IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM SPARKS	:	CIVIL ACTION
	:	
v.	:	
	:	
DUCKREY ENTERPRISES, INC.	:	
HEALTH ADMINISTRATORS, et al.	:	NO. 05-2178

MEMORANDUM AND ORDER

McLaughlin, J. January 30, 2007

William Sparks ("Sparks") has sued Duckrey Enterprises, Inc. ("Duckrey"), Health Administrators, Inc. ("HAI"), and Safeco Life Insurance Co. ("Safeco") to recover medical benefits that are allegedly due under the plaintiff's employee benefit plan. HAI and Safeco have each moved to dismiss four of the complaint's six counts and for summary judgment on the remaining two counts. The plaintiff has moved to compel production of documents from Safeco. The Court will grant the defendants' motions to dismiss and for summary judgment. The Court will deny the plaintiff's motion to compel as moot.

I. BACKGROUND

The plaintiff initiated this action in the Court of Common Pleas of Delaware County on April 3, 2005, alleging a variety of state law claims against Duckrey, Devon Health Services ("Devon") and Trustmark Corporation ("Trustmark"). On

May 6, 2005, the defendants removed this action and shortly thereafter filed motions to dismiss. The plaintiff opposed these motions and moved for leave to amend his complaint. The Court denied the defendants' motions to dismiss without prejudice and granted the plaintiff's motion for leave to amend on July 11, 2005.

The plaintiff's amended complaint consisted of two claims brought under the Employee Retirement Income Security Act ("ERISA"), as well as four "pendent" state law claims. Between July 2005 and May 2006, Devon and Trustmark were dismissed, and HAI and Safeco were joined. Despite this change in parties, the complaint remained virtually unchanged, comprising the following six counts:

I. Breach of the ERISA statute for failure to provide benefits due

II. Breach of fiduciary duties imposed by ERISA for failure to properly and timely process the plaintiff's medical claims

III. Breach of contract against Duckrey for failure to pay for the plaintiff's health insurance coverage

IV. Breach of contract against all defendants for failure to pay for the plaintiff's medical care

V. Fraud for misrepresenting benefits provided through the plaintiff's health plan

VI. Violation of Pennsylvania's Consumer Protection Act for failure to provide health insurance coverage

These claims arise from medical services provided to the plaintiff by Crozer Chester Medical Center ("Crozer") for injuries the plaintiff sustained during a home invasion that occurred on November 30, 2002. Following the attack, the plaintiff was taken to Crozer, where he remained for the next twenty two days, the first seventeen of which the plaintiff spent in a coma. This medical treatment caused the plaintiff to incur healthcare bills that totaled approximately $451,000. At the time of the injury and subsequent treatment, the plaintiff was employed by Duckrey, which provided him with healthcare benefits through the Duckrey Enterprises, Inc., Employee Health Benefit Plan ("the Plan").

A. The Plan

The Plan was a self-funded employee benefit plan sponsored by Duckrey. Being self-funded, the Plan paid benefits directly from employee contributions and from the assets of Duckrey. According to the plan document, the "Plan Administrator" had the sole and final authority to control and manage the operation and administration of the Plan. As such, the Plan Administrator had the authority to amend the Plan, determine policies, and contract with excess loss carriers and utilization review administrators. The Plan Administrator may, however, delegate certain responsibilities to the "Benefit Services Manager." The "Benefit Services Manager" could provide

services in connection with the operation and benefit administration of the Plan, including processing and payment of claims, providing records and statistics on the Plan's operation and such other functions as may be delegated.

According to the summary plan description, the Plan was administered through the human resources department of Duckrey. Exercising its power as the "Plan Administrator," Duckrey retained HAI as the "Benefit Services Manager" to provide independent services in the area of claims processing. HAI served as Duckrey's "Benefit Services Manager" from May of 2000 until February 28, 2003, when Duckrey terminated HAI. Upon termination, Duckrey and HAI negotiated a three-month "run-out" period, during which time HAI would process claims for services provided prior to February 28, 2003, that were submitted after the termination date.

Under the contract between HAI and Duckrey, Duckrey retained all final authority and responsibility for the administration and operation of the Plan as its named fiduciary within the meaning of § 402(a) of ERISA. The contract also obligated Duckrey to furnish HAI with a detailed description of the Plan, determine the claims administration procedures and practices that were not self-evident from the Plan, and assist HAI in determining eligibility of participants to receive benefits.

HAI, on the other hand, was obligated to prepare the plan document and summary plan description, apply the rules for determining participant eligibility for benefits, determine the qualification of claims submitted, make payments to participants from an account funded by Duckrey, review with Duckrey any disputed claims, report to Duckrey matters of general interest to the Plan and submit to Duckrey a monthly accounting of payments made.[1] In short, HAI would make an initial determination of

[1] More specifically, the contract between Duckrey and HAI stated that HAI would undertake the following seventeen obligations: (i) prepare the plan document; (ii) prepare and print descriptive booklets for participants; (iii) follow claims administration procedures and practices established by Duckrey and provide recommendations to Duckrey with respect to plan administration; (iv) provide infrastructure to facilitate the administration of claims within the framework established under the Plan; (v) with the assistance of Duckrey, apply the rules determining eligibility of participants; (vi) determine the qualification of claims submitted, making such investigation as may be necessary under the plan and generally accepted claims administration procedures and practices; (vii) pay any amounts due with respect to claims that qualify under the plan from the benefit plan account funded by Duckrey; (viii) review with Duckrey any disputed claims; (ix) refer to Duckrey any claim or class of claims Duckrey specifies; (x) furnish Duckrey with information that Duckrey deems essential with respect to the plan and procedures thereunder; (xi) report to Duckrey annually matters of general interest with respect to the plan; (xii) submit to Duckrey a monthly accounting of payments made; (xiii) submit to Duckrey an annual accounting of payments to participants and dependants; (xiv) indemnify Duckrey and hold it harmless from harm resulting from the dishonest, fraudulent or criminal acts of HAI's employees; (xv) prepare statistical reports relative to the plan's performance and provider patterns; (xvi) notify participants of their rights to continue benefits under COBRA and process such claims; and (xvii) provide certificates of creditable coverage for all employee and/or dependent terminations reported by Duckrey in compliance with HIPAA.

whether a claim were covered by the Plan. It would then submit this determination to Duckrey, and Duckrey would, in turn, review HAI's determination. If Duckrey agreed that a claim were covered, Duckrey would place funds into the benefit plan account from which HAI would forward payment to the healthcare provider.

If a claim were denied, a participant could submit a written appeal to Duckrey. In reviewing these appeals, Duckrey had the authority to interpret Plan provisions and resolve factual issues. Its decision was final.

In addition to engaging HAI as the Plan's benefit services manager, Duckrey purchased excess loss insurance for the Plan from Safeco. Under the excess loss contract, Safeco would reimburse the Plan for covered expenses that exceeded a $20,000 per-participant deductible. Before reimbursing the Plan, Safeco required Duckrey or its benefit services manager to process the claims in order to verify the claims' eligibility for coverage. Safeco would then review the claims once more to verify that they fell within the contours of the Plan. Once satisfied that the claim was covered by the Plan, Safeco would reimburse the Plan for covered expenses exceeding the $20,000 deductible.

The policy also included an advance funding amendment whereby Safeco would advance funds to the Plan for certain covered expenses that exceeded the $20,000 individual deductible. To obtain advance funding pursuant to this amendment, Duckrey

needed to show that the individual deductible had been met and that the claims had been fully processed and ready for payment within the payment period that applied to the excess loss contract and according to the terms of the Plan document. All covered expenses had to be paid within five days of receiving the advance funding. If such payment were not made, the advance funds would need to be returned to Safeco.

Under the Plan, all hospitalizations required pre-certification through the plan's utilization review manager, United Review. This pre-certification had to be obtained at least five days in advance of services being rendered or within forty eight hours after an emergency hospitalization. Failure to obtain this certification would result in a fifty percent reduction to the covered hospital expenses approved by the Plan.

B. The Plaintiff's Attempts to Obtain Coverage

Upon arrival at Crozer on November 30, 2002, the plaintiff's injuries prevented him from presenting his health insurance card to the hospital or in any way communicating the fact that he possessed health coverage. Crozer consequently admitted the plaintiff as a self-pay client.

On May 2, 2003, the plaintiff returned to Crozer and presented his health insurance card to Heather Martin, a hospital employee. That day, Ms. Martin used a number on the back of the card to contact HAI in an effort to obtain preauthorization for

the plaintiff's hospitalization. HAI informed Ms. Martin that retroactive preauthorization would not be provided. HAI also informed Ms. Martin that the plaintiff was eligible for coverage but that an appeal would be necessary to submit billing.

In the following days, Ms. Martin prepared an appeal letter, gathered the documents necessary to file an appeal and mailed the entire package to HAI. HAI received the appeal documents on May 12, 2003, and forwarded them to United Review, the Plan's utilization review manager. Ms. Martin called HAI on May 28, 2003, and was told that HAI still had not heard back from United Review. At that time, HAI also informed Ms. Martin that HAI's term as third party administrator was to run out on June 1, 2003, and as such, HAI could not address the appeal after that date. Finally, HAI instructed Ms. Martin to call United Review to determine whether the review could be completed by the run-out date. It is unclear whether Ms. Martin ever called United Review.

Ms. Martin communicated this information to Susan Boyle, Crozer's Corporate Director of Patient Access/Patient Financial Services. Seeing the urgency of the situation, Ms. Boyle instructed the appropriate Crozer employees to prorate the account in order to assemble a bill so that once authorization was received from United Review, the bill could be submitted

immediately. On May 30, 2003, the bill was transmitted to Ms. Martin. There is no record of what Ms. Martin did with the bill.

On June 6, 2003, another Crozer employee, Laurine Ucciferru followed up with HAI and was asked to fax the bill to HAI. Ms. Ucciferru complied by faxing the bill to HAI later that day. On June 30, 2003, Ms. Ucciferru called HAI once again and was told that there had been no response from United Review. On July 3, 2003, Ms. Boyle called Duckrey to secure assistance in getting the bill paid. Duckrey never returned Ms. Boyle's call, and the hospital bills remain unpaid.

In his deposition, the plaintiff stated that as a result of his non-payment, Crozer has reported him to collection agencies and has refused to admit him to its emergency room. The plaintiff has not, however, paid any medical bills, and Crozer has stated that it will not seek any such payment, given the plaintiff's income status.

II. THE DEFENDANTS' MOTIONS TO DISMISS

A. Standard of Review

In considering a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6), the Court accepts as true all allegations in the complaint and all reasonable inferences that can be drawn from them, after viewing the allegations in the light most favorable to the non-moving party. Taliaferro v. Darby Twp. Zoning Bd., 458 F.3d 181, 188 (3d Cir. 2005). A Rule

12(b)(6) motion should be granted if it appears to a certainty that no relief could be granted under any set of facts that could be proved. Id.

B. Analysis

HAI and Safeco have both moved to dismiss Counts III through VI of the plaintiff's complaint on the ground that these claims are preempted by ERISA. The Court will grant the defendants' motions.

In enacting ERISA, Congress set forth a comprehensive scheme for regulating employee welfare benefit plans that provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987); 29 U.S.C. § 1002(1) (2006). As part of this undertaking, Congress included preemption provisions that are deliberately expansive and designed to "establish pension plan regulation as exclusively a federal concern." Pilot Life, 481 U.S. at 45 (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981)). Under these provisions, if a state common law or statutory cause of action "relates to" employee benefit plans, it is preempted, unless the law "regulates insurance." Id.; 29 U.S.C. §§ 514(a) & 514(b)(2)(a) (2006).[2] The Supreme Court has read the phrase "relates to"

[2] ERISA also includes the so-called "deemer clause," which prevents state laws purporting to regulate insurance from deeming

according to its broad, common-sense meaning, such that a state law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. Pilot Life, 481 U.S. at 47 (citing Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985)). The Supreme court has concluded that the phrase "regulates insurance" should also be given its common-sense meaning, such that a law must have more than just an impact on the insurance industry; it must be specifically directed toward that industry in order to avoid ERISA's broad preemption provisions. Id. at 50.

In Pilot Life, the Supreme Court examined whether these broad preemption provisions preempt common law tort and breach of contract claims that are based on alleged improper processing of claims for benefits under an ERISA plan. Id. at 43. In holding that these common law claims undoubtedly met the criteria for preemption, the Supreme Court noted that Congress intended ERISA's civil enforcement provisions to be the exclusive vehicle for actions by ERISA-plan participants asserting improper processing claims. Id. at 52. More recently in Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004), the Supreme Court added to this holding by stating that any state law claim that duplicates,

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an employee benefit plan an insurance company. Pilot Life, 481 U.S. at 45; 29 U.S.C. § 514(b)(2)(B) (2006). This provision of ERISA is not relevant to the case at hand because none of the state laws under which the plaintiff sues purports to regulate insurance.

supplements or supplants ERISA's civil enforcement remedies is preempted. Id. at 209.

In the case at hand, the plaintiff's state law claims relate to an ERISA-controlled employee benefit plan and therefore fall under ERISA's express preemption clause. First, the plaintiff pleads, and the defendants admit, that the plaintiff was a participant in an ERISA plan. And second, the state law claims all relate to the alleged improper processing of a claim for benefits under that plan: Counts III and IV allege that the defendants breached their contracts with the plaintiff by failing to pay for his medical care; Count V alleges that the defendants committed fraud by misrepresenting the benefits that would be provided to the plaintiff under the plan; and Count VI alleges that the defendants violated Pennsylvania's Unfair Trade Practices and Consumer Protection Law by failing to provide healthcare coverage. Because these state law claims would duplicate, supplement and/or supplant the statutory remedies provided under ERISA's civil enforcement scheme, they are preempted, unless the laws under which they are brought "regulate insurance."

None of the laws under which the plaintiff's claims are brought regulates insurance. Common law claims for breach of contract and fraud are not specifically directed toward the insurance industry. Likewise, Pennsylvania's Unfair Trade

Practices and Consumer Protection Law applies to all natural persons and all legal entities that engage in any of the enumerated "unfair methods of competition" or "unfair or deceptive acts or practices." 73 Pa. Cons. Stat. § 201-2(2) & (4) (2006). These laws therefore do not regulate insurance and are not saved from preemption.

Because the laws under which Counts III through VI arise relate to employee benefit plans and do not regulate insurance, these counts are preempted by ERISA and therefore will be dismissed.

III. THE DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

A. Standard of Review

Federal Rule of Civil Procedure 56 provides that summary judgment may be granted if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c) (2006). An issue is genuine if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). When considering a motion for summary judgment, a court must review the record in the light most favorable to the non-moving party, who is entitled to all

reasonable inferences that can be drawn therefrom. Merkle v. Upper Dublin School Dist., 211 F.3d 782, 788 (3d Cir. 2000).

B. Analysis

1. Count I: Failure to Provide Benefits Due

HAI and Safeco have both moved for summary judgment on Count I of the plaintiff's complaint, which seeks payment of benefits due.[3] HAI argues that it is entitled to summary judgment because (i) it had no responsibility to pay claims submitted by the participants in Duckrey's plan, (ii) it never received a claim for healthcare services, and (iii) the plaintiff has failed to establish damages. Safeco argues that it is entitled to summary judgment because its only obligations were to Duckrey. The Court will grant the defendants' motions to dismiss because neither HAI nor Safeco is a proper defendant to the plaintiff's claim.

It is undisputed that under § 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)), a plan participant may bring a civil action to recover benefits due to him under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B) (2006). The circuits are split, however, as to who constitutes a proper defendant to such an

[3]This claim is presumably brought under 29 U.S.C. § 1132(a)(1)(B), which offers the only statutory basis for the plaintiff's claim of "failure to provide benefits due." This section of ERISA states, in relevant part, "A civil action may be brought by a participant...to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B) (2006).

action. The United States Court of Appeals for the Ninth Circuit, for example, has concluded that the plan itself constitutes the only proper defendant to an action brought under § 502(a)(1)(B). Gelardi v. Pertec Computer Corp. 761 F.2d 1323, 1324-25 (9th Cir. 1985). The United States Court of Appeals for the Eighth Circuit, on the other hand, has held that the plan, as well as other entities such as the plan administrator, may be proper defendants to such an action. Hall v. Lhaco, Inc., 140 F.3d 1190, 1196 (8th Cir. 1998).

The United States Court of Appeals for the Third Circuit has never directly addressed the issue of who constitutes a proper defendant to a § 502(a)(1)(B) claim, and district courts in the circuit are divided. One set of district courts has held that the plan itself is the only proper defendant. E.g., Hall v. Glenn O. Hawbaker, Inc., No. 4:06-CV-1101, 2006 WL 3250869, at *9 (M.D. Pa. Nov. 8, 2006). The other set has held that both the plan and its fiduciaries are proper defendants. E.g., Briglia v. Horizon Healthcare Serv., Inc., No. Civ.A. 03-6033, 2005 WL 1140687, at *5 (D.N.J. May 13, 2005).

District courts holding that the plan itself constitutes the only proper defendant typically rely on the language of § 502(d)(2) of ERISA in arriving at their conclusion. See, e.g., Hall, 2006 WL 3250869, at *9; see also Guiles v. Metro. Life Ins. Co., No. CIV.A. 00-5029, 2002 WL 229696, at *1

(E.D. Pa. Feb 13, 2002). Section 502(d)(2) reads, "[a]ny money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter." 29 U.S.C. § 1132(d)(2) (2006). According to these courts, the language of §§ 502(a)(1)(B) and 502(d)(2), read together, "clearly and unambiguously provides that the plan is the only entity against whom claims for benefits under the plan may be brought." Guiles, 2002 WL 229696, at *1.

District courts holding that both the plan and its fiduciaries constitute proper defendants rely instead on the holding of Curcio v. John Hancock Mutual Life Insurance Co., 33 F.3d 226 (3d Cir. 1994). See, e.g., Tylwalk v. Prudential Ins. Co., No. Civ.A. 2004-222J, 2006 WL 2815806, at *3 (W.D. Pa. Sept. 28, 2006). In Curcio, the United States Court of Appeals for the Third Circuit held that a claim brought under § 502(a)(3)(B) of ERISA (29 U.S.C. § 1132(a)(3)(B)) can be brought against either the plan itself or against a fiduciary thereof.[4] Id. at 233-35. Many district courts have subsequently cited this holding for the proposition that the proper defendants to a claim brought under §

[4]Section 1132(a)(3)(B) states, in relevant part, that "A civil action may be brought to obtain other appropriate equitable relief (i) to redress [any act or practice which violates any provision of this subchapter or the terms of the plan], or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3)(B) (2006).

502(a)(1)(B), like claims brought under § 502(a)(3)(B), are the plan itself and its fiduciaries. Tylwalk, 2006 WL 2815806, at *3; Briglia, 2005 WL 1140687, at *7; Cimino v. Reliance Standard Life Ins. Co., No. Civ.A. 00-2088, 2001 WL 253791, at *3 n.2 (E.D. Pa. March 12, 2001); Moore v. Hewlett-Packard Co., No. Civ. 99-2928, 2000 WL 361680, at *4 (E.D. Pa. April 6, 2000); Vaughn v. Metro. Life Ins. Co., 87 F. Supp. 2d 421, 425 (E.D. Pa. 2000).

This Court need not, however, decide between these two differing viewpoints. Assuming that both the plan and its fiduciaries are proper defendants to a § 502(a)(1)(B) claim, neither HAI nor Safeco can be held liable because neither party is a fiduciary of the Duckrey Plan.

ERISA defines "fiduciary" as any person[5] who exercises discretionary control or authority over the plan's management, administration or assets.[6] 29 U.S.C. § 1002(21)(A) (2006).

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[5]ERISA's definition of a "person" extends to corporations. See 29 U.S.C. § 1002(9) (2006).

[6]In relevant part, ERISA provides that "a person is a fiduciary to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such 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 such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A) (2006). ERISA also provides that a fiduciary is any person who is named as such in the plan document. 29 U.S.C. § 1102(a) (2006). Neither HAI nor Safeco is named as a fiduciary in the plan document.

According to the United States Court of Appeals for the Third Circuit, the linchpin of fiduciary status is discretion. Curcio, 33 F.3d at 233. Consequently, persons who perform purely ministerial tasks, such as claims processing and calculation, cannot be fiduciaries because they do not have discretionary roles. Confer v. Custom Engineering Co., 952 F.2d 34, 39 (3d Cir. 1991).

Courts typically find that defendants who exercise control over plan interpretation and final authority over eligibility determinations possess the requisite discretion to qualify as plan fiduciaries. See, e.g., Vaughn, 87 F. Supp. 2d at 426-27. In Vaughn, for example, the court found that the defendant was a plan fiduciary where it had the responsibility to interpret the plan and make all final determinations as to when benefits were payable for particular claims. Id. at 426. In coming to this conclusion, the court relied heavily on the fact that all decisions made by the defendant were final. Id. In Universal Health Services, Inc. v. Aetna, Inc., No. 2:03-CV-02235-CG, 2003 WL 22016914, at *4 (E.D. Pa. July 8, 2003), the court likewise found that the defendant was a plan fiduciary where the defendant exercised sole and complete authority to determine plan eligibility. Id. at *4. The court also noted that the defendant exercised complete authority and

responsibility for the plan, its operations and the benefits provided thereunder. Id. at *4 n.7.

In contrast, courts typically find that defendants who merely perform administrative services in conformance with plan rules do not possess the requisite discretion to qualify as plan fiduciaries. See, e.g., Confer, 952 F.2d at 39. In Confer, for example, the court found that a defendant who was hired to draft an ERISA plan, handle claims thereunder and administer the plan on a day-to-day basis nevertheless lacked the requisite discretion to qualify as a plan fiduciary because the defendant was obligated to follow plan specifications in all its actions. See id. In Mulder v. PCS Health Systems, Inc., 432 F. Supp. 2d 450 (D.N.J. 2006), the court likewise found that a defendant who was hired to process claims was not a plan fiduciary because the defendant simply followed the plan's specifications in performing its duties. Id. at 455-56. The court reached this decision despite the fact that the defendant designed, implemented and administered the claims processing system. Id. at 456.

In the case at hand, neither HAI nor Safeco possessed the requisite discretion over administration or management of Duckrey's plan to qualify as a plan fiduciary. Like the defendants in Confer and Mulder, HAI simply provided claims processing services according to the specifications of the Plan.

Under the benefit services agreement, HAI did not undertake any responsibility to pay claims out of its own funds, and Duckrey retained all final authority and responsibility for the administration and operation of the Plan. Indeed, appeals from claim denials had to be submitted to Duckrey, whose decision was final. Although HAI prepared the Plan's document and summary description, Confer makes clear that this action is insufficient to elevate HAI to the level of plan fiduciary.

Safeco likewise lacked the requisite discretion over administration or management to qualify as a plan fiduciary. Although Safeco reviewed claims for reimbursement, it did so simply to ensure that the claims comported with the Plan's specification before reimbursing the Plan or advancing funds to the Plan. This review had no effect on a determination of whether participants in the Plan were actually entitled to benefits under the Plan. Indeed, Safeco's decision of whether to reimburse the Plan or advance funds to it would necessarily come after the Plan had already made the separate and unrelated determination of whether benefits were due.

Possessing no discretion over the administration or management of the Plan, HAI and Safeco are not plan fiduciaries and therefore constitute improper defendants to the plaintiff's claim in Count I.

2. Count II: Breach of Fiduciary Duty

HAI and Safeco have both moved for summary judgment on Count II of the plaintiff's complaint, which seeks recovery for an alleged breach of fiduciary duty. The Court will grant the motions.

In Bixler v. Central Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292 (1993), the United States Court of Appeals for the Third Circuit recognized that a participant in an employee benefit plan may bring a direct cause of action for breach of fiduciary duty under § 502(a)(3) of ERISA. Id. at 1298. As discussed above, however, neither HAI nor Safeco is a plan fiduciary. The plaintiff therefore cannot succeed on a claim for breach of fiduciary duty against either defendant.

IV. THE PLAINTIFF'S MOTION TO COMPEL

The plaintiff has moved to compel production of documents from Safeco. The plaintiff seeks documents that describe the procedures HAI and/or Duckrey were required to follow when providing Safeco with notice of claims that may be eligible for reimbursement or advance funding. As discussed above, however, Safeco's review of eligibility determinations had no effect on whether participants in the Plan were actually entitled to benefits. The procedures whereby Safeco would learn of claims that may be eligible for reimbursement or advance funding are therefore irrelevant to a determination of whether

HAI or Safeco constituted a plan fiduciary. The Court accordingly denies the plaintiff's motion to compel as moot.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM SPARKS	:	CIVIL ACTION
	:	
v.	:	
	:	
DUCKREY ENTERPRISES, INC.	:	
HEALTH ADMINISTRATORS, et al.	:	NO. 05-2178

ORDER

AND NOW, this 30th day of January, 2007, upon consideration of the defendants' motions to dismiss and for summary judgment (Doc. Nos. 83 & 107) and the plaintiff's motion to compel (Doc. No. 113), IT IS HEREBY ORDERED that:

1. Safeco's motion to dismiss and for summary judgment (Doc. No. 83) is GRANTED. JUDGMENT IS HEREBY ENTERED for defendant Safeco and against the plaintiff.

2. HAI's motion to dismiss and for summary judgment (107) is GRANTED. JUDGMENT IS HEREBY ENTERED for defendant HAI and against the plaintiff.

3. The plaintiff's motion to compel (Doc. No. 113) is DENIED as moot.

4. The plaintiff shall inform the Court on or before February 16, 2007, whether and how he plans to proceed against Duckrey, the only defendant remaining in this case.

BY THE COURT:

/s/ Mary A. McLaughlin
MARY A. McLAUGHLIN, J.