UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

HEALTH FIRST HEALTH PLANS, INC.,

Plaintiff,

-vs- **Case No. 6:09-cv-1547-Orl-31GJK**

JEFFREY GLATTER,

Defendant.

ORDER

This matter came before the Court without oral argument upon consideration of Defendant's, Jeffrey Glatter ("Defendant"), Motion to Dismiss (the "Motion") (Doc. 10)[1] and Plaintiff's, Health First Health Plans, Inc. ("Plaintiff"), response in opposition thereto (the "Response") (Doc. 11).

I

Plaintiff brought this Employee Retirement Income Act ("ERISA")[2] case on September 9, 2009, alleging, *inter alia*, that Defendant failed to reimburse it for certain medical care that Defendant received pursuant to a health benefit plan (the "Plan") (Doc. 1). Plaintiff is the health insurer that paid for Defendant's medical care under the Plan.[3] Defendant is a "Covered Person"

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[1]Defendant's Motion was incorporated into his Answer (*see* Doc. 10 at 4-6).

[2]*See generally* 29 U.S.C. §§ 1001 to 1461.

[3]Defendant's employer, Orthopedic and Sports Medicine, is the Plan's administrator. Orthopedic and Sports Medicine is not a party to this action.

and beneficiary of the Plan. Count I of the Complaint purports to state a claim for equitable relief pursuant to 29 U.S.C. § 1132(a)(3). Count II purports to state a claim for breach of fiduciary duty and legal damages pursuant to 29 U.S.C. § 1132(a)(2).

In his Motion, Defendant contends that Count II should be dismissed because he is not a "fiduciary" within the meaning of 29 U.S.C. § 1002(21)(A)(i) (Doc. 10 at 5). The Court addresses this issue, *infra*.

The Court has jurisdiction pursuant to 28 U.S.C. § 1331.

II

On July 4, 2008,[4] Defendant was injured in a car accident (Doc. 1, ¶¶ 14 and 18). Defendant thereafter received approximately $237, 969.46 worth of medical care – all of which was covered and paid for by Plaintiff under the Plan (Doc. 1, ¶¶ 7-8 and 14). However, Defendant also received proceeds from a settlement arising out of a tort claim against the individual who caused the car accident (Doc. 1, ¶ 18).[5]

Plaintiff contends that it should be reimbursed for all of the medical care provided to Defendant because of Defendant's settlement (Doc. 1, ¶¶ 11, 15-19). Specifically, Plaintiff relies on the Plan's "Third Party Liability and Right of Recovery" provision (the Subrogation Provision), which, in pertinent part, provides:

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[4]Plaintiff alleges in paragraph 14 of its Complaint that the accident occurred on "July 4, 2009" (Doc. 1, ¶ 14). However, paragraph 18 alleges that the accident occurred on "July 4, 2008" (Doc. 1, ¶ 18). Based on other allegations in the Complaint, it appears to the Court that the date in paragraph 14 is a typographical error and that the accident allegedly occurred in 2008 – not 2009.

[5]The Complaint does not allege how much Defendant received as a result of the settlement or whether those proceeds where for damages other than the cost of medical care.

> A Covered Person may receive Covered Health Services or other benefits or services in relation to. . .a bodily injury incurred by the Covered Person as a result of the act or omission of an Other Party for which an Other Party may be liable or legally responsible to pay expenses, compensation and/or damages.
>
> An Other Party is defined to include, but is not limited to, any of the following:
>
> > 1. [T]he party or parties who caused the. . .bodily injury . . . .
>
> When Health First Health Plans is obligated to and does pay for or arrange for Covered Health Services that an Other Party is liable or legally responsible to pay for, the Health Plan may:
>
> > 1. [S]ubrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person or his/her legal representative will transfer to Health First Health Plans any rights he/she may have to take legal action arising from the. . .bodily injury to recover any sums paid under the Group Plan on behalf of the Covered Person; and/or
> >
> > > 2. [R]ecover from the Covered Person or his/her legal representative any benefits paid under the Group Plan on the Covered Person's behalf out of the recovery made from the Other Party (whether by lawsuit, settlement, or otherwise).
>
> The Covered Person and his/her legal representative must cooperate fully with Health First Health Plans in regards to subrogation and recovery rights . . . .
>
> Health First Health Plans will have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the Covered Person receives or is entitled to receive from an Other Party . . . .

(Doc. 1, Ex. D).

III

A

In ruling on a motion to dismiss, the Court must view the complaint in the light most favorable to the Plaintiff, *see, e.g.*, *Jackson v. Okaloosa County, Fla.*, 21 F.3d 1531, 1534 (11th Cir. 1994), and must limit its consideration to the pleadings and any exhibits attached thereto.

FED. R. CIV. P. 10(c); *see also GSW, Inc. v. Long County, Ga.*, 999 F.2d 1508, 1510 (11th Cir. 1993). The Court will liberally construe the complaint's allegations in the Plaintiff's favor. *Jenkins v. McKeithen*, 395 U.S. 411,421 (1969). However, "conclusory allegations, unwarranted factual deductions or legal conclusions masquerading as facts will not prevent dismissal." *Davila v. Delta Air Lines, Inc.*, 326 F.3d 1183, 1185 (11th Cir. 2003).

In reviewing a complaint on a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), "courts must be mindful that the Federal Rules require only that the complaint contain 'a short and plain statement of the claim showing that the pleader is entitled to relief.'" *U.S. v. Baxter Intern., Inc.*, 345 F.3d 866, 880 (11th Cir. 2003) (citing FED. R. CIV. P. 8(a)). This is a liberal pleading requirement, one that does not require a plaintiff to plead with particularity every element of a cause of action. *Roe v. Aware Woman Ctr.for Choice, Inc.*, 253 F.3d 678, 683 (11th Cir. 2001). However, a plaintiff's obligation to provide the grounds for his or her entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 554-555 (2007). The complaint's factual allegations "must be enough to raise a right to relief above the speculative level," *Id*. at 555, and cross "the line from conceivable to plausible." *Ashcroft v. Iqbal*, __ U.S. __, 129 S. Ct. 1937, 1950-1951 (2009).

B

A person is a "fiduciary" with respect to a plan covered by ERISA to the extent that:

> (i) he exercises any discretionary authority or discretionary control respecting management of [the] plan or exercises any authority or control respecting management or disposition of its assets;

> (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of [the] plan, or has any authority or responsibility to do so, or
>
> (iii) he has any discretionary authority or discretionary responsibility in the administration of [the] plan . . . .

29 U.S.C. § 1002(21)(A).

Notwithstanding the broad remedial purposes of ERISA, a person will not be attributed fiduciary status and held accountable for performance of the strict responsibilities inherent in that role unless he is "clearly aware of his status as a fiduciary . . . ." *ITPE Pension Fund v. Hall*, 334 F.3d 1011, 1015 (11th Cir. 2003). Accordingly, "without clear contractual language it is improper to impute fiduciary responsibility." *Id*.

IV

As a plan beneficiary who received settlement proceeds from a third party tortfeasor, Defendant contends that he is not a fiduciary (Doc. 10 at 5, citing, *inter alia*, *Chapman v. Klemick*, 3 F.3d 1508 (11th Cir. 1993)). According to Defendant, this conclusion follows as a matter of law because settlement proceeds are not "plan assets" within the meaning of ERISA. However, even if the settlement proceeds are plan assets, Defendant further contends that the Subrogation Provision does not clearly apprise Defendant of his fiduciary status. Accordingly, Defendant argues that Count II must be dismissed.

Plaintiff responds by contending that the settlement proceeds are the Plan's assets because the Subrogation Provision complies with the Supreme Court's decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006) (Doc. 11 at 4). Furthermore, Plaintiff contends that the contractual language in the Subrogation Provision is clear and unambiguous (Doc. 11 at 6).

Plaintiff appears to concede, however, that if the settlement proceeds are not the Plan's assets, then Defendant is not a fiduciary within the meaning of 29 U.S.C. § 1002(21)(A) (Doc. 11 at 3-4).

Upon review, Defendant's Motion is well taken. First, nothing in the Subrogation Clause identifies a recovery from a third party as an "asset" of the Plan. On the contrary, the clause simply sets forth, *inter alia*, the Plaintiff's contractual right to reimbursement. As the Eleventh Circuit has observed, that right does not "automatically convert" the settlement proceeds from a third party tortfeasor into an asset of an ERISA plan. *Chapman*, 3 F.3d 1508, 1510 (11th Cir. 1993). Second, Plaintiff's reliance on *Sereboff* is misplaced. That case arose under 29 U.S.C. § 1132(a)(3) and was solely concerned with the right of an ERISA administrator to obtain equitable relief pursuant to a subrogation clause – not a right to legal damages for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2). *Sereboff*, 547 U.S. 356, 361 (2006).

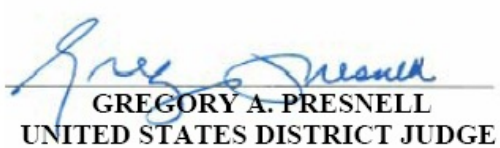
Accordingly, the Court concludes that, as a matter of law, the proceeds from Defendant's settlement are not assets of the Plan and Defendant is not a fiduciary within the meaning of 29 U.S.C. § 1002(21)(A).

V

For the foregoing reasons, it is **ORDERED** that Defendant's Motion to Dismiss (Doc. 10) is **GRANTED**. Count II of the Complaint is hereby **DISMISSED** with prejudice.

DONE and **ORDERED** in Chambers, Orlando, Florida on October 15, 2009.

Copies furnished to:



GREGORY A. PRESNELL
UNITED STATES DISTRICT JUDGE

Counsel of Record
Unrepresented Party