State of South Carolina | Form 4 | Judgment in a Civil Case

County of Florence County

2006 CP-21- 292

Carolina Care Plan

CERTIFIED: A TRUE COPY
CLERK OF COURT C.P & G.S.
FLORENCE COUNTY, S.C.

Anddie Brown Auto Sales of Florence, Inc.

Plaintiff(s)

Defendant(s)

Check one:

( ) **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

( ) **DECISION BY THE COURT** This action came to trial or hearing before the court. The issues have been tried or heard and decision rendered.

( ) **ACTION DISMISSED** (CHECK REASON): ( ) Rule 12(b), SCRCP; ( ) Rule 41 (a), SCRCP (Vol. Nonsuit) ; ( ) Rule 43(k), SCRCP (Settled) ; ( ) Other _____

( ) **ACTION STRICKEN** (CHECK REASON) : ( ) Rule 40(j) SCRCP; ( ) Bankruptcy; ( ) Binding arbitration, subject to right to restore to confirm, vacate modify arbitration award; ( ) Other _____

IT IS ORDERED AND ADJUDGED: (✓) See attached order; ( ) Statement of Judgment by the court:

FILED
2008 JUN 20 PM 4:00

Dated at Florence, South Carolina, this _____ day of _____ 2008.

PRESIDING JUDGE

This judgment was entered on the 19 day of June 2008, and a copy mailed first class this 23 day of June 2008, to attorneys of record or to parties (when appearing pro-se) as follows:

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CONNIE REEL-SHEARIN
Florence County Clerk of Court

SCRCP APP-24

SCRCP FORM 4 (REVISED 5/00

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	
Carolina Care Plan, Inc.,	)	Case No.: 2006-CP-21-292
	)	
Plaintiff,	)	
	)	
v.	)	**ORDER**
	)	
Auddie Brown Auto Sales of Florence, Inc.,	)	
	)	
Defendant.	)	

OVERVIEW

Plaintiff is a health maintenance organization which provided health insurance to the Defendant which is an automobile dealership. The insurance was provided in connection with an ERISA governed group employee benefit policy (hereinafter "the plan" or "the policy") established by Defendant for its eligible employees. According to the testimony, Plaintiff was the insurer of the plan continuously from some point in 1997 until some point in 2006. During 2003, an individual named Gloria Follett (hereinafter "Follett") became covered under the plan. From the point at which she became covered in 2003 through June 2004, Follett worked for Defendant, although she took time off due to illness. Follett last actively worked for Defendant in June of 2004. Defendant paid premiums for coverage for Follett continuously from the point at which she originally became covered in 2003 through December 31, 2005. At some point shortly before or about December 2005, Plaintiff discovered that Follett had not actively worked for Defendant since June 2004 and Plaintiff demanded that Defendant reimburse Plaintiff for approximately $650,000.00 in insurance benefits that Plaintiff had paid to various medical providers for services rendered to Follett during a period Plaintiff contends Follett was not

entitled to coverage. When Defendant refused the demand, Plaintiff filed this action. Plaintiff alleges that it is entitled to recover damages against the Defendant in an amount equal to insurance benefits it paid out for services rendered to Follett during the relevant period less what it has already recouped from medical providers on its own. Plaintiff alleged two causes of action in its complaint, those being (1) for breach of contract and (2) for negligent misrepresentation. The court heard testimony and considered evidence at a day long non-jury trial on May 22, 2008. At the close of the evidence, the parties made their respective arguments. For the reasons that follow, the court holds that the Plaintiff is not entitled to any recovery, that judgment for the Defendant shall be entered and the Plaintiff's case is dismissed with prejudice.

FINDINGS OF FACT

The Plan Document

1. The document governing the legal relationship between the parties is the "group policy" document (and referenced attachments) constitute the contract between the parties. The group policy states:

> "6.1 *Entire Policy*
> The group Policy, including the Certificate of Coverage as Attachment A, the application of the Enrolling Group, Amendments and Riders shall constitute the entire Policy between parties."

(This collection of documents will collectively be referred to in this order as "the plan document".)

CCP drafted the plan document.

2. The plan document specifically states that it is governed by the law of the State of South Carolina and the federal law of ERISA.

3. Under the heading "Who Is Eligible For Coverage?", the plan document specifies that an "eligible person":

". . . usually refers to an employee . . . who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see (Section 10: Glossary of Defined Terms).

• • •

Eligible Employees must be Actively at Work (*i.e.*, regularly working 30 hours or more per week as seen below) with their Employer. For a complete definition of Actively at Work (Section 10: Glossary of Defined Terms).

Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission."

4. The plan document has relevant "defined terms" as follows.

a. "***Actively at Work*** – You are considered Actively at Work when the following requirements apply:

- You are regularly working at least 30 hours per week."

The word "regularly" is not defined in the plan document.

b. "***Eligible Person*** – an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside and/or work within the Service Area."

c. "***Subscriber*** – an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group."

5. The plan document specifies that Plaintiff and Defendant "determine who is eligible to enroll under the policy."

6. The plan document specifies that certain events terminate a participant's coverage. One of the events is when "You Are No Longer Eligible". In that regard, the policy specifies

"Your coverage ends on the date identified in the Policy you are no longer eligible to be a Subscriber . . . . Please refer to (Section 10: Glossary of

Defined Terms) for a more completed definition of the terms "Eligible Person", "Subscriber", "Dependent" and "Enrolled Dependent".

So when a person either terminates or fails to "regularly" work 30 hours a week that person loses eligibility to be covered under the plan. However, the plan document specifies that coverage continues to the last day of the month in which eligibility ceases.

7. The plan document also cites to COBRA (29 U.S.C. § 1161, *et. seq.*) setting forth that if a person's coverage is terminated because of a "qualifying event" that continuation coverage can extend for "18 months from the date continuation began".

8. The plan document specifically obligates Plaintiff as follows:

> "6.13 *Continuation Coverage*
> We agree to provide coverage under the Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in Section 8 of the Attachment A, Certificate of Coverage."

9. The plan document specifies, in at least two different places, that Plaintiff has a right to request any information it desires from Defendant anytime including "payroll records".

10. The plan document specifies:

> "6.7 *ERISA*
> When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C., 1001 *et. seq.*, We (Plaintiff) shall not be named as, and shall not be, the Plan Administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA."

11. The plan document specifies that Plaintiff has a right to seek reimbursement of benefits wrongly paid, as it alleges in the matter *sub judice*, as follows:

> "**Article 4: Enrollment and Eligibility**

Enrollments, terminations, changes to coverage classifications and other changes must be submitted on Our (Plaintiff) approved Enrollment Application or Change Form and signed and dated by the Enrolling Group's Benefit Administrator within 31 days of the effective date.

The signature of the Enrolling Group's Benefit Administrator certifies that the information is complete and accurate. Omissions or incorrect information knowingly submitted may invalidate coverage and result in a demand that the Enrolling Group reimburse Us for any and all healthcare benefit payments previously paid."

The "Resource Manual"

12. Plaintiff provided Defendant a Resource Manual providing instructions on how to administer the plan. The Resource Manual specifies that Defendant has the responsibility of collecting "continuation premiums along with regular monthly premiums" (for COBRA coverage) and submitting them to Plaintiff. The Resource Manual specifies that "The employer (Defendant) is responsible for collecting premiums from continuation members. (Plaintiff) cannot accept premiums paid directly by continuation members." The Resource Manual also specifies that "During the period of continuation of coverage, the plan will not terminate an insured continuation member until we (Plaintiff) receive notice to do so."

Gloria Follett

13. Follett was a sales person for Defendant who was hired on January 8, 2003. Follett became a participant in the plan in 2003.

14. The testimony revealed:

    a. In 2003, Follett did not always work 30 hours or more per week.

b. During 2003, Follett failed to work thirty (30) hours per week during seventeen (17) weeks, but she worked more than 30 hours per week during 35 weeks in 2003.

Weekend	Hours Worked
7/9/2003	26.60
8/22/2003	0.00
8/29/2003	0.00
9/5/2003	0.00
9/12/2003	0.00
9/17/2003	0.00
9/24/2003	0.00
10/1/2003	0.00
10/8/2003	0.00
10/15/2003	0.00
10/22/2003	0.00
10/29/2003	0.00
11/5/2003	23.21
12/10/2003	0.00
12/17/2003	0.00
12/24/2003	0.00
12/31/2003	28.28

c. Defendant's witness testified that Defendant considered Follett a "full time, regular employee" throughout 2003.

d. Follett worked a similar schedule during the first half of 2004 and the last day on which Follett actually worked was June 7, 2004. Again, Defendant's witness testified that Defendant considered Follett a "full-time, regular employee" during 2004.

e. The Plaintiff's witness, at trial, acknowledged that the policy does not define the term "regularly" as used in the defined term "actively at work". The Plaintiff's witness testified that Plaintiff does not cancel a participant's coverage if a person sometimes fails to meet the 30 hour per week requirement. The Plaintiff's witness was not able to provide any specific

guidelines or parameters used by Plaintiff in determining when a person ceases to work "regularly". In other words, there was no evidence that Plaintiff has (or had) some sort of "bright line" test at which point a plan participant will be deemed to no longer "regularly" work 30 or more hours per week. As the Plaintiff's witness admitted, there is no indication as to whether a person who works 26, 32, 40 or any other specific number of weeks of 30 or more hours per week is deemed to "regularly" work 30 or more hours per week for the purpose of the plan document.

COBRA Coverage

15. When Follett ceased actively working in June 2004, Defendant did not issue a written COBRA election notice to her. Beginning on July 1, 2004 and for eighteen (18) months thereafter (until December 31, 2005) Defendant collected Follett's share of her monthly premiums for continuation coverage under the plan. The actual receipts showing proof that Defendant collected the "COBRA premium" from Follett were admitted into evidence. In fact, all of the receipts reference that they are for insurance premiums and several of the receipts specifically reference COBRA. The Defendant's witness testified that she did not understand exactly how COBRA worked and that she believed the post June 2004 premium payments to be "COBRA payments". The Defendant's witness' testimony and the contemporaneous receipts are consistent. Defendant accepted the premium payments from Follett for the entire period from July 1, 2004 to December 31, 2005 and transmitted the full premium payment for coverage for Follett to Plaintiff for the relevant period (Follett's portion paid was

approximately two-thirds of the full premium transmitted to Plaintiff. Defendant paid the other approximately one-third of the premiums.) Plaintiff accepted and retained all of the premium payments and has never tendered any refund of premiums.

16. After allowing Follett to continue her health insurance coverage in the plan for exactly eighteen (18) months beyond the month in which she last worked, Defendant terminated Follett's coverage effective December 31, 2005 and notified Plaintiff of the termination of coverage as of that date.

17. Through some means, which was not clearly developed, Plaintiff learned in approximately October 2005 that Follett might not have been an "active" employee for some period of time. In October 2005, Plaintiff wrote Defendant and requested Defendant to provide its payroll records so that Plaintiff could investigate issues surrounding Follett's coverage. The testimony revealed that at no time prior to October 2005 had the Plaintiff ever exercised its right to request and inspect Defendant's payroll records. The testimony revealed that Defendant promptly provided the requested records without protest. Upon reviewing the records, Plaintiff determined that Follett had not actively worked for some time and Plaintiff wrote to Defendant demanding that Defendant immediately pay approximately $650,000.00 to Plaintiff as reimbursement for benefits which Plaintiff contended it wrongfully paid out to medical providers for services rendered to Follett after Plaintiff alleged her coverage ceased.

18. Plaintiff is aggrieved because it was not provided notice that Follett ceased actively working as of her "qualifying event". Plaintiff contends that it was

entitled to notice that Follett's status had changed from "eligible" employee to not "eligible" under the terms of the plan document. Plaintiff basis its contention that it was entitled to such notice per the specific terms of the plan document.

19. At trial, there was absolutely no evidence presented which established that Defendant knowingly misrepresented Follett's status to Plaintiff at any time. In fact, the Plaintiff's witness candidly admitted that she knew of no evidence of a knowing misrepresentation on the part of the Defendant concerning Follett's coverage. Counsel for Plaintiff even conceded as much in his closing argument. In reality, there was no affirmative misrepresentation made by Defendant regarding Follett's coverage. The evidence merely revealed that Defendant failed to notify Plaintiff of Follett's employment status change. Instead, Defendant merely paid premiums for Follett's coverage through December 31, 2005 without any representation as to her status.

20. One final fact of note is Plaintiff's witness' testimony to the effect that Plaintiff realized it could request any records, including payroll records, it wished from Defendant at any time. Plaintiff's witness even acknowledged that a review of payroll records would have revealed Follett's employment status at any time. However, the Plaintiff's witness testified that Plaintiff did not regularly conduct such record requests and reviews because it would tax its available resources. The witness testified that Plaintiff made a conscious decision to rely upon plan sponsors to notify Plaintiff of status changes instead of Plaintiff affirmatively conducting payroll record reviews to protect its own interests. Plaintiff's witness

acknowledged that Plaintiff realized there was some "risk" in relying upon plan sponsors for the information regarding status changes.

CONCLUSIONS OF LAW

ERISA Preemption

Defendant contends that the Plaintiff's causes of action are preempted by ERISA 29 U.S.C.S. § 1144 which provides, in relevant part:

> "**(a) Supersedure; effective date**
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title. This section shall take effect on January 1, 1975."

The matter *sub judice* was removed by Defendant to Federal Court on the grounds of ERISA preemption. While pending in the United States District Court for the District of South Carolina, the Defendant made a motion pursuant to F.R.Civ.P. 12(b)(6) to dismiss Plaintiff's complaint, on its face, as being preempted by ERISA. Presiding Federal District Court Judge, the Honorable Bryan Harwell, denied Defendant's 12(b)(6) motion and remanded the matter back to this court. In its answer, Defendant asserted ERISA preemption and has preserved that issue and argues it again to this court. Defendant urges that Judge Harwell did not have the benefit of hearing any evidence on the ERISA preemption issue. Defendant further argues that Judge Harwell's decision was issued before a recently published Fourth Circuit Court of Appeals decision that Defendant contends is on-point. Plaintiff contends that Judge Harwell has already decided the issue. It is well established in South Carolina that a ruling on a 12(b)(6) motion is not a ruling on the merits. After all, a Rule 12(b)(6) motion is merely intended to test the sufficiency of the complaint. ("A motion to dismiss pursuant to Rule 12(b)(6) must be based solely on the allegation set forth in the complaint and we must presume all well plead facts to be

true." *Gressett v. South Carolina Electric and Gas*, 370 S.C. 377, 635 S.E.2d 538 (2006). In interpreting the complaint in the face of a Rule 12(b)(6) motion, the court is called upon to interpret all factual disputes in favor of the non-moving party. That task is much different than the task with which the court is faced in deciding the case on its merits.

In the court's factual findings above, it is recited, based upon the testimony and the evidence, that Plaintiff's complaint was based upon the alleged breach of a duty by Defendant to provide Plaintiff notice of a change in employment status for Follett. According to Plaintiff's witness that contractual duty specifically arose as a result of the terms of the plan document. In fact, the only contractual duty that Defendant might owe Plaintiff necessarily arises from the specific terms of the plan document which is the contract between the parties. Additionally, in order to determine whether there was even a change in Follett's status under the terms of the plan document in the first place, the court must review the eligibility provisions and other relevant terms of the plan document. It is undisputed that the plan and plan document are subject to ERISA 29 U.S.C.S. § 1001 *et. seq.* Judge Harwell did not have the benefit of hearing the testimony that this court has now heard and considered.

Moreover, Judge Harwell did not have the benefit of the recent Fourth Circuit decision in *Great West v. Information Systems & Networks Corporation*, 523 F.3d 266 (4th Cir. 2008). In *Great West*, similar but notably distinguishable facts were before the court. In *Great West*, an insurer sought to recover money against the employer sponsor of an ERISA governed benefit plan. The insurer asserted several state law causes of action including breach of contract. Notably, however, in that case, the insurer's state law claims were based upon a service agreement that was separate and distinct from the ERISA governed plan document. (See *Great West*, 523 F.3d 266, *4, stating:

> "Relevant to the preemption issue we decide in the present appeal, in a separate and distinct contractual agreement between ISN and Great-West (the Services Agreement), ISN also hired Great-West to perform certain nondiscretionary administrative services under the Plan. Great-West's state law claims against ISN in this case both arise from Great-West's performance of only one of those nondiscretionary administrative services (based on the separate and distinct agreement), namely, Great-West's nondiscretionary duty to front the payment of claims made by ISN employees and their dependents for self-funded benefits under the Plan. ISN, in turn, agreed to reimburse Great-West for any such payments".)

When the insurer's claim in *Great West* was based upon a document extraneous of the ERISA governed plan document, the Fourth Circuit held that state law causes of action were not preempted by ERISA. The key factual distinction between *Great West* and the matter *sub judice* is that Plaintiff herein does not rely upon a "separate and distinct" document extraneous of the plan document in asserting its causes of action, but, instead, relies squarely, and solely, upon the very terms of the plan document to establish the duty that it alleges was owed and breached and its right to entitlement. On the facts now before the court, there can be no doubt that the Plaintiff's causes of action "relate to" the ERISA governed plan. As the Fourth Circuit stated as to the type of acts presented to the court in the matter *sub judice*:

> "Furthermore, analysis of Great-West's claims do not require interpretation of the Plan terms nor depend upon the existence of an ERISA plan. Thus, Great-West's claims do not fall within the recognized rule that "[w]hen a cause of action under state law is 'premised on' the existence of an employee benefit plan so that 'in order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists,' ERISA preemption will apply." *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371, 378 (4th Cir. 2001) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140, 111 S. Ct. 478, 112 L.Ed.2d 474 (1990)) (citation omitted). *See also Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 313-14 (4th Cir. 1994) (employer/sponsor's state-law claims against its ERISA plan's third-party administrator for improper claims processing preempted because they related to an ERISA plan)." *Great-West*, 523 F.3d 266, *14, *15.

Accordingly, based upon the facts and evidence presented at trial and relevant and very recent authority, the court concludes that the Plaintiff's state law causes of action are wholly

preempted by ERISA and the Plaintiff's case is dismissed with prejudice and judgment entered in favor the Defendant. Although the court finds that Plaintiff's claims are preempted by ERISA, the court, having heard and considered all testimony and evidence, will address and decide the merits of Plaintiff's causes of action nonetheless.

Breach of Contract

Plaintiff bears the burden of proving the essential elements of a contract cause of action. (See *Taylor v. Cummins Atlantic, Inc.*, 852 F.Supp. 1279, *17 (D.S.C. 1994) holding: "In order to prevail on his claim of breach of contract, plaintiff bears the burden of establishing the existence and terms of the contract, defendant's breach of one or more of the contractual terms, and damages resulting from the breach.") The plan document provides that Plaintiff can recoup insurance benefits wrongly paid if "a knowing" misrepresentation lead to the improper payment of benefits. Plaintiff's witness and its lawyer both candidly concede that there is absolutely no evidence of any "knowing" misrepresentation by Defendant in the matter *sub judice*. Plaintiff drafted the plan document and in so doing, premised its right to reimbursement only upon showing of a "knowing" misrepresentation. There have been no facts presented to the court to establish a right of Plaintiff to recoup monies paid to medical providers for services rendered to Follett during the relevant time period. Plaintiff has wholly failed to meet its burden of proof on the breach of contract cause of action and Defendant is entitled to judgment and a dismissal with prejudice on the Plaintiff's breach of contract cause of action.

Negligent Misrepresentation

The Plaintiff's other cause of action is for negligent misrepresentation under State law. South Carolina recognizes a negligent misrepresentation cause of action. However, recognized defenses to negligent misrepresentation claim include contributory negligence, justifiable

reliance and assumption of risk. (See *Gruber v. Santee Frozen Foods, Inc.*, 309 S.C. 13, 419 S.E.2d 795, 800 (Ct. App. 1992) as cited by Felix and Hubbard, The South Carolina Law of Torts, Second Edition, page 365, "As with any negligence claim, a defendant may raise a number of defenses to a suit for negligent misrepresentation. For example, the affirmative defense of contributory negligence applies to a negligent misrepresentation." *Gruber* further recognized that ". . . one of the essential elements of the action (negligent misrepresentation) is reliance. We hold that reliance can only be justified in these cases if the relationship of the parties is such that the defendant occupies a superior position to the plaintiff with respect to knowledge of the truth of the statement made. . . . There can be no reasonable reliance on a misstatement if the plaintiff knows the truth of the matter. Accordingly, we hold that the trial judge properly instructed the jury that if both Gruber and Santee had equal access to the (relevant information) then Gruber had no cause of action." *Gruber*, 419 S.E.2d 795, 799, 700. Finally, in *Matkin v. Fidelity National Bank*, 2002 U.S. Dist. LEXIS 27571 (D.S.C. 2002), the South Carolina District Court, citing relevant South Carolina state court authority, recognized that "There is no liability for casual statements, representations as to matters of law or matters which plaintiff could ascertain on his own in the exercise of due diligence." *Matkin*, *13 citing *AMA Management Corp. v. Strasburger*, 309 S.C. 213, 420 S.E.2d 868, 874 (S.C. Ct. App. 1992).

The court questions whether, based upon the evidence presented to it, Defendant even owed Plaintiff any legal duty under the circumstances. The court further questions whether Defendant actually affirmatively misrepresented any fact or whether Plaintiff had any right to rely upon any representations Defendant might have made concerning Follett's coverage or status. However, the court need not decide those issues because the court concludes that even if a duty was owed and breached and even if Plaintiff had a right to rely then under the facts

presented to the court the Plaintiff was clearly contributorily negligent to an extent which would bar any recovery.

The Defendant is an automobile dealership. The Plaintiff is a for profit insurance company whose sole business purpose is to market and sell insurance products. Clearly, Plaintiff's employees are in a better position to be able to evaluate and know the meaning of the terms of the very insurance plan document which Plaintiff drafted. Clearly, the drafters of the plan document foresaw the need for the Plaintiff to be able to review "payroll records" to protect its own interests and determine important coverage issues for plan participants like Follett. In fact, not just once, but at least twice, the plan document specifies that Plaintiff can request from Defendant any records it wishes at any time including, specifically, payroll records. It is undisputed that Plaintiff never requested any such records from Defendant at any time from the inception of the policy in 1997 until first requesting payroll records in October of 2005. It is undisputed that when the payroll records were requested by the Plaintiff in October of 2005 the Defendant promptly and willingly provided those records to the Plaintiff. It is further undisputed that upon review of those records the Plaintiff immediately determined Follett's true status for the time period in question and it was a review of the payroll records that directly resulted in the Plaintiff's demand that Defendant pay Plaintiff approximately $650,000.00. Plaintiff had every bit equal access to the very payroll records that it eventually requested and promptly obtained. Moreover, in addition to having equal access to relevant records, Plaintiff was in the better position to be able to understand the content and significance of those records in light of the terms of the plan document which Plaintiff actually drafted. It is patently unreasonable for the Plaintiff to ignore its own legal rights under the plan document it drafted and, instead, rely upon

an automobile dealership for information relating to and interpretation of complicated insurance policy terms.

Accordingly, the court holds that on the Plaintiff's negligent misrepresentation claim that (1) Plaintiff was more negligent than the Defendant and that the doctrine of contributory (comparative) negligence forecloses any recovery by the Plaintiff on its cause of action; (2) that the relevant records were just as accessible to the Plaintiff as to the Defendant and that, therefore, there was no justifiable reliance under the circumstances; and (3) that by knowingly waiving its right to request the very payroll records which it ultimately did request and review and, instead, relying upon an automobile dealership to understand complicated insurance principles and practices was a clear assumption of risk that blocks any recovery by the Plaintiff on its negligent misrepresentation cause of action.

Damages

The court has already found that the Plaintiff's state law causes of action are wholly preempted by ERISA and should be dismissed with prejudice. Further, the court has found that Plaintiff has failed to demonstrate any right to recover on either of its causes of action and that, therefore, judgment should be entered for the Defendant. However, in addition to the foregoing holdings, the court finds that even if Plaintiff's causes of action were not preempted by ERISA and if Plaintiff had met its burden of proof on either one or both of its causes of action then it still would not be entitled to recover because it has failed to prove any damage.

It is axiomatic that proof of damages is required for either a breach of contract or a negligence cause of action. (See *Taylor* above. See also *South Carolina Finance Corporation of Anderson v. Westside Finance Company*, 236 S.C. 109, 113 S.E.2d 329 (1960), "the measure of damages for breach of contract is a loss actually suffered by the contractee as a result of the

breach." "In negligence, proof of actual damage is an essential element of the tort. Damage is the gist of the action. (Citation omitted) It is basic that a negligent act is not itself actionable and only becomes such when it results in damages to another. There is no liability if there is no actual damage. It is elementary law that there is no such thing as "negligence in the air". (Citation omitted). *Richardson's Restaurants, Inc. v. The National Bank of South Carolina*, 304 S.C. 289, 403 S.E.2d 669 (Ct. App. 1991).

It is undisputed that the insurance policy document obligates Plaintiff to provide continuation coverage as required by state or federal law. It is further undisputed that COBRA is a federal law that requires that individuals who experience a "qualifying event" are entitled to coverage for up to 18 months.[1] It is undisputed that, at some point, Follett experienced a "qualifying event" and was eligible for COBRA coverage for up to 18 months as long as premiums were paid (which they were). So, based upon the facts presented to the court, Follett was clearly entitled to 18 months of COBRA coverage for which Plaintiff, as the insurer of the subject group policy, was bound to coverage. It is also undisputed that Defendant paid and Plaintiff accepted premiums for coverage for Follett for the entire period from the point of inception of coverage for Follett under the plan through December 31, 2005. There is a factual dispute, however, as to when Follett's "qualifying event" for the purposes of COBRA occurred.[2] Defendant contends that Follett's qualifying event occurred in June of 2004, the point at which she finally ceased actively working. The plan document provides that when coverage terminates the effective date of the termination is the last day of the month in which the termination event occurs. All parties agree that if coverage terminated in June of 2004 that Follett would have been entitled to COBRA coverage effective July 1, 2004. Defendant argues that Follett's

[1] In some circumstances, not applicable here, individuals might be entitled to coverage beyond 18 months.
[2] A "qualifying event" specifically defined by the COBRA provisions of ERISA at 29 U.S.C. § 1163 to include a reduction of hours or termination of employment.

COBRA coverage was effective July 1, 2004 and that the period July 1, 2004 through December 31, 2005 (which is exactly 18 months) qualifies as the COBRA coverage which Plaintiff was obligated to provide under the terms of the plan. The court agrees.

Plaintiff argues that the qualifying event did not occur in June 2004, but really occurred in June 2003. Plaintiff argues that Follett ceased "regularly" working 30 hours or more per week as of June 2003. Defendant counters that Follett did "regularly" work 30 or more hours per week for the period June 2003 through June 2004. The policy does not define the term "regularly". While there is no doubt that Follett had a number of weeks during which she did not work the requisite 30 hours per week, it is also undisputed that there were many weeks in which she did. Moreover, the most compelling evidence on this point is that the Defendant, who is the plan administrator and a named fiduciary of the ERISA plan, viewed Follett as a full time, active employee eligible for coverage. Because of that fact, Defendant actually paid premiums for Follett's coverage for the period June 2003 through June 2004 which were readily accepted and retained by Plaintiff. The court finds that the term "regularly" as used in the relevant language of the subject policy is ambiguous. Other courts have similarly found in nearly identical circumstances. (See *Tester v. Reliance Standard Life Ins. Co.*, 228 F.3d 372 (4th Cir. 2000)) In a case that appears to be factually and legally on-point, *Canada Life Ins. Co. v. Lebowitz*, 185 F.3d 231 (4th Cir. 1999), the Fourth Circuit Court of Appeals found the following facts compelling in determining whether an individual, who did not always work 30 hours per week, was eligible for ERISA governed insurance coverage.

> "WTP (the employer) considered Lebowitz to be covered under the Policy. Coe testified that WTP "treated and recognized [Lebowitz] as a full-time partner." n4 WTP also paid Lebowitz's insurance premiums during the relevant period. As conceded by Canada Life (the insurer), WTP was solely responsible for determining each month (1) "which employees qualified for life insurance coverage" and (2) the amount of premium to be paid to Canada Life "based on

> this determination". Brief for Appellant at 9. Thus, when WTP paid Canada Life insurance premiums in Lebowitz's name it must have considered Lebowitz qualified for life insurance coverage. We find the fact that WTP regularly paid Lebowitz's insurance premiums as conclusive evidence that WTP considered Lebowitz covered under the Policy." *Lebowitz*, 185 F.3d 231, 236.

The court found that in order to decide the matter it needed to determine which party was the fiduciary (as that term is defined in ERISA) for determining eligibility issues. The court stated:

> "Since WTP considered Lebowitz covered and Canada Life did not, we must determine who had the final say concerning coverage. To make such a determination, we must ascertain who was the ultimate fiduciary with regard to coverage. Under ERISA, a fiduciary is "anyone . . . who exercises discretionary control or authority over the policy's management, administration, or assets." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 251, 124 L.Ed.2d 161, 113 S. Ct. 2063 (1993).
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> Thus, WTP was the ultimate fiduciary with regard to employee coverage. When WTP paid Lebowitz's insurance premiums, therefore, it determined that he was covered under the Policy. Since WTP's decision was controlling, further proof of Lebowitz's coverage was unnecessary. There is no question of material fact that Lebowitz was covered under the Policy." *Lebowitz*, 185 F.3d 231, 237.

The *Lebowitz* court held that since the employer was the fiduciary of the policy and since the employer viewed the subject individual as being a full-time active employee eligible for coverage that he was then, in fact, covered. The logic of *Lebowitz* is compelling and equally applicable to the facts before this court. On the one hand, CCP specifically disclaims, in the plan document, that it is a fiduciary for the purposes of ERISA in an obvious attempt to alleviate itself of any fiduciary responsibility of the plan. If Plaintiff wants to alleviate itself from any fiduciary responsibility under ERISA then that is its prerogative. However, on the other hand, Plaintiff cannot insist that the Defendant is the fiduciary of the ERISA plan, thereby, trying to impose potential liability on it without also acknowledging the powers Defendant enjoys as a fiduciary

under ERISA. As a fiduciary of the plan, the Defendant viewed Follett as a full-time employee eligible for coverage and paid premiums for her (which were unequivocally accepted and retained by the Plaintiff). Based upon the logic of *Lebowitz*, the court finds that Follett was an employee eligible for coverage until she ceased actively working in June 2004 because that is how Defendant viewed her. Accordingly, Follett's "qualifying event" for the purposes of her COBRA extension coverage occurred in June 2004. Therefore, for the period July 1, 2004 through December 31, 2005 Plaintiff was absolutely and unequivocally obligated to provide continuation coverage for Follett exactly as it did provide so it has suffered no damage. If Plaintiff was absolutely obligated to provide the subject coverage in any event then no miscommunication or failure to give notice of Follett's status by the Defendant has caused Plaintiff any damage.[3]

CONCLUSION

For all of the foregoing reasons, the court hereby holds that the Plaintiff shall recover nothing on its complaint, that the Defendant is entitled to a verdict in its favor, that judgment shall be entered for the Defendant and that the Plaintiff's case is dismissed with prejudice.

The Honorable Michael G. Nettles
Judge of the Twelfth Judicial Circuit

Date: 6-18-08

Florence, S.C.

[3] The court also notes that even if it were not persuaded that Follett's "qualifying event" occurred in June 2004 and even if Plaintiff was correct that the "qualifying event" occurred in June 2003, the result would be the same. The plan document has a provision which provides an extra 12 months of continuation coverage for individuals who are totally disabled. The evidence submitted to the court contains the disability statement of Follett's physician to the effect that she had been disabled for three (3) years as of 2006. Plaintiff chose not to refute that physician's statement of disability in any way. Accordingly, based upon the record before the court, it has been shown to the court's satisfaction that Follett was disabled and that, if she had needed it, she was entitled to the additional 12 months of continuation coverage under the "total disability continuation" provision. Therefore, even if the Plaintiff's proposed date for the "qualifying event" (*i.e.*, June 2003) was correct, Follett would have still been entitled to an additional 30 months of continuation coverage per COBRA and the terms of the total disability provision.