IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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JAMES H. OATES,

OPINION AND ORDER

Plaintiff,

06-C-0139-C

v.

CENTRAL STATES, SOUTHEAST
AND SOUTHWEST AREAS HEALTH
AND WELFARE FUND, and BOARD
OF TRUSTEES, as PLAN ADMINISTRATOR,

Defendants.

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Early in 2006, plaintiff James H. Oates brought this suit under the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, against defendants Central States, Southeast and Southwest Areas Health and Welfare Fund and Board of Trustees. (The only defendant whose actions and decisions are at issue in this matter is the Board of Trustees. I will refer to it simply as defendant and to the Health and Welfare Fund as the Fund.). The case arises out of the parties' dispute about plaintiff's entitlement to temporary reimbursable benefits that the Fund provides to covered employees in certain circumstances.

The following provisions of the Fund's Plan are critical to an understanding of

plaintiff's claim.

Article XI, § 11.15 is entitled "Worker's Compensation Subrogation." It provides in part:

> If any Covered Individual has a claim denied pursuant to Section 4.03 of this Plan and the Covered Individual's claim for Worker's Compensation benefits is denied by the Worker's Compensation Carrier, the Fund may enter into an agreement with the Covered Individual to provide benefits during the appeal of the denial. Such an agreement would be entitled "Agreement to Reimburse Central States Health and Welfare Fund."
>
> The Fund will enter into such an Agreement subject to the following conditions:
>
> (a) The Covered Individual provides proof that a claim is pending before the appropriate Compensation Commission or court;
>
> (b) The Covered Individual agrees to pursue the claim for Worker's Compensation benefits to a final disposition;
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> (c) The Covered Individual agrees to notify the Fund of the disposition of his claim and to notify the Worker's Compensation Carrier of the agreement;
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> (d) The Covered Individual establishes sufficient need for the Fund to consider application of ths Section; and
>
> (e) The Covered Individual agrees to reimburse the Fund for benefits paid from the proceeds of any recovery.

Art. IV, § 4.03 is entitled "Limitation on Payment of Claims Arising from Work-Related Injury or Covered by Worker's Compensation. It provides as follows:

> A Covered Individual shall not be entitled to payment on a claim for any charge incurred for any treatment or service for any illness or injury which is sustained as a

> result of any enterprise or occupation for wage or profit or is an illness or injury of the type covered by any applicable Worker's Compensation Act or similar law providing benefits to employees for on-the-job injuries.
>
> In the event that a Covered Individual is awaiting disposition of a Worker's Compensation claim (or similar claim arising as a result of an on-the-job injury) and coverage for the illness or injury is disputed, the Covered Individual may be eligible to receive some benefits if the Covered Individual agrees to reimburse the Fund for any benefits advanced in the event he settles or receives an award from any Employer or insurance company relating to his on-the-job injury.

Article XII, § 12.02(a), is entitled "Loss of Time Benefit-Participant Only." It provides in part:

> A Covered Participant shall receive from the Plan a weekly Loss of Time Benefit in the amount and for the maximum benefit period referenced under Section 20.01(a) during a single period of Disability . . . for loss of time from employment as a result of being unable to work because of illness, injury or pregnancy. To qualify for the Loss of Time Benefit a Covered Participant must:
> (1) Be absent from work because of a Disability, the treatment of which is compensable under the Plan . . .

Plaintiff injured his back in 2000, when he was at work as president of his local union. Rather than reporting the injury to the employer's worker's compensation carrier, plaintiff and his employer decided that he would keep working so that the employer's worker's compensation contributions would not increase. Plaintiff applied to the Fund for disability benefits, without saying that his injury had occurred at work, and his employer continued to submit contributions to the Fund.

In November 2003, plaintiff was declared disabled after suffering the onset of

spondylolisthesis, resulting from his 2000 back injury. He reported the disability and his 2000 back injury to defendant and explained why he had not reported the back injury when it first occurred. Around the same time, sought worker's compensation benefits from the state of Illinois.

In June 2004, the Fund sent plaintiff a notice of his potential eligibility for benefits under Art. XI, § 11.15 of the Plan Document, that is, for benefits payable during the appeal of the denial of a claim for worker's compensation benefits and for Loss of Time benefits under Art. XII, § 12.02(a), together with a provisional agreement to reimburse the Fund. On August 17, 2004, the Fund received the signed agreement to reimburse, but did not execute it or approve it immediately. In mid-October 2004, plaintiff's attorney submitted additional information requested by defendant, including a copy of the worker's compensation carrier's denial of plaintiff's application for worker's compensation benefits. About one month later, plaintiff submitted a "Loss of Time" claim form that was necessary to defendant's determination of plaintiff's entitlement to Loss of Time benefits.

A committee of the Fund met and denied plaintiff's request for benefits under a reimbursement agreement, pursuant to Art. XI, § 11.15, telling plaintiff that "it appears that your employer recognized that your injury of September 5, 2000 occurred on-the-job and continued to remit Health & Welfare contributions on your behalf." Plaintiff appealed but was unable to convince the Fund or defendant that he was entitled to benefits while awaiting

a final decision on his belated claim for worker's compensation. Defendant informed plaintiff of its decision on or about September 19, 2005, adding that it had agreed not to pursue the $6,284.12 overpayment created when the Fund provided benefits to plaintiff before learning that his injury was work-related.

Plaintiff filed suit in this court to obtain relief from defendants for what he characterized as their failure to follow their statutory duty and the language of the Plan. Defendants moved for summary judgment. Their motion was denied in an order entered on September 27, 2006, because I concluded that the last two committees to consider plaintiff's claim did not demonstrate that they had focused on the essence of plaintiff's claim, which was that he was asking for the discretionary privilege of a subrogation agreement and Loss of Time benefits. I directed defendant to undertake a fresh review of plaintiff's request.

Before undertaking the new review, defendant afforded plaintiff an opportunity to submit any additional documentation or statements he wished to present for consideration in support of his claim. Among the documents that plaintiff submitted was a letter to him from his worker's compensation attorney, advising plaintiff that the worker's compensation carrier had offered $1000 in settlement and adding that, "[b]ased on the medical evidence in this case, I do not believe that we can prevail at arbitration." He suggested that plaintiff consult with another lawyer to confirm his assessment of the case. Defs.' Report of Board of Trustees Meeting, dkt. #29, exh. B, at 2. Plaintiff submitted a second letter from his

attorney in this case, advising defendant that plaintiff's worker's compensation attorney had withdrawn from representation of plaintiff, that plaintiff had declined to accept the $1000 settlement offer, that he had been without a lawyer on that claim ever since and that "he has no viable workers' comp. claim." Id. at 1. Defendant met on January 16, 2007 to review the administrative record, which included the documentation constituting the original administrative record as well as plaintiff's additional submissions. Plaintiff filed a new motion for summary judgment in this court, contending that defendants got it wrong again. However, it is plaintiff who has it wrong. Defendant undertook the review required of it and reached a decision that is not arbitrary or capricious.

In a letter to plaintiff's counsel, explaining the grounds on which it denied plaintiff's claim, defendant began by stating that plaintiff was not entitled to payment under the Plan for his injuries because they had occurred on the job and the Plan does not provide coverage for charges incurred for any illness or injury sustained as a result of any enterprise or occupation for wage or profit or any illness or injury of the type covered by any applicable worker's compensation act. Defs.' Report, dkt. #29, exh. C. at 2 (citing Art. IV, § 4.03). Although defendant did not say so explicitly, it follows that the only benefits to which plaintiff would be entitled would be available under § 11.15, which provides that the Fund *may* enter into an agreement to provide reimbursable benefits to a Plan member seeking worker's compensation benefits during the appeal of the denial of the member's claim for

such benefits.

In its letter, defendant explained that it will enter into an agreement to provide reimbursable benefits under the conditions outlined in § 11.15, which include proof that a claim is pending, pursuit of the claim to a final disposition, a promise to notify the Fund of the disposition of the claim and to notify the worker's compensation carrier of the agreement, sufficient need for the conditional benefits an agreement to reimburse the Fund out of the proceeds of any recovery. Id., exh. C, at 2. Defendant noted that § 11.15 gives the Fund the discretion to advance benefits to a member if there is a dispute whether the member's illness or injury occurred on the job or is covered by a worker's compensation act or similar law. Id. Defendant explained that it was declining to provide such benefits to plaintiff under an Agreement to Reimburse because he did not meet the necessary conditions. First, his injury occurred on the job and was compensable under worker's compensation. (This is not one of the listed conditions for an Agreement to Reimburse; I assume that defendant is saying is that plaintiff does not even qualify for consideration under § 11.15 because he is not one of the persons for whom the provision was intended. He had no dispute with his employer about coverage, as shown by his and his employer's agreement in 2000 that plaintiff had been injured on the job but would keep working and not apply for worker's compensation. Id.) In those circumstances, defendant said, the Fund does not extend an Agreement to Reimburse; it reserves those agreements for situations in

which an employer does not accept liability and defendant determines that the employer has a good faith basis for the dispute. Id.

Defendant added that it appeared that plaintiff had failed to pursue his claim for worker's compensation to a final disposition, as the claim had been pending before the Illinois Industrial Commission since on or about June 25, 2004. It noted that plaintiff had been advised by counsel to settle for $1000 because his claim could not prevail but had declined the advice and the money. Id. at 2-3.

As another ground for its decision, defendant said that plaintiff had not established "sufficient need" because his injury occurred in 2000, but he continued to work for three years thereafter. During that time he was being paid by his employer at his normal rate *and* being reimbursed by defendant for any medical treatment he needed for his back injury. Id. at 3. Finally, defendant added that it could not anticipate that plaintiff would receive any significant recovery from worker's compensation that would enable him to reimburse the Welfare Fund. Id. (citing § 11.15(e)).

Defendant's letter satisfies the purposes of the remand, which was to explain to plaintiff and to the court why defendant was exercising its discretion as it was, as well as to demonstrate that it understood the precise nature of plaintiff's request, which was to be considered for an agreement to provide him benefits during the appeal of the initial denial of his worker's compensation benefits. Defendant has made it explicit why it denied those

benefits; indeed, it has shown at least three valid reasons for refusing to exercise its discretion to make reimbursable benefit payments to plaintiff.

Plaintiff's arguments to the contrary are not persuasive. He maintains that defendant denied him benefits because it believes that he has a false worker's compensation claim. He argues that if this is true and his claim is denied, he will be eligible for Loss of Time benefits because he will no longer have a worker's compensation claim. Plaintiff misreads defendant's decision. It is evident that defendant did not deny plaintiff benefits because he has a false worker's compensation claim but because he and his employer agreed that his injury was incurred at work. Under the Plan, such injuries are not subject to coverage. Plaintiff has never denied that he injured his back "at work." See, e.g., Plt.'s Br. in Supp. of M. for Summ. Jmt., dkt. #33, at 1 ("On September 5, 2000, Oates injured his back while at work.")

Plaintiff argues that defendant erred in concluding that he was not pursuing his worker's compensation claim actively. Even if this was an error (although plaintiff does not offer any evidence to the contrary other than his decision to reject a settlement offer of $1000 and his own attorney advised defendant that plaintiff does not have a viable claim), this conclusion is not necessary to defendant's decision. It is not surprising that defendant believes that active pursuit of a claim is a precondition to an award of benefits, given that the benefits are intended to be simply a temporary measure to tide a member over until the

worker's compensation decision has been made.

The two remaining reasons are well within defendant's discretion. The idea of Loss of Time benefits is to assist covered members of the Plan when they are first injured on the job and are awaiting a resolution of their claims for worker's compensation. Plaintiff was injured four years before he ever sought Loss of Time benefits. During this time, he continued to work, collect his regular pay and receive benefits from the Fund for his medical expenses. He does not fall into the category of persons who need Loss of Time benefits to meet their expenses while they wait for resolution of their claims.

Furthermore, it was reasonable for defendant to withhold the Loss of Time benefits in 2007 out of concern that plaintiff would be unable to repay the benefits from any worker's compensation payments he might receive. In the thirty months since plaintiff had filed his claim, the only evidence of success was the carrier's offer of a settlement of $1000. Meanwhile, plaintiff's worker's compensation attorney had withdrawn because he believed that the medical evidence would not enable plaintiff to prevail at arbitration and, as I noted, his attorney in this case had told defendant that plaintiff did not have a viable claim.

In summary, I am persuaded that defendant understood the claim that plaintiff was making and exercised its discretion in denying the claim. That plaintiff disagrees with the disposition does not mean that defendant did not give proper consideration to the matter. It is evident from defendant's letter of explanation that it has good grounds for deciding that

awarding reimbursable benefits to plaintiff would not advance the purposes for which defendant makes reimbursable benefits available to Plan members awaiting the resolution of a contested worker's compensation claim. Plaintiff does not have a claim that is contested by his employer, he was in no financial need for four years following his injury and he has conceded that he has no possibility of receiving worker's compensation benefits sufficient to reimburse defendant for any benefits it would advance at this time.

ORDER

IT IS ORDERED that plaintiff James H. Oates's motion for summary judgment is DENIED. Because it is indisputable that defendants Central States, Southwest and Southeast Areas Health and Welfare Fund and Board of Trustees, as Plan Administrator, are entitled to summary judgment in their favor, I will grant judgment for them on the court's own motion. The clerk of court is directed to enter judgment in favor of defendants and close this case.

Entered this 9th day of May, 2007.

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