



The *Defender*

The North Carolina Association of Defense Attorneys • Vol. XVII No. 3 / Spring 2010

President's Comments

David N. Allen, *Parker Poe Adams & Bernstein LLP*

Where does the time go? That is something that I am sure all of us say far too often. Sometimes it's brought on by a landmark in our children's lives, such as entry into kindergarten or high school graduation. Perhaps it is, as one of my friends recounted, sharing a beer with your lawyer son now that he has finally come of age. Perhaps it is watching your favorite old show, which has now become an exile on TV Land and finding that no one else thinks it's nearly as funny as you do. Or hearing younger lawyers discuss music, and learning that Linkin Park is a band, not a suburb of Chicago! Or perhaps even watching a lawyer who's been working with you since day one argue before the North Carolina Supreme Court and taking some pride in the fact that you may have helped her in some small way with the success achieved that day.

Time has indeed flown by as I realize it has been a year since I became your President and recited several bad jokes in my remarks. We have accomplished a lot, moving to our new headquarters and handling our finances so that we are still in good shape financially. We have also enhanced our visibility statewide and been effective in the legislature and the North Carolina State Bar with issues of importance to our members. We have gone online with the Defender. We hope to adopt a bylaw change to create a Law Student Division, allowing us to continue our efforts to collaborate with the law schools of North Carolina.

It has been a remarkable honor to be entrusted with the Presidency over the last year, and while the time has flown by, it has not been so fleeting that it has not given me the opportunity to enjoy this office and the wonderful collegiality of our Association. I have called upon many of you for assistance this year and on each and every occasion the answer has been an unqualified yes. I thank you all for that and for your support. The upward arc of the last sev-



Allen

eral years will certainly continue under our new leadership. Your soon-to-be new President, Bonnie Refinski-Knight, has been working, and will continue to work, tirelessly on your behalf. The Officers and Directors, along with the Chairs of the Practice Groups and Committees, will continue the work that has been started. Incredibly, I will be starting the best job in our Association, Immediate Past President.

I must thank Lynette and Angela, without whom NOTHING would get done. Heartfelt thanks also go to Brian Beverly, Bonnie Refinski-Knight, Trisha Kerner, Chris Smith and Mark Kurdys for their support and collaboration on the Executive Committee and for covering the obligations that I was unable to discharge this year. The final THANK YOU is again to you, our members, for allowing me this opportunity.

See you all at Hilton Head!

Contribute to a Future Issue of *The Defender*

An Opportunity to Be Published

With the revamp of the NCADA's publication, *The Defender*, comes greater opportunities for members to contribute articles. The Editor of *The Defender* invites you to contribute feature articles on a variety of subjects relevant to the defense trial practice. *The Defender* will be published quarterly and circulated electronically to all NCADA members, insurance claims managers, members of the State's judiciary and the Industrial Commission.

If you are interested in contributing to a future issue of *The Defender*, please contact Lynette Pitt at lpitt@ncada.org. The deadlines to contribute articles for the next four issues are:

Summer Issue 2010
Fall Issue 2010
Winter Issue 2011

June 30
September 3
December 3

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Let us know what you think of our new look! Send feedback and suggestions about the new format of the newsletter to Lynette Pitt at lpitt@ncada.org.

Medicare's Mandatory Reporting Requirements & Their Anticipated Impact on the Insurance Industry

Shannon P. Metcalf and Erin T. Collins, *Hedrick Gardner Kincheloe & Garofalo LLP*

It is 2000 and Molly, a Medicare recipient, is involved in a car accident through no fault of her own. As a result of the accident, Molly sustains a lower back injury and incurs \$50,000 in medical bills, all of which are paid by Medicare. Molly settles directly with the liability insurance carrier for \$100,000 and executes a release of all claims, promising to pay any and all "liens" directly out of her settlement proceeds. Molly knows Medicare paid for her treatment; however, she is not aware of any claim of lien by Medicare. Subsequently she spends the entire \$100,000 on her home mortgage, her grandchild's college tuition, and a new car. Molly's case slips through the cracks, and Medicare never discovers the medical claim made by Molly with the insurance company or the settlement of \$100,000. Molly and her grandchild live happily ever after, and the insurance carrier closes its file.

In 2011, these facts will result in a



Metcalf



Collins

different outcome for both Molly and the insurance carrier. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (also referred to herein as the "mandatory reporting requirements") requires insurance companies to electronically report to Medicare any settlement, judgment, award, or other payment made to a Medicare beneficiary, as well as any assumption of or termination of a responsibility to pay for a Medicare beneficiary's medical expenses. Presumably, Medicare will use the reported information to recoup past conditional payments and prevent unnecessary future payments which are the responsibility of another entity. In Molly's situation, if the settlement occurred in 2011, the insurance carrier will be required to electronically report to Medicare that it paid Molly \$100,000 for the settlement of her claim. Medicare may then seek reimbursement for the \$50,000 in conditional payments. If Molly spent the \$100,000 and cannot reimburse Medicare, the federal government has the right to seek reimbursement directly from the liability insurance carrier. In other words, the insurance carrier could have to pay an additional \$50,000 to Medicare, even though it already paid Molly \$100,000 and closed its file.

Since insurance companies bear this risk for exposure if conditional payments are not properly reimbursed, affirma-



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Reporting Requirements, *continued from page 3*

tive measures must be taken to ensure Medicare is reimbursed out of payments made to Medicare beneficiaries for medical claims. The federal government enacted this statute to prevent Medicare from missing reimbursement opportunities, and a significant increase in reimbursement requests by Medicare should be expected upon the commencement of the mandatory reporting provisions of the MMSEA. (Although this article focuses on the mandatory reporting requirements and the reimbursement of past conditional payments, it is important to note that prior to any settlement, the parties must also carefully consider Medicare's potential interest in medical payments that may be made following settlement of a claim. Consideration of these "future interests" of Medicare, however, is a topic deserving of a separate article.)

The MSP and Path to the MMSEA

The Medicare Secondary Payer Act (MSP) prohibits Medicare from making medical payments if a "primary plan" has the responsibility to pay for such treatment. 42 U.S.C. § 1395y(b). A primary plan is an insurance plan (liability, workers' compensation, auto liability, and no-fault) covering an injured individual, and a "primary payer" is an entity responsible for making payments under the primary plan. 42 U.S.C. § 1395y(b)(2). In situations where the primary payer has not made a medical payment and is not expected to make the payment promptly, the MSP permits Medicare to pay for the injured individual's medical treatment, with the understanding that such payment is conditioned upon reimbursement once the primary payer's responsibility for that payment is demonstrated. *Id.* These payments by Medicare are referred to as "conditional payments."

The MSP specifically requires primary plans to "reimburse the appropriate Trust Fund for any payment made by [Medicare] if it is demonstrated that [the] primary plan has or had a responsibility to make payment with respect to such item or service." *Id.* The statute further explains that a primary plan's "responsibility" for payment can be demonstrated by a judgment, a payment made towards a compromise settlement, waiver or release (regardless of whether there has been a determination of liability), or by "other means." *Id.* Accordingly, in a situation where Medicare has made one or more conditional payments and a payment from the primary payer to the injured Medicare beneficiary is made through settlement, judgment, award, med-pay or other payment, the federal statutes require that Medicare be reimbursed for its conditional payment(s) once the primary payment is made.

If Medicare is not reimbursed, Medicare can seek reimbursement through a direct right of recovery from any party who *received* proceeds from the primary payer, including the

claimant, claimant's attorney, medical providers, state agencies, and private insurers, or from entities that are *responsible* for making payment, including employers, insurance carriers, third party administrators (TPAs), employer group health plans, and entities relying on self-insurance. 42 C.F.R. § 411.24(e), (g). When seeking reimbursement directly from a primary payer, Medicare disregards the fact that the primary payer already paid the beneficiary. In fact, the MSP expressly requires the primary payer to reimburse Medicare for the conditional payment made for medical treatment despite the fact that the primary payer has already paid the beneficiary or other party for such medical treatment. 42 C.F.R. § 411.24(i). If Medicare has to take legal action to recover for its claim from the primary payer, Medicare has the right to seek double damages, or double the amount of the Medicare payments. 42 C.F.R. § 411.24(c)(2). Federal statutes confer Medicare with rights of subrogation, intervention, and joinder in addition to its right to reimbursement, to round out its recovery abilities. 42 U.S.C. § 1395y(b)(2)(B)(iv).

As demonstrated by these federal statutes, Medicare has an absolute right to be reimbursed for conditional payments and has the ability to seek reimbursement from almost all involved parties. However, while the language of the MSP provides for nearly complete recovery capabilities, prior to the enactment of the MMSEA, one crucial component impacting Medicare's ability to enforce its statutory rights was missing – awareness of a pending insurance claim. Obviously, Medicare cannot seek reimbursement for conditional payments if it has no knowledge of primary payer responsibility. Prior to implementation of the MMSEA, the only "notice" requirement was found in 42 C.F.R. § 411.25, and it required primary payers to provide notice to Medicare if it was demonstrated to a primary payer that "CMS has made a Medicare primary payment for services which the primary payer has made or should have made." 42 C.F.R. § 411.25. However, this notice requirement does not contain a specific enforcement mechanism or penalty for noncompliance, and as a result, has been largely ignored. As discussed in greater depth below, the passage of the MMSEA has effectively cured the notice problems previously hindering Medicare's enforcement capabilities, which will allow Medicare to ensure that no further reimbursement opportunities are missed.

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

The Medicare Secondary Payer Mandatory Reporting Provisions of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 require responsible reporting entities (RREs) to (1) determine whether a claimant is entitled

to Medicare benefits, and (2) electronically report to Medicare payments made to Medicare beneficiaries as a result of settlements, judgments, awards or other payments, or upon an assumption or termination of an ongoing responsibility for a Medicare beneficiary's medical expenses. 42 U.S.C. § 1395y(b)(7), (8). Electronic reporting takes place between the RRE and the Medicare Coordination of Benefits Contractor (the COBC) and is scheduled to begin in 2011.

- **Who is responsible for reporting?**

The "applicable plan" is responsible for reporting, and the insurance carrier of the "applicable plan" is referred to by Medicare as the "RRE." An "applicable plan" is defined in 42 U.S.C. § 1395y as "liability insurance (including self-insurance)," "no fault insurance," and "workers' compensation laws or plans." Although it is clear from this statute that insurance companies are RREs, there are many unique insurance arrangements; as such, determining "who is the RRE?" can be a complicated question. For example, some insurance carriers use third parties to administer their claims. In these situations, the third party administrators (TPAs) are not RREs. An RRE "may contract with a TPA or other entity for actual file submissions for reporting purposes;" however, the RRE may not shift its reporting responsibility to a third party by contract or otherwise. (MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide (hereinafter referred to as "User Guide"), p. 22.) Therefore, if the reporting by the TPA is not accomplished properly, the RRE is held accountable despite a contract or agreement to the contrary.

Many entities are self-insured or have large deductible arrangements. For purposes of the MSP "where an entity engages in a business, trade, or profession, deductible amounts are self-insurance." (CMS Alert, dated February 14, 2010, at www.cms.gov/MandatoryInsRep/Downloads/NGHPAlertRREsWhoMustReport.pdf.) A fully self-insured entity would pay the Medicare beneficiary directly and thus be responsible for reporting. (User Guide, p. 22.) However, "where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible." (CMS Alert, dated February 14, 2010.) In other words, "[t]he deductible is not reported as 'self-insurance;' it is reported under the applicable policy number." *Id.* The alert further notes, however, that "[i]f an insured entity engages in a business, trade, or profession and acts without recourse to its insurance, it is responsible for Section 111 reporting with respect to those actions." *Id.* Neither the alert nor the User Guide defines "without recourse," but the following example is provided:

A claim is made against Company X which has

insurance through Insurer Y. Company X settles the claim without informing its insurer. Company X is responsible for Section 111 reporting for the claim regardless of whether or not the settlement amount is within the deductible or in excess of the deductible.

Id. Although not 100% clear, it appears that fully self-insured entities and entities paying claims "without recourse" to their insurance policies are considered "RREs." In deductible arrangements, however, where the payment is pursuant to an insurance plan and will ultimately impact that insurance plan, the insurer (or carrier of the plan) is the RRE. *Id.*

In claims involving re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds, etc., "which have responsibility beyond a certain limit, the key in determining whether or not reporting for 42 U.S.C. § 1395y(b)(8) is required . . . is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment to the self-insured entity to reimburse the self-insured entity." *Id.* In the latter situation, the self-insured entity is the RRE, and the insurer paying the self-insured entity a reimbursement amount is not required to report. *Id.*

In situations where government agencies are tasked with directly resolving and paying claims, the government agencies are the RREs. If the government designates a carrier to resolve and pay claims with government funds, but without government review and/or approval, the designated carrier is the RRE. (User Guide, pp. 23-24.) If the government agency designates a carrier to resolve and pay claims using government funds, but retains review or approval authority, the government agency is the RRE. (User Guide, p. 23-24.) Obviously, these examples do not reflect an exhaustive list of complex insurance arrangements, and additional guidance can be found in Medicare's User Guide and the subsequent alert dated February 14, 2010.

- **How does an RRE determine whether a claimant is Medicare eligible?**

An RRE does not have to report settlements, judgments, awards or other payments, or an assumption/termination of an ongoing responsibility to pay medical expenses unless the transaction involves an individual entitled to Medicare benefits. The MMSEA places an affirmative obligation on the RRE to determine if the individual receiving payment or medical treatment is eligible for Medicare benefits, and the User Guide specifically instructs RREs to "implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and gather the information necessary for Section 111 reporting." (User Guide, p. 19.) In an apparent effort to assist RREs with the identification of Medicare beneficiaries, Medicare established a query system designed to run claimant data submitted by RREs

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through the Medicare database. If a match between the claimant and Medicare data occurs, Medicare will respond to the RRE with the Health Insurance Claim Number (HICN) of the Medicare beneficiary and “other updated information for the individual found on the Medicare Beneficiary Database.” (User Guide, p. 19.)

To use this system, RREs must include in their query the HICN or social security number, name, date of birth, and gender of the injured party. The insurance industry expressed concern with obtaining private information from claimants and in response, Medicare provided a sample form to be sent to claimants annually for execution. (This form can be found at www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSFForm081809.pdf.) The form requires claimants to provide certain pertinent information regarding their Medicare status and gives the claimant the opportunity to refuse to provide the requested information. Medicare declared it will “consider the reporting entity compliant for purposes of its next Section 111 file submission” despite a claimant’s failure to supply the information if (1) the RRE obtains a signed copy of the sample form from the claimant; (2) the sample form is re-signed and dated at least once every 12 months in cases where an ongoing responsibility for payment of medicals applies; and (3) the reporting entity retains this documentation.

• What information is reported by the RRE?

RREs are required to report payments to Medicare beneficiaries as a result of settlements, judgments, awards, or other payments. The “Total Payment Obligation to the Claimant” (TPOC) is the term Medicare uses to refer to the actual dollar amount the RRE pays on behalf of the Medicare beneficiary as a result of the settlement, judgment, award, or other payment. The TPOC date is the date the payment obligation was established, which means the date the release was signed or court approval was obtained for settlements requiring court approval. If there is no written agreement, then the TPOC date is the date of payment. (User Guide, p. 149.) Claims are reported on “a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc.” As such, there may be more than one record from an RRE for an individual in a certain quarter. (User Guide, p. 84.) For example, if a Medicare beneficiary involved in a car accident makes a med-pay claim and then subsequently settles her claim with the same insurance carrier, then there will be two reportable TPOCs. (User Guide, p. 84.) In addition, if two insurance carriers make payments on behalf of one Medicare beneficiary for settlement, then each insurance carrier (RRE) would separately report their settlement with that beneficiary to Medicare.

(User Guide, p. 84.) Medicare makes clear that if medicals are claimed and/or released, RREs must report TPOCs in their entirety regardless of any allocation made by the parties or determined by the court. (User Guide, p. 85.)

RREs are also required to report any assumption or termination of an ongoing responsibility for medical expenses (ORM). The date for the ORM is the date when the decision is made to assume responsibility for ongoing future medical expenses for the Medicare beneficiary. (User Guide, p. 75.) When there is an ORM, the RRE does not report each payment separately as a TPOC, but rather reports the assumption of an ORM and, if applicable, the subsequent termination of an ORM. (User Guide, p. 75.) Reporting for ORMs must occur regardless of whether there is a separate TPOC as a result of a settlement, judgment, award or other payment. (User Guide, p. 75.) Medicare emphasizes that “[i]t is critical to report ORM claims with information regarding the cause and nature of the illness, injury or incident associated with the claim” since Medicare will use the information to determine what medical services/items should be paid by the RRE versus Medicare. (User Guide, p. 75.) It should also be noted that payment for a one time defense medical evaluation does not have to be reported so long as this payment is made directly to the provider or physician providing the evaluation. (User Guide, p. 85.)

Medicare has also announced interim thresholds for reporting purposes, which allow RREs to omit certain claims from their reporting submissions for a specified period of time. These claims include (1) workers’ compensation medical only claims involving an ORM where the file submission is due before December 31, 2011, and where the claimant loses no more than seven days from work and the medical expenses (which do not exceed \$750) are paid directly to the medical provider; (2) TPOC dates prior to January 1, 2012, in amounts of \$0 - \$5,000; (3) TPOC dates of January 1, 2012, through December 31, 2012, in amounts of \$0 - \$2,000; and (4) TPOC dates of January 1, 2013, through December 31, 2013, in amounts of \$0 - \$600 (User Guide, pp. 52-53.)

• When do RREs report?

In 2011, RREs will submit an initial claim file and then subsequent quarterly file submissions during their assigned window each quarter. The initial claim files must include all payments as a result of settlements, judgments, and awards, and other payments to Medicare beneficiaries where the TPOC date is October 1, 2010, or later, as well as all claims in which an ORM exists as of January 1, 2010. Many carriers have already started updating their systems and working on the data compilation process in anticipation of this first

submission.

- **What is the penalty for not reporting?**

The penalty for non-compliance with the MMSEA is \$1,000 per day per claimant. Funds received due to penalty payments will be deposited into the Federal Hospital Insurance Trust Fund, which finances Medicare Part A. 42 U.S.C. 1395y(b)(7), (b)(8).

- **Where Do We Go from Here?**

With the implementation of the MMSEA, Medicare will have everything it needs to know about primary payer responsibility and has stated it will begin to regularly seek reimbursement of conditional payments following settlements, judgments, monetary awards, and payment of medpay or PIP benefits. This is especially problematic in the context of settlements and final judgments since the general practice following payment of any settlement amount or judgment is to close the file and ship it to storage. Accordingly, insurance clients need to be aware that a conditional payment letter seeking reimbursement may follow months later, and clients should plan accordingly.

Back to Molly's hypothetical. A well-informed insurance carrier would treat the claim differently upon learning of Molly's beneficiary status. In this case, assume WI (Well-Informed) Insurance is the relevant insurance carrier and upon learning of Molly's beneficiary status, immediately obtains the pertinent information to provide Medicare with notice of Molly's claim (including Molly's social security and HICN numbers). Upon retrieving that information and obtaining a signed release from Molly, the adjuster forwards formal correspondence to Medicare's Coordination of Benefits Contractor advising of the claim and requesting a conditional payment investigation. Within eight weeks of the notice, the parties receive an interim conditional payment amount, which gives the parties an idea of the cost of the treatment paid by Medicare as of the date of the ledger. After confirming the ICD-9 codes match up to Molly's low back injury, the adjuster puts the conditional payment letter in the file and monitors Molly's treatment. As Molly's treatment stabilizes, the adjuster either follows up with Medicare directly or requests a print out of the conditional payment status directly from Molly, who is able to pull up the printout via her link on the mymedicare.gov website. Upon determining the most updated interim amount, the adjuster explains to Molly that they can reach a settlement figure but the conditional payment lien must be paid out of the settlement, and WI Insurance must hold the settlement funds until receiving a final conditional payment lien letter. The adjuster must either convince Molly to settle even though she will not know the final amount she will receive until after the settlement is finalized and the lien paid, or WI Insurance must agree to reimburse Medicare, regardless of the amount of the lien and

bear the risk that the amount could be more than shown in the interim ledgers.

In this case, assume Molly and the adjuster monitor the treatment well and are fairly confident the conditional payment amount will be between \$40,000 and \$50,000. Assume further that Molly agrees to settle for \$100,000 with the understanding that Medicare will be reimbursed before she receives her final amount. WI Insurance reports the settlement to Medicare, requests a final lien amount, and Medicare responds by advising the final amount is \$50,000. WI Insurance pays \$50,000 to Medicare, \$50,000 to Molly, and closes its file. Pursuant to the MMSEA, WI Insurance electronically reports the \$100,000 settlement with Molly to Medicare in WI Insurance's next quarterly file submission. Since the \$50,000 has been paid, Medicare does not seek additional reimbursement. In this scenario, the adjuster, WI Insurance, and Molly live happily ever after without pulling files from storage, paying additional funds, or receiving a Medicare collection notice. Of course, this hypothetical assumes that everyone complies with their obligations under federal law and that Medicare operates in a timely fashion and according to its internal procedures. However, it remains to be seen whether these assumptions will continue to be the exception rather than the rule.

Furthermore, many claims are not as clear cut as Molly's claim, particularly when they are denied due to a dispute in liability or damages. For example, assume there is strong evidence that Molly's own negligence contributed to her injuries, and WI Insurance settles Molly's claim for a compromised amount of \$20,000. In this situation, WI Insurance has acknowledged "responsibility" for \$20,000 of Molly's claim by virtue of payment of its settlement funds, and Medicare, which made conditional payments of \$50,000, would be entitled to the entire \$20,000 settlement (minus procurement costs). WI Insurance would have an obligation to confirm that Medicare is reimbursed. If WI Insurance fails to comply with that obligation, WI Insurance may be required to reimburse Medicare regardless of whether it already paid Molly. Logically, however, if WI Insurance insists on reimbursing Medicare out of Molly's settlement, there will be no money left for Molly, and Molly may have no incentive to settle.

Denied and disputed claims are prevalent in the insurance industry and interesting issues surrounding compromised settlements in cases involving Medicare beneficiaries will continue to flood the desks of defense attorneys. Regardless of whether a claim is accepted or denied, when dealing with a Medicare beneficiary, the best strategy includes a prompt conditional payment investigation (the Medicare Secondary Payer Recover Contractor website can be found at www.msprc.info), consistent communication with the opposing side, and a collective effort from both sides to ensure Medicare's interests are protected in any resolution. 🌀

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ance of Medicare Set-Aside Professionals. **Erin Collins** is an associate in the Wilmington office of Hedrick Gardner Kincheloe & Garofalo, and her practice focuses in the areas of civil litigation, Medicare compliance, and workers' compensation.

Parting Comments of the YLC Chair

Roberta B. King, *Bennett & Guthrie, PLLC*

What an honor and a privilege to serve as Chair of the Young Lawyers Committee ("YLC") this past year! The YLC has been hard at work on several different projects, a few of which I highlight. One of our first projects was the annual book drive which was held during the 2009 Fall Seminar at the Grandover Resort & Conference Center in Greensboro. This book drive was initiated several years ago by Carla Cobb, who practices in Raleigh, under the leadership of past YLC Chair Chad Bomar, who practices in Bermuda Run. Previously, we have donated books to several worthy organizations, including Motherhood, Inc. For the 2009 book drive, Bonnie Refinski-Knight connected us with the Little Red Bookmobile, a small nonprofit organization located in New Bern. Nikki Ingianni, a New Bern resident, started this nonprofit organization approximately five years ago after purchasing a red bookmobile on eBay and driving it from Alabama to New Bern. Although she started with just a few books, the book donations have increased, and now she takes the bookmobile into neighborhoods of lower socio-economic classes for after-school tutoring and reading programs. Thanks to each of you who contributed to this and past book drives.



King

The Executive Board of the YLC met on October 20, 2009, at the Bar Center in Cary. This meeting was well attended and resulted in three YLC subcommittees being formed: (1) Education/CLE, (2) Membership, and (3) Communications.

The Communications Subcommittee was co-chaired this year by Scott Adams of Winston-Salem and Jonathan Bumgardner of Raleigh. Scott and Jonathan did a tremendous job with this subcommittee and have led the YLC to contributing articles for issues of *The Defender*.

The Membership Subcommittee was chaired by YLC Vice-Chair Doug Grimes from Charlotte, Jefferson Moeller from New Bern and Michael Barnette from Hickory. This subcommittee did a terrific job and brainstormed about ways to increase membership, including increasing participation at the annual meeting. The Membership Subcommittee is also discussing and developing regional networking events throughout the state.

The Education/CLE Subcommittee was chaired by J.T. Mlinarcik from Raleigh and included Kelli Burns from Charlotte, Jenny McKeller from Rocky Mount and Laurie Miller from Ra-

leigh (Laurie is also the DRI/YLC liaison from North Carolina). This subcommittee went far beyond the call of duty and worked diligently, developing two upcoming CLE programs. The first CLE program, "Friend or Frenemy: Social Media's Direct Impact on Your Practice," will be held on Thursday, September 30, 2010, the day prior to the Fall Seminar, at the Grandover Resort & Conference Center in Greensboro. Included in this seminar are presentations regarding "Tips, Tricks & How To's of LinkedIn & Facebook," "Ethical Limitations & Implications of LinkedIn & Facebook," and "Making it Work: Using Social Media in Your Practice."

The second CLE/Seminar program, "Not Just Blowing Smoke, Using Oral Advocacy To Bring Home the Bacon," will be held at the UNC Kenan-Flagler Business School, Rizzo Conference Center, in Chapel Hill, on February 18, 2011. Topics for this CLE/Seminar include "Hearing Preparation: Not Getting Smoked in Front of Your Client, Your Opponent, and the Judge," "Out of the Frying Pan into the Fire – Handling Questions or Silence from the Judge," "Adding Flavor to the Meat of Your Argument – Effective Rebuttals," and "Where's the Beef – Powerful Use of Demonstrative Evidence." Attendance at this CLE/seminar will be limited to maximize individualized attention during the practice breakout sessions wherein each participant will have an opportunity to receive real-time in person evaluations, coaching, and feedback.

I encourage all members, especially our younger members, to attend these two CLE programs.

As you can see, the YLC has been quite busy this year. I extend special gratitude to Vice-Chair Doug Grimes, to J.T. Mlinarcik, to Laurie Miller and last, but by no means least, to Lynette Pitt, without whom any of this would have been possible.

It is time for me to pass the baton to my successor, Doug Grimes, who will do a fantastic job in his role as Chair of the YLC this coming year. Thanks for allowing me this most rewarding opportunity, thanks to the law firms for allowing their young attorneys to devote time and energy to these projects, and thanks to all YLC members for your participation and assistance. ☺

Roberta King is an associate with the Winston-Salem firm of *Bennett & Guthrie, PLLC*, and her practice areas include medical malpractice defense, insurance coverage, civil defense litigation, and appellate practice.

Challenges Presented by 2010 FEO 1, Prohibiting Representation of the Insured Where No Contact Can Be Established

R. Scott Adams, *Robinson & Lawing, LLP*

On April 16, 2010, the North Carolina State Bar adopted 2010 Formal Ethics Opinion 1 (hereinafter “2010 FEO 1”), addressing a lawyer’s representation of the insurance carrier under the circumstances where the insured cannot be located.

The formal opinion explains that where the insured cannot be located, a lawyer may not proceed with the representation of the insured absent authorization by law or court order. Furthermore, where a law firm is unable to make contact with an insured, no attorney-client relationship can exist between the law firm and the insured. For lawyers retained by insurance carriers to represent individuals and businesses in civil litigation, this opinion requires lawyers to take several steps in cases where the insured has disappeared or does not respond to your correspondence.

2010 FEO 1 is rooted in *Dunkley v. Shoemate*, 350 N.C. 573, 515 S.E.2d 442 (1999), which explains that where a law firm had no contact with the defendant and was not authorized by the defendant to undertake his representation, no attorney-client relationship existed between the defendant and the lawyers seeking to represent him pursuant to the insurance trust fund for the defendant’s employer. The *Dunkley* court stated that “[n]o person has the right to appear as another’s attorney without the authority to do so, granted by the party for which he is appearing.” *Id.* at 577, 515 S.E.2d at 444 (quoting *Johnson v. Amethyst Corp.*, 120 N.C.App. 529, 532, 463 S.E.2d 397, 400 (1995)). 2010 FEO 1 also notes that the attorney-client relationship is based upon principles of agency, and “two factors are essential in establishing an agency relationship: (1) the agent must



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be authorized to act for the principal and (2) the principal must exercise control over the agent.” *Id.* Accordingly, 2010 FEO 1 explains that “unless allowed by statute, court order, or subsequent case law, a lawyer may not appear in court for a party who has not authorized the representation and with whom the lawyer has not established a client-lawyer relationship.”

The following considerations should allow you to address the ethical concerns raised in 2010 FEO 1.

Attempt to Make Contact with the Insured Upon Receipt of the Referral

Although this step may seem like a given, in certain cases, attorneys step into the trajectory of the case only after a particular motion, TRO, or discovery is filed or served. The basic facts and issues are known from a review of the adjuster’s file, and contact with the insured is not immediately necessary to make an appearance or to file a response. However, pursuant to 2010 FEO 1, you cannot file anything or purport to represent the insured without first making contact with the individual or corporate entity.

If you are unable to reach the insured by telephone and cannot obtain updated contact information through readily available means, then the next step might involve sending certified mail to the insured in order to determine whether he or she still resides at the last known address. The letter might request an immediate response in order to highlight the urgency of contact and in order to expedite your compliance with 2010 FEO 1. Another possible method of establishing contact would involve notice by publication. Although the opinion indicates that in certain instances, you may make an initial appearance, you cannot mislead the court about the insured’s whereabouts. Accordingly, this initial step should be routine and immediate.

Investigate the Extent of the Adjuster's Contact with the Insured

If you cannot make initial contact with the insured, you should mine the file for details of the adjuster's contact, if any, with the insured. For a workers' compensation claim, did a representative of the insured take the steps necessary to initiate a new matter with the carrier? In an automobile negligence case, did the carrier ever obtain a statement from the insured? If the case has been managed by the carrier for a lengthy period of time, when was the last point of contact? In these situations, review the file for possible home telephone numbers, e-mail addresses, or other contact information that might not be readily apparent upon a review of the file. Additionally, the Secretary of State's Corporation Database can provide contact information for a company's registered agent, names of certain officers, and the history of corporate filings and reports.

Even if the adjuster made contact with the insured and exchanged information prior to the insured disappearing, 2010 FEO 1 would nonetheless apply. 2010 FEO 1 states that such contact probably would not be sufficient to create an attorney-client relationship with counsel selected by the insurance carrier. The opinion states that the formation of an attorney-client relationship is a question of fact and law, and the Ethics Committee "doubts that the two factors required to establish an agency relationship exist in this situation." Even if the insurance contract gives the carrier the authority to choose legal counsel and to decide whether to settle the case, the lawyer may not appear on behalf of the insured.

In the context of a "John Doe" defendant, where designating a certain person as "John Doe" is necessary to effect service of process, 2010 FEO 1 indicates that the lawyer may work with the carrier to identify the intended person (the opinion provides the example of an employee of an insured defendant company). Once identified, the lawyer may appear in the lawsuit on behalf of the intended person if he or she authorizes the representation. 2010 FEO 1 does not assess whether the lawyer can represent "John Doe" if his or her identity cannot be ascertained by the lawyer or carrier.

Determine Whether the Insured Authorized the Representation Prior to Disappearing

If the insured received notice of the lawsuit and specifically authorized the representation prior to disappearing, then 2010 FEO 1 indicates that the lawyer may appear in the lawsuit. However, the extent of the appearance is unclear, because if the insured cannot be located following the initial appearance, the lawyer "may not mislead" the court about the insured's absence. If the insured can-


not participate in the representation, then the lawyer may need to file a motion to withdraw because the insured cannot direct the purposes of legal representation.

Additionally, it may be helpful to review the insurance contract to determine whether it contains a provision expressly allowing ongoing representation in the event that contact with the insured is lost. 2010 FEO 1 indicates that this question of law has yet to be answered by the existing case law, and therefore, it is possible that such a provision could be upheld as sufficient to allow ongoing representation. A lawyer in this situation nonetheless would have to be able to prove that the components of an agency relationship are present. Therefore, even if authorization of the agent's action is presumed to be authorized, the principal still must be able to control the course of the representation.

Consider Whether to Withdraw as Counsel

If you are unable to make any contact with the insured, then 2010 FEO 1 explains that you must withdraw as counsel. This process is fairly straightforward in the context of a workers' compensation claim that is "carrier-driven," because you can continue to represent the carrier and reach a resolution of the case. Although you may have difficulty litigating certain issues without the input of the employer (e.g., average weekly wage), at least you can guide the case to a close without the insured's input. Therefore, in a workers' compensation claim, you can file a motion to withdraw as counsel for the defendant-employer and recite your unsuccessful attempts at contacting the insured.

In the general liability context, the situation is more complicated in light of the insured generally being the only named party to the lawsuit. If you file a motion to withdraw as counsel for the insured, then you will pursue the case as counsel for unnamed parties, or you can file a motion to substitute the carrier as a named party. However, if the case progresses to trial, then it obviously would be difficult to try the case without the testimony of the insured, and would be extremely prejudicial to stand before the jury as counsel only for the carrier.

If you have any questions about the application of 2010 FEO 1 to a specific state of facts, you should feel free to contact your district bar councilor or a member of the Ethics Committee. 

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Wallace Farm v. City of Charlotte: A First Look at G.S. § 132-1.9

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One of the differences between representing private clients and governmental entities in North Carolina is that the governmental entity is subject to the Public Records Act (G.S. 132-1, et. seq.), while private entities are not.

Attorneys representing private clients do not have to worry about their trial preparation materials being available to opposing counsel through a public records request prior to the commencement of litigation. They can laugh and politely say no. During litigation, the private client's attorney can also use the work product protection from Rule 26(b)(3) of the Rules of Civil Procedure to withhold documents. However, until 2005, attorneys representing governmental attorneys could not use the work product protection to shield trial preparation materials from public record requests under the Public Records Act. Section 132-1.9 of the General Statutes changed that, and provided work product protection in the public records context for attorneys representing governmental attorneys. The statute was not tested by our appellate courts until recently.

On March 16, 2010, the North Carolina Court of Appeals issued its opinion in Wallace Farm, Inc. v. City of Charlotte, ___ N.C. App. ___, 689 S.E.2d 922 (2010). The Court of Appeals affirmed the trial court's decision allowing the City of Charlotte to protect documents from disclosure as public records by holding that the documents were trial preparation materials under § G.S. 132-1.9. This article will take a look at the background of the statute, the background of the case, the arguments made by the parties, and the Court of Appeals' decision. (Plaintiff filed a Petition for Discretionary Review with the Supreme Court on April 20, 2010, and the Defendants filed a response on May 3, 2010. As of the date this article was written, no decision on the petition had been announced.)



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The McCormick Case and G.S. §132-1.9

Prior to 2005, North Carolina's public records statutes did not contain a specific exception for trial preparation materials or work product. This lack of an exception came to the forefront in the Court of Appeals' decision in *McCormick v. Hanson Aggregates Southeast, Inc.*, 164 N.C. App. 459, 596 S.E.2d 431 (2004), which held that the work product privilege did not apply for public records requests when it came to documents created by local government attorneys. (Mary Penny Thompson's article, "Recent Blow Delivered to Work Product Privilege" from the June 2004 issue of the North Carolina Bar Association's Government and Public Sector newsletter, contains an analysis of the decision, and so the decision will not be reanalyzed here.)

As a result of the *McCormick* decision, the General Assembly enacted Session Law 2005-332, which added G.S. §132-1.9. Section 132-1.9(b) provides that "a custodian [of public records] may deny access to a public record that is also trial preparation material." A custodian of public records is also permitted to deny access on the basis that the documents are "trial preparation material that was prepared in anticipation of a legal proceeding *that has not commenced.*" *Id.* (emphasis added). The statute defines a legal proceeding as not only civil actions in state and federal court, but also a local government administrative or quasi-judicial proceeding. G.S. §132-1.9(h)(1). Trial preparation materials were also defined as those materials that are protected under Rule 26(b)(3) of the Rules of Civil Procedure, and comparable materials for legal proceedings, as well as materials exchanged pursuant to joint defense, joint prosecution, or joint interest agreements connected to a pending or anticipated legal proceeding. G.S. §132-1.9(h)(2).

Essentially, the statute extended the civil discovery trial preparation protection to the Public Records Act, but also allowed governmental units to utilize the protection before any legal proceeding commenced.

Wallace Farm, or How Does Compost Fit Into All This?

Wallace Farm is a former dairy farm located in Northern Mecklenburg County. Operations as a dairy farm started in the early 1900s, but by the 1990s, the Wallace family abandoned dairy farming and turned their farm into an industrial composting facility. As part of this shift, Wallace Farm began contracting with other companies to have the companies' compostable waste hauled in to Wallace Farm so the waste could be used as feedstock (the raw materials for composting). (For example, dairy waste was brought in from Hunter Farms under contract.) At the same time Wallace Farm shifted to industrial composting, previously undeveloped areas around Wallace Farm were developed into large subdivisions such as Highland Creek and Skybrook. Wallace Farm was no longer in the middle of undeveloped land and had plenty of neighbors. Wallace Farm became part of the City of Charlotte's Extraterritorial Jurisdiction ("ETJ") in 1999, before it was annexed by the City of Charlotte on June 30, 2009.

As the shift continued, the North Carolina Department of Environment and Natural Resources (NCDENR) required Wallace Farm to obtain a five-year permit to operate as a Large, Type 3 Solid Waste Facility, which would allow it to continue industrial composting. As Wallace Farm increased the amount of materials it composted, including food waste residuals, odor complaints from the surrounding neighborhoods increased dramatically. Neighbors complained that the smell from the composting facility was offensive and negatively impacted their lives.

As Wallace Farm's initial permit neared expiration in 2005, it submitted a renewal application which allowed it to keep operating when its permit would normally have expired. The City of Charlotte became involved in the renewal process when it was required to issue a zoning verification letter for the facility. The City issued a letter that declared Wallace Farm activities were a legal non-conforming use, but placed conditions on Wallace Farm's operations, all of which were removed from the letter during a hearing by the City's Zoning Board of Adjustment. (An earlier zoning verification letter had been issued that determined that Wallace Farm was an illegal use under applicable zoning, but the letter was withdrawn.) After a lengthy review, with passionate public input for and against (mostly against), NCDENR's Division of Waste Management issued the renewal permit on April 22, 2010. (The final permit, as well as other documents related to the permit renewal and NCDENR enforcement actions are available at <http://www.wastenotnc.org/>.)

The City's Odor Study and the Administrative Warrant

While the permit-renewal process continued, the City of Charlotte received hundreds of odor complaints from neighbors living near Wallace Farm. As part of the process of trying to find solutions to remedy the problem, the City entered into a contract with an engineering firm to perform an odor study of Wallace Farm and its impact on nearby neighborhoods. One of the goals of the study would be determining the link between Wallace Farm and the odors in the neighborhoods. The results of this study were to also be used in two additional ways: (1) as City input into the State's review of Wallace's application for renewal of its State solid waste permit, and (2) as possible documentation in support of any future odor-related notices of violation under the City Zoning Ordinance.

The City negotiated with Wallace Farm in an attempt to gain voluntary access to the property to take air samples. However, Wallace Farm refused to allow voluntary access unless the City agreed that the odor study would take place over a period of years instead of a shorter period of time. The Wallace request would mean that the results of the study could not be used for permit renewal, thus losing value to the City (which may have been Wallace Farm's goal).

In the absence of cooperation from Wallace Farm, the City used an administrative warrant, pursuant to G.S. § 15-27.2, to gain access to Wallace Farm. On September 30, 2008, with members of the Charlotte-Mecklenburg Police Department accompanying a City team of inspectors, engineers and attorneys, the City served the warrant. Despite resistance from the property owners, including threats of bodily harm to City personnel and suggestions that the owners would interfere with the inspection and air sample collection, the zoning inspection and air sample collection took place. (A member of Wallace Farm's management team threatened the author of this article by telling him that he wanted to "kick his ass" once as the warrant was served.)

As the inspection and collection efforts started, Wallace Farm's owners contacted one of their attorneys who arrived on site. The conversation was quite animated (with Wallace Farm's attorney shouting and ordering City personnel to leave his client's property) and included a threat that "everyone connected with the City Attorney's Office is going to find yourself sued. You're going to be sued for this." See Transcription of recording at Wallace Farm on September 30, 2008 at 1 (attached to the City and Curt Walton's Memorandum of Law in Opposition to Plaintiff's Petition to Compel Production of Public Records submit-

ted to the trial court prior to a December 18, 2008 hearing). Nonetheless the inspection and sampling were completed. However, it led to a response by Wallace Farm and their attorneys.

Wallace Farm's Public Records Request and Public Records Lawsuit

Wallace Farm's response came 15 days later when Wallace Farm's Vice President Eric Wallace sent City Manager Curt Walton a public records request seeking to inspect and examine all public records held by the City of Charlotte related to Wallace Farm, Inc. from January 1, 1998 to October 15, 2008, a span of nearly 11 years. The request was repeated in an October 27, 2008 letter. On October 31, 2008, Mac McCarley, Charlotte's City Attorney, responded to Wallace Farm's attorneys and advised them that, as the request was "quite extensive," the City would work to produce documents in full compliance with Chapter 132 of the General Statutes as the records were gathered.

On November 3, 2008, only 13 business days after sending the first request letter, Wallace Farm filed a "Complaint to Compel Production of Public Records" with the Mecklenburg County Clerk of Superior Court, contending that the City failed to respond to Wallace Farm's public records request.

Between November 25, 2008, and December 12, 2008, the City made 24,626 pages of documents available to Wallace Farm's attorneys. However, the City withheld approximately 500 pages of public record documents on the grounds that the documents were protected by G.S. §132-1.9. As the withheld documents were related to a legal proceeding that had not yet commenced, the City provided Wallace Farm's attorneys with the justification letter required by G.S. § 132-1.9(b) on December 15, 2008. In the letter, the City provided three reasons for withholding the documents: (1) The litigiousness of his client; (2) the explicit threat to sue the City and its employees, and (3) the materials contained mental impressions, opinions, conclusions, or legal theories of members of the City Attorney's Office concerning potential litigation.

The withheld documents were of two types: (1) Approximately 300 pages consisting of copies of case opinions researched by the City's attorneys or others working on behalf of the City's attorneys, and (2) 225 pages of documents consisting of memoranda, e-mails, and other correspondence generated by and intended for attorneys or employees of the City Attorney's Office containing the mental impressions, legal theories, opinions, and conclusions related to the evaluation of a potential strategy for zoning enforcement and nuisance abatement. The documents were plainly protected by G.S. §132-1.9.

On December 18, 2008, Wallace Farm's Motion to Compel Production of Documents was heard before Superior

Court Judge Richard Boner. As more than 24,000 pages of public records had been produced prior to the hearing, Wallace Farm's focus shifted to the more than 500 pages of documents the City withheld from inspection and production under G.S. §132-1.9. At the hearing, the City was advised by Judge Boner that the copies of case opinions withheld would not be considered trial preparation materials (in his discretion), but that an *in camera* examination of the other withheld documents would be conducted to determine if the remaining materials were trial preparation materials. (Judge Boner issued an order on December 31, 2008 that ordered that the case opinions would be produced and that the remaining documents would be provided to the Trial Court for the *in camera* review.) After conducting the review, Judge Boner issued a January 6, 2009 order which held that the remaining withheld documents were trial preparation materials (with the exception of portions of two e-mails that were produced in redacted form to Wallace Farm's attorneys). On February 2, 2009, Wallace Farm appealed from the January 6, 2009 order.

The Plaintiff-Appellant's Arguments to the Court of Appeals and the City's Response

Wallace Farm made several arguments in appealing the January 6, 2009, order to the Court of Appeals. It argued: (1) The use of §132-1.9 in this case runs counter to the policy behind and the intent of the Public Records Act; (2) the City failed to meet its burden to show that the withheld materials were trial preparation documents; (3) the withheld documents were prepared in the ordinary course of business by the City, which deprives the records of protection as trial preparation records, and (4) even if the records are trial preparation materials, Wallace Farm has substantial need of the records in the preparation of its case.

Wallace Farm contended that the longstanding policy allowing the public access to public records was frustrated by the City's attempt to withhold some public records on the grounds that the records were trial preparation materials. Wallace Farm argued that the right to inspect public records was fundamental (citing *McCormick v. Hanson Aggregates Southeast, Inc.*, 164 N.C. App. 459, 596 S.E.2d 431 (2004)) and that liberal access to public records was the standard to follow (citing *News and Observer Publ'g v. Poole*, 330 N.C. 465, 412 S.E.2d 7 (1992)). To Wallace Farm, the Court of Appeals' duty was to apply the Public Records Act to carry out the intent of the legislature, and the way to do that was to require disclosure of the withheld records, regardless of G.S. § 132-1.9.

In response, the City argued that Wallace Farm ignored one important point: the right of access to public records is a statutorily provided right, and the General Assembly

was free to modify that right as it saw fit. No one challenged the General Assembly's right to enact G.S. § 132-1.9 or the statute.

Wallace Farm's second argument was that the City failed to meet its burden to show that the materials withheld were trial preparation materials. Wallace Farm argued that the City needed to demonstrate three things to take advantage of the trial preparation protection: "(1) that the material consists of documents or tangible things, (2) which were prepared in anticipation of litigation or for trial, and (3) by or for another party or its representatives, which may include an attorney, consultant, surety, indemnitor, insurer, or agent." Plaintiff-Appellant Wallace Farm's Brief at 19 (citations omitted). Wallace Farm further argued that the City was required to show specific objective evidence that litigation was likely.

The City's response was again simple. Since the documents were created to evaluate options for zoning enforcement and nuisance abatement, and those options had the right of appeal either to a quasi-judicial body (the Zoning Board of Adjustment) or Superior Court, the possibility of litigation ensuing was reasonable and likely. The City contended that it had provided sufficient evidence to the trial court (especially once it conducted the *in camera* review) to meet the burden.

The third argument Wallace Farm made was interesting: because the City Attorney's Office operates like in-house counsel, and not like a retained firm, any materials produced by the City Attorney's Office were produced in the ordinary course of business, and thus could not be protected as work product (in accordance with *Cook v. Wake County Hospital System*, 125 N.C. App. 618, 482 S.E.2d 546 (1997)). Even if the City could show that the documents were prepared in anticipation of litigation, the protection might exist only for documents produced after September 30, 2008, when Wallace Farm's counsel threatened to sue anyone connected with the City Attorney's Office.

Wallace Farm's attempt to reduce the work done by the City Attorney's Office to routine procedural documents prepared in the regular course of business was an interesting argument. The City's response was that the argument, when carried out to its extreme, would deny trial preparation protection for any document produced by the City Attorney's Office, rendering G.S. § 132-1.9 ineffective, just because the members of the office are employed by the municipality. Wallace Farm also appeared to suggest that if the City retained outside counsel, outside counsel could use the G.S. § 132-1.9 protection, but not an attorney employed by the City. This would punish a local government for hiring an attorney instead of retaining one, by being

denied the use of G.S. § 132-1.9. Also, the City argued the withheld documents related to work on a possible zoning enforcement or nuisance abatement strategy which would not be created as a matter of routine, thus not in the ordinary course of business.

The final argument made by Wallace Farm was that even if the Court of Appeals considered the withheld documents to be trial preparation materials, Wallace Farm was entitled to the documents because it needed them in the preparation of its case. Wallace Farm contended it needed the documents in order to prepare a case against the City to "contest the illegal [administrative] warrant, search and evidence gathered, and it is unable to obtain the documents or their equivalent from anyone other than the City." Plaintiff-Appellant Wallace Farm's Brief at 30 (quoting the December 16, 2008 Affidavit of Eric Wallace, located at pages 40-50 in the Record on Appeal submitted to the Court of Appeals). Wallace Farm further argued that the documents were needed not only to defend it from the City's September 30, 2008, inspection, but also "to investigate and articulate potential causes of action against the City." *Id.* at 31. While not stated in its brief to the Court of Appeals, Wallace Farm suggested to the trial court that it might pursue the following claims against the City and its employees:

- (1) Violation of North Carolina and United States Constitutions for searching the Plaintiff's property with a facially invalid affidavit and warrant warrant [sic] and without probable cause;
- (2) Due Process violations under the North Carolina and United States Constitutions for taking samples without prior notice to the Plaintiff and without affording the Plaintiff an opportunity to take split samples in order to prepare an adequate defense;
- (3) Violation of North Carolina Constitution and United States Constitution for wrongfully interfering with the Plaintiff's vested property rights; and
- (4) Title 42 U.S.C. § 1983 claim for the actions of City officials and employees in violating the Plaintiff's civil rights.

Plaintiff Wallace Farm's Memorandum of Law in Support of Plaintiff's Complaint to Compel Production of Public Records at 15. (As of the date this article was written, none of these claims have been pursued by Wallace Farm.)

The City chose to not respond to this argument. The trial court appeared to ignore the argument, and the fact of the matter was that Wallace Farm's complaint was based solely on an alleged violation of the Public Records Act. Wallace Farm had not pursued claims against the City or its employees and contractors for the September 30, 2008 inspection, so there was no reason to respond to the argument.

Oral Argument at the Court of Appeals

When the calendar for the oral argument in this case was issued, it listed Judges James A. Wynn, Jr., Barbara Jackson, and Robert N. Hunter, Jr. as the assigned hearing panel. However, due to Judge Wynn's nomination to the United States Court of Appeals for the Fourth Circuit, Judge Wanda Bryant substituted for Judge Wynn. In the oral argument, Judge Bryant recalled her role in the *McCormick* case as the opinion's author, and noted that the decision led to G.S. §132-1.9. (The author's recollection of the oral argument is based on his notes, as the recording system for the Court of Appeals had a technical problem.)

Judge Bryant also noted her concern with Wallace Farm filing its complaint to compel production of public records fewer than 20 days after making the initial request for public record inspection. In response, Wallace Farm's attorneys noted that they filed the complaint quickly to expedite matters. Judge Bryant also addressed Wallace Farm's substantial need argument and appeared to dismiss it by noting that substantial need must be linked to an actual case, not the prospect of one. During Wallace Farm's rebuttal, Judge Bryant also inquired why 20,000 pages of documents was not enough for Wallace Farm.

Judge Hunter's emphasis was on the standard of review to be used in this case. Wallace Farm suggested in its brief that the standard of review should be *de novo*, based on *State v. Tedeja*, 191 N.C. App. 439, 664 S.E.2d 402 (2008), a case related to investigations of juvenile abuse or neglect, and not a public records case. Judge Hunter wondered whether *de novo* was appropriate, given that this was akin to a discovery issue where abuse of discretion would be the proper standard. Wallace Farm's attorneys stressed that *de novo* was appropriate without being able to fully explain why. The City agreed with Judge Hunter that as this case was similar to a discovery issue, abuse of discretion was the appropriate standard. Judge Hunter continued questioning on this issue and wondered if the Court should even want to open the sealed packet of materials to determine if the trial court abused its discretion. (As noted below, the Court of Appeals did look at the documents in making its decision.)

Judge Jackson pointed out that if the Court accepted Wallace Farm's arguments, it would prevent governments from developing and exploring a strategy to handle an is-

sue. Effectively, governments would be locked in to pursuing a particular strategy and could not vary from it. Judge Jackson noted that it was prudent for corporations to consult their counsel before proceeding with a plan for action, and those discussions with counsel made sense. Wallace Farm's position would have a chilling effect for governmental entities.

During the City's oral argument, the City argued that following the Wallace Farm position was against the intent of G.S. §132-1.9, and if the Wallace Farm position was followed, it would effectively give up a governmental entity's "playbook" for how it might want to handle a situation. During rebuttal, Wallace Farm's attorneys expressed their conviction that instead of trying to get the "playbook," they were seeking a nugget of a document within the 225 pages of documents withheld by the City and Curt Walton to prove the claims they could make against the City. The nugget just had to be there.

While this article's author is biased as he sat at the table opposite Wallace Farm's attorneys, it appeared that the panel was more than a little skeptical of Wallace Farm's arguments, and was leaning toward affirming the trial court's opinion.

The Decision, or How To Protect Your Playbook


In its 3-0 decision, the Court of Appeals affirmed the trial court's order. The Court of Appeals moved quickly to look at the case under the abuse of discretion standard. It noted that while the Public Records Act "provides for liberal access to public records," *Wallace Farm, Inc. v. City of Charlotte*, ___ N.C. App. ___, ___, 689 S.E.2d 922, 923 (2010) (citing *Virmani v. Presbyterian Health Servs. Corp.*, 350 N.C. 449, 462, 515 S.E.2d 675, 685 (1999)), there are exceptions and exemptions to the Public Records Act, which must be construed narrowly. *Id.* at 924 (citation omitted). The Court noted that G.S. §132-1.9 allowed records custodians to deny access to trial preparation materials that are otherwise public records. *Id.* (citing N.C. Gen. Stat. §132-1.9(b) (2007)).

The Court of Appeals then went to a trial preparation material analysis based on the Rules of Civil Procedure. The Court of Appeals looked at the December 15, 2008 justification letter and statements made at the December 18, 2008, hearing which discussed that the withheld materials were all related to the City's research on zoning enforcement. The Court of Appeals then noted that it conducted its own *in camera* review in determining that the withheld materials contained "mental impressions, conclusions, opinions, or legal theories of city attorneys or other agents of the City in reasonable anticipation of litigation," in holding that the G.S. §132-1.9 exception applied. *Id.* at *6-7.

The brevity of the decision was surprising, but perhaps it should not have been. While Wallace Farm made many arguments, the arguments could be disposed of simply and quickly, which the Court of Appeals seemed to do. The Court quickly determined that the documents were prepared in reasonable anticipation of litigation and could take advantage of the trial preparation protection. Based on the Court's approach, it appeared to be a "slam-dunk" decision for the Court of Appeals, with the Court not straying from the statute. The Court appeared to give due deference to the General Assembly's enactment of the statute, and the decision of the trial court.

As a predictor of future action of our appellate courts (assuming that this case is not reversed by the Supreme Court should discretionary review be allowed), it appears that so long as a governmental unit can lay out a compelling justification for why the documents should be pro-

tected (either in the required §132-1.9(b) letter or by other means) and the documents withheld are limited to documents clearly representing mental impressions, legal theories, or conclusions or opinions of attorneys or their agents, a governmental unit will succeed on a challenge to its ability to withhold documents as trial preparation materials. If a governmental unit tries to protect marginal documents, it runs the chance that a trial or appellate court may deny the protection to it, thus risking an award of attorney's fees under G.S. §132-9.

For governmental attorneys, G.S. §132-1.9 is an important tool that levels the playing field in preventing the "playbook" from being turned over to the other team. 

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Calendar of Events

June		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
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September		1	2	3	4
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October			1	2
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June 17-20, 2010
33rd Annual Meeting & Spring Program
 Marriott Resort & Conference Center
 Hilton Head Island, SC

September 30, 2010
Friend or Frenemy: Social Media's Direct Impact on Your Practice
 NCADA Young Lawyers Seminar
 Greensboro, NC

October 1, 2010
Fall Seminar & Judicial Candidates' Forum
 Grandover Resort & Conference Center
 Greensboro, NC

October 20-24, 2010
DRI Annual Meeting
 San Diego, CA

June 16-19, 2011
34th Annual Meeting & Spring Program
 Westin Resort & Conference Center
 Hilton Head Island, SC

Hot Topics in North Carolina Auto Coverage

John P. Barringer, *McAngus Goudelock & Courie, PLLC*

The Extension of UIM Coverage While Occupying a “Temporary Substitute”

In July 2009 the North Carolina Court of Appeals issued an opinion arising out of a Wake County lawsuit holding that the claimant was entitled to “underinsured” motorist coverage under his professional association business policy despite the fact that he was driving his personal auto. The case is *Martini v. Companion Property & Casualty Insurance Company*, ___ N.C. App. ___, 679 S.E.2d 156 (2009). In *Martini* the claimant was a doctor who had a policy in the name of his professional association that listed as a covered auto a Toyota Sequoia. Dr. Martini and his wife had a personal auto policy that listed as covered autos a Montero and an Audi. The night before the subject accident the Martinis noticed a brake light on in the Sequoia. Martini was scheduled to attend a business conference out of town the following day which required him to fly. Rather than drive the Sequoia to the airport, he left it for his wife to take to a shop for service and drove the family Montero to the airport. On the morning of January 10, 2005, Dr. Martini was involved in an accident while driving to the airport in the Montero. It seems to be undisputed that the driver of another vehicle struck the Montero while attempting to change lanes causing the Montero to leave the roadway and flip over a number of times. Martini was seriously injured, including among other things sustaining a fractured C-7 vertebra. The tortfeasor was insured with minimum limits of liability coverage (\$30,000) which were tendered and paid. Martini made a claim under his personal auto policy for both med pay and “underinsured” coverage as a named insured and driver of the Montero. Southern Guarantee (the personal auto carrier) paid its coverage limits of \$250,000 subject to a \$30,000 credit or set off for the liability coverage paid on behalf of the at-fault driver.

Dr. Martini also made a claim under the policy issued by Companion in the name of his professional association that listed the Sequoia as a covered auto. Despite the fact that Martini was not driving the Sequoia at the time of the



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accident, his contention was that he was entitled to “underinsured” coverage as an “insured” which was defined for his “limited liability company” to include anyone “occupying” a covered “auto” or a temporary substitute for a covered “auto.” Companion denied the claim, resulting in the filing of the Declaratory Judgment Action. The plaintiff also included a claim under Chapter 75-1.1 for “Unfair and Deceptive Trade Practices.” The Defendant carrier counter-claimed for Declaratory Relief, setting the stage for cross motions for Summary Judgment. The one additional issue in dispute was raised by Companion, which contended that if it had “underinsured” coverage, it was entitled to a set off in the amount of the \$250,000 that had already been paid by the combination of the tort carrier and the primary UIM carrier. The trial court entered an order of Summary Judgment finding that the Companion policy did provide UIM coverage with limits of \$1,000,000 and that Companion was not entitled to a set off for sums paid by either the liability carrier or the primary UIM carrier. Finally, the Court dismissed the “unfair and deceptive” claims.

On appeal the Court of Appeals upheld the trial court’s rulings with respect to the UIM issues, but overturned the trial court’s dismissal of the “unfair and deceptive” claims. Judge Steelman dissented with respect to the finding of UIM coverage, thus entitling Companion to review by the Supreme Court. Companion also petitioned the Supreme Court to review the Court of Appeals decision with respect to the “unfair and deceptive” claims. The appeal based upon Judge Steelman’s dissent is still pending before the North Carolina Supreme Court. However, the Court denied the petition for discretionary review on the issue involving the “unfair and deceptive” claims in late January. 363 N.C. 805, 690 S.E.2d 704 (2010).

Court of Appeals Rationale in Martini

The Court’s decision in *Martini* is based upon a liberal interpretation of the definition of a “temporary substitute” vehicle as contained in the “Who is An Insured” section of the policy. In order for Martini to qualify for “underinsured” coverage under the policy, he has to be an “insured” under the facts of the case. The UIM policy issued to Dr. Martini’s professional association included the following language:

B. Who Is An Insured

If the Named Insured is designated in the Declarations as:

2. A partnership, limited liability company, corporation or any other form or organization, then the following are “insureds”:

a. Anyone “occupying” a covered “auto” or a temporary substitute for a covered “auto.” The covered “auto” must be out of service because of its breakdown, repair, servicing, “loss” or destruction.

Covered “autos” under the Companion policy were defined to be listed “autos.” The plaintiff was driving his personally owned Montero at the time of his accident. The only listed auto under the Companion policy was the Sequoia. The opinion turned on whether the Montero was a temporary substitute for the Sequoia which was allegedly not driven because the brake indicator light had come on. Despite the existence of evidence to the contrary, the Court accepted that the Plaintiff and his wife were concerned for the safe operation of the Sequoia, and found that “it was reasonable to assume that Mrs. Martini would have taken the car to the mechanic” on the morning of the accident had it not occurred. If she had taken the car in for repair it would have been unusable and out of service. As it turned out, she did not take the car in that morning or for several weeks after the accident. There was also evidence to the effect that Dr. Martini did not want to park the Sequoia at the airport and that was the reason he drove the Montero. Notwithstanding, the Court engaged in the business of “assumption” to liberally interpret what qualifies as a “temporary substitute” in order to extend the scope of UIM coverage to an injured party.

The “temporary substitute” issue can also arise in the context of liability coverage. The standard North Carolina auto policy provides coverage for the payment of damages “for which any insured becomes legally responsible because of an auto accident.” “Insured” is defined in the personal auto policy to include:

1. You or any family member for the ownership, maintenance or use of any auto or trailer.
2. Any person using “your covered auto.”

“Your covered auto” means:

1. Any vehicle shown in the Declarations.
2. a newly acquired auto;
3. any trailer you own; and
4. any auto or trailer not owned by you while used as a temporary substitute for any other vehicle described

in this definition which is out of normal use because of its:

- a. breakdown;
- b. repair;
- c. servicing;
- d. loss; or
- e. destruction.

Provision 4 does not apply to Part D—Coverage for Damage to Your Auto.

The *Martini* decision will directly affect how future courts view so called “temporary substitute” cases from a liability coverage perspective. The threshold question is whether the listed vehicle has to be completely out of use in order for another vehicle to qualify as a temporary substitute or whether, as in *Martini*, the listed vehicle can simply be less attractive to drive or have some issue. The court’s standard in *Martini* which seems to be based on a subjective concern for safety opens the door wide to abuse and expansion of both liability and UM/UIM coverage. As an example, one could almost always assert a concern over the operating condition of the vehicle (tires, wiper blades, brakes, etc.) as justification to drive a substitute, either borrowed, rented or simply previously out of service and uninsured.

Historic Look at the “Temporary Substitute” Issue

The Court of Appeals in *Martini* references three prior appellate cases that address this issue of the “temporary substitute.” These provide a good historical look back at how our Courts have dealt with the issue and the threshold question referred to above of “out of service” vs. convenience or choice. The cases are *Ransom v. Fidelity & Casualty Co.*, 250 N.C. 60, 108 S.E.2d 22 (1959), *Maryland Casualty Co. v. State Farm Mutual Automobile Insurance Co.*, 83 N.C. App. 140, 349 S.E.2d 307 (1986), and *Nationwide Mutual Insurance Co. v. Fireman’s Fund Insurance Co.*, 279 N.C. 240, 182 S.E.2d 571 (1971). In *Ransom*, Francis Lee drove his brother’s car because his own car, a Buick, was “low on gas.” Lee collided with a man on a bicycle, who was killed. The man’s estate sued Lee for wrongful death and sought payment from the Buick’s insurer, arguing that the brother’s car was a temporary substitute vehicle for the Buick. The brother’s car was not insured. The Supreme Court affirmed the trial court’s dismissal because the policy required that the covered vehicle be “withdrawn from normal use.” The Court found that being “low on gas” did not mean that the Buick had been withdrawn from normal use. The Supreme Court did note that “[i]t would seem there could be circumstances under which one might be justified in substituting another car, if the one insured was so defective mechanically

that the owner was afraid to drive it on an extended trip.”

Maryland Casualty also involved a collision, this time between Kell Thomas and Max Sherrill. Sherrill was injured in the collision and his insurer sought payment from Thomas’ insurer. However, the truck that Thomas was driving that day was not insured. Thomas’ only vehicle insurance policy was on a car. Sherrill’s insurer argued that the truck was a temporary substitute vehicle for the car and, thus, was covered by the insurance policy. The policy defined a temporary substitute vehicle as one driven because the covered vehicle was “out of normal use because of its: a. breakdown; b. repair; c. servicing; d. loss; or e. destruction.” The Court concluded that Thomas’ truck was not a temporary substitute vehicle because the car was only “rusted out” and “in bad condition,” which did not remove the car from normal use.

In *Nationwide Mutual Insurance Co. v. Fireman’s Fund Insurance Co.*, 279 N.C. 240, 182 S.E.2d 571 (1971), our Supreme Court affirmed coverage when the covered vehicle was at a paint and body shop to be repainted and the insured wrecked the car he had borrowed while his was being repainted. The Court of Appeals in *Martini* relied on this case as being analogous based on its assumption that Martini’s wife would have taken the car in for service and thus placing it out of service had not the accident occurred. It is important to note that in his dissent, Judge Steelman points out with emphasis that the Court’s responsibility upon considering a motion for summary judgment is not to become the fact finder itself “but solely to determine whether there is an issue of fact to be tried.” He clearly opines that the Court overstepped its bounds in making assumptions and ignoring conflicting testimony. He also notes with respect to the “temporary substitute” question that the *Maryland Casualty* case requires that “the initially covered vehicle must nonetheless be actually withdrawn from use.” While each case is factually different, the dissent in *Martini* provides a good framework for properly evaluating the issues as they arise in future cases.

The Unfair and Deceptive Claims in Martini

The *Martini* opinion includes a pretty fair summary of both the governing law for recovery of damages under the North Carolina Unfair and Deceptive Trade Practices Act (N.C.G.S Chapter 75-1.1) and a recitation of those elements of the Unfair Claims Settlement Practice Act (N.C.G.S Chapter 58-63-15 (11)) which are most typically pled in these type cases. *Martini* also presents a good example of a dispute that appears to involve a good faith difference of opinion regarding application of the “temporary substitute” issue. Notwithstanding, the “honest mistake” or “good faith difference of opinion” is not a defense under Chapter 75. The result is that what once was and should be a fair

dispute tailored for resolution by Declaratory Judgment is clouded by extra-contractual claims. Perhaps the best defense to the “unfair and deceptive” claims is to prevail on the coverage issue. While our appellate courts have held that a claimant can pursue extra-contractual claims even when the carrier pays under the contract, a favorable result on the contract claim is probably the best way to combat the questionable or unmeritorious Chapter 75 claim.

The 2008 decision by the Court of Appeals in *Moore v. Nationwide*, 191 N.C. App. 106, 664 S.E.2d 326, *aff’d*, 362 N.C. 673, 669 S.E.2d 321 (2008), presents a good example of this. In *Moore*, Nationwide denied an “uninsured” claim where the claimant contended that he had struck a pine log in the roadway that had fallen off of a truck. The claimant sued Nationwide for breach of contract, unfair and deceptive trade practices, bad faith, etc. The Court of Appeals dismissed the matter on Nationwide’s 12(b)(6) motion on the basis that the pleadings had made clear there was no “contact” between the claimant’s vehicle and the so called “uninsured” or phantom vehicle as required by the statute and policy. The extra-contractual claims appear to have been dismissed with the contract (“contact”) claim. *Moore* is significant in that Judge McCullough dissented, creating an automatic review by the Supreme Court. The Supreme Court affirmed *per curiam* the opinion of the Court of Appeals, effectively leaving in place the requirement for “contact” between vehicles as a requirement for “uninsured” coverage.

The Set Off Issue

Martini also involved the question of whether an excess UIM carrier would be entitled to an offset or credit for sums paid by a primary UIM carrier. The Court of Appeals reiterated the statutory provision for stacking of UIM coverage under N.C. Gen. Stat. 20-279.21(b)(4) and held that Companion was not entitled to a credit for what Southern Guarantee had paid. The Court also supported its conclusion by referral to its recent decision in *Benton* for the proposition that the North Carolina statute provides for stacking.

Benton v. Hanford — Inter and Intra Policy Stacking

Benton v. Hanford and Progressive Southeastern Insurance Company, 195 N.C. App. 88, 671 S.E.2d 31 (2009), involved a motor vehicle accident wherein Benton was a guest passenger in a car driven by Hanford. Hanford lost control of the vehicle and struck a tree in a one car accident, causing injury to Benton. Hanford was insured by Nationwide with a \$50,000 per person liability limit. Nationwide paid Benton its limit under its liability coverage. The Nationwide policy issued to Hanford also provided for “underinsured” coverage with limits of \$50,000. That coverage

provided “underinsured” motorist coverage to the named insured, resident relatives of the named insured, and “any other person occupying your covered auto.” Progressive had a policy in place where Benton was the named insured. That policy provided UIM limits of \$100,000 per person per accident. The question considered by the Court in *Benton* was whether the Nationwide policy provided UIM coverage to Benton in addition to the UIM coverage provided by the Progressive policy. Based on the key fact that Benton was a guest passenger and occupant of the Nationwide insured vehicle, the Court held that the UIM coverage under the Nationwide policy did apply and should be stacked with the UIM coverage under the Progressive policy.

The opinion in *Benton* starts with the following language:

This case presents two issues to this Court: (1) whether a tortfeasor’s underinsured motorist (“UIM”) insurance policy which covers a person occupying the tortfeasor’s vehicle may be stacked with the injured party’s separate UIM policy in order to determine the total UIM coverage available to the insured party, and (2) how the credit for the applicable liability coverage should be divided between the tortfeasor’s insurer and the injured party’s insurer.

Benton seems to be the appellate decision de jure of 2009 for the Plaintiffs’ bar.

We have seen numerous attempts to apply *Benton* and even extend its holding beyond its very narrow factual application. Essentially, *Benton* applies in the limited circumstance where: (1) the claimant is a guest passenger (2) in a vehicle operated by an at-fault driver (3) who has bodily injury liability coverage and “underinsured” coverage (4) and qualifies as an insured for “underinsured” coverage under another policy. It does not apply in a typical accident scenario where there is no connection or relationship between the claimant and the at-fault driver. In *Rutherford v. General Ins. Co.*, 2009 WL 236124, 2009 N.C. App. LEXIS 860, 672 S.E.2d 782 (N.C. App. 2009) (unpublished decision), the Court of Appeals considered another “guest passenger” case and found that the guest passenger was insured under both a personal underinsured motorist policy as well as the underinsured coverage on the vehicle she was a passenger in. Judge Steelman, writing for the Court, stated:

This case presents the identical issue as was decided by this Court in *Benton v. Hanford*. In *Benton*, we held that a tortfeasor’s underinsured motorist coverage, which provided coverage to a passenger occupying

that vehicle, may be stacked with the injured passenger’s separate underinsured motorist policy in order to determine the total underinsured coverage available. We further held that the credit for the payment under the liability portion of the tortfeasor’s policy was to be applied against the underinsured motorist coverage for the tortfeasor’s vehicle and not against the excess coverage.

Id. (emphasis added).

Perhaps the confusion created by *Benton*, whether legitimate or feigned, stems from the Court of Appeal’s reference to the statutory definition of trigger for “underinsured” coverage which is cited in the opinion as follows:

An “uninsured motor vehicle,” as described in subdivision (3) of this subsection, includes an “underinsured highway vehicle,” which means a highway vehicle with respect to the ownership, maintenance, or use of which, *the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner’s policy.*

(Emphasis added.)

Therefore, in order for there to be a trigger of “underinsured” coverage, the exhausted liability coverage(s) have to be less than the “applicable limits of underinsured motorist coverage.” The other thing about *Benton* that is frustrating is that the Court fails to acknowledge the non-duplication provisions of the policy prior to stacking the “underinsured” coverage. The standard North Carolina “underinsured” coverage reads as follows with respect to reduction or non-duplication:

Limits of Liability

The limits of bodily injury liability shown in the Declarations for each person and each accident for this coverage shall be reduced by all sums:

1. Paid because of bodily injury by or on behalf of persons or organizations who may be legally responsible; This includes all sums paid under Part A [liability section].

The interplay between the non-duplication clause and the statutory set off is not discussed in the opinion.

It can be reasonably assumed that the Court of Appeals either treated the clause as the statutory set off or found it to be contrary to the purpose of the act and would not apply it since the result would have been to negate the application of the second UIM policy. While *Benton* has drawn a lot of attention this past year, the premise behind the decision is not new to North Carolina. In 1994 the Court of Appeals considered the same issue involving a minor who was a passenger in a family vehicle. In *State Farm Mutual Automobile Ins. Co. v. Young*, 115 N.C. App. 68, 443 S.E.2d 756 (1994), a minor claimant sought recovery under both his father's liability coverage and UIM coverage where he was injured in an accident in which his father was the driver and solely at fault. The parents were divorced and it was stipulated that the boy was a resident of both households. The mother had her own policy with "underinsured" coverage. *Young* specifically addressed the issue of whether an "owned auto" could be an "uninsured" or "underinsured" vehicle. While the policy included a provision prohibiting "underinsured" coverage for an owned auto, the Court found that the statute did not prevent such coverage and emphasized that the statute is incorporated into the policy. In essence, the question became whether you could stack or utilize liability coverage and "underinsured" coverage under the same policy. Unlike G.S. § 20-279.21(b)(3), section (b)(4) does not specifically exclude a motor vehicle "owned by the named insured" from the term "underinsured motor vehicle," although it does specifically exclude three other types of vehicles. The Court observed:

The question of whether an insured is entitled to stack liability coverage from the tortfeasor's policy with the underinsured coverage under the same policy presents a novel issue in this State. Plaintiff directs this Court to several decisions wherein courts in other jurisdictions have disallowed such recovery citing the danger of effectively converting underinsured motorist coverage into liability coverage, resulting in insurance carriers charging more for underinsured motorist coverage to match the cost of the presently more expensive liability coverage. . . . We have reviewed these decisions, and while we do not necessarily disagree with their rationale, the language of our statute and the principles of statutory interpretation require us to reach a different conclusion. Rather, we must conclude that any interpretation of the policies at issue which would exclude "an owned vehicle" from UIM coverage is void as being contrary to the requirements of the Act.

Young, 115 N.C. App. at 72, 443 S.E.2d at 759. (Although this opinion was vacated by the North Carolina Supreme Court to provide the Court of Appeals an opportunity to

reconsider its decision in light of *Nationwide Mutual Ins. Co. v. Mabe*, 342 N.C. 482, 467 S.E.2d 34 (1996), see *State Farm Mutual Automobile Ins. Co. v. Young*, 342 N.C. 647, 466 S.E.2d 275 (1996), the Court of Appeals ruled consistent with its earlier opinion. *State Farm Mutual Automobile Ins. Co. v. Young*, 122 N.C. App. 505, 470 S.E.2d 361 (1996).)

It is a bit surprising that *Young* has not been cited more often for the proposition that one can utilize coverage under both the liability and "underinsured" sections of the same policy. Perhaps this is because the case was issued prior to the statutory prohibition against intra-policy stacking of cars. In *Young*, the dad's policy had two cars on it. The Court ultimately allowed "underinsured" coverage to be doubled and then stacked again with the mom's policy. Shortly thereafter, the legislature amended the statute to include the anti-stacking provisions that are still in place with respect to intra-policy stacking of vehicles. Notwithstanding, the premise upon which the claimant recovered under both the liability section and the "underinsured" section was not affected by the statutory change.

"Use" vs. "Occupy" When Considering "Underinsured" Coverage

In the cases discussed above, "underinsured" coverage is triggered where the claimant is "occupying" a covered auto. In fact, most "underinsured" coverage forms include a definition of "Who is An Insured" to include in addition to the named insured, persons "occupying" the covered auto. This is slightly different than the typical liability coverage grant which defines as an insured any person "using" your covered auto. The term "occupying" is often defined in the policy to mean "in, upon; getting in, on, out or off." The question arises when a person who was once in the vehicle exits for some reason and is not in physical contact with the vehicle. This issue was the subject of appellate review in *Smith v. Harris*, 181 N.C. App. 585, 640 S.E.2d 436 (2007), where a police officer contended entitlement to "underinsured" coverage for damages from a broken ankle resulting from chasing a suspect on foot only after driving his police cruiser as far as possible. The Court held that the injury did not arise out of the "ownership, maintenance or use" of the vehicle. For a claim to be covered there must be a causal connection between the use of the vehicle and the injury. As the Court noted:

This connection is shown if the injury is the *natural and reasonable consequence of the vehicle's use*. However, an injury is not a natural and reasonable consequence of the use of the vehicle if the injury is the result of something "*wholly disassociated from, independent of, and remote from the vehicle's normal use*."

Auto Coverage, *continued from page 21*

Id. at 588, 640 S.E.2d at 438 (emphasis in original) (quoting *Scales v. State Farm Mut. Auto. Ins. Co.*, 119 N.C. App. 787, 790, 460 S.E.2d 201, 203 (1995)).

Similarly, in *Busby v. Simmons*, 103 N.C. App. 592, 406 S.E.2d 628 (1991), the plaintiff was struck by an automobile while riding her bicycle. She sought coverage for UIM benefits under a policy issued to a corporation in which she owned the majority of the stock. The corporation was the named insured. The policy defined “insured” as used in the UIM coverage to mean:

1. You or any family member.
2. Any other person occupying;
 - a. Your covered auto . . .

In that the plaintiff did not qualify as a class one insured and was not occupying a covered auto at the time of the accident, she did not qualify as an insured for UIM benefits. Notwithstanding the *Smith v. Harris* and *Busby v. Simmons* cases, there is a body of case law in North Carolina in which the Courts have extended “underinsured” coverage where the claimant is not an occupant of the covered auto but rather is “using.” The key consideration is whether there is a causal connection between the so called “use” of the vehicle and the injury.

In *Estate of Dutch v. Harleysville Mutual Insurance Co.*, 139 N.C. App. 602, 534 S.E.2d 262 (2000), the Court of Appeals found that the decedent (Dutch) was either “occupying” the subject vehicle or at least was “using” it so as to trigger “underinsured” coverage under the subject policy. Dutch had borrowed a car that he drove into a ditch. He then walked to a nearby house to ask for help. The neighbor drove Dutch to the site of the ditched car. Dutch had hooked a chain to the ditched vehicle and was crawling under the neighbor’s vehicle when an oncoming car collided with both cars, killing Dutch. The oncoming driver was deemed to be at fault and his liability carrier tendered its limits. USAA insured the neighbor’s car and contended that its “underinsured” coverage would not apply in that Dutch was not “occupying” the car. The Court found that given the definition of “occupying” which included being “upon” or “on” the vehicle, Dutch’s actions to place a chain on the vehicle meant that he was in contact with the vehicle and was thus “on” or “upon” the vehicle. More importantly, the Court referred to the Financial Responsibility Act which is incorporated into every policy and defines “insured” to include “any person who uses with the consent, express or implied, of the named insured, the vehicle to which the policy applies.”

The Court stated:

In the context of the interpretation of policies of insurance, this Court has “adopted the ordinary meaning of the word ‘use,’ . . . ; that is, “to put into action or service[,] . . . to carry out a purpose or action by means of[, or] . . . [to] make instrumental to an end or process. . . . [T]he verb “use” is general and indicates any putting to service of a thing” Further, while the test for determining whether an automobile liability policy provides coverage for an accident is not whether the automobile was a proximate cause of the accident[, . . . there must be] a causal connection between the use of the automobile and the accident.

Id. at 607, 534 S.E.2d at 265.

Similarly, in *Floyd v. Integon General Insurance Corp.*, 152 N.C. App. 445, 567 S.E.2d 823 (2002), the Court actually found that an insured may use more than one vehicle at a time for coverage purposes. In *Floyd*, a gentleman was driving his truck that became disabled. He left the vehicle in the ditch off the road. He later returned with another vehicle and with a chain to tow the disabled vehicle. Both vehicles were insured under the same policy. As he was attempting to chain the two vehicles together, an oncoming car collided with the second vehicle which was in the roadway waiting to pull the disabled vehicle. The Court found that the liability coverage for both the disabled vehicle and towing vehicle should apply, since the insured was “using” both at the time of the accident. This is not an “underinsured” case, but demonstrates the principle of “use” quite well.

The “Tail” or “Tale” of Williams v. Nationwide

Few North Carolina cases have drawn as much interest or been as instrumental in expanding insurance coverage over the last five years as the North Carolina Court of Appeals decision in *Williams v. Nationwide*, 174 N.C. App. 601, 621 S.E.2d 644 (2005). In *Williams*, the Court of Appeals mandated that where the carrier could not show that it had offered its insured a choice to select or reject “underinsured” motorist coverage following the 1991 amendment requiring utilization of the state promulgated form to document such choice, then the carrier was required to write the coverage at the maximum limits allowed by law or \$1,000,000. The North Carolina Supreme Court initially granted Nationwide’s petition for review (see 360 N.C. 492, 631 S.E.2d 520 (2006)), but later entered an order finding

that the petition was “improvidently” allowed, 360 N.C. 586, 634 S.E.2d 887 (2006), leaving the Court of Appeals decision in place.

Since *Williams* came down, carriers and coverage counsel have struggled with the concept of having to write on “underinsured” coverage where the coverage was either not bargained for at all or was purchased with limits lower than either the statutory mandate or the million dollars argued by plaintiff’s counsel. The legislature amended 20-279.21(b)(3) and (4) in 2008, abolishing the mandatory requirement of a selection/rejection form for policies issued on or after January 1, 2009. The amended version still requires carriers to give insured persons “reasonable notice” of their right to purchase “underinsured” coverage with limit up to \$1,000,000. Notwithstanding the 2008 amendment, claims under *Williams* can and will continue for policies issued or renewed prior to the effective date. The number of outstanding claims where the issue has been or can be raised going forward warrants a closer look at the current case law and options available to the industry.

The typical presentation of a *Williams* case is where a claimant has an injury serious enough that the primary liability carrier(s) tenders the “bodily injury” limit and yet the claimant is not fully compensated for damages. The plaintiff’s attorney requests that the carrier provide a copy of the “selection/rejection” form to confirm the amount of “underinsured” coverage the claimant or named insured chose. The carrier cannot locate a copy of the form often due to the fact that the form was executed in 1992 and has been lost or misfiled. The plaintiff’s attorney then demands entitlement to the million dollar maximum coverage limit, citing *Williams*. The starting point for determining how to respond and react to the demand for a million dollars of coverage is understanding the facts of *Williams* and exactly what the Court held.

Importantly, in *Williams*, it was stipulated that: “Neither Mr. Canady nor Mrs. Canady were offered by Nationwide or its authorized agent an opportunity to select or to reject UIM limits greater than their liability limits at any time prior to July 17, 2001.” In addition to this key fact, the Court acknowledged that while the right to choose “underinsured coverage” is mandatory, an insured that failed to choose will have the coverage at limits equal to the highest bodily injury liability limit. (“If the named insured does not reject underinsured motorist coverage and does not select different coverage limits, the amount of underinsured motorist coverage shall be equal to the highest limit of bodily injury liability coverage for any one vehicle in the policy.” 1991 N.C. Sess. Laws 837, § 9.) Applying the statutory provision, the Court of Appeals concentrated on the first word “if” to draw a distinction between failing to choose and not being given an opportunity to choose:

“Underinsured coverage is mandatory unless rejected by the insured in accordance with the provisions of N.C. Gen. Stat. § 20-279.21.” ... The statutory limitations for UIM coverage established in N.C.G.S. § 20-279.21(b) (4) take effect if the named insured does not reject UIM coverage or does not select UIM coverage limits different than the bodily injury liability coverage contained in the policy. N.C.G.S. § 20-279.21(b)(4) (2001). Here, however, the insured was not given the opportunity to reject or select different coverage limits.”

Williams, 174 N.C. App. at 605, 621 S.E.2d at 647.

Finally, the Court in *Williams* held that it was this “total failure” of choice that triggers the imposition of maximum limits or \$1,000,000. “A total failure on the part of the insurer to provide an opportunity to reject UIM coverage or select different UIM policy limits violates the requirement that these choices be made by the policy owner.” *Id.*

The responsive position to the demand for the *Williams* million is, assuming the facts support, that the insured was given a choice and either failed to choose or did choose as evidenced by the coverage written and the policies issued. Commonly, the carrier can show multiple renewals of coverage with the lower limits or no “underinsured” limits at all. The carrier can also provide evidence of its mailing program to the insured, showing that it mailed the “form” with explanation to the insured. The agent will occasionally have a note in the file evidencing a discussion with the insured regarding the coverage or even a note of mailing the form to the carrier. Is this enough to satisfy the requirement of choice? These issues were addressed in *Progressive Southeastern Insurance Co. v. Greene*, 2008 WL 4170058, 2008 U.S. Dist. LEXIS 68633 (M.D.N.C. Sept. 5, 2008). In *Greene*, the carrier attempted to meet its burden of showing that it did in fact offer its insured a choice to select or reject “underinsured” motorist coverage by presenting evidence through affidavits of its business practices. The policy in question was not written with “underinsured” coverage. The policy was written in the year 2000 and as of the time of the accident had been renewed 11 times. The initial policy Declarations showed that the insured had “rejected” “underinsured” coverage and chosen “uninsured” coverage only. The insured, Greene, was deposed and could not recall what her selection was or if the coverage was discussed with her. Furthermore, Progressive presented affidavits to the effect that, pursuant to its internal system, it could only issue coverage after receipt of all necessary executed forms. In fact, if it had not received the form it would have issued the policy with “underinsured” coverage at limits equal to the bodily injury liability limits;

therefore, it had to have received the form in order to issue the policy with “uninsured” coverage only.

The Magistrate Judge rejected Progressive’s argument. Rather, the Court noted that the Financial Responsibility Act is to be liberally construed to achieve its purpose of providing innocent victims the “fullest possible protection” from the acts of negligent drivers. Thereafter the Magistrate found that a carrier cannot meet its strict burden of compliance with the Act by presenting evidence of its business practices. Fortunately, the Magistrate’s recommendation was reviewed and revised by U.S. District Judge Osteen. The Judge’s opinion provides that while the burden of proof is on the carrier to show compliance with statutory requirement of written rejection of “underinsured” coverage, the carrier can presumably meet that burden by presentation of evidence of its business practice. While the evidence in *Greene* was not sufficient because there was no connection between the practices and the particular insured, the Court left open the possibility that business practices could be used to show that the insured was given a choice to select or reject “uninsured” and “underinsured” coverage. Importantly, Judge Osteen’s opinion acknowledged that in *Williams*, it was stipulated that the insured was not offered an opportunity to select or reject UIM coverage. Consequently, the determination of whether *Williams* will apply to a given case depends on the evidence of whether the insured was given an opportunity to choose. The following important comment appears in a footnote: Section 20-279.21 requires only “[r]ejection of or selection of different coverage limits for underinsured motorist coverage” to be in writing. . . . This section does not specifically require that the offer of different coverage amounts be in writing.” *Greene*, at n. 4 (emphasis in original). Furthermore, the opinion stands for the proposition that business practices can be used to prove compliance as long as the evidence of the practice is admissible. While Progressive failed to satisfy the federal standard for admissibility of habit under Rule 406 of the Federal Rules of Evidence, the Court left open the real possibility that evidence of custom and habit, as established by business practices, could be used to meet the compliance requirement in other cases.

The Reasonable Belief Exclusion

One of the more common fact patterns faced by claims professionals involves the issues of permissive use and lawful possession. The claim often involves a contention that the wrecked car was stolen or taken by an acquaintance or family member without the knowledge or permission of the owner. While the Financial Respon-

sibility Act provides that automobile liability coverage in North Carolina will apply to permissive users of a covered auto, the Act does not compel coverage in every situation. The insuring agreement of the standard North Carolina auto policy contains an exclusion negating coverage for a driver that does not have a reasonable belief that he or she is entitled to drive the car. This allows the carrier to deny coverage under the situation where someone is hurt by the negligence of one who has stolen the car or driven the car without a “reasonable” belief of entitlement to do so. The North Carolina policy reads as follows:

Insuring Agreement

We will pay damages for bodily injury or property damage for which any insured becomes legally responsible because of an auto accident. “Insured” as used in this Part means:

1. You or any family member for the ownership, maintenance or use of any auto or trailer.
2. Any person using your covered auto.

“Family member” means a person related to you by blood, marriage or adoption who is a resident of your household. This includes a ward or foster child.

“Your covered auto” means:

1. any vehicle shown in the Declarations.

Exclusions

A. We do not provide Liability Coverage for any insured:

8. Using a vehicle without a reasonable belief that that insured is entitled to do so. This exclusion does not apply to a family member using your covered auto which is owned by you.

The exception to the exclusion is a relatively new amendment in North Carolina. Previously, carriers could deny coverage even to family members if they had been specifically prohibited from driving. As an example, in *Newell v. Nationwide*, 334 N.C. 391, 432 S.E.2d 284 (1993), the court dealt with a son who operated a vehicle contrary to the direct prohibition of his father. The Court held:

We conclude as a matter of law that Robert Blackmon could not have had a reasonable belief that he was entitled to use his father’s vehicle. Not only was Robert’s driver’s license under revocation by the North Carolina Division of Motor Vehicles for a previous driving while impaired conviction, the Record also contains separate affidavits of his father and

stepmother stating that Robert was expressly forbidden to use any of his father's motor vehicles while living in his father's home. There is no forecast of evidence to the contrary. The Record further discloses, without contradiction, that on the night of the accident with plaintiff, Robert was once again charged with driving while impaired. On this forecast of evidence there is simply no genuine issue of material fact as to whether Robert Blackmon could have had a reasonable belief that he was entitled to use his father's vehicle.

Id. at 397, 432 S.E.2d at 288.

Notwithstanding the policy change whereby family members are excepted from the exclusion, the exclusion remains applicable to a number of fact situations. *Newell*, along with *Aetna Casualty & Surety Co. v. Nationwide Mut. Ins. Co.*, 326 N.C. 771, 392 S.E.2d 377 (1990), make clear that the question of "reasonable belief" is subjective to the driver and presents a jury question. As the latter case noted:

A jury might well conclude that while he knew that it was "wrong to be driving without a license regardless of what goes on," he nevertheless believed he was entitled to drive the truck under the circumstances because he believed that he had the permission of the owner to do so. . . . Slater's reasonable belief is a question of fact to be determined by a jury. . . .

Id. at 776-77, 392 S.E.2d at 380.

Newell is equally instructive in its consideration of the interplay between the Financial Responsibility Act and policy language. Since the exclusion does not contradict any particular language of the Act, it is applicable assuming there really is no reasonable belief. Note the discussion by the Court:

The public policy goals of the Financial Responsibility Act apply only when the Act itself is being construed or when determinations are being made regarding the extent to which the Act as to its mandatory minimum coverage's may override conflicting insurance policy provisions. Plaintiff has conceded that the Act itself provides no mandatory coverage to the tortfeasor here; this concession forecloses plaintiff's argument, as we understand it, on this point. Neither do the cases relied on by plaintiff support this argument. The cases are *Nationwide Mut. Ins. Co. v. Aetna Life and Casualty Co.*, 283 N.C. 87, 194 S.E.2d 834 (1973); *Nationwide Mut. Ins. Co. v. Roberts*, 261 N.C. 285, 134 S.E.2d 654 (1964); and *Allstate Ins. Co.*

v. Webb, 10 N.C. App. 672, 179 S.E.2d 803 (1971). It is true that in all of these cases the courts refused to apply exclusionary provisions in insurance policies which conflicted with mandatory minimum coverage requirements of the Financial Responsibility Act. But in all the cases the courts first determined that the Financial Responsibility Act afforded mandatory coverage to the tortfeasor. In *Aetna* the tortfeasor was operating the motor vehicle with the permission of the named insured; in *Roberts* and *Webb* the tortfeasor was the named insured. Because of these facts in these cases, facts which are not present here, the Act afforded mandatory minimum coverage despite any conflicting exclusionary provisions in the policies under consideration.

Newell, 334 N.C. at 391, 432 S.E.2d at 284.

Given the exception to the "reasonable belief" exclusion, the question of who qualifies as a "family member" is an important part of the coverage analysis. The definition includes "a person related to you by blood, marriage or adoption who is a resident of your household. This includes a ward or foster child." The questions of residency and household have been reviewed a number of times in North Carolina. The issue often arises with respect to a child away at college, a child who is the subject of a joint custody arrangement or who has partially left the home of a parent as part of the emancipation process. Where a question arises as to whether a person is a relative of the named insured who is a member of the same household, the individual's "status is determinable on the basis of conditions existing at the time the casualty occurred." *Newcomb v. Great American Ins. Co.*, 260 N.C. 402, 405, 133 S.E.2d 3, 6 (1963).

Second, summary judgment should not be entered if the evidence raises a factual conflict as to a party's residence. See *Great American Ins. Co. v. Allstate Ins. Co.*, 78 N.C. App. 653, 338 S.E.2d 145 (1986) (summary judgment for insurer properly denied where evidence raised question of fact as to whether driver was a resident of his parents' household at the time of the collision); *Lumbermens Mut. Cas. Co. v. Smallwood*, 68 N.C. App. 642, 644, 315 S.E.2d 533, 535 (1984) (summary judgment improper if "there is some question about whether [driver] was a 'resident' of her mother's household at the time of the accident"). "Whether a person is a resident of a particular place is not determined by any given formula, but rather depends significantly on the facts and circumstances surrounding the particular issue." *Glover v. Farmer*, 127 N.C. App. 488, 491, 490 S.E.2d 576, 578 (1997). A college student does not automatically become a resident of his or her college com-

munity. *Barker v. Iowa Mut. Ins. Co.*, 241 N.C. 397, 399-400, 85 S.E.2d 305, 307 (1955). Further, "in determining whether a person in a particular case is a resident of a particular household, the intent of that person is material to the question." *Great American Ins. Co. v. Allstate Ins. Co.*, 78 N.C. App. 653, 656, 338 S.E.2d 145, 147 (1986).

These issues are often not what they appear to be on the surface. Given the fact that the determination of residency and reasonable belief both have an element of subjectivity, recorded statements, early depositions, or "examinations under oath" will be beneficial to find out the true facts before a hard stand is taken on application of the exclusion.

Interesting 2009 Auto Liability Case: "Damages" in UIM Arbitration Matter

Before ending, reference will be made to an interesting case opinion rendered last year. In *Hamby v. Williams*, ___ N.C. App. ___, 676 S.E.2d 478 (2009), the Court of Appeals overruled the trial court's refusal to award the plaintiff interest on a binding arbitration award. The Court noted that where the "underinsured" motorist provisions of an automobile insurance policy provide for payment of "compensatory damages" and the arbitration award defers the issue of prejudgment interest to the trial court, the trial court erred in refusing to award the plaintiff prejudg-

ment interest on the amount of the arbitration award. The UIM carrier contended that the policy did not specify that a party is entitled to prejudgment interest on an arbitration award. The Court noted this assertion is incorrect. The applicable provision of the policy provides that the UIM carrier "will pay all sums the insured is legally entitled to recover as compensatory damages." In *Sprake v. Leche*, 188 N.C. App. 322, 658 S.E.2d 490 (2008), the Court held that prejudgment interest is part of compensatory damages for which a UIM carrier is liable. Since the policy specifically provided for payment of "compensatory damages," *Sprake* controlled and the UIM carrier would be required to pay the interest on the arbitration award. ☞

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ERISA Plan Subrogation & Reimbursement Claims – Strategies for Risk Management

Roy F. Harmon III, *Harmon & Major, P.A.*

Overview of Self-Funded Group Health Plans

The Employee Retirement Income Security Act of 1974, or ERISA, was designed to protect the assets of employee benefit plan funds. ERISA sets fiduciary standards for management of plan assets and confers a number of duties and rights on plan fiduciaries. Among those rights are a set of civil remedies which may enable the plan to recoup funds from plan participants, beneficiaries, and even third parties in some circumstances.

A. Types of Plans

ERISA plans provide retirement benefits (often described as “pension” benefits), as well as life, disability, accident, and health and severance benefits, often described as “welfare” benefits. Health and disability plans frequently contain provisions authorizing recoupment of funds expended where third parties may be at fault. These plans constitute the primary threat to personal injury or worker’s compensation settlements that fail to address plan rights.

B. Administration

ERISA employee benefit plans may be either insured or self-funded. Almost all disability plans are insured and administered by insurance carriers. Group health plans are frequently self-funded. In such cases, the plan will use a third party administrator (“TPA”). Among other things, the TPA pays claims, arranges the PPO networks, sets up the prescription drug card program, arranges the utilization review, and brokers the stop loss insurance. In most states, third party administrators must be licensed.

The duties of the TPA will be set forth in a contract with the employer. This administrative services agreement will provide the basic mechanism for funding of claims, provision of ancillary services, such as utilization review, stop loss insurance, etc. and fees.

Insurance companies may also perform the function

of a TPA. In such situations, the insurance company operates under an administrative services arrangement such that the employer bears the actual claims risk. These arrangements, sometimes referred to as “administrative services only” or ASO contracts, can look very much like a fully insured plan to the casual observer since the claims paying entity is an insurance company. They are not insured plans, however, and the consequence has important ramifications, most important of which is the preemption of state insurance laws.

C. Plan Documents

In addition to the administrative services agreement, the other document describing the role of the TPA is the plan document. This document will primarily address issues of eligibility, claims review, and benefits payable, but it will also identify the plan sponsor, the plan administrator, and the claims administrator. The terms used to describe these roles can vary, but one important distinction should be noted.

D. Plan Administrator

The term “claims administrator” must not be confused with the term “plan administrator.” Under ERISA, the term “administrator” means:

- a. the person specifically so designated by the terms of the instrument under which the plan is operated;
- b. if an administrator is not so designated, the plan sponsor; or
- c. in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

Since plan administrators are fiduciaries, most TPAs will provide in the administrative agreement that the employ-

er functions as the “plan administrator” and describe the TPA’s role as that of a “claims administrator” or “plan supervisor.”

Identifying Self-Funded Plans

In a self-funded plan, though the employer will typically contract with a third party administrator to assist in the administration of the plan, and even though an employer may purchase stop loss insurance, the employer bears the risk of plan solvency. In other words, the employer is responsible for claims under the plan regardless in a true self-funded plan. See *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994); *Thompson v. Talquin Bldg. Prods. Co.*, 928 F.2d 649, 653 (4th Cir. 1991). Whether a plan is self-funded or not may be extremely significant since many states limit, and in some cases, prohibit, subrogation. These state laws are preempted if the plan is self-funded.

Section 514(a) of ERISA provides that ERISA preempts “any and all State laws” that “relate to” an ERISA plan. 29 U.S.C. § 1144(a). For ERISA preemption purposes, “State law” includes both statutory and common law. 29 U.S.C. § 1144(c)(1). On the other hand, if a plan is insured, ERISA permits the application of state insurance laws to the plan.

A. Form 5500 Filings

Inquiring as to the filing of Form 5500’s is a good starting point for determining whether a plan is a self-funded ERISA plan. The plan participant (perhaps not the participant’s attorney, according to some cases) is entitled to request the most recent Form 5500 under 29 U.S.C. 1024(b) (4). The Form 5500 will have a section, Box 9, that indicates the plan funding arrangement. If the form says “general assets of the employer,” that suggests a self-funded plan. If it says “insurance,” that suggests a fully insured plan. (Fully insured plans may still be ERISA plans, but the preemptive force of ERISA Section 514 only applies with its full force and effect in the case of self-funded ERISA plans.) But evaluation of the Form 5500 is not conclusive.

B. Governmental Plans

Governmental plans are exempted from ERISA and this affects the reach of their reimbursement rights. Understanding what is a governmental entity for ERISA can be complicated. For now, assume that any entity that purports to serve the public in some fashion and appears to have some element of government control should be evaluated for exemption from ERISA as a governmental entity. On the other hand, just because such an entity files a Form 5500 does not mean that the plan is necessarily an ERISA plan.

C. Statements in Plan Documents

Plan documents should have a section that refers to the type of plan administration. That section will typically state “contract administration” in the case of a self-funded plan, and “insurance” in the case of a full-insured plan. The description should not be viewed as determinative, but rather indicative of the plan’s funding status.

D. Claims Administrators

Consider state licensing information and what policy forms may be on file with the state insurance department. If claims are paid by a third-party administrator (as opposed to an insurance company), and the TPA is licensed as such with the State insurance department, then that is an indication that the plan is self-funded. Yet, insurance companies can also pay claims for self-funded plans through “administrative only” agreements. Thus, you cannot rely on the fact that an insurance company versus a third-party administrator is adjudicating claims. You can, however, evaluate the ASO contract to determine if the employer bears the “insurance risk” for claims under the plan or if the administrator assumes the risk.

E. Hybrids

Also, one must distinguish self-funded plan arrangements in which the employer obtains stop loss insurance from forms of insurance that may appear very similar. For example, under a “minimum premium” policy, the employer pays a reduced premium to the insurer and assumes the burden of paying off claims up to a certain amount. These policies can again be distinguished from a self-funded plan based upon the allocation of risk. The minimum premium policy bifurcates risk for claims between carrier and plan sponsor based upon the risk retention points.

Because of the many parties that may be involved in the administration of a group health plan, it is important to seek information from the plan administrator (as defined), and ensure that the party providing information is authorized to represent the plan in the transaction as opposed to merely one of the service providers, such as the stop loss carrier.

Note also that if a plan is a multiple employer welfare arrangement (“MEWA”), virtually every defense against state law regulation is removed. Further, a MEWA will often constitute a non-ERISA plan such that it is entitled to no deference whatsoever by ERISA considerations. In short, if the plan purports to be sponsored by multiple employers, an association of any kind, including a leasing organization or a “professional employer organization,” think twice before conceding ERISA status even if the plan is “self-funded.”

(Distinguish multi-employer plans (i.e., union funds) from MEWA's; multi-employer plans can and do assert subrogation rights.)

Right to Assert Claims in Subrogation and Reimbursement

Note that ERISA specifically authorizes a plan to sue in its own capacity. See 29 U.S.C. §1132(d). In addition, plans may pursue reimbursement rights against their own participants and members. The scope of available remedies in this context has been the subject of considerable litigation.

A. Checklist

The following checklist provides a basic set of criteria for evaluating the rights of group health plans to enforce reimbursement, or "subrogation," rights.

- To assert a claim for reimbursement under ERISA, the plan must first be subject to ERISA.

This means that the plan must not be a governmental plan, a church plan, a non-ERISA multiple employer welfare arrangement ("MEWA"), etc. See "[How to Identify a Self-Funded ERISA Plan](#)"; "[How to Identify an Exempt Governmental Plan](#)" (both available at [healthplanlaw.com](http://www.healthplanlaw.com) on the Tutorials page, http://www.healthplanlaw.com/?page_id=20). Distinguish MEWA's, whose reimbursement rights may be questionable, from multi-employer plans which typically have ERISA plan reimbursement rights. Do not assume that governmental plans do not have recovery rights – just be aware such rights are not pursuant to ERISA.

- To avoid potential state regulation of reimbursement rights, the plan must be a self-funded plan.

This means that the plan must fund benefit payments from general assets. Complex issues may arise where the plan is self funded but benefits provided through a MEWA that claims ERISA status.

- The plan language should, and in some circuits, must, adequately reject application of the "make whole" doctrine, the "common fund" doctrine, and other equitable doctrines. These issues can become complex depending on venue and plan language.

For a good overview, see E. Farish Percy, "Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement," 61 FL. L. REV. 55 (2009). See also *Cagle v. Bruner*, 112 F.3d 1510 (1997). The Fourth Circuit is unlikely to require this disavowal. See, e.g., *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998).

- The defendant must be in possession of specifically identifiable funds.

For example, in *Sereboff v. Mid Atlantic Medical Services*, 547 U.S. 356 (2006), the plan sought "specifically identifiable" funds that were "'within the possession and control of the Sereboffs'" – that portion of the tort settlement due Mid Atlantic under the terms of the ERISA plan, set aside and 'preserved [in the Sereboffs'] investment accounts.'" *Id.* at 363 (quoting *Mid Atlantic Medical Services v. Sereboff*, 407 F.3d 212, 218 (4th Cir. 2005)).

- The plan must impose an equitable lien by agreement.

This requirement stems from several sources. This requirement dovetails with the requirement for specifically identifiable funds in that it focuses relief on an "in rem" claim, directed at property, as opposed to seeking personal liability. A subrogation lien "is not an express lien based on agreement, but instead is an equitable lien impressed on moneys on the ground that they ought to go to the insurer." *Sereboff*, 547 U.S. at 364 (noting issue of "appropriate" relief not before the Court). It also dovetails with the nature of equitable remedies since, in the days of the divided bench, a plaintiff could seek restitution in equity only "where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002).

- The plan must assert an equitable remedy.

As observed in *Knudson*, for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession. *Knudson*, 534 U.S. at 214. In *Sereboff*, the plan "sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law." For a general overview of this requirement, see Roy F. Harmon III, "Equitable Relief Claims Under ERISA Section 502(a)(3)," *BENEFITS LAW JOURNAL* (Spring 2007); Roy F. Harmon III, "Settling Personal Injury Claims after *Sereboff v. Mid-Atlantic*," *THE SOUTH CAROLINA LAWYER* (2006).

B. Refunds

In addition to denying medical claims, benefit administrators may request refunds if subrogation or reimbursement forms are not returned pursuant to the terms of the plan.

Plaintiff relies on a provision titled, "Third-Party Liability (Subrogation)" but Premera is not asserting subrogation rights. Premera might have asserted subrogation rights if Allied had not paid the PIP benefit, but Allied did so. Nor did Premera assert subrogation rights when it sought reimbursement from the providers because those providers were not liable to plaintiff.

Cooper v. Premera Blue Cross, 2008 WL 2180148, at *3 (W.D. Wash. May 23, 2008).

The foregoing case sets the stage for discussion of reimbursement issues by illustrating the complexity involved in sorting out plan claims for reimbursement in the overall setting of obtaining medical care. Most plans and policies contain provisions authorizing the administrator to obtain refunds of payments. These provisions must be evaluated carefully.

C. Additional Observations on Common Law Doctrines

A frequent set of defenses in ERISA reimbursement cases may be found in the "make whole" and common fund doctrines. If these doctrines apply, and when, is of substantial importance, but unfortunately, often substantial confusion as well.

The make-whole doctrine, when applicable, limits an insurer's right to subrogation of an insured's recovery against a third party. Under the doctrine, an insurer is entitled to subrogation of an insured's recovery against a third party only to the extent that the combination of the proceeds the insurer has already paid to the insured and the insured's recovery from the third party exceed the insured's actual damages. *In re Paris*, No. 99-1558, 24 Employee Benefits Cas. (BNA) 2547, 2000 WL 384036, 211 F.3d 1265 (4th Cir. April 17, 2000) (unpublished).

The Fourth Circuit has not been particularly friendly to the doctrine. As noted in *Paris*:

As a federal matter, our decision in *United McGill* . . . prevents us from resorting to federal common law in this case, let alone adopting the make-whole doctrine as a new federal common-law principle for ERISA cases. As Appellants conceded at oral argument, the subrogation provision in the Fund's Plan is plain and clear. It entitles the Fund to reimbursement of the full amount of Appellants' recovery. We must enforce this unambiguous provision in accordance with its plain language and literal meaning, and it would therefore be inappropriate for us to override the

provision by grafting onto it the make-whole doctrine.

Paris, at *2 (Westlaw).

The Fourth Circuit decision in *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998), referred to in the above quote from *Paris*, found the following language unambiguous:

REFUND TO U.S. [sic] FOR OVERPAYMENT OF BENEFITS

If you or your dependent recover money for medical, hospital, dental or vision expenses incurred due to an illness or injury for which a benefit has been paid under this plan, we will have the right to a refund from you or your dependent.

The amount refunded to us will be the lesser of:

1. the amount you or your dependent recover;
2. *the amount of benefits we have paid.*

RIGHT OF SUBROGATION

If you or your covered dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this plan, we are subrogated to such claim or right of recovery. Our right of subrogation will be *to the extent of any benefits paid* or payable under this plan, and shall include any compromise settlement. . . .

United McGill, 154 F.3d at 170 (emphasis in original).

Other jurisdictions, such as the Eleventh and Sixth Circuit Courts Of Appeal, have been more inclined to find plan language ambiguous on these issues. If a subrogation provision does not state in unambiguous terms what "the right to recover from the covered persons" encompasses, such as using modifying terms such as "all," "first lien," "any recovery," or "100% reimbursement," a recent district court decision held that Third Circuit precedent requires application of federal common law to determine the propriety of apportioning attorney's fees. *Sheet Metal Workers Local 27 Health & Welfare Fund v. Beenick*, No. 08-CV-00346 (FLW), 2008 WL 5156663, 2008 U.S. Dist. LEXIS 99345 (D.N.J. Dec. 9, 2008) (citing *Wal-Mart Stores v. Bond*, No. 96-7522, 1997 U.S. Dist. LEXIS 8058, at *9 (E.D. Pa. June 3, 1997)).

Where courts have applied default common law rules, such as the make-whole doctrine or the common fund

doctrine, they have nonetheless allowed for disavowal of those rules by the plan.

D. Liability of Attorneys for Reimbursement

From time to time the issue arises of whether personal injury attorneys may be held liable as ERISA fiduciaries. In the context of a motion to dismiss, a district court ruled that attorneys could be held liable as fiduciaries. In *Trustees of the Teamsters Local Union No. 443 Health Servs. & Ins. Plan v. Papero*, 485 F. Supp. 2d 67 (D. Conn. 2007), the Reimbursement Agreement had a provision stating "I hereby direct my attorney or attorneys or any person or entity holding proceeds on my behalf to pay over such proceeds to the Plan." The plan alleged that the attorney was in receipt of \$50,000 of his client's \$150,000 settlement. The Court stated that "[a]s possessor of a portion of the funds received by Papero, Ross is obligated to the Plan, pursuant to the terms of the Agreement, to 'pay over' the moneys due and owing to plaintiffs. Defendant Ross, therefore, need not be a signatory to the Agreement in order to be bound by it." *Id.* at 71.

On the other hand, the district court in *UFCW Local 1776 v. DeBoer*, No. 07-cv-00738-JF, 2008 WL 4367485, 2008 U.S. Dist. LEXIS 73499 (E.D. Pa. Sept. 25, 2008), refused to hold the attorneys liable. In that case, when negotiations between the attorney defendants and the plaintiff concerning a possible settlement of plaintiff's subrogation claim failed, the client demanded her share of the settlement, and the attorney defendants paid over to her the amounts they had recovered, less their counsel fees and expenses. In doing so, they carefully notified Ms. DeBoer of her obligation to repay the plaintiff's subrogation claim, and obtained from Ms. DeBoer an agreement to indemnify them against any claims which might ensue because they had paid over the proceeds to her.

Additional facts of interest in *DeBoer* were (1) that the plan obtained a default against Ms. DeBoer, the personal injury plaintiff, who failed to respond to the complaint and (2) the defendant attorneys did not represent Ms. DeBoer in the dispute over recovery of the settlement funds. The district court saw the ERISA case as essentially a dispute between DeBoer and the plan, stating:

I have no difficulty in concluding that plaintiff's claims against Ms. DeBoer are the only ones which arise under the ERISA statute itself. Plaintiff is alleging that the terms of the plan have been violated, but the defendant attorneys are not signatories to the plan and are not directly bound by its terms. Neither are they ERISA fiduciaries, since they do not hold, and have never held, any of the plan's assets, and are not involved in its management.


DeBoer, at *1 (Westlaw).

In the court's view, the plan's claims against the defendant attorneys arose under state law. Applying Pennsylvania law, the court held that the attorneys could not be held liable for interference with Ms. DeBoer's "contract" to repay the plan nor conversion. The court distinguished a case in which the personal injury attorneys interfered with the recovery, stating:

This case is easily distinguishable from the case principally relied upon by the plaintiff, *Greenwood Mills, Inc. v. Burris, et al.*, 130 F. Supp. 2d 949 (M.D. Tenn., 2001), where attorneys were held liable for non-recognition of a subrogation claim under Tennessee law. In that case, the attorneys had caused their client to lie about the third-party recovery, and had misrepresented it to the subrogation claimant. Moreover, the case was decided under Tennessee law, which apparently differs from the law of Pennsylvania.

Id. at *2.

These cases are fraught with ethical issues, such as the duties of counsel for the plan participant to health care providers and health plans. See, e.g., S.C. Ethics Advisory Opinion 95-29 (regarding Rule 1.15, where lawyer is aware of interest claimed by a third party).

Of course, if an attorney is in possession of funds, then the attorney is properly a defendant without regard to fiduciary status. In that case, the attorney holds specifically identifiable funds, and an equitable remedy may be imposed on the funds and thus a cause of action under ERISA will lie. See *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5th Cir. 2003). See also *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006); *AT&T, Inc. v. Flores*, 2009 WL 1067953, 2009 U.S. App. LEXIS 8538, 322 Fed. Appx. 391 (5th Cir. April 22, 2009) (unpublished); *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006). 

Roy Harmon practices law with his firm of *Harmon & Major, P.A.*, in Greenville, S.C. His practice focuses on ERISA group health plans, and he has written extensively on the subject. For more information on ERISA generally and subrogation issues, please visit his website at <http://www.health-planlaw.com>. This article is adapted from Mr. Harmon's paper regarding "Managing Risk in ERISA Claims" presented at the Workers' Compensation Practice Group's breakout session at the 2009 Fall Seminar.

2010 NCADA Annual Meeting

June 17-20, 2010 – Marriott Resort & Conference Center, Hilton Head, SC

“Change is inevitable – except from a vending machine.”

– Robert C. Gallagher



Kerner

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– Patricia P. Kerner, Executive Vice President

General Session Highlights

- **A Panel Study of Comparative Fault**
– Molly H. Craig, Hood Law Firm, Charleston, SC; Gray T. Culbreath, Collins & Lacy, Columbia, SC; John T. Lay, Ellis Lawhorne & Sims, Columbia, SC; David T. Rheney, Gallivan White & Boyd, Greenville, SC
- **Stop Courting Trouble: Approach Settlement with a Mediation Mindset**
– Ellen Gelbin, Lewisville
- **“Never Enough”**
– Michael J. Burke, BA, JD
- ***Iqbal v. Ashcroft* – A New Approach to Federal Rule 12(b)(6) and its Relevance to North Carolina**
– Brian C. Vick, Williams Mullen, Raleigh
- **Recent Decisions of Relevance**
– J. Donald Cowan, Jr., Ellis & Winters, LLP, Greensboro
- **Practice Group Breakout Sessions:** Commercial, Construction, Employment, General Liability, Medical Malpractice, Products Liability, Workers’ Compensation

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