IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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DOLLY and STEVE BOLLIG,

Plaintiffs,

v.

CHRISTIAN COMMUNITY HOMES AND SERVICES, INC.,

Defendant.

OPINION and ORDER

02-C-532-C

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This is a civil action for monetary relief brought pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461. Plaintiffs Dolly and Steve Bollig seek damages from defendant Christian Community Homes and Services, Inc., Dolly Bollig's former employer, for unpaid medial expenses they incurred in July 2000 in preparation for a liver transplant that their son later received. At the time their son was treated, plaintiffs were covered by an employee health insurance plan sponsored by defendant. This case is unusual, in that plaintiffs ask the court to award them more than $100,000, representing the total amount of unpaid medical bills related to the transplant, even though they have never been billed for these medical services or otherwise asked to pay for them and even

though the hospital that provided the relevant medical services has expressed no intention of seeking payment from plaintiffs. The case is before the court on the parties' cross-motions for summary judgment and defendant's motion to supplement its responses to plaintiffs' requests to admit. Because I conclude that plaintiffs have failed to demonstrate that they have suffered a concrete injury or that such an injury is imminent, plaintiffs do not have standing under Article III of the United States Constitution to bring their claim. Thus, this court lacks jurisdiction to reach the merits of the parties' dispute. Accordingly, I will grant defendant's motion for summary judgment and deny plaintiffs' motion. Defendant's motion to supplement its responses to plaintiffs' requests to admit will be denied as moot.

From the parties' proposed findings of fact, I find that the following facts are material and undisputed.

UNDISPUTED FACTS

Defendant Christian Community Homes and Services, Inc. is a non-profit Wisconsin corporation doing business in Hudson, Wisconsin. Plaintiffs Dolly and Steve Bollig are the parents of Ryan Bollig. During 2000, defendant employed plaintiff Dolly Bollig and provided her with an employee medical and short term disability benefit plan that covered her family. In July 2000, Ryan Bollig received medical services related to a liver transplant at Fairview University Medical Center. The total cost of these services was $100,663.21.

At the time Ryan was treated, defendant was the sponsor of plaintiffs' health insurance policy. The Fairview medical center submitted the bills for Ryan's July 2000 medical services to plaintiffs' health insurance carrier through H.E.P. Administrators, the third-party contract administrator for defendant's health plan. H.E.P. Administrators processes group health claims on the basis of the plan that defendant has developed and funded. Plaintiffs' claim was denied. To date, defendant's health and welfare plan refuses to pay for the medical services Ryan received in July 2000.

In early October 2000, plaintiffs were notified that Ryan was eligible for the Katie Beckett Wisconsin Medicaid program and that his coverage was retroactive to March 1, 2000. Fairview was notified on or about November 1, 2000, that Ryan was eligible for the medicaid program. Fairview first sought payment through the medicaid program on April 10, 2002, more than 365 days after the dates Ryan received medical services and more than 365 days after Fairview was first notified that he was eligible for medicaid. The medicaid program denied Fairview's claims solely on the basis of Fairview's untimely submission of the claims. Fairview has never billed plaintiffs for the medical services at issue in this case and plaintiffs have never paid for the services. The bills remain unpaid.

OPINION

Pursuant to Article III of the Constitution, federal courts have jurisdiction only over

"Cases" and "Controversies." U.S. Const. art. III, § 2, cl. 1. Standing "is an essential and unchanging part of the case-or-controversy requirement of Article III." Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992). If plaintiffs lack Article III standing, this court has no subject matter jurisdiction to hear their claim. Because the standing issue goes to the court's jurisdiction, it can be raised at any time, see United States v. Viltrakis, 198 F.3d 1159, 1160 (9th Cir. 1997), including on a motion for summary judgment. See generally, Lujan v. National Wildlife Federation, 497 U.S. 871, 888-89 (1990). Three elements make up the "irreducible constitutional minimum of standing," only the first of which is at issue in this case. Defenders of Wildlife, 504 U.S. at 560. To have standing, a "plaintiff must have suffered an 'injury in fact' — an invasion of a legally protected interest which is (a) concrete and particularized and (b) 'actual or imminent, not conjectural or hypothetical.'" Id. (Citations omitted). As the party invoking federal jurisdiction, plaintiffs bear the burden of establishing that they have suffered a concrete injury, or are on the verge of suffering one. See id. at 561. At the summary judgment stage, plaintiffs "can no longer rest on . . . 'mere allegations,' but must 'set forth' by affidavit or other evidence 'specific facts'" showing that they have standing. Id.

Under ERISA's civil enforcement provision, a health plan participant or beneficiary may sue "to recover benefits due to him under the terms of the 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 U.S.C. § 1132(a)(1)(B). To the extent plaintiffs respond at all to defendant's standing argument, they appear to assume that § 1132(a)(1)(B) is all that is necessary to give them standing. They confuse statutory standing (which they have as plan participants) with the constitutional prerequisites for invoking the court's subject matter jurisdiction. As other courts have noted, "Status as a plan participant which provides statutory standing under ERISA section [§1132(a)] . . . does not necessarily provide constitutional standing." Carducci v. Aetna U.S. Healthcare, 247 F. Supp. 2d 596, 621 (D.N.J. 2003). Although courts have recognized that a plaintiff may have Article III standing to obtain injunctive relief related to ERISA's disclosure and fiduciary duty requirements without a showing of actual harm, see Horvath v. Keystone Health Plan East, Inc., __ F.3d __, No. 02-1731, 2003 WL 21436801, at *4-5 (3d Cir. June 23, 2003), requests for individual damages under ERISA are different. They require a plaintiff "to demonstrate individual loss." Id. at *5. In other words, to have standing to seek monetary relief under ERISA, plaintiffs must demonstrate, among other things, that they have suffered an injury-in-fact. For the reasons that follow, I am not convinced that plaintiffs have made such a showing.

Although the parties' proposed findings of fact on the topic leave much to be desired, it appears from the facts and the record that the following transpired with respect to Ryan Bollig's medical bills for his treatment in July 2000. In early October 2000, plaintiffs were notified that Ryan was eligible for Wisconsin Medicaid and that his coverage was retroactive

to March 1, 2000. Plaintiffs informed Fairview of this fact on or about November 1, 2000. At some point, some person or entity submitted Ryan's medical bills to plaintiffs' insurer. (Presumably the bills were submitted by Fairview University Medical Center, the hospital where Ryan was treated, although plaintiffs' use of the passive voice makes this unclear). At some point, plaintiffs' insurer refused to pay the bills. On April 10, 2002, Fairview sought payment of the July 2000 bills through the Wisconsin Medicaid program. Fairview submitted its Medicaid claim more than 365 days after Ryan received medical services and after Fairview was first notified that he was eligible for Medicaid. In general a claim for Medicaid reimbursement must be received by the state within 365 days after the date the covered services are provided, see Wis. Admin. Code § HFS 106.03(b), so the Medicaid program denied Fairview's claim as untimely. Although plaintiffs suggest that the claim may have been denied for other reasons, their suggestion is not supported by any evidence in the record. The Medicaid records submitted by defendant indicate that the only ground for the denial was "late billing." See Aff. of Connie Bennett, dkt. #35, at Ex. A. The bills remain unpaid.

It is undisputed that in the nearly three years since Ryan was treated, Fairview University Medical Center has never billed plaintiffs for the medical services their son received in July 2000. It is also undisputed that plaintiffs have never paid any money for those services. Plaintiffs have submitted the affidavit of Kenneth H. Reid, a transplant

financial case manager for Fairview medical center who was responsible for overseeing the financial aspects of Ryan's transplant for the hospital, including his insurance coverage. In his affidavit, Reid states that plaintiffs "are responsible for the entire amount of the [unpaid July 2000] medical bills." Reid Aff., dkt. #20, at ¶ 10. However, when asked about this statement at his deposition, Reid repudiated his affidavit. He admitted that he did not know whether plaintiffs were responsible for payment of the outstanding bills. See Reid Dep., dkt. #37, at p. 36. Further, Ruth Satchell, a senior customer service representative in Fairview's billing department, testified that Fairview would not bill plaintiffs for the unpaid medical services at issue in this case. See Satchell Dep., dkt. #38, at p. 9.

In addition, defendant points out that under Wisconsin's Medicaid program, a health care provider such as Fairview may not bill a health care recipient such as plaintiffs for "covered services" that are deemed "non-reimbursable." See Wis. Admin. Code § HFS 106.02(11). Relying on Wis. Admin. Code § HFS 107.02(2)(h), which categorizes as non-reimbursable those claims that are denied because they are not timely submitted, defendant argues that Fairview can never hold plaintiffs liable for the $100,663.21 in outstanding medical bills related to Ryan's transplant because the Medicaid program rejected Fairview's claim as untimely. Plaintiffs' response to this argument is cryptic. They note that the administrative code provides that "[b]efore submitting a claim to [Wisconsin Medicaid] for the same services, a provider shall properly seek payment for the services provided to a

[Medicaid] recipient from . . . another health care plan if the recipient is eligible for services under . . . the other health plan." Wis. Admin. Code § 106.03(7)(b). Without any discussion of their employer-provided plan's coordination of benefits clause, plaintiffs maintain that this code provision makes their employer-provided plan their primary insurer and Medicaid their secondary insurer. Even assuming this is true, plaintiffs do not explain how this demonstrates that they remain liable for the outstanding medical bills at issue in this case. Presumably they are suggesting that Medicaid refused to cover the treatment of their son on the ground that it was not a "covered service" under Wis. Admin. Code § HFS 106.02(11) because their employer-provided plan, as the primary insurer, should have paid the bills. But it is undisputed that Wisconsin's Medicaid program rejected Fairview's claim because it was late, not because Ryan's treatment was not covered by the program. Indeed, it appears from the record that Fairview and other providers reimbursed defendant for certain other bills that Ryan incurred during the same period because he was covered by Medicaid. See Richter Aff., dkt. #26, at Ex. A. In any case, plaintiffs cannot simply leave it to the court to unearth factual or legal support for their argument that a timely Medicaid claim would have been denied. See Central States, Southeast and Southwest Areas Pension Fund v. Midwest Motor Express, Inc., 181 F.3d 799, 808 (7th Cir. 1999) (arguments not developed in any meaningful way are waived).

It is true that the Court of Appeals for the Seventh Circuit has noted in the context

of an ERISA case that a "concrete dispute about who is entitled to a pot of cash is a routine case or controversy within Article III." Construction Industry Retirement Fund of Rockford v. Kasper Trucking, Inc., 10 F.3d 465, 467 (7th Cir. 1993). However, Kasper Trucking involved an employer that had paid a large sum of money into an employee health plan and was seeking a refund of the money. Here, plaintiffs have paid nothing and have not demonstrated that they face an imminent request for payment or even a likely one. See Defenders of Wildlife, 504 U.S. at 564-65 n.2 ("Although imminence is concededly a somewhat elastic concept, it cannot be stretched beyond its purpose, which is to ensure that the alleged injury is not too speculative for Article III purposes — that the injury is 'certainly impending.'") (Citation omitted)). This is particularly important in light of the fact that plaintiffs are not simply seeking a declaration of their rights under the plan but are asking to be awarded more than $100,000 in damages that they may be under no obligation to turn over to Fairview.

Under these circumstances, it is difficult to identify any concrete injury plaintiffs have suffered. Without citing any authority, plaintiffs maintain that "[r]egardless of whether Fairview can now hold [plaintiffs] responsible for the outstanding bills, [defendant] is responsible for those bills because [defendant] is the primary insurer." Plts.' Reply Br., dkt. #46, at 3. This is a bold proposition, both in terms of its implications for standing analysis and in light of the plan language. If plaintiffs have no obligation to pay any bills, they have

suffered no injury. See Carducci, 247 F. Supp. 2d at 622-23 (plaintiff suffered no injury for standing purposes because he was never required to pay insurance company's subrogation lien on his recovery from third-party tortfeasor); cf. Harley v. Minnesota Mining and Manufacturing Co., 284 F.3d 901, 906 (8th Cir. 2002) ("[T]he limits on judicial power imposed by Article III counsel against permitting participants or beneficiaries who have suffered *no* injury in fact from suing to enforce ERISA fiduciary duties on behalf of the Plan.") (Emphasis in original). Moreover, the health plan defendant sponsors defines a "covered expense" as "an expense, fee or charge incurred by or on behalf of a Covered Person . . . for which the Covered Person is obligated to pay." Aff. of Sarah Tischer, dkt. #19, Ex. 2 at 6. This definition is inconsistent with plaintiffs' assertion that they are entitled to recovery regardless whether Fairview can bill them for the unpaid medical services.

It appears that the one entity that has suffered a concrete injury is Fairview University Medical Center. It is out more than $100,000 and thus has "such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which . . . court[s] so largely depend[]." Baker v. Carr, 369 U.S. 186, 204 (1962). However, Fairview is not a party to this litigation, even though a provider of medical services can sue under ERISA as an assignee of a plan participant. See Kennedy v. Connecticut General Life Insurance Co., 924 F.2d 698, 700-01 (7th Cir. 1991). Because Fairview is not a party, it would be inappropriate to decide whether *it* can recover the cost

of its services from defendant in light of Wisconsin Medicaid's denial of its claim. What is clear is that plaintiffs are not the proper parties to be seeking to recover medical expenses for which there is no evidence that they ever have or will be held responsible. I conclude that plaintiffs have failed to demonstrate that they have standing to bring this suit.

Defendant seeks an award of attorney fees, contending that plaintiffs' suit is "clearly frivolous and was brought for no other reason than to harass" it. Dft.'s Resp. to Plts.' Summ. J. Mot., dkt, #32, at 13. Defendant has not specified any statutory source of authority for an award of attorney fees, such as ERISA's section 502(g)(1), see 29 U.S.C. § 1132(g)(1), perhaps because it is questionable whether a court can award attorney fees under that section when it lacks subject matter jurisdiction over the action in the first place. See, e.g., In re Knight, 207 F.3d 1115 (9th Cir. 2000). Instead, defendant cites Alyeska Pipeline Service Co. v. Wilderness Society, 421 U.S. 240, 258-59 (1975), for the proposition that a district court "does not need a statutory basis for awarding a defendant reasonable attorney's fees; the common law powers of the court are sufficient." That is not an accurate characterization of Alyeska, which notes only that "a court may assess attorneys' fees for the 'willful disobedience of a court order . . . or when the losing party has 'acted in bad faith, vexatiously, wantonly, or for oppressive reasons.'" Id. (Citations omitted). Defendant has not shown that plaintiffs' suit was brought in bad faith. Rather, plaintiffs suit appears to have been prompted by a genuine concern that they might some day be held liable for

unpaid medical bills. On the record in this case, I have found that plaintiffs' concerns are too speculative to support standing, but I cannot conclude that their suit was intended to harass or vex defendant. Accordingly, defendant's request for attorney fees will be denied.

Finally, I note that defendant has filed a motion to supplement its responses to plaintiffs' requests to admit. Now that I have concluded that this court lacks jurisdiction over plaintiffs' claim, defendant's request will be denied as moot.

ORDER

IT IS ORDERED that

1. The motion for summary judgement of defendant Christian Community Homes and Services, Inc. is GRANTED. Plaintiffs do not have Article III standing to bring the claim at issue in this case. Defendant's request for attorney fees is DENIED;

2. The motion for summary judgment of plaintiffs Dolly and Steve Bollig is DENIED;

3. Defendant's motion to supplement its responses to plaintiffs' requests to admit is DENIED as moot;

4. The clerk of court is directed to enter judgment in favor of defendant and close

this case.

Entered this 10th day of July, 2003.

BY THE COURT:

BARBARA B. CRABB
District Judge