IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

WILLIAM M. BLUE,

Plaintiff,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,

Defendant.

OPINION AND ORDER

10-cv-499-slc

In this civil action, plaintiff William Blue brought breach of contract and bad faith claims against defendant Hartford Life and Accident Insurance Co. for denying his claim for long-term disability (LTD) benefits under an employee welfare benefit plan sponsored by his former employer, the City of Madison. The parties filed cross motions for partial summary judgment (dkts. 10 and 20), Blue on the breach of contract claim and Hartford on the bad faith claim.

In his February 10, 2011 summary judgment brief, Blue argued for the first time that Hartford had applied the wrong standard in denying him benefits. After investigating the matter, Hartford determined that Blue was correct. So, Hartford reinstated all of Blue's past and future LTD benefits, effectively rendering Blue's breach of contract claim moot. *See* dkt. 33. As a result, no court decision is required on Blue's claim for benefits.

Having provided Blue with the direct relief he was seeking, Hartford then moved for a new round of briefing on its motion for summary judgment on Blue's only remaining claim, alleging bad faith by Hartford. Dkt. 32. (At that point, neither party had responded to the opposing party's brief or proposed findings of fact). The court granted Hartford's motion on March 18, 2011. Dkt. 37.

On the day that Blue's response to Hartford's summary judgment motion was due, Blue's lawyer filed a letter asking for a two-day extension based on emergency circumstances. Dkt. 51. The court granted that request on the assumption that Blue's responsive materials would be filed within two days. *See* dkt. 52. As subsequently became clear, however, Blue actually wanted two more days to file a motion for a much longer deadline extension so that he could undertake additional discovery. Dkt. 53. Because Blue failed to show good cause for the second extension, I denied his motion for another extension. Dkt. 57. This leaves Hartford's motion for summary judgment on Blue's bad faith claim unopposed.

As a result, Hartford's proposed findings of fact must be treated as undisputed to the extent that they are supported by admissible evidence. *Doe v. Cunningham*, 30 F.3d 879, 883 (7th Cir. 1994); *Strong v. Wisconsin*, 544 F. Supp. 2d 748, 759-60 (W.D. Wis. 2008). This leads me to conclude that Blue has not offered sufficient evidence to support his claim that Hartford acted in bad faith when it denied his LTD claim. Therefore, Hartford is entitled to summary judgment.

From Hartford's proposed findings of fact, I find the following facts to be material and undisputed:

FACTS

I. Background

Plaintiff William Blue is a former bus driver for the City of Madison and was insured under a group long-term and short-term disability plan. The city funded the plan by purchasing group insurance policy No. GLT/GRH-33731 from defendant Hartford Life and Accident Insurance Co. Blue stopped working on September 10, 1998 because of chronic headaches and,

as of September 18, 1998, was approved by Hartford for short-term disability ("STD") benefits. Hartford paid Blue STD benefits until September 13, 2001, the maximum period under the city's STD policy.

On March 29, 2001, Blue applied for long-term disability ("LTD") benefits. Hartford initially denied Blue's claim, but after receiving additional information about Blue's condition, approved him for LTD benefits effective October 12, 2001. Thereafter, Blue and Hartford had heated disputes regarding Blue's continuing eligibility for LTD.[1] In 2003, Hartford requested and began receiving annual attending physician statements (APS) tracking Blue's condition. These annual statements reported that Blue's headaches either were worse or unchanged between 2004 and 2006.

II. Signs of Improvement

In May 2007, Dr. Ed Ferguson, a cardiologist from University of Wisconsin Hospital, reported that Blue had "improved cranial nerves" and checked a box noting that Blue's condition had improved. Also in May 2007, Maureen Van Dinter, a nurse practitioner and Blue's primary medical provider, also reported improvement:

> He is beginning to notice significant improvement in his headaches w/ a marked reduction in discomfort w/ the change to the Lyrica [medication] . . . I do expect that if he continues as he has been that he will be able to return to work in approximately 6–8 months.

Def.'s PFOF, dkt. 11, at 7-8, ¶ 39.

[1] Although Hartford proposes several facts related the termination of Blue's benefits in 2002 and again in 2003, those decisions were reversed and do not appear to be material to the instant claim.

In March 2008, Van Dinter again reported that Blue "has been doing fairly well with his headaches noting only sporadic headaches at this point." She questioned whether the headaches might be "due to dehydration as he has been working more about the farm."

III. Functional Capability Assessment

In an April 2008 APS that assessed Blue's functional capabilities, Van Dinter reported that Blue was impaired by chronic pain, could sit for one to two hours at a time, stand for one hour at a time, walk for two hours at a time, occasionally lift up to 50 pounds and occasionally reach to various levels. Van Dinter did not fill in the box requesting the total number of hours that Blue could sit, stand and walk in a day. Van Dinter reported the expected duration of Blue's limitations as "indeterminant" [*sic*].

In a letter dated July 2, 2008, Hartford asked Van Dinter whether, in her opinion, Blue was capable of working. On the first page of the letter, Hartford presented the U.S. Department of Labor definition of light work and asked whether Van Dinter believed Blue was capable of full-time light work. She checked the space indicated for "Yes." On the second page of the letter, Hartford presented the definition of sedentary work and asked whether Van Dinter believed Blue was capable of full-time sedentary work. Van Dinter checked the space indicated for "Yes." The second page of Hartford's letter also invited Van Dinter to provide a rationale if she believed Blue was unable to return to work. She left that space blank. Hartford followed up by completing an employability analysis report that identified a number of occupations Blue could perform, including retail store manager and receiver-dispatcher.

IV. Denial of Benefits

In a letter dated September 24, 2008, Hartford notified Blue that he no longer met the policy's definition of disabled and therefore was ineligible for LTD benefits. Hartford's letter stated that it had based its decision on "[a]ll the papers contained in [Blue's] file . . . viewed as a whole." This included Blue's initial LTD application in 2001, his medical records and interviews with him on March 19 and July 7, 2008. Hartford specifically cited Van Dinter's statement that Blue could work and the employability report. Quoting language from "[p]age 25 of your policy," Hartford stated that Blue's policy contained a definition of Totally Disabled requiring him to be "prevented by Disability from doing any occupation or work for which you are or could become qualified by: 1. training; 2. education; or 3. experience."

Blue appealed Hartford's termination of his LTD benefits. For purposes of the appeal, Hartford referred Blue's claim for a medical records review. Hartford's reviewer, Robert L. Marks, M.D., examined Blue's records and spoke with Van Dinter. Dr. Marks reported to Hartford that Blue could work because he had concluded that Blue's medical records showed no abnormal neurological findings or any "neurological deficit" and Blue was not physically precluded from performing light-demand work. As a result, Hartford upheld its decision that Blue was ineligible for LTD benefits. In a letter to Blue dated February 10, 2009, Hartford incorporated by reference the explanation contained in its initial September 24 decision and cited Dr. Marks' report. Hartford stated that Blue was capable of alternative sedentary occupations and therefore no longer satisfied the policy definition of disability.

V. Ensuing Lawsuit

Blue retained counsel, who on March 17, 2010 sent a demand letter to Hartford. On July 13, 2010, Blue filed suit against Hartford in Wisconsin state court. Blue did not alert Hartford in his demand letter and did not claim in his complaint that Hartford had used the wrong standard when deciding that Blue no longer qualified for benefits. Hartford removed the case to this court under 28 U.S.C. §§ 1332 and 1441.

On February 10, 2011, Blue filed a motion for partial summary judgment. In his submissions, Blue asserted for the first time that Hartford had erred by applying the stricter "any occupation" standard to his claim, when it should have determined his eligibility for benefits under the more lenient "own occupation" standard. To be eligible for LTD benefits under the "own occupation" standard, an insured must be totally disabled by accidental bodily injury, sickness, mental illness, substance abuse or pregnancy from performing the essential duties of his *own*—versus any—occupation. Blue had never raised this issue with Hartford before filing his lawsuit.

As soon as Blue raised this issue, Hartford investigated what had occurred and determined that in its September 24, 2008 decision, it inadvertently applied the original, but later superseded, "any occupation" policy to Blue's claim. Hartford discovered that, when it had first adjudicated Blue's LTD claim in 2001, his policy was government by the "any occupation" standard. However, on February 5, 2002, Blue's insurance policy had been amended, retroactive to February 1, 1993; this 2002 amendment changed the policy's definition of disability to the more lenient "own occupation" standard.[2]

[2] Because Blue already had qualified for and was receiving LTD benefits under the stricter "any occupation" standard, this change had no effect on Blue's eligibility for benefits at that time.

Hartford's investigation determined that the termination letter to Blue dated September 24, 2008 had been issued by Madeleine Farrell, a Senior Ability Analyst for Hartford, who worked in Hartford's claim office in Alpharetta, Georgia, where Blue's disability claim was evaluated. Hartford further determined that before the termination of Blue's benefits on September 24, 2008, his claim had been handled previously by Hartford's Minneapolis area claim office. Blue's claim file indicates that before Farrell completed her analysis of Blue's claim, she requested a copy of the applicable policy from Hartford's Minneapolis-area office. The policy that the Minneapolis-area claim office provided to Farrell was the "any occupation" policy that had been in effect at the time of Hartford's initial approval of Blue's LTD benefits in 2001. The claim file does not reflect that the Minneapolis-area claim office sent Farrell the 2002 amendment.

Because Farrell did not have the amendment, Hartford inadvertently analyzed Blue's claim under the wrong definition of disability in both its September 24, 2008 termination letter and its February 10, 2009 decision on Blue's administrative appeal. Realizing the error, Hartford reinstated Blue's monthly LTD benefits and is issuing back benefits dating from his termination on September 24, 2008.

VI. Hartford Policies and Procedures

In evaluating claims under employee benefits plans insured by Hartford, it is Hartford's practice and intention to review such claims fairly, without regard to the manner in which the plan is funded, and to consistently award benefits on claims that are entitled to payment pursuant to the provisions of the applicable benefit plan while consistently denying claims that

are not entitled to such payments. Hartford administers claims in substantially the same manner whether it is doing so under a fully insured policy or pursuant to an administrative services only agreement.

Hartford does not provide its decision-makers with any incentives, remuneration, bonuses, awards, achievements or other recognition based in whole or in part upon the denial or termination of claims. Hartford's claims decision-makers are paid fixed salaries and performance bonuses that are wholly unrelated to the number of claims paid or claims denied. They are evaluated on the quality and accuracy of their claims decisions in accordance with the applicable plan and policy documents. Hartford does not discourage its claim decision-makers from paying legitimate claims.

Hartford's appeals unit is structured so as to keep it separate and independent from the personnel that decide claims on an initial review. Its decision-makers are not involved in Hartford's financial decisions, including, but not limited to, any review or analysis of Hartford's financial performance, or the financial performance or claims experience of any particular long term disability plan insured by Hartford. Hartford's claims department and appeals unit are completely separate business units from the financial and underwriting departments. Neither the claims department nor the appeals unit seeks approval from Hartford's financial underwriters in connection with their decision-making on claims for disability benefits. Hartford's financial and underwriting departments do not advise or influence the claims department or appeals unit with respect to the denial or termination of a claimant's benefits.

OPINION

I. Summary Judgment Standard

Summary judgment is proper where there is no showing of a genuine issue of material fact and where the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). "'A genuine issue of material fact arises only if sufficient evidence favoring the nonmoving party exists to permit a jury to return a verdict for that party.'" *Sides v. City of Champaign*, 496 F.3d 820, 826 (7th Cir. 2007) (quoting *Brummett v. Sinclair Broadcast Group, Inc.*, 414 F.3d 686, 692 (7th Cir. 2005)). In determining whether a genuine issue of material facts exists, the court must construe all facts in favor of the nonmoving party. *Squibb v. Memorial Medical Center*, 497 F.3d 775, 780 (7th Cir. 2007). Even so, the nonmoving party must "do more than simply show that there is some metaphysical doubt as to the material facts." *Matsushita Electric Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). The party that bears the burden of proof on a particular issue may not rest on its pleadings, but must affirmatively demonstrate, by specific factual allegations, that there is a genuine issue of material fact that requires a trial. *Hunter v. Amin*, 538 F.3d 486, 489 (7th Cir. 2009); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986).

II. Bad Faith

Under Wisconsin law, bad faith conduct by a party to a contract is a tort separate from breach of contract. Wisconsin intends the availability of this cause of action to encourage fair treatment of the insured and penalize unfair and corrupt insurance practices. *McEvoy v. Group Health Coop. of Eau Claire*, 213 Wis. 2d 507, 518, 570 N.W.2d 397, 407 (1997). To prove bad faith, a plaintiff must show: (1) the absence of a reasonable basis for denying the benefits of the

policy; and (2) the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. *Anderson v. Continental Ins. Co.*, 85 Wis. 2d 675, 691, 271 N.W.2d 368, 376 (1978).

A. Reasonable Denial

"Determining whether an insured has satisfied the first element requires an objective analysis that at its core asks whether the validity of the insurance claim is 'fairly debatable.'" *Quast v. State Farm Fire & Cas. Co.*, 2010 WL 4339132, *5 (W.D. Wis. Oct. 26, 2010) (citing *Farmers Auto. Ins. Ass'n v. Union Pac. Ry. Co.*, 2008 WI App 116, ¶ 25, 313 Wis.2d 93, 116, 756 N.W.2d 461, 472 (2008)). An insurer has a reasonable basis to suspend payment if it is clear that the insurer properly investigated the claim and that the results of the investigation were subject to a reasonable evaluation and review. *Brown v. Labor and Industry Review Commission*, 2003 WI 142, ¶ 25, 267 Wis. 2d 31, 49-50, 671 N.W.2d 279, 287-88 (2003). The reasonable or unreasonable character of the insurer's conduct is gauged by examining the circumstances existing when the insurer made its decision to deny benefits. *Id.*, 267 Wis. 2d at 50, 671 N.W.2d at 288.

Here, Hartford terminated Blue's LTD benefits in September 2008 after learning that his headaches had improved as of May 2007, his primary care provider (Van Dinter) believed that he was capable of full-time light or sedentary work and an employability analysis identified a number of occupations that Blue could perform. Following Blue's appeal, Hartford upheld its decision based on a medical records review performed by Dr. Marks, who reported that Blue's medical records showed no abnormal neurological findings or any neurological deficit. These

undisputed facts sufficiently establish that Hartford took reasonable steps to investigate Blue's entitlement to continued benefits. The problem arose because Hartford incorrectly applied the "any occupation" standard to these facts.

It is undisputed that at the time of the claim determination in 2008, Hartford's decision maker had before her only Blue's old policy, which contained the "any occupation" standard. Hartford since has admitted that the resulting determination was incorrect because the policy had been amended to include the own occupation standard. Therefore, the validity of Blue's claim is not debatable. Further, it is possible that a reasonable jury could conclude that Hartford failed to exercise ordinary care and reasonable diligence when it botched the handling of Blue's claim by failing to uncover the amendment to the policy. *See Judd v. AIG/American Gen. Life Ins. Co.*, 2006 WL 3337360, * 11 (W.D. Wis. Nov. 16, 2006) (noting same standard but reaching opposite conclusion where insurance company applied wrong legal standard because it had no actual notice of lawsuit involving similar facts). Therefore, I cannot conclude as a matter of law that Hartford had a reasonable basis for denying Blue's claim.

B. Hartford's Knowledge

Although Hartford may not have had a reasonable basis for terminating Blue's benefits, that is not enough to make out a claim of bad faith. A claimant also must show that the insurer knew of, or recklessly disregarded, the lack of a reasonable basis for denying benefits. *Brown*, 267 Wis. 2d at 50, 671 N.W.2d at 288. Knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of the absence of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the

insured. *Id.* (citing *Anderson*, 85 Wis. 2d at 693, 271 N.W.2d at 377). The focus for determining whether an insurer is liable for bad faith is on the sufficiency or strength of its reasoning. *Id.*

In his complaint, Blue alleges that Hartford showed an "intentional disregard" for his rights through its "arbitrary and capricious discontinuation" of his LTD benefits. The complaint contains no specific allegations of what conduct Blue believes was "arbitrary and capricious" on the part of Hartford. More importantly, nothing in the record before the court shows–or reasonably allows the inference–that Hartford knew about, or recklessly disregarded, evidence of its mistake when it terminated Blue's benefits. The "any occupation" standard *had* been in place at the time Hartford made Blue's original LTD benefits decision ten years ago, a decision that ultimately was favorable to Blue. When, in light of new medical information, Hartford's reviewer in Georgia asked the Minneapolis office to send her Blue's file, it did not include the subsequent retroactive amendment to the policy that lowered the standard for LTD benefits (but which did had not affected Blue because he already had qualified for benefits under the stricter standard). There is no evidence that the Georgia reviewer realized that she had not received all relevant documents from Minnesota, and there is no evidence that Minnesota's failure to send more documents was intentional or reckless. After all, the then-six year old retroactive 2002 amendments never previously had been relevant to or used by Hartford when determining Blue's benefits, and none of Hartford's employees had any employment incentive to ignore documents relevant to making the correct decision about Blue's eligibility for benefits. In sum, there is a logical factual basis to conclude that Hartford's mistake regarding Blue really was a mistake.

Further, when Blue asserted during motions practice in this lawsuit that Hartford had applied the wrong standard, Hartford promptly investigated this assertion, found that Blue was

correct and remedied its mistake. *Cf.*, *Trinity Evangelical Lutheran Church and School-Freistadt v. Tower Ins. Co.*, 2003 WI 46, ¶ 40-43, 261 Wis. 2d 333, 349-51, 661 N.W.2d 789, 796-97 (finding insurer acted in bad faith when it knew of mistake made in issuing policy but failed to take "honest, intelligent action or consideration" by reforming contract and refused to follow controlling case law involving actions taken by it in an earlier case).

So, however cynical one generally might be about mistakes by an insurance company that inure to the company's benefit, the uncontradicted evidence in this case is that Hartford's corporate policy, practice and intention is to review LTD benefit claims fairly, without regard to the manner in which the plan is funded, and to consistently award benefits on claims that are entitled to payment pursuant to the provisions of the applicable benefit plan.[3] Accordingly, Hartford is entitled to summary judgment on Blue's claim that it acted in bad faith in terminating his LTD benefits in 2008.

As noted above, Blue has persuaded Hartford to reinstate his long term disability benefits and to pay those benefits retroactively from the date of Hartford's erroneous decision. Therefore, because plaintiff already has prevailed on his substantive claim, albeit informally, there is nothing left in this lawsuit for the court or a jury to decide.

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[3] The evidence is uncontradicted because Blue did not take discovery on his bad faith claim despite ample time to do so and despite the court's warning as early as the preliminary pretrial conference that the parties would not get deadline extensions to develop such evidence in the face of a dispositive motion. *See* Sept. 30, 2010 Prelim. Pretrial Conf. Order, dkt. 9, at 3; *see also* May 19, 2011 text only order, dkt. 57. Whether Blue could have developed any evidence that would have entitled him to a trial on his bad faith claim is completely speculative.

ORDER

IT IS ORDERED that defendant Hartford Life and Accident Insurance Co.'s motion for partial summary judgment on plaintiff William's Blue claim of bad faith (dkt. 10) is GRANTED.

The clerk of court is directed to enter judgment in favor of defendant on the bad faith claim and close this case.

Entered this 13th day of June, 2011.

BY THE COURT:

/s/

STEPHEN L. CROCKER
Magistrate Judge