for summary judgment may not create issues outside the pleadings and are not a substitute for an amendment to the pleadings.'"'" [Citation.]" (*Falcon v. Long Beach Genetics, Inc.* (2014) 224 Cal.App.4th 1263, 1275.) Thus, a plaintiff may not defeat a summary judgment motion by "present[ing] a 'moving target' unbounded by the pleadings." (*Melican v. Regents of University of California* (2007) 151 Cal.App.4th 168, 176.)

Nothing in the SAC reasonably suggests that Achem agreed to pay for Ouyang's HMO health insurance pursuant to an individual contract separate from Achem's ERISA plan. The SAC alleges that after Ouyang began her unpaid leave, Achem notified her that she was eligible for a health insurance benefit --- namely, no-cost HMO insurance --

generally available to Achem's employees, and that in accordance with instructions from Achem and ADP, she repeatedly registered for coverage through Achem's group health insurance plan. Although the SAC refers to Achem's "false promises" to pay for her health insurance, that phrase, viewed in context, designates a benefit of Achem's ERISA plan -- namely, the no-cost HMO insurance generally available to employees -- that Achem allegedly assured Ouyang she was eligible to receive. The SAC thus alleges only that Achem's alleged misconduct denied Ouyang a benefit of Achem's ERISA plan.

Achem's alleged false assurances that Ouyang was eligible for an ERISA plan benefit do not foreclose ERISA preemption of the SAC's claims. In *Wise v. Verizon Communications, Inc.* (9th Cir. 2010) 600 F.3d 1180, 1183, the plaintiff worked for a period for an employer, during which she was diagnosed with multiple sclerosis, and then left. (*Ibid.*) The employer, in order to lure the plaintiff to return to work, promised that her benefits coverage under its ERISA plan would "'bridge'" back to her initial period of employment, and that her multiple sclerosis would not be subject to coverage limitations as a pre-existing condition. (*Wise, supra,* at p. 1183.) In making those promises, the employer's recruitment team understood the bridging of benefits to be a "standard practice." (*Ibid.*) Later, after the plaintiff returned to work for the employer, the administrator of the employer's ERISA plan ruled that the multiple sclerosis was a pre-existing condition that limited

the plaintiff's benefits coverage, and she asserted a state law claim against her employer, alleging fraud, misrepresentation, and negligence. (*Wise, supra,* at p. 1184.) The Ninth Circuit held that ERISA preempted the claim, stating that "[t]he state law theories of fraud, misrepresentation, and negligence all depend on the existence of an ERISA-covered plan to demonstrate that [she] suffered damages: the loss of insurance benefits." (*Id.* at p. 1191.) That rationale also applies to the SAC's state law claims.

The three decisions upon which Ouyang relies are distinguishable, as each involved a promise or contract under which an employer agreed to provide benefits to an individual employee. In *Miller v. Rite Aid Corp.* (9th Cir. 2007) 504 F.3d 1102, 1104-1105, relatives of a deceased employee asserted claims for breach of employment contract and negligence, alleging the employer offered the decedent life insurance as an element of the decedent's employment contract, and repeatedly told the decedent and her relatives that such insurance existed, but failed to ensure that the decedent had an effective life insurance policy when she died. In holding that the plaintiffs' claims were not subject to ERISA preemption, the Ninth Circuit concluded that the employer's promise to provide life insurance, by itself, did not constitute an ERISA plan. (*Miller, supra,* at p. 1108.) As explained above, the claims in the SAC rely on an ERISA plan benefit, rather than any such promise.

The remaining two decisions involve contracts between an employer and an individual employee. In *Dakota,*

Minnesota & Eastern Railroad Corp. v. Schieffer (8th Cir. 2011) 648 F.3d 935, 936 (*Dakota, Minnesota & Eastern*), a railroad entered into a contract with its president in order to encourage his ongoing employment. The contract entitled the president to "lucrative" benefits should he be terminated without cause. (*Id.* at p. 936.) Later, after being so terminated, the president requested contract-based arbitration to determine his benefits, and the railroad successfully sought an injunction to bar the arbitration on the ground that it was subject to ERISA preemption. (*Dakota, Minnesota & Eastern, supra,* at p. 936.) Reversing, the Eighth Circuit concluded that the president's contract was not an "'employee welfare benefit plan'" within the meaning of ERISA because it provided benefits only for a single individual. (*Dakota, Minnesota & Eastern, supra,* at p. 938.)

In *Graham v. Balcor Co.* (9th Cir. 1998) 146 F.3d 1052, 1053-1054, an employee received an unfavorable performance review and faced termination of her employment. After contesting the review and threatening litigation if terminated, the employee entered into an agreement with her employer. (*Ibid.*) Under the agreement, the employee promised to forego her legal claims in exchange for continued health care benefits through the employer's plan. (*Ibid.*) Later, after the employee took a medical leave of absence, the employer discontinued her health insurance coverage, and she asserted state law claims against the employer based on that conduct. (*Ibid.*) The trial court

ruled that the claims were subject to ERISA preemption. The Ninth Circuit rejected that determination, concluding that the claims arose from the employee's agreement as a individual with her employer, which did not constitute an ERISA plan. (*Graham, supra*, at p. 1055.) In contrast to *Dakota, Minnesota & Eastern* and *Graham*, the claims pertinent here, as pleaded in the SAC, are dependent upon a plan generally available to Achem's employees. In sum, summary judgment was improperly denied on the SAC.

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DISPOSITION

Let a peremptory writ of mandate issue directing that respondent trial court vacate its order denying petitioner's motion for summary judgment and enter a new order granting summary judgment on the SAC. The alternative writ, having served its purpose, is discharged, and the temporary stay is vacated effective upon the issuance of remittitur. Petitioner is awarded its costs.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

MANELLA, J.

We concur:

EPSTEIN, P. J.

COLLINS, J.