IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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JENNIFER A. LINDSTROM,

Plaintiff,

OPINION AND ORDER

v.

05-C-304-C

W.J. BAUMAN ASSOC., LTD.,

Defendant.

- -

Plaintiff Jennifer Lindstrom filed this civil action in the Circuit Court for Eau Claire County against defendant W.J. Bauman Associates, Ltd., contending that defendant negligently failed to enroll her infant son in its health insurance plan. Contending that plaintiff's claim is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § § 1001-1461, defendant removed the action to this court on May 26, 2005. Jurisdiction is present under 28 U.S.C. § 1331.

The case is before the court on defendant's motion for summary judgment and motions to strike plaintiff's responses to its proposed findings of fact. Defendant contends that plaintiff's state law claim is preempted by ERISA, under which the decision of its plan administrator is entitled to deferential review. I agree that plaintiff's claim is cognizable only

under the provisions of ERISA. Furthermore, because the plan administrator reasonably interpreted plan documents requiring plaintiff to enroll her son in the health benefits plan within thirty-one days of his birth, I will grant defendant's motion for summary judgment. I will deny plaintiff's motion to strike as unnecessary.

In response to defendant's motion for summary judgment, plaintiff submitted responses to defendant's proposed facts along with her own proposed findings of fact. Defendant contends that plaintiff's submissions contain legal conclusions and lack adequate foundation. I agree that plaintiff's proposed "facts" are not facts at all, but rather are proposed legal conclusions, as are many of her objections to defendant's proposed facts. I have not considered proposed facts or responses that lack adequate foundation and appropriate citations to admissible evidence; therefore, it is unnecessary to strike plaintiff's submissions in their entirety.

Although both parties discuss the terms of defendant's health plan at length in their briefs, neither party has proposed as fact the text of the relevant plan provisions. The parties have, however, submitted identical copies of the plan summary. Therefore, from defendant's proposed findings of fact and the health plan summary document submitted by both parties, I find the following to be material and undisputed.

UNDISPUTED FACTS

Plaintiff Jennifer Lindstrom is a resident of Chippewa Falls, Wisconsin. From August 11, 2003 to October 31, 2004, plaintiff was employed by defendant Bauman Associates, Ltd. Defendant is a Wisconsin corporation, with its principal place of business in Eau Claire, Wisconsin.

At the time of plaintiff's employment, defendant offered a health insurance plan as a benefit to its employees. Brian Schilling was the plan administrator. The plan was governed by a document entitled "Summary Plan Description for W.J. Bauman Associates, Ltd." The plan summary was amended on October 1, 2004. From that date through the present, the new summary, entitled "Bauman Associates, Ltd. Employee Benefit Plan, Plan Document, Amended effective 10/01/04," has governed benefits issued under the plan. The plan document conveys discretionary decision-making authority on the plan administrator, providing in relevant part:

> **DISCRETIONARY AUTHORITY**
> The Plan Administrator shall have full discretionary authority to interpret this Plan and its provisions and regulations with regard to eligibility, benefit determination and general administrative matters. The Plan Administrator's decisions shall be binding on all Plan Participants and conclusive as to all questions of coverage under this Plan. If challenged in court, such decision shall not be subject to *de novo* review and shall not be overturned unless proven to be arbitrary and capricious, based upon the evidence considered by the Plan Administrator at the time of such decision.

As an employee, plaintiff was eligible to participate in defendant's health plan.

Shortly after she was hired, plaintiff was given an employee enrollment form, which permitted her to enroll in the health plan or decline coverage. On September 10, 2003, plaintiff completed the employee enrollment form and waived coverage under the plan. At the top of the form was the following sentence: "IMPORTANT: READ NOTICE ON REVERSE SIDE." The back side of the form stated, in relevant part:

> ***IMPORTANT: PLEASE READ PRIOR TO ENROLLMENT***
> Notice of Special Enrollment Period Rights
> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and certain dependents provided request enrollments within 30 days after the marriage, birth, adoption or placement for adoption.

On January 7, 2004, plaintiff completed a new employee enrollment form, requesting coverage for herself, her husband, Karl Lindstrom, and her son, Isaac. The form she completed contained the same "notice of special enrollment period rights" quoted above. Plaintiff, Karl and Isaac were permitted to enroll in the plan under the plan's special enrollment provision, which permitted an employee to enroll when she or her dependents lost coverage provided by another health plan.

On October 29, 2004, plaintiff submitted a resignation letter to defendant, resigning her employment effective October 31, 2004. The day after she submitted the letter, plaintiff

gave birth to her second son, Ezra. Under the plan provisions, dependents are eligible for enrollment as follows:

> Dependent Eligibility
>
> Eligible dependents are the persons shown below who are not eligible as employees:
> ***
> B. each unmarried child of the Employee who is not yet 19 years of age subject to the following:
>
> 1. a newborn child shall be considered a covered individual from and after the time of birth as to covered expenses which are due directly to:
>
> a. injury or illness;
> b. premature birth;
> c. a condition which exists at birth; and
>
> 2. also, a newborn child, born while the mother is covered, who becomes covered as a dependent in accordance with the terms of this policy, shall be covered for:
>
> a. routine Room and Board (or nursery charges);
> b. routine Physician visits;
> c. circumcision

The plan summary describes the special enrollment provisions for dependent beneficiaries as follows:

> **Special Enrollment Periods**
>
> ***
> B. Dependent beneficiaries. If:
>
> 1. The Employee is a Participant under the Plan . . . and
> 2. A person becomes a Dependent though marriage, birth, adoption or placement for adoption, then the Dependent . . . may be enrolled under this Plan as a covered Dependent of the covered Employee. . .

The Dependent special enrollment period is a period of 31 days and begins on

the date of marriage, birth, adoption or placement for adoption.

The coverage of the Dependents enrolled in the special enrollment period will become effective:
***
2. in the case of a Dependent's birth, as of the date of birth.

On November 5, 2004, plaintiff filed a "medical expense reimbursement account form" relating to her health plan. The form listed Ezra as a dependent whose medical expense reimbursement account plaintiff wished to continue.

On December 15, 2004, plaintiff completed a form entitled "employee change form," naming Ezra as a dependent. The same day, plaintiff sent an email message to Shilling. Her message included the following sentence: "I realize I was responsible for enrolling Ezra in the insurance plan, but considering the circumstances I hope it's easy to understand how it was overlooked."

The plan summary defines a late enrollee as "a Plan Participant who enrolls under the Plan other than during the initial enrollment period in which the individual is eligible to enroll under the Plan or during a special enrollment period." Under the plan "an enrollment is 'late' if it is not made on a 'timely basis' or during a special enrollment period."

Schilling treated plaintiff's request for enrollment of her son, Ezra, as having occurred on December 15, 2004, after the thirty-one day special enrollment period had expired. Under the plan, "late enrollees" are covered beginning on the first day of the month

following the date on which the application for enrollment was made. Schilling treated Ezra's coverage as beginning on January 1, 2005.

OPINION

The Employee Retirement Income Security Act applies to "any plan, fund or program which was heretofore and hereinafter established or maintained by an employer or employer organization or both." 29 U.S.C. § 1002(1). The parties do not dispute that defendant's plan is governed by ERISA. They do, however, dispute three issues: whether (1) ERISA preempts plaintiff's state law claim for denial of plan benefits; (2) what standard of review applies to the plan administrator's decision to treat Ezra Lindstrom as a late enrollee under the plan; and (3) whether the administrator's decision was legitimate.

A. Preemption

Plaintiff contends that she is pursuing both ERISA and state law-based negligence claims. However, the law does not provide for hybrid claims relating to benefits due under ERISA-governed health plans. Congress enacted ERISA to "protect . . . the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for employee benefit plans and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); Aetna

Health Inc. v. Davila, 542 U.S. 200, 208 (2004). ERISA's purpose is to provide a uniform regulatory regime over employee benefit plans. Aetna Health Inc., 542 U.S. at 208. To that end, ERISA's comprehensive legislative scheme includes an integrated system of procedures for enforcement, found in § 502(a), 29 U.S.C. § 1132(a). Id.

The detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). The United States Supreme Court has stated in no uncertain terms that "the policy choices reflected . . .under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." Aetna Health Inc., 542 U.S. at 208-9. For that reason, when a state law claim is capable of being recharacterized as one arising under § 502(a) of ERISA, the state law claim is completely preempted and is treated as an ERISA claim, even if the complaint makes no mention of § 502(a). Speciale v. Seybold, 147 F.3d 612, 615 (7th Cir. 1998); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 67 (1987).

Plaintiff's negligence claim is premised upon alleged misconduct by the plan administrator, which resulted in the denial of benefits to plaintiff's infant son. However, under § 502(a)(1)(B) "a civil action may be brought [under ERISA] by a participant or

beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Plaintiff is attempting to do just that. Therefore, her state law claim is preempted and will be treated as arising under ERISA.

B. Standard of Review

Under ERISA, courts apply a de novo standard of review to a plan administrator's benefit denial unless the plan's plain language gives the administrator discretionary authority to determine eligibility. When an administrator is given discretionary authority under a plan, courts examine administrative decisions under the deferential "arbitrary and capricious" standard of review. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Militello v. Central States, Southeast & Southwest Areas Pension Fund, 360 F.3d 681, 685 (7th Cir. 2004).

In determining which standard of review is appropriate, "the critical question is whether the plan gives the employee adequate notice that the plan administrator is to make a judgment within the confines of pre-set standards, or if it has the latitude to shape the application, interpretation, and content of the rules in each case." Diaz v. Prudential Ins. Co. of America, 424 F.3d 635, 639-40 (7th Cir. 2005). In Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000), the Court of Appeals stated that plans using the

following "safe harbor" language would insure deferential review: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them." Although that language guarantees discretion, a plan may retain discretionary authority for its administrators without using the exact "magic words" adopted in Herzberger. Id. The focus of the inquiry is whether the employee has adequate notice: "[E]mployees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." Id. at 333.

Plaintiff does not contend that the language adopted by the plan failed to put her on notice of the plan administrator's discretion. Instead, without citing a single authority or providing any explanation for her position, she contends that the plan language "is an affront to the court" and that "judicial review is not limited to an arbitrary and capricious standard." On the contrary, the plan language provides an accurate summary of the law.

Defendant's plan retains discretion in unequivocal terms. The plan states that the plan administrator has "full discretionary authority" to interpret the plan provisions regarding "eligibility, benefit determination and general administrative matters." The plan goes one step further and spells out the effects of this discretion, explaining that the administrator' s decisions are binding and, in accordance with Firestone Tire & Rubber Co., 489 U.S. at 115, "shall not be overturned [by a court] unless proven to be arbitrary and

capricious." Because the plan appropriately notifies employees of the plan administrator's discretion, the plan administrator's decision to treat Ezra Lindstrom as a late enrollee will be reviewed solely to insure it was not arbitrary or capricious.

Lurking in the background of plaintiff's brief is the suggestion that her notice of resignation, filed days before she gave birth to her son, created a conflict of interest between the plan administrator's fiduciary duties to plaintiff and his business interests in avoiding incurring the costs associated with an ex-employee's medical expenses. When "a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). When a conflict is present, the court continues to apply the arbitrary and capricious standard of review, but does so with more suspicion and less deference than it would in the absence of a conflict. Manny v. Central States, Southeast and Southwest Areas Pension and Health and Welfare Funds, 388 F.3d 241, 243 (7th Cir. 2004).

In her brief, plaintiff refers to the fiduciary duty of the plan administrator and makes reference to events that may have relevance to her undeveloped conflict of interest claim. However, none of the events upon which she relies have been proposed as facts. Courts have repeatedly held that perfunctory and undeveloped arguments, and arguments that are unsupported by pertinent authority are waived and need not be considered by the court.

United States v. Berkowitz, 927 F.2d 1376, 1384 (7th Cir. 1991); Murphy v. Keystone Steel & Wire Co., 61 F.3d 560, 568 (7th Cir. 1995) (theory undeveloped before district court waived when no cases were cited and plaintiff did not explicitly name claim); American Trans Air, Inc., 17 F.3d 998, 1005 (7th Cir. 1994) (Undeveloped arguments are waived; summary judgment will not be reversed "based on skeletal snippets of argument."). Therefore, because plaintiff has not developed an argument relating to a possible conflict of interest on the part of Schilling, the arbitrary and capricious standard of review will be applied without heightened suspicion to the facts of plaintiff's case.

C. Decision of Plan Administrator

Under the arbitrary and capricious standard, courts do not ask whether a plan administrator's conclusion was correct or even whether it relied on the proper authority. Kobs v. United Wis. Ins. Co., 400 F.3d 1036, 1039 (7th Cir. 2005). Instead, the only question is whether the administrator's decision was completely unreasonable. Id. If not, the decision is entitled to deference.

Plaintiff makes two arguments against the decision of defendant's plan administrator. First, she contends that she requested enrollment for Ezra within thirty-one days of his birth by naming him on a "reimbursement form." She has not proposed facts describing to whom the form was submitted, what information it contained, the purpose of the form, or how

naming Ezra would have provided notice to the plan administrator that she was enrolling Ezra in the plan. Moreover, she has not presented any other evidence that the plan administrator had notice of her intention to enroll her son.

Plaintiff's second argument is difficult to understand. She appears to contend that because Ezra was an "eligible dependent" under the plan, he was automatically a "covered beneficiary," as well. If that is her argument, it is unavailing. The plan distinguishes dependent beneficiaries from eligible dependents, who include children born while their mothers are covered by the plan. An eligible dependent may become a dependent beneficiary, but only if he is "enrolled under th[e] Plan as a covered Dependent of the covered Employee" within 31 days' of his birth.

"Under the arbitrary and capricious standard, [the court] will overturn a plan administrator's decision only if it is downright unreasonable." Herman v. Central States, Southeast and Southwest Areas Pension Fund, 423 F.3d 684, 692 (7th Cir. 2005). In this case, not only was the decision reasonable; it was an accurate application of the plan's plain language. It is unfortunate that plaintiff's missing the enrollment deadline by two weeks resulted in a lack of coverage for the costs associated with her son's birth. Nevertheless, the plan administrator's decision was firmly grounded in the plan's enrollment requirements. For that reason, defendant's motion for summary judgment will be granted.

ORDER

IT IS ORDERED that

1. The motion for summary judgment of defendant W.J. Bauman Associates is GRANTED.

2. Defendant's motions to strike plaintiff's proposed findings of fact and responses to plaintiff's proposed findings of fact are DENIED as unnecessary.

Entered this 3rd day of February, 2006.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge