IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

EARL HARRISON and
MARIAM P. HARRISON,

Plaintiffs,

vs.

ROCKWELL COLLINS, INC.,
AETNA LIFE INSURANCE COMPANY, and
ROCKWELL COLLINS EMPLOYEE
HEALTH PLAN NUMBER 700,

Defendants.

No. C06-0072

RULING ON BENEFITS DETERMINATION UNDER ERISA

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I. INTRODUCTION

This matter comes before the Court on Plaintiffs Earle W. Harrison ("Earle") and Mariam P. Harrison's ("Mariam") challenge of the denial of benefits under the Rockwell Collins Employee Health Plan Number 700 funded by Earle's employer, Defendant Rockwell Collins, Inc. ("RCI") and administered by Defendant Aetna Life Insurance Company ("Aetna"). Plaintiffs request payment of benefits for Mariam's hospitalization and treatment at the Mayo Clinic in May, 2003.

II. PROCEDURAL BACKGROUND

On May 24, 2003, Mariam was examined by doctors at the Mayo Clinic emergency room. On May 25, 2003, she was admitted, through the emergency room, to St. Mary's Hospital for surgery on her mesenteric artery. Mariam was discharged from St. Mary's Hospital on June 14, 2003.

On June 16, 2003, Aetna denied payment for all treatment that Mariam received at St. Mary's Hospital. On June 23, 2003, Plaintiffs appealed Aetna's denial of their claim for payment of Marian's medical treatment at St. Mary's Hospital. On September 3, 2003, Aetna denied Plaintiffs' claim for benefits on the first-level appeal. On September 25, 2003, Plaintiffs appealed Aetna's denial of their claim on the first-level appeal through the second-level appeal process. On October 17, 2003, Aetna denied Plaintiffs' claim on the second-level appeal.

On June 13, 2006, Plaintiffs filed a Complaint (docket number 1) alleging breach of contract (Count I) and breach of fiduciary duty (Count II) under the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(a)(1)(B).[1] On September 1,

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[1] 29 U.S.C. § 1132(a)(1)(B) provides in pertinent part:

> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> (B) to recover benefits due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan.

2006, Defendants filed an Answer (docket number 13) and a Motion to Dismiss (docket number 9). On October 10, 2006, Plaintiffs filed an Amended Complaint (docket number 21), amending the caption to properly identify the Defendants by their legal names. On October 16, 2006, Defendants Aetna and Rockwell Collins Employee Health Plan Number 700 filed an Answer to Plaintiffs' Amended Complaint (docket number 24). Defendant RCI filed a Renewed Motion to Dismiss (docket number 23) on October 16, 2006. On October 17, 2006, Magistrate Judge John A. Jarvey entered an Order (docket number 25) denying Defendants' initial Motion to Dismiss (docket number 9) as moot and denying RCI's Renewed Motion to Dismiss (docket number 23) as premature. On November 1, 2006, RCI filed an Answer to Plaintiffs' Amended Complaint (docket number 26).

On June 4, 2007, Plaintiffs filed a Trial Brief on the Merits (docket number 32). On July 9, 2007, Defendants filed a Brief in lieu of Trial (docket number 33). On August 1, 2007, Plaintiffs filed a Reply Trial Brief (docket number 34). On August 3, 2007, Defendants filed a Motion for Permission to File Sur-Rebuttal (docket number 35). In their motion, Defendants requested, in the alternative to filing a sur-rebuttal, oral argument on the trial briefs. On August 7, 2007, the Court filed an Order (docket number 36) denying Defendants' Motion for Permission to File Sur-Rebuttal and granting the request for oral argument. Oral argument was held telephonically on August 22, 2007. Plaintiffs were represented by their attorney, Karen A. Lorenzen. Defendants were represented by their attorneys, Amy L. Reasner and Wilford H. Stone. After considering the briefs and oral arguments of the parties, the Court enters the following ruling.

III. FACTUAL BACKGROUND

A. Introduction

In 2003, Earle was employed by RCI. As part of his employment, Earle and Mariam received health insurance benefits from RCI.[2] Earle selected the Exclusive

[2] Plaintiffs were covered under the Rockwell Collins Employee Health Plan Number 700. This plan was funded by RCI and administered by Aetna. On July 1, 2001 RCI entered into an "Administrative Services Agreement" with Aetna. The agreement provides (continued...)

Provider Organization ("EPO") plan from several options. Under the EPO plan, the plan participant selects a Primary Care Physician ("PCP") for treatment, and when necessary, the PCP may refer the plan participant to a network specialist. The Specific Plan Description ("SPD") provided to Plaintiffs states that, except for emergencies, the plan participant's care will not be covered unless a network provider is used.

B. Mariam's Medical Condition

On April 19, 2003, Mariam visited St. Luke's Hospital in Cedar Rapids, Iowa with abdominal pain. She had been experiencing abdominal pain for several months and had visited her doctor and the hospital on several occasions prior to April 19, 2003.[3] It is unclear from the record what type of treatment Mariam received from St. Luke's on April 19, 2003. However, she returned to St. Luke's emergency room on April 21, 2003 with continued abdominal pain and diarrhea. A colonoscopy revealed a large ceum ulcer and two large ulcers descending in her colon. On April 22, 2003, Mariam had a surgical consultation and was scheduled for colon surgery on April 23, 2003. A right hemicolectomy for ischemia of the colon was performed on April 23, 2003.[4] While recovering from surgery, Mariam continued to have abdominal pain and felt nauseous. An abdominal CT revealed significant ascites and possible active bleeding. Mariam underwent a laparotomy on April 27, 2003. She was discharged from St. Luke's hospital on May 2, 2003.

On May 3, 2003, Mariam was readmitted to St. Luke's through the emergency room for persistent vomiting and severe abdominal pain. On May 7, 2003, Mariam was

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[2](...continued)
that RCI "established one or more self-funded employee health benefits plan for certain eligible individuals pursuant to [ERISA] . . . ; and . . . the [Employee Benefit Plan] Committee desires to engage the services of Aetna to provide certain administrative services for the Plan." *See* Record at 1-2.

[3] According to Mariam's medical records from the Mayo Clinic, she began suffering from abdominal pain in December, 2002.

[4] Sometimes the record indicates that this surgery was performed on April 22, 2003.

examined by a gastroenterologist. The gastroenterologist determined that Mariam might be suffering from pancreatitis; however, the record indicates that no treatment was provided at that time. Mariam was discharged from St. Luke's on May 8, 2003.

On May 12, 2003, Mariam visited her doctor with continued abdominal pain. She also had been unable to eat due to the pain. She was admitted to St. Luke's from her doctor's office. Mariam was placed on a soft diet and observed to see whether she could tolerate such a diet. She was discharged from the hospital on May 16, 2003.

On May 23, 2003, Mariam continued to have abdominal pain and was examined by a network provider, Dr. Leon Qiao. A CT angiography showed a total occlusion of the superior mesenteric artery, causing ischemia. Dr. Qiao obtained an appointment for Mariam to be evaluated by a vascular surgeon at the Mayo Clinic in Rochester, Minnesota on May 30, 2003.[5] According to Plaintiffs, Dr. Qiao told them to immediately go to the emergency room at the Mayo Clinic if Mariam developed pain prior to her May 30, 2003 appointment.

On May 24, 2003, Mariam had severe abdominal pain which was worse than the abdominal pain she had been experiencing in April and the early part of May. Earle and Mariam decided to follow Dr. Qiao's orders, and go to the Mayo Clinic emergency room. At the Mayo Clinic emergency room, Dr. Dennis A. Laudon, M.D. diagnosed Mariam with subacute mesenteric ischemia with abdominal pain. She was admitted to St. Mary's Hospital through the emergency room. An angiogram taken at St. Mary's confirmed that Mariam suffered from an SMA occlusion and had progressive chronic mesenteric ischemia due to thromboembolic occlusion of the superior mesenteric artery. On May 29, 2003, a thromboendarterectomy of the superior mesenteric artery was performed on Mariam.[6] She

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[5] On May 23, 2003, Plaintiffs sought Aetna's approval for Mariam to be evaluated at the Mayo Clinic. Aetna informed Plaintiffs that the Mayo Clinic was an "out of network" provider. Therefore, Plaintiffs were required to submit a referral from their doctor showing that evaluation at the Mayo Clinic was "medically necessary" in order to obtain approval to use an "out of network" facility.

[6] Plaintiffs assert that "[t]he delay between admission [to St. Mary's] and surgery
(continued…)

stayed at St. Mary's for post-operative recovery and was discharged from the hospital on June 14, 2003.

C. Aetna's Denial of Plaintiffs' Claim for Benefits

On June 16, 2003, Aetna denied Plaintiffs' claims for coverage of Mariam's admission to St. Mary's Hospital and subsequent surgery and post-operative recovery because the Mayo Clinic was an "out of network" facility.[7] On the first-level appeal, Aetna denied Plaintiffs' claim for benefits because the plan they were under:

> [did] not cover out-of-network non-emergency care and services, unless these care and services [were] pre-approved on precertification review by Aetna. The submitted medical information reveals the member, the treating physicians in Cedar Rapids, and the physicians at the Mayo Clinic did not receive precertification approval by Aetna for the out-of-network care and services rendered at the Mayo Clinic.

(Record at 401) On the second-level appeal, Aetna denied Plaintiffs' claims because "[Mariam] has Elect Choice with no out of network benefits. [Mariam] was without referral from primary care physician, not transferred, not an emergency. There are participating tertiary facilities in the network." (Record at 140) Plaintiffs chose not to seek external review of Aetna's decisions to deny their claims for benefits.

D. Relevant Plan Provisions

Plaintiffs' plan requires the use of primary physicians for referrals and the use of "network providers." The plan also provides that "[i]f you do not use a network provider,

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[6](…continued)
was explained by the need to switch blood thinners and generally stabilize Mariam." Plaintiffs point to the Record at 171 to support their assertion. The Court has reviewed Mariam's medical records from the Mayo Clinic. The records are not entirely clear, but it appears that the Mayo Clinic doctors constantly monitored Mariam and transitioned her off certain medications she was taking after she was admitted to St. Mary's hospital and before she underwent surgery. *See* Record at 170-90. *See also* Record at 162 (In the notes of an Aetna reviewing doctor, regarding Mariam's hospitalization at the Mayo Clinic, it states "[a]dmitted for pain control and transition off coumadin to IV heparing -- [due to] high risk of SMA clot leading to bowel infaction.").

[7] *See* Record at 118.

your care will not be covered (except in emergencies)."[8] The plan defines an "emergency admission" as:

> One where the Physician admits the person to the hospital right after the sudden and at, that time, unexpected onset of a change in a person's physical or mental condition that:
>
> - Requires confinement right away as a full-time Hospital inpatient; and
> - If immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
>   -- Loss of life or limb; or
>   -- Significant impairment to bodily function; or
>   -- Permanent dysfunction of a body part.

(Record at 512) The plan also provides a definition for "emergency condition:"

> This means the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment was not performed right away could, as determined by Aetna, reasonably be expected to result in:
>
> - Loss of life or limb; or
> - Significant impairment to bodily function; or
> - Permanent dysfunction of a body part.

(Record at 512)

Aetna also has a clinical claim review policy for emergency room services which provides that:

> Aetna covers emergency services necessary to screen and stabilize the member when:
>
> - A Primary Care Physician or Specialist Physician directs the member to the ER.
> - The member is directed to the ER by an Aetna representative (employee or contractor).
> - The member acting as a prudent layperson believed that an emergency condition existed.

(Record at 542) The guiding principle for the review policy is:

[8] *See* Record at 483.

> All reviews should consider the perspective of a reasonable or prudent layperson when making a coverage determination regarding emergency room services. If a reasonable prudent layperson could perceive the situation as being an emergency at the time the emergency care was sought, the claim should be considered medically necessary and paid according to contract provisions. . . . Ambiguous situations should be evaluated in favor of the member.

(Record at 544) Other facts that are significant for making a determination in this matter will be discussed, as necessary, in the Court's consideration of the legal issues presented.

IV. STANDARD OF REVIEW

"'ERISA provides a plan beneficiary with the right to judicial review of a benefits determination.'" *Shelton v. ContiGroup Companies, Inc.*, 285 F.3d 640, 642 (8th Cir. 2002) (quoting *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998)). Review of plan determinations is *de novo*, unless the plan provides discretionary authority to the plan administrator "'to determine eligibility for benefits or to construe the terms of the plan.'" *Johnson v. U.S. Bancorp Broad-Based Change in Control Severance Pay Program*, 424 F.3d 734, 738 (8th Cir. 2005) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). In this case, Aetna is given discretion to determine eligibility for plan benefits and interpret the plan's terms.[9] When a plan administrator is given such discretion, the court must review a decision by the administrator for abuse of discretion. *Shelton*, 285 F.3d at 642. "'This deferential standard reflects [the] general hesitancy to interfere with the administration of a benefits plan.'" *Id.* (quoting *Layes v. Mead Corp.*, 132 F.3d 1246, 1250 (8th Cir. 1998)). In *Hunt v. Metropolitan Life Insurance Co.*, 425 F.3d 489 (8th Cir. 2005), the Eighth Circuit described this standard of review as follows:

> Because the plan gives [the plan administrator] discretion to determine eligibility, we review the administrator's decision

[9] The Service Agreement between RCI and Aetna provides that Aetna "shall have discretionary authority to determine whether and to what extent Members and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms." *See* ¶ 8 of the Service Agreement; Record at 8. Additionally, the SPD provided to Plaintiffs states: "Aetna is responsible for determination of benefits." *See* Record at 540.

> for abuse of discretion. Under this standard of review, we consider whether the administrator adopted a "reasonable interpretation" of uncertain terms in the plan, and whether the administrator's decision was supported by substantial evidence.

Id. at 490 (citations omitted). When the abuse of discretion standard is applied, the reviewing court "must affirm if a 'reasonable person could have reached a similar decision, given the evidence before him [or her], not that a reasonable person would have reached that decision.'" *Smith v. Unum Life Insurance Co. of America*, 305 F.3d 789, 794 (8th Cir. 2002) (quoting *Ferrari v. Teachers Ins. and Annuity Ass'n*, 278 F.3d 801, 807 (8th Cir. 2002)). A reasonable decision is a decision which is based on substantial evidence that was before the plan administrator. *Id*. Substantial evidence is evidence which a reasonable mind could accept as adequate to support a conclusion. *Johnson*, 424 F.3d at 738.

"When reviewing a denial of benefits by an administrator who has discretion[,] . . . a reviewing court, 'must focus on the evidence available to the plan administrators at the time of their decision and may not admit new evidence or consider *post hoc* rationales.'" *King v. Hartford Life and Accident Insurance Co.*, 414 F.3d 994, 999 (8th Cir. 2005) (quoting *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999)). Furthermore,

> an administrator with discretion under a benefit plan must articulate its reasons for denying benefits when it notifies the participant or beneficiary of an adverse decision, and the decision must be supported by both a reasonable interpretation of the plan and substantial evidence in the materials considered by the administrator.

King, 414 F.3d at 1000.

A less deferential standard of review may be applied if a plaintiff presents "'material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty' to the plaintiff." *Shelton*, 285 F.3d at 642 (quoting *Woo*, 144 F.3d at 1160). An alleged conflict of interest or procedural irregularity must be connected in some way to the substantive decision reached by the plan administrator. *Id*.

"A claimant must offer evidence that 'gives rise to serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim'" for a less deferential standard to be applied. *Id.* (quoting *Layes*, 132 F.3d at 1250).

V. LEGAL ANALYSIS

A. Standard of Review to be Applied

Plaintiffs argue that the less deferential standard of review should be applied in this case. Plaintiffs contend that Aetna was acting under a conflict of interest when it made its benefits determination because "Aetna was not only the plan's insurer, but also its fiduciary/administrator. Aetna was, therefore, deciding whether to spend its own money."[10] Plaintiffs further argue that Aetna was also acting under a conflict of interest because Aetna's own doctors reviewed the appeals to Aetna's decision to deny benefits. Defendants argue that the deferential standard of review is the appropriate standard to be applied in this case because Aetna did not act under any conflict of interest. Defendants point out that RCI funds the plan and Aetna administers it.[11] Defendants conclude that "Aetna in determining the Plaintiffs' eligibility for coverage, was not 'deciding whether to spend its own money' as Plaintiffs claimed, but was deciding whether to spend RCI's money."[12]

Because RCI funded the benefits plan and Aetna administered the plan, the Court finds that Plaintiffs have failed to present "material, probative evidence demonstrating . . . a . . . conflict of interest." *Shelton*, 285 F.3d at 642. Furthermore, in determining Plaintiffs' second-level appeal, Aetna offered external review of its decisions. Plaintiffs

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[10] Plaintiffs' Brief at 7.

[11] The Service Agreement between RCI and Aetna provides that RCI "established one or more self-funded employee health benefits plan for certain eligible individuals pursuant to [ERISA] . . . ; and . . . the [Employee Benefit Plan] Committee desires to engage the services of Aetna to provide certain administrative services for the Plan." *See* Record at 1-2. The Service Agreement also provides that Aetna may terminate the contract with RCI if RCI fails to provide sufficient funds for payment of benefits. *See* Record at 4.

[12] Defendants' Brief at 11.

declined to have Aetna's determinations reviewed by external doctors. Therefore, the Court concludes that Plaintiffs' complaint that their appeals were determined by doctors employed by Aetna is without merit. Because Plaintiffs have failed to present evidence demonstrating a conflict of interest, the Court will apply the deferential standard of review articulated in section ***IV*** of this decision.

B. Whether Defendants Properly Denied Benefits

Plaintiffs argue that they are entitled to benefits for Mariam's treatment at the Mayo Clinic, an out-of-network provider, from May 24, 2003 to June 14, 2003, because Mariam was in need of emergency medical care.[13] Defendants argue that Aetna's decision to deny benefits was reasonable because the evidence in the record establishes that Mariam's admission to the Mayo Clinic emergency room and her condition when she arrived at the Mayo Clinic was not an "emergency."

Specifically, Aetna denied Plaintiffs' claims for benefits on both levels of appeals because Mariam's visit to the Mayo Clinic was to an out-of-network provider. Plaintiffs were required to get pre-approval from Aetna before visiting an out-of-network provider. It is undisputed that Plaintiffs were not granted pre-approval from Aetna before their visit to the Mayo Clinic. Pre-approval was not required pursuant to Plaintiffs' plan, however, if the treatment was an emergency. Aetna concluded that Mariam's visit to the Mayo Clinic on May 24, 2003 was not an emergency situation and therefore, benefits were denied. In their brief, Defendants argue:

> The Plaintiffs argue that it was an emergency because they did not go immediately to Mayo after diagnosis of the SMA occlusion by Dr. Qiao--but rather waited a *whole day* before traveling over three hours for care in an "emergency" situation. . . . [T]here is no evidence in the record at all that on May 25, 2003, [Mariam] could not have returned to Iowa

[13] Under Plaintiffs' plan, "[i]f you do not use a network provider, your care will not be covered (except in emergencies)." *See* Record at 483.

> for stabilization and "competent" surgical intervention at a participating facility, like UIHC. . . .[14]
>
> A prudent layperson who knows they have a [sic] blockage of a major artery and who believes that their condition is worsening--putting their body functions and even their life at risk--does not drive over three hours to obtain emergency treatment. Rather, a prudent layperson goes to the nearest hospital, informs the emergency room of their diagnosis and allows the emergency room doctor to treat them. It strains credulity that someone who believes they have a life or death "emergency" would drive over three hours to a hospital for treatment. . . .
>
> The SPD provided to Plaintiffs in this case likewise defined an "emergency admission" as having an element of "suddenness" or unexpected changes in condition needing "immediate" care. In this case, Dr. Qiao informed [Mariam] of her SMA occlusion [on] May [23], 2003. The Plaintiffs knew [Mariam] had a serious condition that required treatment, but it did not require *immediate* attention since Dr. Qiao made an appointment for a week later. Further, [Mariam] reported "typical" symptoms to the Mayo Clinic Emergency Room doctors, who found her to be in only "moderate distress." This evidence . . . establishes a "known" condition that had not suddenly occurred, and was not unexpected.

(Defendants' Brief at 21-23)

Defendants summarize the evidence which they contend supports the decision to deny benefits to Plaintiffs as follows: (1) Dr. Qiao, Mariam's doctor in Cedar Rapids, scheduled a consultation for her occluded SMA at the Mayo Clinic for one week after his diagnosis; (2) Plaintiffs pushed for a referral to the Mayo Clinic;[15] (3) Dr. Qiao normally

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[14] UIHC is the University of Iowa Hospitals and Clinics. However, the UIHC is also an out-of-network provider like the Mayo Clinic.

[15] *See* Record at 105. Defendants base this conclusion on a discussion Aetna's case manager for Plaintiffs' claim had with a woman named Barbara who worked for Dr. Qiao. Barbara informed the case manager that Plaintiffs "pushed for Mayo."

refers his patients to the UIHC;[16] (4) Mariam's network doctors did not establish a "medical necessity" for treatment at a out-of-network facility; (5) Plaintiffs did not inform Aetna that Dr. Qiao advised them to go to the Mayo Clinic emergency room before Mariam's scheduled appointment on May 30, 2003, if her condition worsened; (6) Mariam described "typical" symptoms and was in only "moderate distress" when she arrived at the Mayo Clinic emergency room;[17] and (7) Mariam "did not receive surgical intervention for almost five days" from the date she was admitted to St. Mary's Hospital from the Mayo Clinic emergency room.[18] Defendants contend that the foregoing evidence is substantial evidence which supports their interpretation of the plan and decision to deny benefits to Plaintiffs.

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[16] *See* Record at 119. Dr. Qiao informed the case manager for Plaintiffs' claims that he "normally refers to the U of I because he graduated from there," but he would not change his determination to have Mariam referred to the Mayo Clinic.

[17] The full text of the Mayo Clinic emergency room doctor's report states:

> This is a very nice 50-year-old woman who has had a five-month history of progressive diffuse abdominal pain, worse after eating. An extensive outside workup diagnosed with mesenteric ischemia with an occluded SMA. Has actually had colon resection for ischemic bowel. Outside physicians did not know how to manage her any further, she is actually set up for an eval here later this coming week. She presents tonight because of increasing pain which is typical of her episodes, however, much more severe. She is unable to eat because that causes increased pain. She is nauseated but no vomiting. She has had no fevers, chills, or sweats. Again, pain is quite typical, only more severe.

Under the "Physical Examination" portion of the doctor's report it states: "General: Very pleasant female, alert and oriented, in moderate distress." The report diagnosed Mariam with "[s]ubacute mesenteric ischemia with abdominal pain." *See* Record at 170-71.

[18] The purpose for delaying Mariam's surgery was to take her off of coumadin, a blood thinner, before surgery in order to decrease the chances that she would bleed to death during the surgery.

After a thorough review of the record, the Court notes the following evidence: (1) On May 23, 2003, Dr. Qiao diagnosed Mariam with a total occlusion of the superior mesenteric artery, causing ischemia;[19] (2) On May 23, 2003, Dr. Qiao scheduled an appointment for Mariam at the Mayo Clinic on May 30, 2003 and told Plaintiffs that if her condition worsened before May 30, 2003, they should go directly to the Mayo Clinic emergency room; (3) Mariam experienced greater abdominal pain than normal on May 24, 2003[20] and Plaintiffs decided to go to the Mayo Clinic emergency room in accordance with Dr. Qiao's directions; (4) On May 24, 2003, Dr. Laudon at the Mayo Clinic emergency room diagnosed Mariam with subacute mesenteric ischemia with abdominal pain; (5) Doctors concluded that Mariam's "urgent admission to [St. Mary's] hospital was necessary upon presentation to [Mayo Clinic's] ER--symptoms were classic for intestinal ischemia related to . . . SMA clot";[21] (6) On May 27, 2003, an angiogram performed at St. Mary's hospital confirmed her SMA occlusion; (7) Mariam was continually monitored by doctors at St. Mary's hospital from the time she was admitted until the time of her surgery;[22] (8) the delay from the date Mariam was admitted to St. Mary's and the date of her surgery was due to her need to "transition off coumadin to IV heparing--[due to] high

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[19] "Mesenteric artery ischemia is a narrowing or blockage of one or more of the three mesenteric arteries, which are the major arteries supplying the small and large intestines." *See* MedlinePlus Medical Encyclopedia at www.nlm.nih.gov/melineplus/ency/article/001156.htm.

[20] *See* Record at 170 and 172. Dr. Laudon, in his Mayo Clinic emergency service report noted "increasing pain which is typical of her episodes, however, much more severe. . . . Again, pain is quite typical, only more severe." Dr. J.C. Routh, M.D., in his Mayo Clinic vascular surgery report noted "[Mariam] was scheduled to be seen on Friday here at Mayo for further evaluation of her abdominal pain; however, her pain was too great for her to tolerate."

[21] *See* Record at 162.

[22] *See* Record at 176-90.

risk of SMA clot leading to bowel infarction [sic]";[23] and (9) On May 29, 2003, a thromboendarterectomy of the superior mesenteric artery with bovine patch angioplasty was performed on Mariam.

The Court, having reviewed the entire record, finds that a reasonable person, considering the evidence before Aetna, could not have reached the conclusion that Mariam's admittance to St. Mary's Hospital and her subsequent treatment and surgery was not an "emergency admission" for an "emergency condition." *See Smith*, 305 F.3d at 794 (setting forth that, on review, a court "must affirm if a 'reasonable person could have reached a similar decision, given the evidence before him [or her], not that a reasonable person would have reached that decision.' *Ferrari v. Teachers Ins. and Annuity Ass'n*, 278 F.3d 801, 807 (8th Cir. 2002)."). Contrary to Defendants' suggestion that "[a] prudent layperson who knows they have a [sic] blockage of a major artery and who believes that their condition is worsening . . . does not drive over three hours to obtain emergency treatment," the Court determines that a prudent layperson in Plaintiffs' situation *would* travel over three hours to the Mayo Clinic for emergency treatment.

Mariam was suffering from a serious medical condition, complete blockage of a major artery causing ischemia, which her doctors in Cedar Rapids could not diagnose for nearly four months and apparently could not treat. Dr. Qiao, one of her Cedar Rapids doctors, scheduled an appointment for Mariam to be evaluated by doctors at the Mayo Clinic. Dr. Qiao told Plaintiffs that if Mariam's abdominal pain increased before her appointment, she should immediately go to the Mayo Clinic emergency room. On May 24, 2003, six days before her scheduled appointment, Mariam had severe abdominal pain which was much greater than her typical abdominal pain. Thus, Plaintiffs decided to follow Dr. Qiao's orders and go to the Mayo Clinic emergency room instead of waiting for the scheduled appointment. It should be noted that Plaintiffs' health insurance plan does not require them to go to the nearest emergency room in an emergency situation. Considering the situation, including Plaintiffs' lack of confidence in their local doctors,

[23] *See* Record at 162.

Dr. Qiao's direction to go to the Mayo Clinic emergency room if her condition worsened, Mariam's sudden and unexpected increase in abdominal pain, and the flexibility to seek treatment at any emergency room under Plaintiffs' health insurance plan, the Court concludes that "a reasonable prudent layperson could perceive the situation as being an emergency" and properly travel to the Mayo Clinic emergency room for treatment.

Furthermore, upon being examined at the Mayo Clinic emergency room, the emergency room doctors concluded that "urgent" admission to St. Mary's Hospital was necessary, so that Mariam's blocked artery could be treated. After being admitted to St. Mary's, Mariam was closely monitored by doctors and she was transitioned off of coumadin and given other medication in order to prepare her for surgery. On May 29, 2003, Mariam underwent surgery to repair her blocked mesenteric artery. Mariam suffered from a deterioration in her condition which, if untreated, could have resulted in loss of life or permanent dysfunction of a body part. Doctors at the Mayo Clinic determined that her immediate hospitalization was required. These circumstances meet the plan definitions of "emergency condition" and "emergency admission/" *See* part III(D) above. Aetna's guidelines for reviewing a claim for emergency services provides:

> If a reasonable prudent layperson could perceive the situation as being an emergency at the time the emergency care was sought, the claim should be considered medically necessary and paid according to contract provisions. . . . Ambiguous situations should be evaluated in favor of the member.

(Record at 544) The Court concludes that Aetna's conclusion that Mariam did not suffer from an "emergency condition" is not supported by substantial evidence. Accordingly, the Court finds that the decision of the plan administrator should be reversed and all benefits owing to Plaintiffs for Mariam's treatment at the Mayo Clinic should be paid.

C. Whether RCI is a Fiduciary

In their Brief in lieu of Trial (docket number 33), Defendants argue that RCI is not a proper party in this case because the Service Agreement between RCI and Aetna

delegated "complete authority to review all denied claims for benefits" to Aetna.[24] Because Aetna was the sole administrator of Plaintiffs' health insurance plan, it would appear that RCI is not a proper party defendant. *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998).[25] At the telephone hearing held on August 22, 2007, however, the parties agreed that a determination on the issue of whether RCI was a fiduciary was unnecessary because judgment would not need to be entered against RCI. The attorney for RCI and Aetna assured Plaintiffs' attorney and the Court that if Aetna was ordered to pay benefits, it would pay the benefits. Plaintiffs' attorney accepted RCI and Aetna's assurances on this issue. Accordingly, the Court will not enter judgment against RCI in its order that benefits be paid to Plaintiffs.

VI. PREJUDGMENT INTEREST AND ATTORNEY FEES AND COSTS

In addition to payment of benefits, Plaintiffs request an award of prejudgment interest on all benefits due and an award of attorney's fees and costs. Defendants do not address either of these requests.

A. Prejudgment Interest

The Eighth Circuit has explained the purposes of prejudgment interest on ERISA awards as follows:

> Prejudgment interest awards are permitted under ERISA where necessary to afford the plaintiff other appropriate equitable relief under section 1132(a)(3)(B). While one purpose of the remedy is to compensate the prevailing party for financial damages incurred, another important purpose is to promote settlement and deter attempts to benefit unfairly from the inherent delays of litigation. A common thread throughout the prejudgment interest cases is unjust enrichment--the wrongdoer

[24] *See* ¶ 8 of the Service Agreement; Record at 8.

[25] *Layes* cites *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) ("The proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan") and *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir. 1988) ("Unless an employer is shown to control administration of a plan, it is not a proper party defendant in an action concerning benefits").

> should not be allowed to use the withheld benefits or retain interest earned on the funds during the time of dispute.

Christianson v. Poly-America, Inc. Medical Benefit Plan, 412 F.3d 935, 941 (8th Cir. 2005) (internal citations and quotations omitted). Because Defendants improperly denied Plaintiffs' claim for benefits, the Court determines that they have been unjustly enriched by withholding benefits and retaining interest earned on funds during the time of the dispute. *See id.* Therefore, the Court will award prejudgment interest on the withheld benefits.

B. Attorney Fees and Costs

Pursuant to 29 U.S.C. § 1132(g)(1), a court may, in its discretion, award reasonable attorney fees and costs to either party under ERISA. 29 U.S.C. § 1132(g)(1).[26] A court considering whether to award attorney fees under ERISA should "'apply its discretion consistent with the purposes of ERISA, those purposes being to protect employee rights and to secure effective access to federal courts.'" *Welsh v. Burlington Northern, Inc., Employee Benefits Plan*, 54 F.3d 1331, 1342 (8th Cir. 1995) (quoting *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1984)). "[A]lthough there is not presumption in favor of attorney fees in an ERISA action, a prevailing plaintiff rarely fails to receive fees." *Starr v. Metro Systems, Inc.*, 461 F.3d 1036, 1041 (8th Cir. 2006). *See also Martin v. Arkansas Blue Cross and Blue Shield*, 299 F.3d 966, 972 (8th Cir. 2002) ("[F]ew, if any, fee awards have been denied a prevailing plaintiff in ERISA cases nationwide. This is true even though nine of the circuit courts of appeals did not employ any kind of presumption in favor of fees. Thus, the absence of a presumption has obviously not doomed ERISA plaintiffs' attorney fee requests."). When determining whether to award fees, the Eighth Circuit has set forth the following five non-exclusive factors for consideration by a court exercising its discretion:

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[26] 29 U.S.C. § 1132(g)(1) provides:

> (1) In any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

> (1) the degree of culpability or bad faith of the opposing party; (2) the ability of the opposing party to pay attorney fees; (3) whether an award of attorney fees against the opposing party might have a future deterrent effect under similar circumstances; (4) whether the parties requesting attorney fees sought to benefit all participants and beneficiaries of a plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

Starr, 461 F.3d at 1041 (citing *Martin*, 299 F.3d at 969 and n.4).

Considering ERISA's remedial nature and the facts of this case, the Court determines that the balance of the above factors weigh in favor of Plaintiffs being awarded attorney fees and costs. Specifically, the Court finds that Defendants have the ability to pay attorney fees and costs, an award of attorney fees may have a future deterrent effect in a similar situation, and Plaintiffs were in the more meritorious position. The precise amount of any such award, however, must be determined in a subsequent order, after the parties have made the appropriate submissions required under the applicable local rules for fee claims.[27]

VII. CONCLUSION

The Court concludes that the plan administrator abused its discretion in denying Plaintiffs' claim for benefits. Therefore, the Court reverses the decision of the plan administrator and orders that all Plaintiffs' claims for benefits be paid. The Court further finds that an award of prejudgment interest on the benefits withheld from Plaintiffs and an award of attorney fees and costs is appropriate.

VIII. ORDER

IT IS THEREFORE ORDERED as follows:

1. Aetna's denial of Plaintiffs' claim for benefits is **REVERSED**, and Plaintiffs are awarded benefits due under the terms of the Plan pursuant to 29 U.S.C. § 1132(a)(1)(B).

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[27] *See* Local Rules 54.1 and 54.2.

2. This matter is **REMANDED** solely for the purpose of calculation by Aetna of the benefits to which Plaintiffs are entitled under the Plan.

3. Plaintiffs shall be awarded prejudgment interest on all past due benefits as further equitable relief pursuant to 29 U.S.C. § 1132(a)(3)(B).

4. Upon appropriate submissions in accordance with applicable local rules, Plaintiffs shall be awarded attorney fees and costs pursuant to 29 U.S.C. § 1132(g)(1).

DATED this 25th day of September, 2007.

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JON STUART SCOLES
United States Magistrate Judge
NORTHERN DISTRICT OF IOWA