UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

PHYLLIS FRANKLIN, Plaintiff, v. H.O. WOLDING, INC., GROUP HEALTH AND WELFARE PLAN, MIDWEST SECURITY ADMINISTRATORS, INC., RICHARD G. GRASSY, JR., M.D., and MICHAEL J. MEYER, M.D., Defendants.	)	CASE NO. 1:04-cv-0367-DFH-WTL

ENTRY ON ATTORNEY FEE AND SANCTION MOTIONS

Both sides claim victory in this ERISA action concerning whether the health insurance plan would pay for a potentially life-saving liver transplant for plaintiff Phyllis Franklin. The fact that both sides claim victory would ordinarily signal a satisfactory resolution of the case. Both sides, however, use their claims of victory to seek substantial awards of attorney fees pursuant to 29 U.S.C. § 1132(g)(1). Defendants also seek fee awards under Rule 11 of the Federal Rules of Civil Procedure. Plaintiff seeks some of her fees pursuant to 28 U.S.C. § 1927. For the reasons explained below, the court denies defendants' requests for fees under ERISA and Rule 11, grants in part plaintiff's fee petitions pursuant to both ERISA and 28 U.S.C. § 1927, and denies plaintiff's motion to strike one exhibit.

Facts

Plaintiff Phyllis Franklin contracted Hepatitis C through a blood transfusion in 1987. In January 2003, she was evaluated for a possible liver transplant by Dr. Paul Kwo at the Indiana University Hospital in Indianapolis, which is part of Clarian Health Partners. Dr. Kwo concluded that Mrs. Franklin met the medical criteria for a liver transplant. His opinion was confirmed by the hospital's transplant committee, which reviewed Mrs. Franklin's case in March or April 2003. However, Dr. Kwo and Clarian Health Partners were unwilling to put Mrs. Franklin on a list of patients for liver transplants until they received some assurance that they could be paid the hundreds of thousands of dollars that a liver transplant typically costs. Mrs. Franklin has never had the means to pay for such expenses herself.

Mrs. Franklin's husband works for H.O. Wolding, Inc., which provides health insurance to employees and their families under the H.O. Wolding, Inc. Group Health and Welfare Plan, a defendant in this case. The plan is administered by defendant Midwest Security Administrators, Inc. Defendants Dr. Richard G. Grassy, Jr. and Dr. Michael J. Meyer work for Midwest Security. Mrs. Franklin has been covered by the plan at all relevant times, and the plan provides coverage for medically necessary treatments, including liver transplants.

Mrs. Franklin and Dr. Kwo asked Midwest Security to pre-approve her for a liver transplant. Midwest Security denied the request on April 30, 2003. The

denial letter (Kwo Ex. 7) stated that there was "insufficient information to document end-stage liver disease." Mrs. Franklin appealed that denial. According to the plan, an appeal regarding medical necessity would involve a medical review by "a medical consultant that has appropriate training and experience in the field of medicine in question."

On May 20, 2003, Dr. Grassy, who is Midwest Security's medical director, concluded that Mrs. Franklin was not then sick enough to need a transplant. Kwo Ex. 6. On July 1, 2003, Midwest Security then denied Mrs. Franklin's appeal.

According to Dr. Kwo, a liver patient who has been diagnosed with ascites has only about a 50 percent chance of surviving for two to three years after that diagnosis. Kwo St. at 19; Kwo Ex. 2. Mrs. Franklin was diagnosed with ascites in October 2001.

Dr. Kwo then spoke directly with Dr. Grassy. Dr. Kwo got the impression that Midwest Security would not approve a liver transplant unless Mrs. Franklin exhibited all of the following end-stage manifestations of liver disease: "progressive jaundice, intractable ascites, encephalopathy, intractable pruritus, variceal bleeding, bleeding diathesis or coagulopathy, spontaneous bacterial peritonitis, and a MELD score greater than 15." Def. Ex. 1. Dr. Kwo wrote: "I find it hard to believe this is correct, as the morbidity and mortality rate would be extraordinarily high." Midwest Security has stated on several occasions that it did

not require all of these symptoms, but only some of them. See, *e.g.*, Def. Ex. 4 (Sept. 22, 2003 letter to plaintiff's counsel, stating: "The criteria for transplant does not require, nor does it state, that the patient must have all of the conditions stated in those standards."); see also Def. Ex. 7 (Jan. 9, 2004 letter to plaintiff's counsel stating that denial had "not been based on any expectation that Mrs. Franklin have all of the manifestations of a patient who has reached the 'end stages' of her disease. Our policy has been, and continues to be, that there should be *some* 'end stage' manifestations as objective factors to be considered in determining if the liver transplant is covered by the Plan.") (emphasis added).

The internal manual that Midwest Security provided to plaintiff's counsel, however, plainly states that the plaintiff must have *all* of those symptoms listed by Dr. Kwo in his July 16, 2003 memorandum:

> END-STAGE MANIFESTATIONS (patient must have ALL of the following):
>
> - Progressive jaundice
> - Intractable ascites
> - Encephalopathy
> - Intractable pruritus
> - Variceal bleeding
> - Bleeding diathesis or coagulopathy
> - Spontaneous bacterial peritonitis
> - MELD score = > 15

Def. Ex. 1.

On August 15, 2003, counsel for plaintiff sent Midwest Security another "official demand of coverage" for a liver transplant. Pl. Ex. 11. That letter was supported by a June 27, 2003 letter from Dr. Kwo stating that Mrs. Franklin met the listing requirements for a liver transplant. Midwest Security responded by asking for more information on August 21, 2003. Def. Ex. 3.

On September 15, 2003, counsel for plaintiff sent counsel for Midwest Security a copy of Mrs. Franklin's medical records and an updated report from Dr. Kwo dated September 3, 2003. Pl. Ex. 12. The letter threatened suit unless a transplant was approved within five business days. On September 22, 2003, Midwest Security responded and wanted to know if there were medical records confirming Dr. Kwo's statement that Mrs. Franklin had decompensation with hepatic hydrothorax, encephalopathy, and evidence of synthetic dysfunction, and it asked for objective test results or other records supporting Dr. Kwo's opinion. Def. Ex. 4. That letter from Midwest Security indicated that additional information would then be submitted to an independent reviewer, and then later to arbitration.

On November 21, 2003, counsel for plaintiff again wrote to counsel for Midwest Security with additional documentation of Mrs. Franklin's claim. Pl. Ex. 13. Plaintiff's counsel and/or doctor sent still more documents on December 10, 2003. Def. Ex. 7.

On January 9, 2004, Midwest Security adhered to its view that it did not believe a liver transplant was medically necessary for Mrs. Franklin. Def. Ex. 7. Midwest Security suggested more appeals or an independent review.

On February 18, 2004, counsel for plaintiff again wrote to counsel for Midwest Security with additional documentation, including a videotape and transcript of a sworn statement from Dr. Kwo. Pl. Ex. 14. On February 23, 2004, counsel for Midwest Security responded with more questions, including whether Mrs. Franklin wanted to proceed with an independent review or arbitration. Def. Ex. 8.

On February 24, 2004, Mrs. Franklin filed this lawsuit seeking preliminary and permanent injunctive and declaratory relief requiring defendants to pay for the liver transplant and associated treatments. The same day, the court scheduled a hearing on the motion for preliminary injunction for March 4, 2004, and set a conference for March 2, 2004. On February 26, 2004, plaintiff's counsel received telephone messages from defendants. She interpreted the messages as advising that defendants were willing to cover a liver transplant for Mrs. Franklin. Plaintiff's counsel asked for written confirmation. Def. Ex. 9. A response from defendants referred only to "a proposal to provide coverage," not to a firm commitment to provide coverage. Pl. Ex. 3.

The March 2nd conference went forward. During the conference, it appeared likely that defendants would agree to provide coverage. On March 3, 2004, the Plan and Midwest Security agreed to cover a liver transplant for Mrs. Franklin, though they insisted they "continue to believe that there is a good faith basis" for denying coverage. Pl. Ex. 4. The court therefore postponed the hearing that had been scheduled for March 4th.

An issue then arose as to whether defendants would cover the transplant at Indiana University in Indianapolis, or whether they would effectively require Mrs. Franklin to travel to St. Louis for the transplant and extensive follow-up care. The plan provided that it would cover 100 percent of transplant costs, up to $1,000,000, if the operation were performed within defendants' network of health care providers, but only 70 percent otherwise, with a limit of $250,000. This issue was resolved when, as a result of a process unrelated to this lawsuit, Indiana University was approved for so-called "in network" coverage for several types of transplants including liver transplants. The approval decision was reflected in correspondence dated March 5, 2004. Pl. Ex. 5.

On March 24, 2004, counsel for plaintiff wrote to defendants' counsel asking them to confirm that Mrs. Franklin could receive an in-network liver transplant at Indiana University. On March 29, 2004, plaintiff filed a motion for preliminary injunction on the issue of in-network v. out-of-network coverage. (The difference in costs could have been on the order of several hundred thousand

dollars.) The next day, counsel for defendants wrote plaintiff's counsel and confirmed that Indiana University would be deemed an in-network provider. Plaintiff then withdrew her motion for a preliminary injunction. The court denied the motion as moot. The parties then began filing their requests for fee awards.

Discussion

I. *Defendants' Requests for Fees and Sanctions*

Defendants have filed separate requests for fees and sanctions under ERISA and under Rule 11 of the Federal Rules of Civil Procedure.

First, defendants contend that they agreed to provide coverage for a liver transplant before the lawsuit was filed, so that the lawsuit was completely unnecessary. See Docket No. 41 at 1 (Plan "agreed to provide coverage for Plaintiff's liver transplant before the lawsuit was filed"); see also Docket No. 62 at 2 and 6 (Plan changed position based on additional information rather than in response to litigation). Defendants have not supported that claim with specific evidence, and the available correspondence indicates the opposite.

Right up to the time that suit was filed on February 24, 2004, defendants declined to provide assurance that they would cover a liver transplant. See Def. Ex. 8 (February 23, 2004 letter from defendants' counsel to plaintiff's counsel asking about interest in further medical review and binding arbitration). Even

after the suit was filed, the defendants did not provide such written assurance until after the conference with the court. Defendants' letter of February 26, 2004 referred only to a "proposal to provide coverage." The first indication of a firm commitment to provide coverage is defendants' March 3, 2004 letter. Pl. Ex. 4. Defendants are not entitled to fees on the theory that they had already agreed to cover a transplant before suit was filed. Cf. *Poteete v. Capital Engineering, Inc.*, 185 F.3d 804, 807 (7th Cir. 1999) (where defendant plan had stated its willingness to pay plaintiff his account balance before he filed suit, a district court judgment confirming that obligation did not make plaintiff a prevailing party).

The evidence shows that the litigation was a significant catalyst in prompting the defendants' decision to cover a liver transplant for Mrs. Franklin. See Pl. Ex. 3 (Midwest Security's counsel stating to plaintiff's counsel on Feb. 26, 2004 that Plan's change in position was based in part on "the belief that the Plan's interest and Mrs. Franklin's interest were better served by avoiding ongoing legal fees and expenses once we were advised that Mrs. Franklin would not agree to an independent medical review or binding arbitration").

In support of their requests for fees and Rule 11 sanctions, defendants devote most of their pages and energy to the argument that plaintiff misled the court as to the urgency of the case. Defendants contend that plaintiff misrepresented the relationship between defendants' denial of coverage and Mrs. Franklin's eligibility for a liver transplant. Specifically, defendants contend that

plaintiff and her attorneys based the lawsuit on a false premise, that the defendants' refusal to pre-approve coverage for a liver transplant prevented plaintiff from being listed on the eligibility list maintained by the Organ Procurement and Transplantation Network (OPTN) operated by the United Network for Organ Sharing (UNOS). According to defendants, the UNOS and OPTN criteria for eligibility for that list do not depend at all on financial considerations. Defendants assert that the reason Mrs. Franklin was not listed earlier is that Indiana University and Clarian Health Partners chose not to list her unless and until they had some assurance that they would be paid if they performed a liver transplant. Defendants contend that the supposed misrepresentations violated Rule 11 of the Federal Rules of Civil Procedure, whether they were deliberate or negligent.

In fact, though, defendants themselves have rewritten plaintiff's assertions and have then argued that the revised assertions were wrong. Plaintiff actually asserted in Paragraph 20 of her motion for a preliminary injunction: "Mrs. Franklin cannot be listed on the organ donee list until she receives approval for this operation. Once on the list, Mrs. Franklin will have to wait 3-9 months for a liver." In Paragraph 27 of her original complaint, she alleged:

> The recommendation of denial by Dr. Grassy and Meyer has had a direct impact on the treatment received by Mrs. Franklin, namely, she has not been listed for a liver donation and therefore is unable to undergo the transplant operation. This violates the standard of care owed to Mrs. Franklin.

Defendants have re-written these assertions as if plaintiff had claimed that defendants' actions prevented her from meeting the medical listing criteria *for the OPTN list*. Then, defendants have shown that the OPTN list does not take into account financial factors and that this fact is publicly available. On that foundation, defendants have argued that plaintiff and her counsel either knew or should have known that their assertions in Paragraph 20 of the preliminary injunction motion and Paragraph 27 of the original complaint were false.

Defendants' presentation of this issue has seriously distorted the issue here. Plaintiff's general statement that she could not be listed on the organ donee list until she received approval to pay for a transplant was accurate. As the first sentence of the document defendants rely upon plainly shows, a patient must first be accepted onto a transplant hospital's waiting list before OPTN will add a patient to the OPTN transplant list. Docket No. 31, Exhibit A (April 20, 2004 printout of www.optn.org/about/transplantation/matchingProcess.asp). Indiana University Hospital was unwilling to list Mrs. Franklin for a liver transplant until it had some assurance that it would be paid for this staggeringly expensive treatment, *i.e.*, that it would be paid by entities that had received substantial insurance premiums in return for promises to pay for medically necessary treatments, including liver transplants. Defendants cannot secure fees or other sanctions by rewriting plaintiff's assertions and then showing that the rewritten assertions were not accurate.

Thus, the very foundation of defendants' Rule 11 motion is itself false and misleading. If defendants had given pre-approval based on medical necessity, plaintiff would have been listed earlier on both the hospital's donee list and the OPTN transplant list. That was the essential thrust of this case from the beginning. Plaintiff accurately described the core issues and facts.

Defendants have tried to shift the focus of the case from their failure to approve a liver transplant to the decision by Indiana University Hospital to insist on a showing of financial coverage before listing Mrs. Franklin for a transplant. Defendants assert: "In other words, this case was not about medical necessity or any action on the part of MSA that prevented Plaintiff from being eligible for a liver transplant; it was about Clarian's desire to get paid." Docket No. 62 at 1; accord, Docket No. 60 at 4 ("This lawsuit was really about Clarian's desire to get paid."); Docket No. 59 at 2 (same).

The court understands defendants' desire to try to shift the focus to Clarian and Indiana University Hospital. They are not parties to this lawsuit, however, so the court has no occasion for evaluating or commenting upon their decision to insist on a showing of ability to pay before a patient would be listed for a life-saving transplant.

In response to defendants' effort to claim the moral high ground here, however, it is worth recalling the purpose of health insurance. Employers and

employees pay businesses like Midwest Security precisely so they can be assured that money will be available for medically necessary but very expensive treatments like liver transplants.

In fact, defendants' attempt to portray Clarian as greedy presents a rather ironic twist on reality here. When people have paid for health insurance, they are entitled to enforce the contracts against the business holding the money. Patients, doctors, and hospitals should not feel shy about enforcing such contracts. An insurer or plan administrator is not entitled to insist that a patient ask hospitals and doctors for charity care when the patient has paid for applicable coverage. In deciding who stands on higher or lower moral ground here, there is a substantial difference between (a) an institution that believes it cannot afford to provide charity and (b) an institution that breaches its contractual commitment, for which it was paid the requested premium or fee, to pay for that treatment. These defendants are not entitled to the moral high ground here.[1]

Accordingly, defendants' requests for fees and their Rule 11 motions for sanctions are all denied.

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[1]Also, contrary to defendants' assertion in their brief, Midwest Security itself always maintained that the issue was in fact medical necessity. That was always the stated basis for its denials of coverage. Even in the March 3, 2004 letter confirming coverage, it claimed to still have a "good faith" basis for finding no medical necessity. Defendants have accused plaintiff of playing a "shell game," but plaintiff is not the guilty party on that score.

II. *Plaintiff's Request for Sanctions Under 28 U.S.C. § 1927*

Plaintiff has suggested that the distorted foundation for defendants' requests for fees shows that those requests are unjustified and have unreasonably and vexatiously multiplied the proceedings, authorizing sanctions under 28 U.S.C. § 1927. The statute provides:

> Any attorney or other person admitted to conduct cases in any court of the United States or any Territory thereof who so multiplies the proceedings in any case unreasonably and vexatiously may be required by the court to satisfy personally the excess costs, expenses, and attorneys' fees reasonably incurred because of such conduct.

Sanctions imposed pursuant to 28 U.S.C. § 1927 require prior notice and an opportunity to respond, though not necessarily a hearing. *Larsen v. City of Beloit*, 130 F.3d 1278, 1286 (7th Cir. 1997); *Kapco Mfg. Co. v. C & O Enters., Inc.*, 886 F.2d 1485, 1494-1495 (7th Cir. 1989). Plaintiff's response was sufficient to put defendants on notice that the court could consider § 1927, and neither side has asked for a separate hearing. Also, the prospect of filing and briefing a separate motion for § 1927 sanctions based upon the filing of four fee and sanction motions is an invitation to a nearly endless cycle of litigation.

The court agrees that sanctions are warranted here under § 1927. Defendants' principal arguments in favor of their own fee and sanction requests were based on clear distortions of plaintiff's assertions. In essence, defendants set up a straw man they could easily knock over.

Was this (a) unreasonable and (b) vexatious? It was certainly unreasonable. Defendants knew before the lawsuit was filed that Dr. Kwo and Indiana University Hospital were not listing Mrs. Franklin because of defendants' refusal to confirm coverage. In all four of their motions (Midwest Security's fee request and Rule 11 motion, and the Plan's fee request and Rule 11 motion) and four reply briefs, defendants repeatedly claimed that plaintiff was misleading the court by supposedly failing to tell the court that the UNOS/OPTN criteria do not consider financial factors. The defendants repeatedly ignored the fact that the list requires that a transplant hospital first list the patient as eligible, and the Indiana University Hospital requires some showing of financial ability to cover the staggering costs of a liver transplant, which for all but extraordinarily wealthy individuals will involve some private or public form of insurance. Thus, defendants' four requests all alleged distortion on a matter that plaintiff described accurately, and a matter that defendants must have realized she had described accurately. By pursuing these misguided motions, defendants forced plaintiff to respond to four different motions seeking to hold her and her counsel responsible for more than $60,000 in attorney fees. These efforts have been unreasonable and unjustified.

The four defense motions have also been vexatious, in the court's view. Defendants have been threatening sanctions from the time the suit was filed, though they folded quickly on the underlying question of coverage. Recognizing that plaintiff would have a solid (though debatable) claim for her own fees,

defendants apparently decided that the best defense would be a good offense. A good offense, however, is not one based on such distortions of the supposedly offending statements to the court. "If a lawyer pursues a path that a reasonably careful attorney would have known, after appropriate inquiry, to be unsound, the conduct is objectively unreasonable and vexatious." *In re TCI Ltd.*, 769 F.2d 441, 445 (7th Cir. 1985) (affirming fee award under § 1927); accord, *Johnson v. C.I.R.*, 289 F.3d 452, 456 (7th Cir. 2002) ("Bad faith under section 1927 of the Judicial Code . . . is not a subjective concept, as the words 'who so multiplies the proceedings in any case unreasonably and vexatiously' (emphasis added) might be thought to imply; 'reckless' or 'extremely negligent' conduct will satisfy it."); *IDS Life Ins. Co. v. Royal Alliance Associates, Inc.*, 266 F.3d 645, 654 (7th Cir. 2001) (reversing denial of sanctions under § 1927: "So clear is it that the defendants filed a frivolous suit in a New York court in order to complicate this already far too complicated and absurdly protracted litigation, to the cost of the plaintiffs, that the district judge committed an abuse of discretion in refusing to sanction the defendants' counsel under section 1927.").

The court finds that the defendants' requests for fees and Rule 11 motions amounted to violations of 28 U.S.C. § 1927. The amount of the fees awarded is addressed below.

III. *Plaintiff's Fee Petition Under ERISA*

Plaintiff also seeks attorney fees under 29 U.S.C. § 1132(g)(1), which provides that in a civil action for benefits like this one, "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." All parties agree that the court should apply the standard in *Hooper v. Demco, Inc.*, 37 F.3d 287 (7th Cir. 1994), to determine whether any party to this lawsuit is entitled to a fee award under § 1132(g)(1). The issue in *Hooper* was whether fees should be awarded where the defendants had eventually agreed, without a court order, to pay for the costs of the cancer treatments in question. Judge Coffey explained:

> When a cause is settled or disposed of without full litigation on the merits (as in this case), this Circuit applies a two-step analysis to determine if the party prevailed in the litigation. In *In re Burlington Northern Inc.*, 832 F.2d 422, 425 (7th Cir. 1987), we ruled that a party must initially prove that the outcome of the plaintiff's lawsuit must be causally linked to the achievement of the relief obtained. The lawsuit is causally linked to the relief obtained if it played a "provocative role in obtaining relief." *Nanetti v. University of Illinois*, 867 F.2d 990, 993 (7th Cir. 1989) *citing DeVito*, 656 F.2d at 267. Therefore "the lawsuit must [be] a 'catalyst' or 'material factor' in obtaining concessions from the opponent and a favorable outcome to the dispute." *Id. quoting Ekanem v. Health & Hospital Corp.*, 778 F.2d 1254, 1258 (7th Cir. 1985); *Stewart v. Hannon*, 675 F.2d 846, 851 (7th Cir. 1982).
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> Under the second step of the *Burlington* analysis, however, the suit must have prompted the defendant (the settling party) to act or cease its behavior based on the strength of the case, not "wholly gratuitously" in response to the plaintiff's claims. *Id.* We review the second step, whether the defendant acted "wholly gratuitously" under the abuse of discretion standard. *Id.*; *Dixon v. Chicago*, 948 F.2d 355, 358 (7th Cir. 1991). Thus, we must determine whether Demco settled this case with an eye towards its possible exposure if litigation

> progressed, or whether their motivation to settle was "wholly gratuitous."

37 F.3d at 292-93.

In this case, defendants changed their approach and decided to authorize coverage of a liver transplant for Mrs. Franklin. The evidence shows that the lawsuit was causally linked to that change. After months of delays and requests for more information, without having submitted the information to a qualified hepatologist, and after applying overly stringent medical criteria that defendants have since abandoned, defendants changed their position the day after the initial conference with the court. The conference was two days before the scheduled hearing on plaintiff's motion for a preliminary injunction. The evidence also shows that defendants' change of heart was not "wholly gratuitous." In fact, defendants' own statements show that they considered the litigation costs and risks as one of the key factors in their decision to provide coverage. Pl. Ex. 3.

In some cases, of course, a defendant may choose to settle a modest but frivolous claim simply because it would be more expensive to fight it. This case does not fit that description. The financial stakes – the cost of a liver transplant and follow-up care – are measured in the hundreds of thousands of dollars. On the merits, even if the denial were subject to review under the "arbitrary and capricious" standard that often applies under ERISA, plaintiff had a substantial case. In the event of a disagreement about medical necessity, the plan called for

evaluation by a qualified specialist. Neither of the doctors who reviewed Mrs. Franklin's case was qualified to evaluate and challenge Dr. Kwo's opinion, backed up by the Indiana University Hospital Transplant Committee, that she qualified for a liver transplant as early as January 2003. In other words, defendants' change of position cannot fairly be described as "wholly gratuitous" or as a nuisance-value response to a weak lawsuit.

Defendants have attempted to justify their change of position as resulting from the information that Indiana University Hospital had refused to list Mrs. Franklin for a liver transplant until she could show an ability to pay for it, through insurance coverage. Taking that statement at face value, however, it is only one reason for the change of position. Defendants also acknowledged that the prospect of litigation also played a role. Pl. Ex. 3. Also, the defendants' explanation should not be taken at face value, for it is inconsistent with the position that defendants have taken all along, which was that a liver transplant was not medically necessary for Mrs. Franklin.

Accordingly, Mrs. Franklin qualifies as a prevailing party under the standard adopted in *Hooper* and argued by defendants as well as plaintiff in this case.[2]

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[2]There is a potential issue lurking here: whether the plaintiff may recover a fee award under 29 U.S.C. § 1132(g)(1) when her lawsuit acts as a catalyst in prompting the defendant to change its position and give her the relief she had sought, but without a court order granting relief. In other words, the issue is (continued...)

For nearly twenty years, the Seventh Circuit has described in two ways the approach the district courts should take in determining whether to award fees in ERISA cases. As the court recently explained:

> The first looks to five factors that the court should consider in connection with the fee question: (1) the degree of the losing party's culpability or bad faith; (2) the ability of the losing party to satisfy an award of fees; (3) whether an award of fees against the losing party would deter others from acting under similar circumstances; (4) whether the party requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal

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[2](...continued)
whether the Supreme Court's reasoning in *Buckhannon Bd. & Care Home, Inc. v. West Virginia Dep't of Health & Human Resources*, 532 U.S. 598 (2001), which rejected the well-established "catalyst" theory for fee awards under statutes that authorize fee awards to "prevailing parties," should be extended to claims for attorney fees under ERISA, which does not use that statutory phrase. See *Reed v. Shenandoah Memorial Hosp.*, 2002 WL 1964826, *2-3 (D. Neb. Aug. 12, 2002) (noting issue but finding that court-approved settlement under ERISA met standard under *Buckhannon*); *Kerkhof v. MCI WorldCom, Inc.*, 204 F. Supp. 2d 74, 75 (D. Maine 2002) (noting issue but declining to decide it; plaintiff did not qualify for fee award under prior ERISA law where summary judgment in her favor was vacated as moot when defendant granted relief on grounds independent from lawsuit); see also *Center for Biological Diversity v. Norton*, 262 F.3d 1077, 1080 n. 2 (10th Cir. 2001) (declining to extend *Buckhannon* to Endangered Species Act because fee statute does not use term "prevailing party," but denying fee award where plaintiff failed to show lawsuit was catalyst for defendant's change in policy).

Defendants have waived any argument based on *Buckhannon*. They have not raised this argument. They chose instead to pursue their own fee petitions under ERISA on the theory that they qualify as prevailing parties under the broad view of that status under pre-*Buckhannon* cases decided under 29 U.S.C. § 1132(g)(1). See, *e.g.*, Docket No. 62 at 2 (Midwest Security brief claiming prevailing party status under *Hooper*), and Docket No. 48 at 3 (Plan brief arguing that a party may be considered a "prevailing party" under ERISA "by persuading one's adversary to retire from the field," quoting *Connolly v. National School Bus Service, Inc.*, 177 F.3d 593, 595 (7th Cir. 1999)). Since the catalyst issue is fairly debatable and defendants made a strategic decision to argue for a different legal rule for their own benefit, they have waived any argument they might have raised under the reasoning of *Buckhannon* or similar cases.

> question regarding ERISA; and (5) the relative merits of the parties' positions. *Meredith* [*v. Navistar Int'l Transp. Corp.*, 935 F.2d 124, 128 (7th Cir. 1991)]. The second approach indicates that the district court should award fees to the prevailing party unless either (1) the losing party's position was substantially justified or (2) special circumstances make a fee award unjust. *Id.* In the end, we think these two formulations are simply alternative ways of making the same basic point: as we have put it before, "the bottom-line question is . . . : was the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" *Id.* We review the district court's decision to award fees for abuse of discretion. *Bowerman v. Wal-Mart Stores, Inc.*, 226 F.3d 574, 592 (7th Cir. 2000).

Central States, Southeast and Southwest Areas Pension Fund v. Hunt Truck Lines, Inc., 272 F.3d 1000, 1004 (7th Cir. 2001).

Under either approach, Mrs. Franklin is entitled to a fee award for the litigation leading to defendants' decision to approve coverage for the liver transplant. Under the first method, the first factor does not require a finding of subjective bad faith, but defendants' culpability in this case weighs in favor of a fee award. Defendants strung Mrs. Franklin out for more than a year after her highly-qualified hepatologist found that she needed a liver transplant. Defendants have tried hard to present their repeated requests for more information as merely prudent enforcement of the plan for the benefit of all participants and beneficiaries. Defendants cannot, however, justify the failure to have a qualified specialist evaluate the case after a dispute arose. They repeatedly prolonged the appeal process with assurances of further consideration, which were followed by still more requests for documentation to support Dr. Kwo's opinion. There is no

evidence that defendants ever submitted the documentation to a qualified hepatologist who might have been in a position to provide a reasoned disagreement with Dr. Kwo. The defendants also denied coverage based not on the plan standard of medical necessity but based on an internal manual with extraordinarily stringent criteria – requiring a patient to have all manifestations of end-stage liver disease. Def. Ex. 1. Defendants have since disavowed those criteria and even denied that they applied them. Compare Def. Ex. 1 with Def. Exs. 4 & 7.

The second factor under the first method is the ability of the defendant to pay a fee award. This factor appears to weigh in favor of a fee award; there is no argument to the contrary. Third, a fee award would help deter other plans and plan administrators from taking similar actions in similar cases in the future. Fourth, Mrs. Franklin was presumably trying primarily to benefit herself, to save her life by securing the funds needed to pay for life-saving therapy. Her case, however, has broader ramifications as to how health plans and administrators handle claims, especially claims for very expensive life-saving therapy. This factor also weighs in favor a fee award. As for the fifth factor, the relative merits of the parties' positions, that factor also weighs in favor of a fee award. After months of delays, when faced with a preliminary injunction hearing and the serious risk of an adverse court judgment, defendants finally approved the transplant, clinging to their assertion that they had a good faith basis for denying medical necessity. Pl. Ex. 4.

Under the second approach to fees under ERISA, the first issue is whether the defendants' position was substantially justified. For the reasons summarized above, the answer is no. The second issue is whether special circumstances would justify denial of a fee award. The answer is also no.

Further, a fee award in this case should be consistent with the purposes and policies of ERISA. When a family buys health insurance, whether through an employer or not, they seek the security of knowing that if they face catastrophic health care expenses, the insurer they have paid to assume the risk will step in and take responsibility for those costs. ERISA already removes the risk of punitive damages and consequential damages that might apply if the case were governed by state law. To provide full equitable relief, and to encourage insurers to fulfill their obligations rather than delay until a patient's health has deteriorated substantially, or worse, a fee award is needed to take a step toward making the insured patient financially as well off as she would have been if the insurer had acknowledged its contractual responsibility in the first place.

Accordingly, plaintiff Franklin is entitled to a fee award under ERISA as a prevailing party for her litigation efforts to obtain coverage. However, the preliminary injunction motion regarding in-network v. out-of-network care appears to have been unnecessary. Plaintiff is not entitled to fees for work incurred in obtaining this result. The evidence shows that the issue was resolved independently from this lawsuit, and before plaintiff filed her motion. See Ex. 5

(March 5, 2004 letter to Clarian). On this issue, a fee award would be akin to paying off a bet placed after the race had been run. The short delay in having defendants' counsel confirm in writing for plaintiff that Indiana University would be in-network would not justify a fee award for that work.

At the same time, the court sees no basis for awarding fees to defendants for work relating to the in-network v. out-of-network issue. Plaintiff did not act unreasonably in asking for confirmation, especially in light of the prior levels of friction and mistrust. When plaintiff received the written confirmation she requested, she immediately withdrew the motion for preliminary injunction.

IV. *Amount of Fee and Cost Award to Plaintiff*

In determining a reasonable fee under both ERISA and § 1927, the court applies the lodestar method described in *Hensley v. Eckerhart*, 461 U.S. 424, 433-34 (1983), taking the attorney time reasonably spent on the matter, using the exercise of "billing judgment," multiplied by a reasonable hourly fee, which is measured best by the attorney's market rate for non-contingent work. See *Stark v. PPM America, Inc.*, 354 F.3d 666, 674 (7th Cir. 2004) (affirming application of lodestar method to fee award under ERISA). Defendants have not raised objections to attorney Bridget O'Ryan's hourly rate of $240 or attorney Steven Kincaid's hourly rate of $150. The court believes those rates are reasonable.

Two other general principles are relevant here. First, plaintiff is not entitled to a fee award for attorney work directed primarily at the administrative review process, as distinct from the litigation. *E.g.*, *Dishman v. UNUM Life Ins. Co.*, 269 F.3d 974, 987-88 (9th Cir. 2001). Second, the fee award should include time that plaintiff's attorneys reasonably spent on the fee disputes in this case. That approach has been applied in ERISA cases, *e.g.*, *Stark*, 354 F.3d at 674; *Brewer v. Protexall, Inc.*, 50 F.3d 453, 459 (7th Cir. 1995); *White v. Martin*, 290 F. Supp. 2d 986, 992 n.5 (D. Minn. 2003), and is routine in federal fee-shifting litigation.

Attorney O'Ryan did most of the work for plaintiff's case. She has submitted time records that combine all time in a particular month, without specifying time for particular days and tasks. This is most definitely not a recommended procedure. Defendants have objected that her request for fees is excessive because of these vague entries. The defect in the records would not warrant a complete denial of fees, though, and the overall amounts of time are reasonable, in fact rather modest, in light of the pace and stakes of the litigation. From O'Ryan's requested time, the court makes the following deductions:

1. The court denies all but 0.5 of the 14.4 hours claimed for December 2003, for that time appears to have been directed primarily at the administrative review process. The remaining 0.5 hour was spent on a telephone call with co-counsel Steven Kincaid, whose work was primarily on the litigation.

2. The court discounts by 20 percent (13.5 hours) the 67.6 hours claimed for January and February 2004; this discount addresses the record-keeping problems just noted.

3. The court subtracts 20 of the 27.5 hours claimed for March 2004. Much of that time was devoted to the in-network v. out-of-network issue, for which plaintiff is not entitled to fees. Twenty hours is the court's best estimate of the non-reimbursable time, giving defendants the benefit of doubts raised by record-keeping problems.

4. The court discounts by 20 percent (18.3 hours) the 91.5 hours claimed for April through June 2004 to account for the record-keeping problems.

The result of these calculations is a fee of $32,742.00 for O'Ryan's time (135.3 hours).

Attorney Steven Kincaid has submitted detailed time records showing a total of $6,796.66 in fees from December 2003 through May 2004. All of his time was devoted to litigation, and the overall time is reasonable. The court has subtracted $225 for time entries in March that relate to the in-network issue. That leaves a fee of $6,571.66 for Kincaid's time.

The overall result of these calculations and adjustments is that plaintiff is entitled to a total fee award of $39,313.66 and total costs of $1,224.49. Plaintiff is entitled to recover the entire sum from defendants Midwest Security and the Plan.

In addition, pursuant to § 1927, defendants' attorneys are jointly liable for the portion of the fee for plaintiff's attorneys' time spent in May and June 2004 to oppose defendants' fee and sanctions petitions, as distinct from supporting

plaintiff's own fee petition and addressing other litigation matters. The court conservatively estimates the time attributable to opposing defendants' petitions and sanction motions to be $4,800 (20 hours for O'Ryan times $240/hour).

V. *Plaintiff's Motion to Strike*

Plaintiff's motion to strike Defendants' Exhibit A, the document from the Organ Procurement Transplantation Network (OPTN), is hereby denied. Plaintiff relies on *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 982 (7th Cir. 1999) ("when review under ERISA is deferential, courts are limited to the information submitted to the plan's administrator"). Although the OPTN document is not part of the administrative record in the case, defendants did not offer it to show that their denial of coverage was consistent with the plan. It is being offered to try to prove a point on the collateral issue of attorney fees, though the document actually shows that defendants were distorting the relevant facts. The document from outside the administrative record is as relevant to the fee issue as are the attorney's affidavits about their fees, which also were not part of the administrative record.

Conclusion

For the foregoing reasons, the court denies defendants' petitions for fee awards and Rule 11 sanctions, denies plaintiff's motion to strike, and grants in part and denies in part plaintiff's petition for fees under ERISA and 28 U.S.C. § 1927. The court will enter judgment awarding to plaintiff the sum of $40,538.15. Defendants Midwest Security Administrators, Inc. and the H.O. Wolding, Inc. Group Health and Welfare Plan are jointly and severally liable for the entire sum, and the law firms of Thompson Coburn LLP and Scopelitis, Garvin, Light & Hanson are jointly and severally liable for $4,800.00 of the total.

So ordered.

Date: December 8, 2004

s/ David F. Hamilton

DAVID F. HAMILTON, JUDGE
United States District Court
Southern District of Indiana

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