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# News

## WC Appellate Division Decision issued on May 14, 2019 – Social Security Retirement Benefits and 14-Day Violation

**Social Security Retirement Benefits and 14-Day Violation**

The Appellate Division recently issued a notable decision in a case titled Butler v. City of Portland. This decision addresses two issues: (1) the applicability of the Social Security retirement benefit authorized under the coordination of benefits provision in §221; and (2) whether a 14 day violation exists in the absence of an affirmative request for lost time benefits.

The first argument was that the City of Portland was not entitled to take the statutory offset for Social Security retirement benefits being paid because the City had never contributed to the Social Security system on the employee's behalf. Based on the plain language of the statute, the Administrative Law Judge had rejected this argument and allowed the City to take the offset. The Appellate Division affirmed this finding and expressly noted that while the legislature could have implemented a provision limiting the offset to the contributing employer, it chose not to do so.

The employee had also argued that a 14 day violation occurred when the City's insurer had failed to either increase his partial benefits to total or file a Notice of Controversy within 14 days of having actual knowledge that he was taken out of work in part due to his restrictions. The employee had been working part time in an accommodated position due to his work injury while receiving partial benefits based on his reduced wages. He ultimately left work when the City told him that they could no longer accommodate the restrictions. He took a disability retirement package and continued to receive partial benefits. The administrative law judge found that he did not seek an increase in incapacity benefits when he went out of work, neither did anyone on his behalf. Per these facts, the administrative law judge rejected the argument of a Rule 1.1 violation. On appeal, the employee did not dispute the factual findings but argued that the City's actual knowledge of his out of work status was sufficient to trigger Rule 1.1. The Appellate Division disagreed and affirmed the underlying decision. In doing so, they noted that Mr. Butler continued to have earning capacity and in fact found part-time work thereafter. "As a matter of law, he was not automatically entitled to benefits on account of the circumstances that ended his employment. To invoke the penalty provision in Me. WCB Rule, ch. 1, § 1, he had to make an affirmative claim for benefits." Of note, a footnote suggests a potentially different answer may have been reached if the employer had "knowledge 'from the circumstances of the injury' that is responsible to pay benefits. This could occur when an ALJ finds as fact an actual loss of earning capacity implied by the circumstances of the injury."

We continue to recommend that Notice of Controversies be filed anytime when there is knowledge that an employee loses time as a result of an injury; regardless of whether a verbal assertion of a claim is made. With that said, this case will clearly be helpful in defending allegations of a 14 day violations premised on what the employer knew or should have known.

Please feel free to contact Lindsey M. Sands, Esq. at lsands@nhdlaw.com with any questions.

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# The First Circuit Significantly Expands the Scope and Reach of the Maine Human Rights Act

By Devin W. Deane, Esq.

In a recent decision, *Roy v. Correct Care Solutions, LLC*, 914 F.3d 52 (1st Cir. 2019), the United States Court of Appeals for the First Circuit significantly expanded the scope and reach of employer and non-employer liability under the Maine Human Rights Act ("MHRA"). Addressing "unresolved questions of Maine Law," the First Circuit held:

- Non-employers may be liable for employment-related discrimination under § 4633 of the MHRA;
- Employers may be liable for a hostile work environment created by non-employees as long as the employer knew of the harassment and failed to take reasonable steps to address it; and
- Employers may be liable for retaliation where its adverse action was caused by a third party's action or demand, which the employer knew was motivated by a retaliatory or discriminatory animus.

The case arises out of the Maine State Prison in Warren, Maine. The plaintiff, Tara Roy, worked at the Maine State Prison as a nurse, employed by defendant Correct Care Solutions, LLC—a government contractor that contracted with the Maine Department of Corrections ("MDOC") to provide health care services at the prison.

As alleged by the plaintiff, while working at the prison, several MDOC corrections officers made derogatory comments about the plaintiff and women in general; referred to her using sexual epithets; and spread rumors that she had slept with multiple corrections officers. After she complained about the conduct to her employer, Correct Care Solutions, corrections officers began ignoring her requests for assistance and frequently left her alone with inmates in violation of prison protocols. The plaintiff reported the protocol violations to her employer, which she claimed were retaliatory and put her at risk of harm. Correct Care Solutions notified the MDOC of the complaints. After investigating at least one of the incidents, the MDOC concluded that the plaintiff had exaggerated the circumstances of the alleged protocol violations. The MDOC revoked the plaintiff's security clearance, which was a requirement of plaintiff's position at Correct Care Solutions. Citing the revocation of her security clearance, Correct Care Solutions terminated the plaintiff's employment.

The plaintiff sued the MDOC and Correct Care Solutions alleging, among other things, that she was subjected to a hostile work environment created by the MDOC correction officers; that her employer, Correct Care Solutions, knew of the officers' harassment and failed to take reasonable steps to address it; and that her termination and the revocation of her security clearance were in retaliation for her complaints about the hostile work environment created by the MDOC corrections officers.

The United States District Court for the District of Maine entered summary judgment in the defendants' favor. With respect to the claims against the MDOC, the District Court held that non-employers, like the MDOC in this instance, cannot be liable under the MHRA. With respect to the claims against Correct Care Solutions, the District Court held that the plaintiff did not generate a dispute of fact regarding the existence of a hostile work environment and that the plaintiff's complaints regarding the corrections officers' conduct were not protected activity—and therefore could not be the basis of a retaliation claim—because Correct Care Solutions was without the ability and authority to correct the officers' behavior.

On appeal, the First Circuit reversed summary judgment for each defendant finding error with each of the bases of the District Court's opinion.

*Non-employer liability under the MHRA*

Relying on the Law Court's decision in *Fuhrmann v. Staples Office Superstore East, Inc.*, 2012 ME 135, 58 A.3d 1083, the District Court concluded that the MHRA allows employment discrimination actions against employers only, and never against non-employer entities like the MDOC. The First Circuit disagreed, holding, based on the text and history of § 4633 of the MHRA, the MHRA allows retaliation claims against any "person," including non-employers. The First Circuit distinguished *Fuhrmann*, where the issue before the Law Court was individual supervisor liability for a claim under § 4572, the MHRA provision that prohibits unlawful employment discrimination an "employer." In contrast, § 4633 prohibits discrimination by any "person," which, according to the First Circuit, targets actions by third parties, like the MDOC—not the employer, its employees, or agents. The First Circuit declined to extend *Fuhrmann*'s holding to bar suits against non-employer third parties under § 4633.

*Employer liability for a hostile work environment created by non-employees*

The District Court did not address the issue of whether Correct Care Solutions could be liable for the alleged hostile work environment created by the non-employee, third-party corrections officers. The District Court entered summary judgment for Correct Care Solutions on the basis that the plaintiff did not establish a genuine dispute of fact as to whether the corrections officers' conduct constituted a hostile work environment. The First Circuit disagreed, concluding that the plaintiff had produced enough evidence to generate a dispute of fact as to the existence of a hostile work environment. The First Circuit then addressed Correct Care Solutions' potential liability for the alleged hostile work environment created by the non-employee, third-party corrections officers. Citing a number of federal cases interpreting similar claims under Title VII, the First Circuit held that "an employer can be liable under the MHRA for a hostile work environment created by non-employees as long as the employer knew of the harassment and failed to take reasonable steps to address it."

*Employer liability for adverse action caused by a third party's discriminatory animus*

In entering summary judgment for Correct Care Solutions on the plaintiff's retaliation claim, the District Court ruled that the plaintiff's complaints were not protected activity because, in its view, Correct Care Solutions lacked the ability and authority to correct the complained-of violations by the corrections officers. Because it concluded that the plaintiff's complaints were not protected activity, the District Court did not address the plaintiff's argument that Correct Care Solutions terminated her because of her complaints. The First Circuit reversed, concluding that the plaintiff's complaints were protected activity under the MHRA and that factual disputes existed as to whether the plaintiff was terminated in retaliation for her complaints. Rejecting Correct Care Solutions' argument that its reason for firing the plaintiff— the MDOC's revocation of her security clearance—was neutral, the First Circuit held that "a jury could conclude that MDOC's retaliatory animus caused the revocation of the security clearance and, in turn, caused [the plaintiff's] termination." The First Circuit held that an employer may be liable for retaliation under the MHRA where a third party's retaliatory or discriminatory actions or demands caused the employer's adverse action and "the employer knew that [retaliatory or discriminatory] animus motivated the third party's actions or demands and simply accepted those actions or demands."

*The First Circuit's opinion is non-binding but likely persuasive authority to Maine courts*

Because it was interpreting and applying a state statute, and not reviewing the statute with respect to its constitutionality, the First Circuit's opinion is not binding on Maine state courts' interpretation and application of the MHRA. However, the First Circuit's opinion is likely to be persuasive authority unless and until the Law Court addresses the issues specifically.

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# Breach of Home Construction Contracts Act Does Not Entitle Homeowner To Substantial Damages or Recovery of All Attorney's Fees Incurred in Prosecuting Claim

By Matthew T. Mehalic, Esq., CPCU

In *John Sweet II v. Carl E. Breivogel et al.*, 2019 ME 18 (Jan. 29, 2019), the Law Court looked at the connection between the Home Construction Contracts Act (HCCA) and the Unfair Trade Practice Act (UTPA). The case arose out of the home construction of a timber frame home by Sweet for the Breivogels on Mount Desert Island. The parties had exchanged communications prior to the commencement of construction. The Breivogels were shown several examples of Sweet's construction. Sweet gave the Breivogels estimates for construction of similar homes he showed them. The Breivogels inquired about whether Sweet could build them a saltbox style timber frame home for $275,000. The Breivogels contended that they believed they had requested a fully completed home, ready for occupancy. Sweet contended that he understood that the Breivogels only wanted an enclosed, weather tight timber frame home – including only a frame, walls, roof, insulation, doors, windows, chimney, and exterior shingles.

The Breivogels authorized Sweet to begin construction, but there was no contract. The Breivogels asked Sweet when they would formalize the project terms and Sweet responded that he had never signed a written contract in over thirty years. They did agree that the Breivogels would be billed biweekly and pay for all materials and labor at a rate of $32/hour. Throughout the construction, Sweet sent the Breivogels emails containing photographs of the progress and biweekly invoices.

Upon completion of the work that Sweet had believed the Breivogels had originally requested, it was understood by both parties that Sweet would continue to construct a fully completed home ready, for occupancy. "At this point, the Breivogels determined, without informing Sweet, that they would have Sweet continue to work on the project, but would initiate legal action against him after they obtained a certificate of occupancy. They intended to seek damages for payments made in excess of $275,000." *Id* at ¶ 9. Despite this, the Breivogels paid Sweet a total of $601,195.75 through the end of construction. Sweet invoiced the Breivogels a total of $602,250.98, but the Breivogels refused to pay any additional amounts. Sweet then placed a lien on the home for $51,953.94 for unpaid labor and plumbing work and filed an action against the Breivogels. The Breivogels filed counterclaims for negligence, breach of contract, fraud, negligent misrepresentation, breach of the implied warranty of workmanship, and violation of the Unfair Trade Practices Act.

The Superior Court determined that Sweet was entitled to the money he had received under a theory of quantum meruit for the work he performed in constructing the home, but also held that he overcharged the Breivogels by $640.77. On the Breivogels' counterclaims, the Superior Court held that they failed to establish that Sweet was negligent, that he breached any contractual obligation to perform in a workmanlike manner, that he breached an implied warranty, or that Sweet committed fraud or negligent misrepresentation. The Superior Court did determine that Sweet violated the Home Construction Contract Act by failing to provide a written contract, which also resulted in a finding of violation of the Unfair Trade Practices Act. The Superior Court awarded costs to the Breivogels in the amount of $3,832.43 and attorneys' fees of $30,000, as allowed under the Unfair Trade Practices Act. The Breivogels appealed the Superior Court judgment arguing that the Superior Court erred in (1) concluding that they failed to establish their counterclaims for fraud, negligent misrepresentation, and breach of contract; (2) "calculating the damages recoverable under the Unfair Trade Practices Act arising out of the violation of the Home Construction Contract Act; and (3) awarding insufficient attorneys' fees." *Id.* at ¶ 13.

The Law Court held that the Superior Court did not err in its determinations in regards to the counterclaims for fraud,

negligent misrepresentation, and breach of contract.

In regards to the calculation of damages recoverable under the Unfair Trade Practices Act, the Court found that the trial court was correct in awarding only the amount overcharged by Sweet – $640.77.

> In this case, while it is clear that the parties did not sign a contract or share an exact understanding of the scope and terms of construction, the court's application of quantum meruit was appropriate. The parties engaged in months of discussions and planning before the project began and remained in fairly constant communication throughout every phase of construction. . . The Breivogels permitted Sweet to continue the project beyond the [weather tight] phase – the point at which the Breivogels realized that Sweet had a different understanding of the scope and cost of construction – and allowed him to continue working until their home was fit for occupancy.

*Id.* at ¶ 18. Furthermore, the Court determined that the amounts charged by Sweet to the Breivogels was appropriate for the product received.

In regards to the Breivogels recovery under the Unfair Trade Practices Act, the Court also found that the trial court was correct in the awarded damages. "To recover under the [Unfair Trade Practices Act], a party must demonstrate a loss of money or property as a result of a UTPA violation." *Id.* at 21. In performing this analysis, the court looks to whether the homeowner has suffered a financial or tangible loss, whether the materials claimed to be furnished were in fact furnished, and whether the price charged was fair and reasonable. The Court determined that the Breivogels failed to establish that they did not receive value for their payments. There also was no loss sustained because of Sweets' failure to provide a contract.

Finally, in regards to the award of attorneys' fees, the Court determined that the Superior Court award was appropriate. "An award of attorney fees pursuant to the [Unfair Trade Practices Act] is recoverable only to the extent that it is earned pursuing a UTPA claim." *Id.* at ¶ 24. The Breivogels argued that they were entitled to recover all of their attorneys' fees because all of the claims were inextricably entwined with, and arose from the UTPA violations. The Law Court rejected this argument and held that the Superior Court properly exercised its discretion where the Breivogels failed to distinguish between the fees incurred associated with the UTPA violation and those associated with the counterclaims.

This decision reemphasizes that violation of the Home Construction Contract Act does not necessarily result in an imposition of damages, but the attorneys' fees and costs awarded may be substantial – especially when considering that the contractor violating the Home Construction Contract Act will have costs and fees of his or her own.

## No Insurance Coverage for Doctors Who Snoop in Patient Records

**By Christopher C. Taintor**

In *Medical Mutual Insurance Company of Maine v. Burka*, the First Circuit Court of Appeals addressed a question that has come up with increasing frequency in recent years: what liability insurance coverage, if any, is available to a doctor (or other health care professional) who uses a hospital's electronic medical record to "snoop" on a person with whom he has no professional relationship? In *Burka*, the Court of Appeals found no coverage under a policy which was written to protect against risks associated with the delivery of healthcare services.

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Douglas Burka was a surgeon who moved to Maine in 2013 with his wife, Allison, and briefly practiced in the Southern Maine Healthcare system. In 2016, Allison (having taken back her maiden name, Cayne) sued Dr. Burka in both Maine and Maryland. She alleged, among other things, that Dr. Burka had "used his clinical privileges at Southern Maine Medical Center to access [her] medical records"; that he had done so as part of a "campaign to . . . to learn about her mental and gynecological health and other confidential medical information," which he then exploited in a pattern of "abusive, emotionally destructive and controlling" behavior; that he continued to enter her electronic record even after she left him and started divorce proceedings; and that because of Dr. Burka's access to her records, Allison was harmed when she chose not to seek out necessary psychiatric treatment. Notably, although Dr. Burka claimed that Allison had given him authority to look at her records when he was advising her about her health, Allison did *not* allege that he had ever been her doctor.

Dr. Burka tendered the defense of both lawsuits to Medical Mutual, under the terms of a policy issued to his employer. Medical Mutual denied that it had a duty to defend, and promptly brought suit in federal court, asking for a judgment declaring that the company had no obligation to defend Dr. Burka in either action. Under Maine law, an insurer declining a defense faces an uphill battle, since a duty to defend exists so long as a complaint, when compared to an insurance policy, "discloses a potential for liability within the coverage and contains no allegation of facts which would necessarily exclude coverage." *Travelers Indemnity Co. v. Dingwell*, 414 A.2d 220, 227 (Me. 1980). Nonetheless, the United States District Court entered a judgment in Medical Mutual's favor, which was affirmed by the First Circuit Court of Appeals.

The critical issue in the lawsuit was whether Dr. Burka's act of accessing his wife's records constituted "Professional Services" within the meaning of the policy – or, more precisely, whether the Complaint left open the *possibility* that he had been providing "professional services." Dr. Burka argued that because the Complaint said nothing about the existence or non-existence of a physician-patient relationship, there was a "potential factual basis" for coverage, which was enough to trigger a duty to defend. The Court disagreed, reasoning:

> The pleading does not merely omit any reference to a doctor-patient relationship between Burka and Cayne; its allegations directly contradict a professional association between them. We note, in particular, Cayne's assertion that Burka's actions involved unauthorized *access* to her medical records in Maine and improper disclosure to himself. The allegation that Burka was not entitled even to see her records leaves no room for a factual finding that he was involved in her medical treatment. Indeed, the complaint depicts his actions as solely animated by his personal objectives. Accordingly, the complaint unequivocally places Burka's alleged improper access to, and disclosure of, Cayne's medical records outside the Policy's coverage.

Although the Court of Appeals recognized that Maine courts historically have "employ[ed] an expansive concept of the duty to defend," it cited a recent decision of the Law Court, *Barnie's Bar & Grill, Inc. v. U.S. Liability Insurance Co.*, for the proposition that a "court may neither 'read extrinsic facts or allegations *into* an underlying complaint' nor 'selectively read facts or allegations *out of* that complaint in order to conclude that the insurer has a duty to defend.' " Because it was impossible to rule in Dr. Burka's favor without ignoring Allison Cayne's allegations that he had acted maliciously, and with the intent to cause her harm, the Court properly concluded that Medical Mutual owed Douglas no defense as a matter of law.

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# Decision to Discharge Patient Appropriate and Medical Malpractice Prelitigation Screening Panel Not Equivalent to Trial

By Matthew T. Mehalic, Esq., CPCU

In *Randy N. Oliver, II et al. v. Eastern Maine Medical Center*, 2018 ME 123 (August 21, 2018), the Law Court addressed whether EMMC was negligent when it discharged an individual despite contrary instructions given by the individual's limited guardians to the hospital. The Superior Court entered judgment in favor of EMMC and the Law Court affirmed holding that EMMC was not negligent.

The case arose out of the hospitalization of an individual, Randy Oliver. Randy was found severely intoxicated at his home and was taken to EMMC by his daughter and his ex-wife. The conditions of Randy's home were unsanitary, there was no running water, and there were a number of fire hazards. Randy was admitted with diagnoses of liver-related brain damage, possible alcohol withdrawal, deterioration of functional status, and a neglected state. He also had burns on his hands. The day after his admission, a psychiatrist conducted an evaluation of Randy, at which Randy expressed that he did not understand why he was at the hospital. The evaluation concluded that Randy's alcohol addiction was potentially lethal, that he suffered from significant cognitive impairment, and that a guardian might need to be appointed. About a week later another evaluation was performed by a neuropsychologist that concluded that Randy lacked the capacity to manage simple or complex finances independently or make informed decision about his health.

Randy's son and daughter filed a petition with the Probate Court to be appointed Randy's co-guardians. After a hearing Randy's son and daughter were appointed as co-guardians. However, the appointment was limited in that the guardians were authorized to "act only as necessitated by [Randy's] actual mental and adaptive limitations or other conditions warranting this procedure." *Id.* at ¶ 9.

Over the course of Randy's two month hospitalization his condition improved and he expressed that he wanted to leave the hospital. Another neuropsychological evaluation was performed. The evaluation indicated that Randy was alert, friendly, pleasant, and very cooperative. Randy was noted as "strikingly different" from the earlier evaluation. It was concluded that Randy had the capacity to "manage simple or complex finances independently" and "make better informed decisions regarding his health." *Id.* at ¶ 10. Randy had also indicated that he planned to quit drinking.

Based on the evaluation, EMMC concluded that Randy "no longer needed acute medical care and that the hospital was possibly holding him there against his will." *Id.* at ¶ 11. Randy's son and daughter, his limited guardians, disagreed with the evaluation findings and disapproved of Randy's discharge from the hospital. EMMC offered to have another evaluation performed by another practitioner, but the guardians informed EMMC that they did not want another evaluation. EMMC ultimately discharged Randy based on the Probate Court's order providing limited guardianship to Randy's son and daughter only where Randy was unable of making decisions and Randy's request to be discharged. When Randy was discharged a plan was generated that included a referral to Randy's primary care provider, a pain clinic, community case management, and a recommendation to participate in substance abuse treatment. Randy's son and daughter were informed by EMMC of Randy's discharge on the date of discharge.

Randy's son and daughter visited Randy twice over the course of the night and when they left him the last time he was intoxicated. Randy died later that night as the result of a fire.

Randy's son and daughter, individually and as personal representatives of the estate filed a complaint in the Superior Court against EMMC based on negligence for breach of the standard of care. Judgment was entered in favor

of EMMC. An appeal was filed by Randy's son and daughter.

The issues raised on appeal were whether the Superior Court erred in: (1) "concluding that the Probate Court's guardianship order did not preclude EMMC from discharging Randy, given the contrary instructions they had given in their capacity as Randy's court-appointed guardians"; (2) "concluding that Randy had regained capacity to make the decision to be discharged"; and (3) "concluding that EMMC's discharge plan was reasonable." *Id.* at ¶ 26.

With regard to the first issue, the Law Court held that the Superior Court was correct in concluding that the Probate Court guardianship order did not preclude EMMC from discharging Randy. The guardianship order was a limited guardianship order, pursuant to 18-A M.R.S. § 5-105. This section allows appointment of a guardian with fewer than all of the legal powers and duties of a guardian. In addressing healthcare decisions, per the Probate Code, the limited guardian is to make decisions in accordance with the ward's individual instructions when the ward has capacity. *See* 18-A M.R.S. § 5-312(a)(3). Furthermore, the healthcare provider, per the Uniform Healthcare Decisions Act contained within the Probate Code, is to presume capacity and when capacity is lacking if the individual regains capacity the healthcare provider is to communicate the determination to the patient and any other person authorized to make decisions on behalf of the patient. Because of the determination by the healthcare provider that Randy had regained capacity and because of the limited scope of the Probate Court guardianship order, EMMC was not precluded from discharging Randy.

In regards to the second issue, the Court concluded that EMMC met the standard of care involved in concluding that Randy regained capacity. Having the same neuropsychologist evaluate Randy upon the initial admission and almost two months later in order to compare the condition of Randy met the standard of care. Also, the other EMMC providers that had interacted with Randy during his hospitalization also concluded that he had regained capacity. The medical records supported Randy's improvement and regaining of capacity. The expert witnesses called by EMMC to testify also supported that the EMMC met the standard of care for evaluating whether Randy had regained capacity to make the decision to be discharged.

Finally, with regards to the third issue, the Court concluded that the discharge plan was safe and reasonable. Appointments were scheduled for Randy to a pain clinic and his primary care physician. Information was provided for case management services. EMMC also gave strong recommendations that Randy stop drinking, attend group meetings, and EMMC even offered substance abuse counseling. Randy's acknowledgment that he needed to stop drinking was evidence that the discharge plan was appropriate. Therefore, the discharge plan was held to be safe and reasonable and not negligent. Judgment in EMMC's favor was affirmed.

Another issue involved in the appeal, was whether the Superior Court had erred when it refused to award EMMC its expert costs incurred during the medical malpractice prelitigation screening panel process. Title 14 M.R.S. § 1502-C allows the courts within their discretion to award reasonable expert witness fees and expenses as allowed under 16 M.R.S. § 251. Section 251 provides in pertinent part, "The court in its discretion may allow at the trial of any cause, civil or criminal, in the Supreme Judicial Court, the Superior Court or the District Court, a reasonable sum for each day's attendance of any expert witness or witnesses at the trial." Due to the confinement of section 251 to "trial" in a court, the Law Court held that the prelitigation screening panel proceeding was not a "trial" that permitted the courts to award expert witness fees and expenses incurred in the panel proceeding.

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# No Liability Coverage Under Homeowner's Policy for Premeditated Assault

**By Matthew T. Mehalic, Esq., CPCU**

In *Vermont Mutual Insurance Company v. Jonathan Ben-Ami, et al.*, 2018 ME 125 (August 21, 2018), the Law Court addressed whether the expected or intended injury exclusion applied where an individual carried through a premeditated attack on another. James Poliquin, Esq. of Norman, Hanson & DeTroy, LLC represented Vermont Mutual on this claim and successfully argued that the exclusion applied.

The case arose out of Joshua Francoeur's attack on a fellow high-school student, Jonathan Ben-Ami. The two individuals had a verbal altercation at a football game several days before the attack. Francoeur was encouraged by his friends to plan an attack on Ben-Ami. During the school day, Francoeur went to Ben-Ami's classroom. The door to the classroom was locked, but Francoeur was able to convince the teacher to open the door. Francoeur went up behind Ben-Ami who was wearing headphones and punched him repeatedly in the face resulting in injuries and a broken jaw.

Francoeur's father had a homeowner's policy with Vermont Mutual. The policy included an exclusion for expected or intended injury which provided in pertinent part that coverage was excluded for "bodily injury . . . which is expected or intended by the insured." *Id.* at ¶ 12. Ben-Ami filed a complaint against Francoeur and Vermont Mutual provided a defense under a reservation of rights based on the expected or intended injury exclusion and on other grounds not addressed by the Law Court on appeal. Eventually, Ben-Ami and Francoeur agreed to a stipulated judgment with a covenant not to execute against the personal assets of Francoeur. Ben-Ami proceeded solely against any liability coverage that was provided under the Vermont Mutual policy. Vermont Mutual filed a declaratory judgment action on the basis of the application of the exclusion, among other reasons, and Ben-Ami filed a reach-and-apply action against Vermont Mutual. The two matters were consolidated.

The Superior Court denied Vermont Mutual's motion for summary judgment and held a bench trial on the applicability of the expected or intended injury exclusion and ruled in favor of Ben-Ami. The Superior Court did not conclude that Francoeur "subjectively intended to inflict the level of damage that ultimately was inflicted upon Mr. Ben-Ami in the form of his broken jaw." *Id.* at 6. Furthermore, the Superior Court determined that, "Mr. Francoeur's testimony that he did not consider the consequences of his action or consider the likelihood that his punching of Mr. Ben-Ami would produce a serious injury [was] credible." *Id.* Vermont Mutual appealed the Superior Court's decision.

The Law Court framed the dispositive issue as "whether the evidence compelled the court to find that Francoeur either "intended or expected" bodily injury to Ben-Ami, which would trigger the exclusion." *Id.* at ¶ 14. The Court determined that the evidence did compel such a finding.

Crucial to the Courts determination were the following facts:

> Francoeur and Ben-Ami had had a hostile verbal encounter several days earlier; Francoeur then developed a plan to attack Ben-Ami; in execution of that plan, Francoeur left his classroom and proceeded to another classroom where Ben-Ami was present; Francoeur induced the teacher to unlock the door in order to allow him into the classroom; Francoeur approached Ben-Ami from behind so that Ben-Ami, who had headphones on, was "likely unaware" of the imminent attack; Francoeur punched Ben-Ami about the face with a closed fist "multiple times"; and, as the direct result of the assault, Ben-Ami sustained serious injuries, including a broken jaw.

*Id.* at ¶ 15. The Court could not rectify these facts with the Superior Court's findings that Francoeur did not consider the consequences of his action or did not subjectively intend the extent of damage he could, and did, cause. "Given the premediated nature of the assault, the ambush tactic that Francoeur used, and the location and magnitude of the resulting injuries, the evidence compelled the court to find, at the very least, that Francoeur must have subjectively foreseen as practically certain (i.e., expected) that his deliberately violent conduct would result in bodily injury to Ben-Ami." *Id.* at 17.

Despite the Court's decision in favor of Vermont Mutual, the Court refused to categorically hold that an assault, as that at issue in the matter, always fell within the expected or intended exclusion without consideration of the subjective intent or expectation of harm of the perpetrator, as was requested by Vermont Mutual.

In a concurring opinion, Justices Mead, Alexander and Jabar, three of seven Justices on the panel, agreed with the Court's entry of judgment in favor of Vermont Mutual, but wished that the Court had gone further, as requested by Vermont Mutual. "I would go further and conclude that this factual scenario – the intentional striking of an unsuspecting person in the face with a closed fist – leads to a conclusion that as a matter of law the physical injuries resulting from the attack were intended and expected." *Id.* at ¶ 25. The concurring Justices wished to do away with an examination of the subjective intent of the perpetrator under these circumstances when determining if the expected or intentional injury exclusion applied.

## Medicare Set-Asides: Are You Paying Too Much?

**By: Stephen Hessert**

Background

Medicare came into being in 1935 as part of the original Social Security Act enacted by Congress. It was described as "a federally funded health insurance program for the elderly and the disabled." Over the years, its cost became problematic and in the late 1970s, a General Accounting Office study suggested that forty-one billion dollars of Medicare benefits were being used to subsidize other insurance programs such as workers' compensation and liability insurance. Consequently, in 1980, Congress passed the Medicare Secondary Payor Act which required beneficiaries to exhaust all other health insurance options before Medicare would pay benefits. Those other options include insurance for workers' compensation, liability, auto etc. The Act provided that Medicare would make "conditional payments" and provide benefits if the other carriers initially denied liability, but it is required that Medicare be repaid if other benefits are found to be applicable.

In the workers' compensation arena, a Medicare set-aside arrangement (MSA) is necessary to account for the future medical component of the primary payor's responsibility. MSAs are the tool used to account for the future medical expense associated with injuries, in order to avoid shifting responsibility for future medical from the primary payor to the Medicare system. This article will briefly touch on two separate issues. The first will be to describe the appeal process for dealing with contested conditional payments. The second will deal with the question of whether too much is being set-aside in providing for Medicare's future interests.

Conditional Payments

Conditional payments are made by Medicare based upon diagnosis codes. The Centers for Medicare and Medicaid

Services (CMS) will attribute certain diagnosis codes to an injury. In workers' compensation, it will depend upon the diagnosis of the injury, but will also include any payments for any diagnoses that are made voluntarily and without prejudice. These potentially unrelated codes/conditions become part of the liability for the work injury in Medicare's point of view.

Once liability for a primary payor is "demonstrated" by either an acceptance of liability or by settlement of the claim, conditional payments must be addressed. The parties should request that the case be put into the "final conditional payment process" which notifies the CMS Benefit Coordination and Recovery Center that the case is within 120 days of settlement. A request may be made for a final conditional payment amount within three business days of settlement via the Medicare Secondary Recovery portal. Once you have that amount, the question becomes whether it is an accurate description of the medical costs of the consequences of the actual injury, or whether it includes other treatment for which there should be no liability, either in a liability case or in the workers' compensation arena.

Appeal Process

The law is now clear that workers' compensation administrative bodies and state courts lack subject matter jurisdiction over Medicare Secondary Payor (MSP) reimbursement disputes that have not been fully exhausted through the mandatory Medicare appeal process. Any challenge to MSP's entitlement "arises under the Medicare Act" and the appellant, or the Medicare enrollee, must first proceed with an administrative appeal prior to any judicial review. *See, e.g., 42 U.S.C. §405(g-h) §1395w-22g5; 42 C.F.R. §422.560-422.612.* That appeals process has five steps:

1. The parties must appeal the conditional payment demand letter within thirty days.
2. The appealing party will receive an independent outside entity review (qualified independent contractor) that contracts with CMS to do this work.
3. If the result from the independent qualified contract review is unfavorable, an Administrative Law Judge hearing may be requested.
4. If the Administrative Law Judge hearing produces an adverse result, the party may appeal to a Medicare Appeal Council, if the ruling is adverse to the appellant and exceeds a threshold amount ($1,000).
5. Finally, if the ruling is still adverse, an appeal may be made for federal judicial review, to the Federal District Court in the appropriate jurisdiction. From there, an appeal can be taken to the Circuit Court of Appeals and possibly to the United States Supreme Court.

The important point is that absent a timely utilization of this appeal process, there is no possibility of attacking the issue of whether a conditional payment was, in fact, for the workers' compensation injury or automobile accident in question in any state proceeding, or whether other defenses such as the statute of limitations are available. Any factual issues will be resolved either through the initial administrative steps of the appeal process, or before the Administrative Law Judge.

Are You Paying Too Much?

Accounting for Medicare's interests for future medical expense for an injury is a well-developed process in workers' compensation. CMS has established work review thresholds of $25,000 for a current Medicare beneficiary, or $250,000 and the potential that the Medicare beneficiary is likely to become enrolled in Medicare within thirty months, for workers' compensation cases. If those thresholds are met, CMS will review a future MSA proposal and

will provide an opinion that the parties can rely upon in settling their case. This conventional practice of submitting an MSA proposal to CMS for review and approval, which is entirely voluntary, predictably inflates costs and over burdens claim payors. In 2017 alone, some 26,000 claims had an average of about $93,000 each set aside as funds to reimburse Medicare for future medical treatment. Care Bridge International, a vendor that does work on MSAs recently did a study focusing on the actual spending on behalf of an injured worker for the first five years post MSA report approval. Their finding was that in the fifth year post settlement, the pace of medication spending was 64% of the forecast and 55% for all other medical care. In another study, they analyzed a huge database of eight million non-settled workers' compensation claims noting the medical spending for up to eleven years after injury.

Why the inflated numbers?

1. Medicare requires that medications be priced unrealistically high at RED BOOK average wholesale price. Most claims payors pay for drugs with pharmacy benefit managers and arrange for prices that are up to 35% lower.
2. Medicare unrealistically requires that medications be budgeted unaltered for the projected life of the worker. There is no scientific assurance that this will be the case.
3. Medicare requires that treatment the worker is receiving or has planned, as of the time of settlement, will continue but, in reality, treatment evolves as patients adapt.

MSA vendors are learning this and using it to their advantage. There are several vendors who now will produce an MSA proposal and recommend that it not be submitted to CMS regardless of whether it falls within the work-review threshold. Those vendors offer to stand behind their proposal and take over and pay if CMS rejects their analytics and if, in fact, payment exceeds the amount proposed. It is my understanding that they are developing or utilizing an insurance product for this purpose. Moreover, in some states, MSAs that are structured are being negotiated with consideration given to making the beneficiary the insurance carrier or the self-insured employer, rather than the claimant's estate. These products are new to the market, but should be considered as potential cost savings can be significant.

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## WC Appellate Division Decision issued on June 14, 2018 – Average Weekly Wage

**Average Weekly Wage**

The employee was employed by the same employer for 52 weeks prior to a December 17, 2014 injury, but for approximately 13 of those weeks she was out of work for non-occupational reasons and received STD benefits which were substantially lower than her customary weekly earnings. The ALJ determined the average weekly wage by excluding the weeks on which the employee was out of work on medical leave and averaging the remainder. The employer appealed to the Appellate Division.

In *Thibeault v. Twin Rivers Paper Company, LLC*, Me. W.C.B. No. 18-20 (App. Div. 2018) the Division ruled that the STD benefits were not analogous to vacation pay and should not be included in the wage calculation. The Division found that during the period in which the employee had been taken out of work by her physician she received no wages, earnings, or salary. The Division found that including the weeks of STD benefits would artificially deflate the average weekly wage and would not fairly compensate the employee for the loss of earning capacity.

Accordingly, the Division found that the ALJ had properly excluded from consideration the weeks in which the employee did not work and had correctly calculated the average weekly wage.

## WC Appellate Division Decision issued on May 14, 2018 – Statute of Limitations

**Statute of Limitations**

Ten years ago the Law Court ruled in *Wilson v. Bath Iron Works*, 2008 ME 47, 942 A.2d 1237 that the two-year statute of limitations does not begin to run until the employer files a First Report of Injury, regardless of how much time may have passed since the injury occurred. In the years following the employer community invested considerable effort to amend Section 306(1) to reverse the *Wilson* decision, as the effect of that case was to delay the commencement of the statute of limitations until such time as an employer had an obligation to file a First Report. Ultimately, the legislature amended Section 306(1) effective August 30, 2012. The Law Court has never had an opportunity to interpret the language of the amended statute, but in a recent decision the Appellate Division addressed the matter “head on” and ruled how the amended statute is to be applied.

In *Bickmore v. Johnson Outdoors*, Me. W.C.B. No. 18-18 (App. Div. 2018) the employee sustained two separate injuries eight years apart while working for the same employer but when different insurers were on the risk. The insurer at the time of the second injury filed a Petition for Award seeking to establish the compensability of the first injury and a corresponding obligation on the part of the first insurer to contribute to benefits owed to the employee. The first insurer had paid medical expenses but was never required to file a First Report. More than six years from

the date of the last payment had elapsed before the duty to file a First Report arose.

The Division tackled the complex legislative history behind the 2012 amendment to Section 306(1), and it is not necessary to recite the sequence of events in this brief article. Ultimately, the adopted amendment lacked clarity and was susceptible of different interpretations. Indeed, the Division found that it was not clear exactly what the Legislature had intended and that the Legislature had never specifically stated that it was acting to modify *Wilson.* Because the meaning of the statute was found to be ambiguous, the Division analyzed the legislative history and concluded that the Legislature had actually intended to limit the scope of *Wilson*. Specifically, the Division held as follows:

> …we conclude that the appropriate interpretation of Section 306(1) as amended is: except as otherwise provided in section 306, a claim is barred two years after the date of injury or, if within that two year period the employee's employer is obligated to file a First Report under Section 303 and fails to do so, two years from the date the employer files the First Report.

Thus, the Division held that if an employer is not required to file a First Report within the two year period immediately following the injury, the statute of limitations bars a claim after that point.

The Division then addressed whether the amended version of Section 206(1) could be applied retroactively. The Court found no express or implied legislative intent that the amendment should be given retroactive effect. However, the panel concluded that this finding was not determinative, and that retroactive application must be determined by the timing of two events. Specifically, if the date that an employer becomes obligated to file a First Report of Injury and the date that the employer actually files a First Report of Injury occur after the effective date of the 2012 amendment, the amended version of Section 306(1) will therefore apply to determine whether or not a claim is barred by the statute of limitations. Accordingly, because of the passage of time the first insurer in *Bickmore* had no obligation to file a First Report for the initial injury until long after the amendment took effect, all claims with respect to the initial injury were barred by the statute of limitations.

This is an extremely important decision and resolves a number of questions that have remained unanswered since the 2012 attempt to modify or reverse the scope of *Wilson*. Carriers and self-insureds can now determine with greater accuracy whether or not the statute of limitations on a particular claim has expired.