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IN THE CIRCUIT COURT FOR CABELL COUNTY, WEST VIRGINIA

FILED

DANNY FISCHER and
BRITTANEY FISCHER,

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Plaintiffs,

ADELL CHANDLER
CIRCUIT CLERK
CABELL WV

v.

CIVIL ACTION NO. 07-C-1100
The Honorable F. Jane Husted

SWVA, INC., et al.,

Defendants.

**PROPOSED ORDER GRANTING DEFENDANTS'
RENEWED MOTION FOR SUMMARY JUDGMENT**

This matter came before the Court pursuant to a Renewed Motion for Summary Judgment filed by Defendants SWVA, Inc. ("SWVA") and the SWVA, Inc. Employee Health Care Plan ("the Plan"). Upon consideration of the motion, the memoranda in support thereof and in opposition thereto, the arguments of counsel and the entire record, the Court **GRANTS** Defendants' renewed motion for summary judgment and **ORDERS** that Plaintiffs' claims against Defendants be **DISMISSED WITH PREJUDICE** based upon the findings and conclusions of law set forth below.

FINDINGS OF FACT

1. In this case, the Plaintiffs allege that Defendants wrongfully denied certain claims for benefits under the SWVA, Inc. Employee Health Care Plan. On January 26, 2006, Plaintiff Brittaney Fischer was seriously injured in a motor vehicle accident. The cause of the accident was that the driver of the car in which Ms. Fischer was a passenger lost control of his vehicle.

Record (“R.”) at SWVA0215 (accident report).¹ The medical providers that treated Ms. Fischer for her injuries submitted claims for benefits under the Plan on her behalf.

A. Relevant Features of the Plan

2. SWVA, Inc. has complete financial liability for the payment of benefits under the Plan. Where Plan benefits exceed a specified amount, SWVA, Inc. may be reimbursed under a stop-loss insurance policy. The stop-loss policy provides that the insurer will reimburse SWVA for “Covered Expenses Paid in excess of the Specific Deductible” Memorandum in Support of Defendants’ Renewed Motion for Summary Judgment (“Defs’ SJ Brief”) Ex. I (stop-loss policy) at 7; *see also id.* at 1, 3, 7. “Covered Expenses” are Plan benefits incurred by a participant or beneficiary. *Id.* at 4. “Paid” means that the expenses are “covered and payable” under the Plan, “adjudicated and approved,” and actually paid by check or draft backed by sufficient funds. *Id.* at 6. Reimbursements to SWVA, Inc. under the policy are not made until benefits have been “paid” under the Plan. *Id.*

3. Affidavits from Dexter Childers, Jr. (SWVA’s Controller), Larry Gue (Manager of Human Resources), and Linda Sites (claims manager for the Plan’s third party administrator) explain the mechanics of funding under the Plan. Defendants’ Reply to Plaintiffs’ Response to Defendants’ Renewed Motion for Summary Judgment (“Defs’ SJ Reply”) Ex. A. The affidavits explain that Plan benefits are paid by the third party administrator by means of checks drawn on a bank account into which SWVA deposits funds for that purpose. That bank account is the only source of Plan funding (Sites Aff. ¶ 5), and at no time did funds deposited into the Plan’s bank

¹ Citations to “R.” herein refer to the documents that were submitted to the court as exhibits to the parties’ briefs. Specific page numbers are the bates numbers affixed to documents produced by Defendants to the Plaintiffs in discovery. Citations to documents that were provided to Plaintiffs’ counsel and submitted to the court without bates numbers are to the exhibit designation assigned in the briefs.

account come from an insurance company (Childers Aff. ¶ 5). Plaintiffs have not attempted to controvert any of these facts stated in the affidavits submitted by Defendants.

4. The stop-loss insurance carrier is not involved in the administration of claims for Plan benefits. In this regard, the policy provides: “This is a reimbursement policy. You [SWVA], or Your Plan Supervisor, are responsible for making benefit determinations under Your Employee Benefit Plan. We [the stop-loss carrier] have no duty or authority to administer, settle, adjust, or provide advice regarding claims filed under Your Employee Benefit Plan.” Defs’ SJ Brief Ex. I at 1, 3, 7.

5. In a Rule 56(f) affidavit that accompanied Plaintiffs’ opposition, Plaintiffs argued that they could not adequately oppose Defendants’ motion for summary judgment because, among other things,² they had not been able to depose Larry Gue, “an officer of the Defendants and named fiduciary” of the Plan. Plaintiffs’ Response in Opposition to Defendants’ Renewed Motion for Summary Judgment (“Pls’ SJ Opp.”) Ex. I ¶ 6. During oral argument, Defendants explained that Gue was not the Plan’s named fiduciary at the time Plaintiffs’ claims for benefits were denied, nor was he the Plan’s named fiduciary at the time of the hearing on Defendants’ motion. The individual who acted as the Plan’s named fiduciary in connection with the adjudication of Plaintiffs’ benefit claims is no longer employed by SWVA; Plaintiffs were, however, permitted to depose the Plan’s current named fiduciary, John O’Connor, SWVA’s vice president of administration, concerning the Plan’s funding mechanism. Nothing in Mr. O’Connor’s depo-

² Plaintiffs also sought discovery relating to the merits of the underlying benefits claim, which discovery Defendants resisted because (1) their motion for summary judgment was based solely on the Plan’s limitations period and (2) discovery beyond the administrative record is not appropriate in the context of claims for benefits under employee benefit plans. The Court agrees with Defendants’ positions on these issues and denies Plaintiffs’ motion to compel discovery concerning the merits of the benefits claims.

sition casts into doubt the fact that SWVA, and not the stop-loss carrier, is liable for benefits to the Plan's participants and beneficiaries at all times.

6. The Plan limits benefits payable for expenses incurred in connection with injuries sustained as a result a third party's negligence. Generally, the Plan prohibits payment for "expenses incurred for injuries received in, or as the result of, an accident for which a third party may be liable." R. at SWVA0068 (Plan excerpts). Where the plan administrator determines there is a reasonable opportunity for the injured party (and thus the Plan) to obtain a reasonable recovery from the culpable third party, however, the Plan can enter into a reimbursement agreement with the injured party and pay benefits up to the amount of the anticipated recovery. R. at SWVA00069; SWVA0228 (final denial letter).

7. The Plan provides, "No legal action concerning the denial of benefits under this Plan may be commenced or maintained against the Plan or the Employer more than ninety (90) days after your receipt of notice of a decision on review of your appeal" R. at SWVA0063.

B. Adjudication of Plaintiffs' Claims for Benefits

8. Upon receiving notice of the claims for Ms. Fischer's accident-related expenses, the Plan Administrator undertook to determine whether there was a reasonable opportunity for the Plan to secure a recovery from the driver of the vehicle. Following denial of the claims by the Plan's third party administrator due to the Fischers' failure to furnish specifically requested information about the accident, the Fischers' attorney asked for reconsideration of the denial and submitted supporting documentation. R. at SWVA0205-06. On November 29, 2006, the named fiduciary designated by the Plan for claims adjudication upheld the denial based on the absence of evidence that a reasonable recovery for the Plan would be possible. R. at SWVA0227-30.

9. The Plan's 90-day limitations period began to run upon issuance of the decision denying the Fischers' appeal on November 29, 2006. Under the Plan's terms, therefore, the limitations period for seeking judicial review of the denial of benefits would have expired on February 27, 2007.

10. The Plan, however, determined to "toll" the limitations period for the purpose of allowing the Fischers to submit additional information. The Plan was looking for evidence tending to show that there was a realistic opportunity for the Plan to obtain a reasonable recovery. R. at SWVA0229-30 (final denial letter). The Plan's named fiduciary set the February 27, 2007 date as the deadline for the submission of additional supporting evidence and gave notice that, **"[i]f by that date the Plan has not received any such evidence, then the Plan's denial of Mr. Fischer's appeal will hereby and automatically become final without further action of the Plan."** *Id.* at SWVA0230. The Plan's 90-day limitations period would then begin to run on February 27, 2007, meaning that the Fischers had until May 28, 2007 to file their lawsuit.

11. In December 2006, Plaintiffs, by counsel, requested copies of relevant documents, which were provided. R. at SWVA0232, 233. In January 2007, in response to a letter from counsel for one of Brittaney Fischer's medical providers, Plan counsel again stressed the need for prompt submission of additional information. R. at SWVA0423-25.

12. On August 29, 2007, the Fischers' new counsel, Jeffrey V. Mehalic, sent a letter to the Plan's attorney. R. at SWVA0437-38. Mehalic implicitly acknowledged the possibility that the 90-day limitations period had expired, but stated:

Under the circumstances, the deadline imposed by the Plan must be extended so as to allow for the conditions to be fulfilled, which are, by Plan definition, imposed on establishing claim eligibility, *i.e.*, investigation of third party liability. Otherwise the claim limitations period would begin to run before the claim accrues.

Id. at SWVA0438. Thereafter, counsel for the Plan and for the Fischers exchanged additional correspondence regarding the Fischers' claims, which correspondence is not material to the issues presented in Defendants' renewed motion for summary judgment.

13. This action was filed on December 17, 2007, nearly seven months after the Plan's 90-day limitations period had expired.

CONCLUSIONS OF LAW

1. Under W. Va. R. Civ. P. 56(c), "summary judgment is required when the record shows that there is 'no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.'" *Conley v. Stollings*, 223 W. Va. 762, 679 S.E.2d 594, 598 (2009). In some circumstances, "summary judgment prior to the completion of discovery is 'precipitous.'" *Id.*, 679 S.E.2d at 599. At the same time, however, "[t]he mere contention that issues are disputable is not sufficient to preclude summary judgment." *Id.* For purposes of the instant motion, there are no disputed issues of material fact, and Defendants are entitled to judgment as a matter of law.

A. ERISA Applies for Purposes of Determining the Limitations Period Applicable to Plaintiffs' Claims

2. The Plan is an "employee welfare benefit plan" for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). It is a "plan . . . maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital . . . benefits." ERISA § 3(1), 29 U.S.C. § 1002(1). Plaintiff Danny Fischer is a "participant" under the Plan by virtue of his employment; Plaintiff Brittany Fischer, at the relevant time, was a "beneficiary," generally eligible for benefits under the Plan as Danny Fischer's dependent. *Id.* § 3(7), (8), 29 U.S.C. § 1002(7), (8). This action involves claims submitted for expenses incurred for treatment of Brittany Fischer, as described above.

3. The Plaintiffs' claims in this case arise under § 502(a)(1)(B) of ERISA, which authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B); Compl. Count I ¶ 37. "State courts of competent jurisdiction and the district courts of the United States . . . have concurrent jurisdiction of actions under [§ 502(a)(1)(B)]." 29 U.S.C. § 1132(e)(1). When such claims are entertained in state court, the substantive law of ERISA applies. *See, e.g., Anderson v. HMO Nebraska, Inc.*, 505 N.W.2d 700, 705 (Neb. 1993); *see also McGraw v. Norfolk & Western Ry. Co.*, 201 W. Va. 675, 679, 500 S.E.2d 300, 305 (1997) (recognizing that when exercising their concurrent jurisdiction over actions arising under the Federal Employers' Liability Act ("FELA"), state courts must apply FELA and "interpretive decisions of FELA given by the federal courts").

4. Federal law applies for purposes of determining the limitations period applicable to Plaintiffs' claims if the Plan is "self-funded," as the Plaintiffs have acknowledged. Pls' SJ Opp. at 11. Under the substantive law of ERISA, the Plan is "self-funded" if employer/plan sponsor is responsible for funding the benefits payable under the plan's terms. As explained below, an ERISA plan is "self-funded" even where the employer obtains stop-loss insurance coverage designed to reimburse the employer for benefits paid under the Plan in excess of specified amounts.

5. In general, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). The insurance "saving" clause provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance" ERISA § 514(b)(2)(A), 29 U.S.C. § 1144 (b)(2)(A). The "deemer" clause provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of

insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts” *Id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

6. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Supreme Court concluded that under ERISA’s preemption provisions self-funded ERISA plans are exempt from state laws regulating insurance. *Id.* at 61. Courts applying *FMC Corp.* uniformly have concluded that an ERISA plan is “self-funded” for purposes of ERISA preemption even though the plan or the plan’s sponsor (the employer) obtains stop-loss coverage from an insurance company to protect against large losses. *See, e.g., Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206, 213-14 (3d Cir. 2001) (“the purchase of stop-loss insurance does not make a self-funded plan an insurance carrier under ERISA’s ‘savings clause’”); *accord American Medical Security, Inc. v. Bartlett*, 111 F.3d 358, 361 (4th Cir. 1997); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Benefit Plan*, 970 F.2d 206, 210 (6th Cir. 1992); *Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 652-53 (4th Cir. 1991).

7. The SWVA, Inc. Employee Health Care Plan is self-funded as a matter of law. Benefits under the Plan are paid of SWVA’s general assets up to a specified dollar amount, after which the stop-loss carrier reimburses SWVA, the employer, an amount equal to the amount of benefits that have been paid out under the Plan to a Plan participant or beneficiary.

8. Plaintiffs contend that, if the Plan is not self-funded for purposes of ERISA preemption, Plaintiffs contend, then West Virginia’s statute prescribing a minimum two-year limitations period for actions on insurance policies might override the Plan’s 90-day contractual limitations period. *See* W. Va. Code § 33-6-14. In support of that contention, Plaintiffs have pointed to certain language in the stop-loss policy.

9. Under “Plan Funding,” the Plan provides: “The Plan is primarily ‘self-insured.’ This means that SWVA, Inc. has complete financial liability for the payment of benefits under the Plan. However, the Plan . . . is partially insured through a contract of insurance between SWVA, Inc. and Pacific Life Insurance Company The contract provides for insurance coverage only in cases where Plan benefits . . . exceed a certain amount.” R. at SWVA0073. Plaintiffs asserted that in light of that language it is not clear that the Plan is self-funded for purposes of ERISA preemption. Pls. SJ Opp. at 10-11. Plaintiffs also expressly acknowledged, however, that, if the insurance policy “only provides for reimbursement of SWVA, and SWVA remains primarily liable to Plan beneficiaries, the Plaintiffs have no quarrel with the application of federal law.” *Id.* at 11.

10. The Court concludes that the terms of the stop-loss policy, as described above, establish that the policy provides for reimbursement of SWVA; SWVA remains liable to the Plan’s participants and beneficiaries at all times. That conclusion is further confirmed by the affidavits of Childers, Gue, and Sites, which together explain the mechanics of funding benefits under the Plan. Defs’ SJ Reply Ex. A. Because the Plan is self-funded, West Virginia Code § 33-6-14 is preempted by ERISA.

B. The Plan’s Limitations Period Is Enforceable Under ERISA

11. Plaintiffs have acknowledged “an ERISA plan can establish a contractual limitations period.” Pls’ SJ Opp. at 14. It is “well established . . . [that] plans can craft their governing principles as they think best.” *Gayle v. United Parcel Service, Inc.*, 401 F.3d 222, 228 (4th Cir. 2005). Such “governing principles” can include reasonable contractual limitations periods, and, as *Gayle* makes clear, those limitations periods are enforceable, even when enforcement produces a harsh result. *See* 401 F.3d at 229-30 (dismissing plaintiffs’ claim for benefits with prejudice

where she failed to meet the plan's deadline for appeal); *see also White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 250 (4th Cir. 2007); *Northlake Regional Med. Center v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998) (an ERISA plan "is nothing more than a contract, in which the parties . . . are free to include whatever limitations they desire"); *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997).

12. The Plan's 90-day limitations period is reasonable as a matter of law. *See Northlake Regional Medical Center*, 160 F.3d at 1304 (90-day limitations period for bringing a lawsuit is reasonable and consistent with plan provisions "designed to process claims with dispatch"), *cited with approval in White*, 488 F.3d at 250. In this regard, courts have observed that suits challenging denial of benefits under an ERISA plan are akin to proceedings seeking judicial review of action by an administrative agency – both are "review proceedings, not evidentiary ones." *Northlake*, 160 F.3d at 1304 n.4; *accord Doe*, 112 F.3d at 875. In the administrative law context, relatively short limitations periods are common. *See, e.g.*, W. Va. Code § 29A-5-4(b) (parties adversely affected by a decision of administrative agency must appeal the decision to Circuit Court "within thirty days after the date upon which such party received notice of the final order or decision of the agency"); *id.* § 5-11-13(b) (complainant must institute legal action within 90 days after he is given notice of a right to sue under the Human Rights Act).

13. ERISA plans are free to establish contractual limitations periods, which are enforceable so long as they are reasonable. Plaintiffs have not contended that the Plan's 90-day limitations period is not reasonable. Rather, they argued that the Plan's application of that limitations period was flawed. The Court rejects that argument for the reasons explained below.

C. The Plan's Limitations Period Was Properly Applied

14. The Plaintiffs' argument with respect to application of the Plan's limitations period was based on the Fourth Circuit's decision in *White v. Sun Life Assurance Co. of Canada*, which turned on ERISA's exhaustion of remedies requirement.

15. Claims for benefits under an ERISA plan arise under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). Such actions may not be commenced until the claimant has exhausted his remedies under the Plan's internal claims review procedures. *White*, 488 F.3d at 247 (citing cases). In *White*, the court held that in light of the exhaustion requirement a claimant's claim for benefits does not "accrue" for purposes of triggering the limitations period until the Plan has issued its final decision. *Id.* at 246. "This means," according to the Fourth Circuit, "that the statute of limitations begins to run at the moment when the plaintiff may seek judicial review, because ERISA plaintiffs must generally exhaust administrative remedies before seeking judicial relief." *Id.*

16. *White* involved Sun Life's application of the plan's "accrual rule" – a provision specifying that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is required." *Id.* at 242. The date on which proof of claim was required on White's claim is not clear from the decision, but her application for benefits was dated May 5, 2000. *Id.* at 244. Sun Life's final decision denying the claim was dated March 28, 2001. The lawsuit was filed on March 26, 2004. *Id.* at 245. Thus, the lawsuit was timely if the Plan's accrual rule was overridden by the legal principle that claims for benefits accrue when the Plan issues a final decision. The action was not timely, however, if (as argued by Sun Life) the three-year limitations period began to run when "proof of claim was required," presumably in or about May 2000.

17. The Fourth Circuit rejected Sun Life's argument, reasoning that under Sun Life's reading of the plan's accrual provision, the limitations period could expire before the claimant was able to bring an action on the claim. No lawsuit could be filed until the plan's internal claims review procedures had been completed. Conceivably, then, if the three-year limitations period began to run when the claim was submitted, the limitations period could expire before the plan's claims procedures resulted in a final decision – the claim arguably would have been extinguished before it had accrued. *White*, 488 F. 3d at 247-48. Finding that result untenable, the court of appeals applied the federal common law accrual rule, holding that the claim accrued only upon exhaustion of the plan's claims review procedures. Because White's lawsuit was filed within three years of Sun Life's final decision denying her claim, the court concluded, the plaintiff was not time barred from seeking judicial review of the denial.

18. The circumstances of this case are not like those of *White v. Sun Life*. Under this Plan's application of its 90-day limitations period, Plaintiffs' cause of action for judicial review was not deemed to have accrued when the application for benefits was submitted under the Plan in the first instance. Rather, consistent with the Fourth Circuit's accrual rule, the 90-day limitations period ran from the date of the Plan's final decision denying Plaintiffs' claims (November 29, 2006) and was tolled for an additional 90 days. Further, unlike the plaintiff in *White*, these Plaintiffs had "fair notice" that their cause of action for judicial review had accrued. *See* 488 F.3d at 250. The November 29, 2006 denial letter stated: "With this denial of [her] appeal, Ms. Fischer has exhausted her administrative remedies under the Plan's claims review procedures. Accordingly, *Ms. Fischer has the right to bring a lawsuit against the Plan challenging the denial.*" R. at SWVA 0229 (emphasis added). The Fischers had until May 28, 2007 (November 29, 2006 plus 180 days) to file a lawsuit and were so advised in the final denial letter. *Id.*

19. Plaintiffs have suggested that their claim could not accrue until litigation brought by the Fischers against the tortfeasor is resolved. Pls. SJ Opp. at 12-13. That contention reflects a misunderstanding of the basis on which the claims were denied by the Plan. The claims were denied because there was no evidence indicating that the tortfeasor, either personally or through insurance coverage, would be able to satisfy a judgment in any substantial amount. Plaintiffs have never suggested that additional evidence on that point was, or likely would become, available. If the Plaintiffs disagreed with the Plan's reasons for denying the claims at issue, their recourse was to file a lawsuit on or before May 28, 2007. Having failed to do so, they have forfeited their right to judicial review.

CONCLUSION

Based on the foregoing findings of fact and conclusions of law and the principles set forth in Rule 56 of the West Virginia Rules of Civil Procedure, as well as the case law interpreting such rule, this Court concludes that there are no genuine issues of material fact relevant to Plaintiffs' failure to have timely filed this action. According, it is hereby **ORDERED** that Defendants' Renewed Motion for Summary Judgment is hereby **GRANTED** and this action is dismissed with prejudice.

ENTER: December 30, 2009

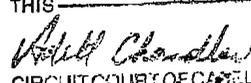


The Honorable F. Jane Hustead

ENTERED Circuit Court Civil Order Book

No. _____ Page _____ this
STATE OF WEST VIRGINIA
COUNTY OF CASSELL

I, ADELL CHANDLER, CLERK OF THE CIRCUIT COURT FOR THE COUNTY AND STATE AFORESAID DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE COPY FROM THE RECORDS OF SAID COURT ENTERED ON _____
GIVEN UNDER MY HAND AND SEAL OF SAID COURT

THIS _____ 2010
 CLERK
CIRCUIT COURT OF CASSELL COUNTY WEST VIRGINIA