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# Workers' Compensation- Regulation of Medical Expenses

BY KEVIN M. GILLIS

## Statutory and Regulatory Background

The Workers' Compensation Act of 1992 achieved a variety of reforms designed to reduce the costs of the workers' compensation system in Maine. One of the provisions of the Act, which has been largely overlooked over the years, is Section 209, which pertains to the regulation of medical fees. Although medical expenses comprise slightly more than 50% of all costs of the system, participants in the system have over the years directed much greater attention to provisions of the statute pertaining to the entitlement to and liability for incapacity benefits paid to injured workers than to the regulation of medical fees. In recent years, however, much greater attention has been paid to the issue of regulation of medical fees in the workers' compensation system, both in Maine and nationally.

Under Section 209 of the Maine Workers' Compensation Act, the Workers' Compensation Board is required to adopt a medical fee schedule, considering the maximum charges paid by private third-party payors for similar services rendered by healthcare providers in Maine. The reference to "private third-party payors" is to the private health insurers in the market in the State, the number of which is small. The statute also requires that the Board adjust the schedule annually. The statute states that a healthcare facility or provider must be paid either its "usual and customary" charge or the maximum charge under the schedule adopted, whichever is less. Finally, the statute provides that, in order to qualify for reimbursement for health care services under the Act, providers may not charge more for the service than is charged to private third-party payors for the same service.

The clear intent of the 1992 statute was that medical providers would charge employers and insurers under the Act at the same level that they are charging health insurers for the same services. In addition, the intent was that the Workers' Compensation Board would immediately promulgate a schedule regulating the fees of medical professionals and facilities under the Act, and that the schedule would be updated annually.

The intent of the 1992 statute with respect to regulation of medical fees has never been realized. The Workers' Compensation Board did not promulgate any medical fee schedule until 1997. At that time, the Board promulgated a schedule pertaining to professional services which did not at all consider the charges paid by health insurers in the State for the same services, and set fees at a level believed to be far in excess of those payment rates. With respect to the fees charged by facilities, mostly hospitals, the Board did

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not promulgate a fee schedule at all, but rather provided that employers and insurers were responsible for payment of the facilities' "usual and customary" charges, with the exception being that a 5% discount from those charges could be taken if payment is made within 30 days of receipt of the bill. No annual updates to these regulations have occurred. The result of the action of the administrative agency, or lack thereof, has been that employers and insurers in the system have been required to pay medical expenses at levels far above those intended by the 1992 reform legislation.

## Interpretation of the Statute by the Law Court

In the 2008 case of *Fernald v. Shaw's Supermarkets, Inc.* and *Babine v. Bath Iron Works Corp.,* 2008 ME 81, 946 A. 2d 395, employers litigated the level of fees being charged by a hospital for medical services. The employers argued that they should be permitted to examine the levels of payment being received by the hospital from health insurers for the same services, to determine whether the hospital was charging the employers more than the amount being charged to health insurers for the same services, and therefore whether the reimbursement sought by the hospital exceeded the amount which could be charged under the statute.

In a 4 to 3 decision, the Court held that the employers were not entitled to this information, because the level of payments by health insurers to providers was only relevant to the process of setting the medical fee schedule. It was held that the "schedule", providing for a 5% discount from the "usual and customary" charges if payment were made within 30 days, is a valid applicable schedule, and that the hospital was entitled to payment of its usual and customary charge or the 5% discount in an individual case. The majority concluded that the limitation on reimbursement to the amount "charged" to third-party payors simply referred to the level of charges on the original bill, as opposed to the actual payment made by health insurers pursuant to privately negotiated arrangements between the health insurer and the provider. As long as the original charge was the same made to all parties, the hospital was entitled to payment of that charge under the Act, or the 5% discount from that charge, regardless of the amount the hospital is actually paid by health insurers for the same service.

The dissent, written by the Chief Justice, pointed out that the majority's interpretation rendered meaningless the statutory limitation on reimbursement, intended to create approximate parity between the level of payments made by health insurers and the level required to be paid by employers and insurers under the Act, and that the interpretation allowed providers to charge whatever they pleased to employers and insurers.

## Superior Court Litigation

In *Bath Iron Works Corp. et. al v. Maine Workers' Compensation Board*, filed in Superior Court, the plaintiffs challenged the statutory validity of the medical fee schedules promulgated by the Board, arguing that the Board had failed to fulfill the statutory requirement of promulgating a professional fee schedule which considered the level of payment by health insurers for the same services, had failed to promulgate a facilities fee schedule at all, and had failed to annually update its schedules.

In that action, Justice Mills issued an Order, dated August 11, 2008, ruling that the 5% discount "schedule" for facilities did not constitute a valid schedule as required by the statute, and directed the Board to comply with the statute by promulgating a valid medical facilities fee schedule. In the same action, Justice Murphy issued an Order, dated July 9, 2010, ruling that the existing medical professional fee schedule was invalid under the statute because there was no evidence that the Board had considered payments made for the same services by health insurers in promulgating the schedule, and because the schedule had not been annually updated as required. The Court directed the Board to comply with the statute in promulgating a professional fee schedule, and to annually update the schedule.

## Recent Action by the Workers' Compensation Board

In 2011, the Workers' Compensation Board has begun the process for promulgating a facilities fee schedule for the first time. The schedule, which will soon be processed for public comment prior to possible promulgation, is based upon a relatively sparse amount of data concerning payment levels by health insurers to facilities for the same services. A chronic problem which has been encountered by the agency has been the acquisition of sufficient data concerning payment to medical providers by health insurers upon which to base an appropriate medical fee schedule consistent with the intent of the statute. The proposed facilities fee schedule will include a provision which will require facilities to annually report to the Workers' Compensation Board data concerning payments they receive from health insurers for the same services for which they are paid under the Workers' Compensation Act in the same year. It is hoped that this or a similar data collection requirement will assist the Board in the future in

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promulgating fee schedules which are consistent with the statutory intent and which can be annually updated.

Although the professional fee schedule has been ruled invalid in the Superior Court, no updated professional fee schedule has been proposed by the Workers' Compensation Board to date, and this issue presumably will be on the Board's agenda in the near future.

## 2011 Legislation

In 2011 legislation, LD 1244, was introduced to effectively reverse the Law Court's interpretation of the statute in *Fernald*, to provide that reimbursement to medical professionals and facilities was limited to the lesser of the maximum amount under the applicable medical fee schedule or the average payments received from health insurers for the same services. Opposition to the legislation focused on the possibility that the legislation could lead to protracted litigation of levels of medical fees in individual cases, causing delays in payment. Eventually, a compromise bill was enacted by the Legislature, which is Public Laws, Chapter 388, which was signed by the Governor on June 14, 2011.

The new statute repeals Section 209 of the Workers' Compensation Act, and creates Section 209-A. Under the statute, the applicable medical fee schedule promulgated by the Workers' Compensation Board primarily governs the maximum reimbursement for medical services and supplies. In the event that a fee schedule has not been promulgated by December 31, 2011, or otherwise does not apply, the standard for governing reimbursement is 105% of the average payment to that provider by health insurers for the same service, including any amounts to be paid by the patient based upon co-pays or deductables. The statute requires the Workers' Compensation Board to promulgate a medical fee schedule which considers the average payments made for the services involved by health insurers and insured patients, and requires the Board to annually update the schedule, and to comprehensively review the schedule every three years. The statute calls for the executive director of the Workers' Compensation Board to obtain annually from the Maine Health Data Organization data concerning the average payment received by providers in the State for the most commonly rendered services and supplies. Finally, the statute requires the executive director of the Workers' Compensation Board to report back to the legislative committee on the status of the medical fee schedule by February 15, 2012.

## Conclusion

For almost 20 years since the enactment of the 1992 reform of the Workers' Compensation Act, the legislative goal of regulating medical fees so that the level of fees would approximate those paid in the health insurance situation has not been realized. It is hoped that recent action by the administrative agency and the Legislature will lead to that goal being realized in the near future. Accomplishment of this goal will not insulate employers and insurers from rising medical costs in the workers' compensation system, as health care costs paid by health insurers presumably will continue to rise, but more effective regulation of these costs by the Workers' Compensation Board should place employers and insurers in the workers' compensation system in roughly the same position as health insurers with respect to payment of medical costs, which was the intent of the Legislature in 1992. □

# Workers' Compensation – Law Court Decisions

By Stephen W. Moriarty

## Court Upholds 14-Day Rule

Late last year the Law Court agreed to accept an employer's appeal from a hearing officer's decision which found a violation of the so-called "fourteen-day rule" in highly unusual circumstances. As a result of the decision the employer owed approximately $140,000 in retroactive benefits, and although the Court declined to issue an order staying the award of benefits pending an appeal, it did agree to hear the appeal on an expedited basis. Because the Court had previously upheld the validity of the fourteen-day rule in *Bridgeman v. S. D. Warren Co.,* 2005 ME 38, 872 A.2d 961, it was believed by many that the Court's decision to accept the appeal indicated an intent to modify or overrule *Bridgeman*. As it developed, such was not the case.

The facts of *Doucette v. Hallsmith/Sysco Food Services, Inc.,* 2011 ME 68 (June 9, 2011) are particularly compelling. The employee injured his back on April 1, 2004 but did not lose any earnings as a result. In fact, he had no residual problems with his back until re-injured while working for a different employer in 2008. Ultimately, he filed a Petition for Award against Sysco in early 2009 claiming benefits for "total/partial compensation from April 1, 2004 to the present and continuing". The third-party administrator for the employer attempted in a timely fashion to electronically file a Notice of Controversy, but the filing was rejected on grounds of incomplete information. A second NOC was then prepared but it was not transmitted electronically until after midnight on the 15th day following knowledge of the filing of the petition. Thus, the NOC was electronically received by the Board after the close of business on the 14th day but before the opening of business on the 15th day.

The employee alleged a violation of the 14-day rule, and the presiding hearing officer ruled that the NOC was late because the electronic filing was not completed until the 15th day. The violation was ultimately cured by the employer in mid-April, 2009, but the hearing officer ordered payment of benefits for total incapacity from April 1, 2004 to the date of the cure. Accordingly, even though the employee had not suffered any loss of earnings, he was awarded retroactive benefits because Ch. 1, § 2 of the WCB Rules states that benefits must be awarded from the date of incapacity if the NOC is late.

In response to a motion for findings of fact, the hearing office affirmed his decision since the NOC had not been filed until "the early morning hours" on the 15th day following employer notice of the claim.

In a 6-1 decision, the Court upheld the validity of the 14-day rule and the decision of the hearing officer. In its opinion the Court addressed the following issues.

**Board Rule-Making Authority.** As it has on many occasions, the Court noted that the Legislature had intended to grant broad rule-making authority to the Board to interpret the Act and to fill in "gray areas" deliberately left by the Legislature. In *Bridgeman* the Court had rejected a challenge to Ch. 1, § 1 of the WCB Rules and had found that the Board had not exceeded its legal authority in promulgating the 14-day rule. In *Doucette* the Court refused to reconsider the *Bridgeman* opinion, and essentially held once again that the Board had properly adopted and applied the rule. Since the Court had already upheld the rule in *Bridgeman*, and since it refused to change its analysis of the legality of the rule to any extent, one can only wonder why the Court agreed to accept the *Doucette* appeal in the first place.

STEPHEN W. MORIARTY

**Timeliness of Filing.** The Court noted that the hearing officer had made a factual finding that the NOC was actually filed on the 15th day, even though the Board was not yet open for business as of the time of filing. Noting that by statute all findings of fact are considered to be final, the Court refused to overturn the hearing officer's decision. However, for what it may be worth, the Court did not hold that the hearing officer was required to find that the NOC was filed on the 15th day. Presumably, therefore, if the hearing officer had found that the filing had been made on the 14th day (as extended through the overnight hours), the Court would have upheld that finding as well and there would have been no violation.

**Equitable Remedies.** The Court recognized the harsh result of the hearing officer's decision under all of the circumstances, but held (as it has in the past) that the Board has no equitable authority and cannot mitigate a severe penalty even where fairness and reasonableness would seem to require it. As a result, the Court found that the hearing officer had no option but to strictly enforce the terms of a validly-adopted

Board rule, notwithstanding the unforeseen consequences of such action.

**Date of Incapacity.** The employer challenged the retroactive award of benefits on the grounds that in fact the employee was not actually incapacitated from the time of the original injury forward. Noting that Ch. 1, § 1 requires payment of benefits "from the date of incapacity" in the event of a late NOC, the Court interpreted the rule to refer to the date of alleged incapacity rather than the date of actual incapacity. The Court did not require that an allegation of incapacity be made in good faith or upon some factual or rational basis. As a result, the Court has virtually given express approval to the making of unsubstantiated allegations in asserting claims. Remarkably enough, the Court found that disallowing an award of benefits where no entitlement actually existed would conflict with the basic premise of the 14-day rule, which is to encourage timely filings.

**Legislative Intent.** The employer made a compelling argument that sanctioning a $140,000 award when no disability existed would conflict with the goals of the Legislature in enacting the Workers' Compensation Act of 1992. Specifically, the employer pointed out that the Legislative objectives were to save costs, promote fairness within the system, and to require that an injured worker be paid all benefits to which he or she was entitled by virtue of the injury. The Court observed that the 14-day rule also achieved the Legislative purpose of promoting a speedy, efficient, and inexpensive disposition of disputes arising under the Act. The Court apparently concluded that achieving these administrative goals was relatively more important than promoting actual cost savings and fairness within the system, and refused to reconsider its prior affirmation of the rule in *Bridgeman*.

**Concurring and Dissenting Opinions.** Three justices wrote a concurring opinion in which they correctly observed that "it is hard not to be left with the sense that the end result in this case is not just", but nevertheless found that the Board had no equitable powers to produce a more appropriate result. Instead, the concurring justices encouraged the Board to examine the result of the case and to determine whether the 14-day rule should be modified or amended. The single dissenting justice wrote that the hearing officer erroneously awarded benefits retroactively to 2004, and should have limited the award of benefits from the time of the 2008 injury, when actual incapacity and wage loss began.

**Board Action.** To its great credit, the Board responded immediately to the *Doucette* decision. At its first meeting following the issuance of the decision held on June 15, 2011, the Board took preliminary steps to re-evaluate the 14-day rule. Executive Director Paul Sighinolfi clearly stated that in his opinion the rule was unfair and needed to be revised substantially. Plans are in the works to form a stakeholder group to reach consensus on appropriate changes. The matter will appear on the agenda for the next Board meeting scheduled to take place on July 12th in Bangor.

## Average Weekly Wage

A long distance truck driver was paid thirty-one cents per mile instead of salary, and included within that rate was nine cents per mile of "per diem pay" designed to cover expenses such as lodging and meals. The issue before the Board was whether the per diem pay was includable in the average weekly wage, or, in the alternative, was to be treated as a fringe benefit. The presiding hearing officer found that the per diem payments were not includable in the wage by statute, and similarly could not be included as fringe benefits. The employee appealed.

In *Hackett v. Western Express, Inc.,* 2011 ME 71 (June 23, 2011), the Law Court affirmed that §102(4)(F) of the statute excludes from consideration in the average weekly wage all sums paid to reimburse an employee for "special expenses" incurred by virtue of the nature of the employment. In this case there were no restrictions on how the employee could use his per diem income and he was not required to report to the employer how the money had been spent, if at all. The hearing officer had found as a fact that the per diem payments were intended to cover the costs of lodging, meals, and related expenses, and the Court refused to disturb that factual finding.

Chapter 1, §5 (1)(B)(6) of the WCB Rules excludes "reimbursement for travel, parking, etc." from consideration as fringe benefits. The hearing officer found that the per diem payments fell into this category, and therefore could not be considered as fringe benefits within the meaning of the statute. The Court found no error in this determination.

In sum, when the unique nature of the employment requires an employee to potentially incur special expenses, and when that employee is paid a sum to cover those expenses, such income may not be considered as part of the average weekly wage and cannot be treated as a fringe benefit.

Lindsey Morrill Sands represented the employer in this proceeding. □

# What You Do Not Know About Cloud Computing And Social Media Networks Can Hurt You

By Darya I. Haag

With each passing day, there remain fewer and fewer people in the United States and worldwide who do not know what Facebook is. Those who still do not know should Google it. Indeed, the words Facebook and Google have become ubiquitous in the modern vocabulary, defying language and cultural barriers. Businesses and individuals alike have been quick to appreciate and acclimatize to the utilities of social media networks (such as Facebook, Myspace and LinkedIn), blogs (such as Tumblr.) and microblogs (such as Twitter) that not only allow people to keep in touch and share information, but also represent powerful tools for marketing, advocating, fundraising, recruiting and providing customer service.

Contemporaneously with the astounding growth of popularity of social networking sites, the so-called "cloud computing" has also been rapidly spreading across various facets of modern life. Cloud computing allows users to store and access applications and computer data off site through a web browser without having to install specific software or keep the data on their personal computer or office server. Many Internet users may already be "in the cloud" without realizing it. For instance, Google mail and Google document review services, which allow their users to access their email accounts or review and modify documents from multiple locations and at the same time, represent a basic example of cloud computing. Similarly, Apple recently unveiled its cloud computing service that allows its users to store various content online instead of taking up space on their hard drive. But cloud computing goes beyond data storage and editing tools. It has made it possible for almost anyone with a computer and a web browser to access a broad range of applications capable of performing numerous tasks that would have otherwise required prohibitively expensive hardware and software investments. Only recently, the New York Stock Exchange announced the launch of the financial services industry's first cloud platform that enables financial trading companies to easily purchase the computing power required at any given time to increase their trading speed.

While benefits of social media networks and cloud computing are many and obvious, diving into the cloud or joining a social media network can also involve serious risks and responsibilities that are not always self-evident. Understanding important privacy, security and electronic discovery considerations is essential for deriving the most utility out of these new tools and avoiding pitfalls that may be very costly and otherwise painful.

**1. Do Not Dive Into the Cloud Unprepared.**

The basic principle behind cloud computing is that data gets stored in a remote location under the control of a certain cloud service provider and its personnel, over whom the owner of the data does not have any direct control. Although client's data generally gets encrypted when stored in the cloud, Dropbox, a popular cloud provider with 25 million customers, recently admitted that it may decrypt users' information and even disclose it to third parties (sometimes without obtaining the data owner's prior permission) under certain circumstances, including where there has been a compulsory legal request. Carefully choosing a reputable cloud provider is of paramount importance. There is a growing number of brand new cloud computing providers that lure customers by offering cheap prices. However, if the cloud provider goes bankrupt or gets acquired by another entity (such as Boomi, DocVerse, Makara, and others acquired in 2010), it is not always clear what happens to the customers' data and who is liable for data damage or loss. Naturally, a user's ability to access the data and applications in the cloud depends entirely on the availability, quality and speed of Internet connection. Also, like any information available and transmitted online, data stored in the cloud runs a higher risk of being hacked or intercepted during transmission. Because the access to the software and stored information occurs via virtual channels, there is a risk of security breaches if the channel of data transmission is not secure, or if the cloud provider encrypts and decrypts information on its own servers. For example, a recent glitch on Dropbox's website let visitors use any password to log in to customers' accounts, making potentially all of the information stored in Dropbox's cloud available to public for four hours.

DARYA I. HAAG

Understanding and planning around these and other risks before entrusting

your data to the cloud is essential for a positive cloud computing experience. Thus, before entering into an agreement with a cloud provider, it is necessary to develop a thorough familiarity with the provider's terms and conditions. A lot depends on whether the cloud computing is used for professional purposes and the type of industry the client is in. It is crucial to ensure at the onset that the cloud provider satisfies any compliance requirements that may be applicable to a particular customer. It is also essential to understand the cloud provider's privacy and security policies, whether and how the data gets encrypted and when it may be decrypted or disclosed to a third party. This involves having full knowledge of what would happen to the data or application support if the provider goes out of business or suffers serious technical problems, as well as who is going to be liable for lost or damaged data.

Similarly, the customer should be familiar with the provider's protocol, time-frame and associated costs for retrieving the stored data from the cloud and ensuring that all copies of the data are properly destroyed. It is equally important to find out who the cloud provider is and where it is located because the storage of data in a certain state or country may subject the customer to that state or country's jurisdiction. In addition, some providers may be willing to custom tailor their terms and conditions to accommodate a specific client's needs and interests, including better privacy protections. Where there is no option to negotiate an agreement (for example, in case of a typical shrink wrap agreement where the user must agree to the provider's terms to gain access to the service), it is particularly important to weigh risks and benefits of cloud computing, including the sensitivity of data to be stored in the cloud, before checking the "I agree" box.

**2. Take Full Control of Your Social Network Account But Do Not Expect Privacy.**

Social media networks similarly raise a host of privacy and security considerations typical for web-based services, such as exposure to viruses, malware, identity theft, cyber harassment and cyber stalking. Companies that use social networks for business purposes are generally troubled by finding a balance between disclosing sufficiently detailed information about their goods and services to attract customers, and at the same time protecting the company's legal and proprietary information that may be misused by competitors. While companies should be mindful about the type and amount of information and the manner in which they disclose it to the public, there are ways to protect intellectual property without keeping it secret and missing out on great benefits that social networks stand to offer.

Any company that decides to use social networks for business-related purposes should first define the specific goals it wishes to achieve by, for example, maintaining a presence on Facebook, and design a master plan of Facebook uses that directly advance these goals. This plan should outline privacy, ethics and other considerations that may be specific to the type of business the company is engaged in, summarize laws and regulations that may prohibit or restrict disclosure of certain information, and also create a list of issues and topics that would be interesting and useful to the targeted audience. If the company has employees, it should set forth clear rules under which employees may post information on the company's page or about the company, and outline sanctions for making posts that adversely impact the company's reputation or financial well-being. The company should regularly update its policy to reflect technological innovations, conduct training for its employees and ensure consistent implementation of the established policy.

Furthermore, all users of social networks—whether used for business or personal purposes—should be aware that social media networks offer little privacy regardless of the privacy settings selected by the user. For example, only recently Facebook announced the implementation of new facial recognition technology that automatically identifies people in photographs on its website. Even though Facebook facial identification is not always accurate, it is automatically enabled in Facebook users' privacy preferences. Therefore, in order to manage the exposure of personal information and data stored in the social network account, it is critically important to keep up-to-date with the network's privacy policies.

However, everybody with a social network account must understand that any information stored in a social network account, including wall posts, photographs, songs, messages and even deleted pages may be discoverable. This means that in the event of a lawsuit or an audit, the social network may be legally required to provide some or all of the data associated with the user's account. A recent scandal involving now former congressman Anthony Weiner, who was forced to resign because of what he thought were private Facebook messages and Skype video chat, is a good example of how careless social interaction on the Web may come at a very high price.

Neither Maine or Federal Rules of Civil Procedure, nor Maine or Federal Rules of Evidence address social networks as a form of evidence. Therefore, the courts have used their discretion to determine the degree of privacy to be afforded to the information disclosed or shared though Facebook, Linkedin or other online social networks.

For example, in one of the few Maine cases involving access to and evidence gathered from a social network account, the Superior Court ruled that where probable cause existed, detectives could search the defendant's computer and associated storage media, cellular telephone and associated storage media, and Internet social media site. *State of Maine v. Chad Gurney,* 2010 WL 3830832 (Me. Super. July 12, 2010).

Similarly, in a case before the United States District Court for the

District of Maine, the defendant successfully offered into evidence (although ultimately losing the lawsuit) various posts, pictures and status updates posted on her husband's Facebook page to show his consent to her permanently moving to the United States with the couple's child. *Nicolson v. Pappalardo*, 674 F.Supp.2d 295 (D. Me. 2009), *aff'd*, 605 F.3d 100 (1st Cir. 2010).

A New York court has also allowed the defendant to access the plaintiff's MySpace and Facebook accounts data (including the information that was previously deleted) where the information contradicted the plaintiff's claims in a personal injury suit. *Romano v. Steelcase, Inc.,* 907 N.Y. S.2d 650 (N.Y. Sup. Ct. 2010). Plaintiff's account contained photographs depicting the plaintiff physically active during the time when he claimed he was physically impaired. The court found that "preventing Defendant from accessing to Plaintiff's private postings on Facebook and MySpace would be in direct contravention to the liberal disclosure policy." *Id.* at 654.

In another a case brought by former employees against their employer, the court granted the employer's request for access to the employees' Facebook and MySpace accounts. *Equal Employment Opportunity Commission v. Simply Storage Management, LLC,* 270 F.R.D. 430 (S.D. Ind. 2010). The court specifically found that even though the requested data was "private" based on the social networks' privacy settings it was not immune to a legitimate discovery request. *Id.* at 434. The court allowed the employer to obtain profiles, postings and messages, including status updates, wall comments, causes or groups joined, activity streams, and blog entries. *Id.* at 436.

At the same time, just as defendants are using social networks data as evidence to undermine plaintiff's claims, plaintiffs have been equally successful in using evidence of defendants' online activity in support of their claims. For example, in a recent employment dispute, the employer offered his former employee's LinkedIn account records as evidence that the defendant employee contacted with the employer's customers and former co-workers. *TekSystems, Inc. v. Hammernik,* et al., 2010 WL 1624258 (D. Minn. Mar. 16, 2010).

**3. Begin to Manage Your Electronically Stored Data Now.**

The discovery of information generated through the use of web resources is not limited to the information generated by or exchanged through the use of social networks, but includes all electronically stored information. Gathering and sorting though all of the electronically stored data in response to a request for production may be extremely costly. However, this cost may be significantly reduced by adequate preparation. Any company would benefit from implementing or adjusting its document retention policy that would have a schedule for retention and destruction of certain electronically stored business records, provided such destruction complies with applicable laws.

The policy should identify the information that is the company's main asset and must be preserved, such as personnel and tax records, board minutes, accounting records, etc.; and the data that is only incidental to the company's business activities and may be safely disposed of. Similarly, any company that maintains a social media network account should have a strategy for retention, preservation and production of data generated by its use. To be effective, any document retention policy must be objectively and consistently enforced. If there is a reasonable anticipation of litigation, there is a duty to preserve electronic evidence within limits set by the court. This means that any destruction of information must be suspended as the failure to implement such a "litigation hold policy" could result in charges of spoliation of evidence. In Maine, the typical sanctions for spoliation of evidence include the exclusion of evidence concerning the spoliated material, the exclusion of any expert testimony based upon that evidence, and even dismissal of the case.

Essentially, both social media networks and cloud computing enable their users to accomplish an amazingly broad range of tasks, saving time and money in the short run. To retain these and other benefits in the long run, it is vital to learn how to identify and navigate the risks implicated by these essential new tools that are here to stay. □

# MMG Prevails at Law Court on Sexual Molestation Exclusion

By Lance E. Walker

The Maine Supreme Judicial Court overturned a Superior Court decision, (Cuddy, J.) that interpreted a homeowners insurance policy as providing coverage for sexual molestation claims. In *Jacobi v. MMG* Insurance Co., 2011 ME 56 (May 10, 2011), Justice Alexander, writing for a unanimous court, held that the homeowners policy issued by MMG Insurance Company ("MMG") excluded coverage for sexual assaults on the plaintiff's young daughter by MMG's insured's 17 year old son.

## Background

Ms. Jacobi and her minor daughter, Summit, rented a house in Blue Hill from MMG's insured, Barbara Bennett. Bennett left for New Mexico, but Bennett's 17 year old son remained in Blue Hill, living in an in-law apartment attached to the home that Jacobi rented. The son repeatedly sexually assaulted Jacobi's daughter from September to November 2006. Jacobi learned of the assaults in January 2007 and reported the abuse to the police. Jacobi informed Bennett two weeks later of the assaults and that the police had been notified. In March 2007, Bennett sent Jacobi an eviction notice for non-payment of rent. The eviction notice caused Jacobi to have to seek alternative housing "at a time when she was preoccupied with caring for her daughter and attending to her daughter's needs," according to plaintiff's counsel.

## Underlying Action

Jacobi filed a five count complaint, individually and on behalf of her minor daughter, against Bennett alleging: premises liability, intentional infliction of emotional distress, negligent infliction of emotional distress, punitive damages, and loss of services of a minor child. Jacobi based her claim for IIED for Bennett's "notifying Jacobi of her intention to evict Jacobi and her daughter from the rental property, forcing them to find alternative living arrangements during the winter months at a time when Jacobi was busy attending to her daughter's needs." Jacobi based her claim for NIED on two allegations: 1) Bennett "knew or should have known that her failure to provide Jacobi and her daughter with secure and safe premises could cause them to suffer severe emotional distress"; and 2) Bennett "knew or should have known that evicting Jacobi and her daughter at a time when the daughter was recovering from injuries and damages perpetrated by Bennett's son, would cause Jacobi and her daughter to suffer severe emotional distress."

In an effort to circumvent the intended injury and sexual molestation exclusions, plaintiff's claims for emotional distress were also predicated on a claim for "wrongful eviction."

MMG declined the defense of Bennett. Bennett in turn failed to file an answer in the underlying action and a default was entered against her. After a damages hearing, the Superior Court (Cuddy, J.) entered judgment on the emotional distress claims for $100,000 for Summit and $30,000 for Jennifer Jacobi. The Court dismissed all of the other counts as not legally cognizable.

## Reach and Apply Action

Jacobi filed a reach an apply action against MMG. Justice Cuddy concluded that because there were "multiple causes of damages alleged, one of which was not excluded under the policy (the so-called "wrongful eviction" claim), that the reach and apply action was an appropriate remedy, and that MMG was responsible for the entire judgment. MMG brought the appeal.

LANCE E. WALKER

## Law Court Analysis

The Law Court dispensed with the Superior Court's judgment on the IIED count, holding that the policy exclusion precludes coverage for Jacobi's intentional infliction of emotional distress claim because "the allegations of sexual molestation giving rise to the claim demonstrate intentional conduct, the natural object of which is to cause emotional distress in sexual molestation cases."

As for the NIED count, the Court rejected Jacobi's creative argument that the damages were supported by the underlying tort of "wrongful eviction," concluding that the argument was undermined by the fact that no such cause of action was pled, much less adjudicated. NEID claims, save for familial relations and other special relationships require as a predicate a separate underlying tort. Here, the Court held there was no such underlying tort. Jacobi urged the Court to consider the "wrongful eviction" as the underlying tort. The Law Court declined to adopt a tort of wrongful eviction that was based on a duty which plaintiff claimed was owed by Bennett to ensure that "no harm would befall the tenant, particularly having been evicted in the winter months."

Justice Alexander rightly noted that the eviction process is usually attended by a significant amount of stress in the first instance and, as a more practical matter, evictions occur throughout the calendar year, including the winter months. The seasonal inconveniences of the eviction process notwithstanding and the financial stressors that have caused them in the first instance do not give rise to any tort-based duty owed by the landlord to the tenant. The Court agreed with appellant's counsel's characterization of the eviction as, at worst, one that was made in "poor taste." The Court concluded that "poor manners that do not constitute a violation of a statutory or common law duty do not create and actionable, independent tort of wrongful eviction that can serve as a basis for recovery of damages for negligent infliction of emotional distress."

## Impact of Jacobi Decision

This was the Law Court's first opinion interpreting the sexual molestation exclusion and it was consistent with its historic antipathy toward requiring liability insurers to indemnify insureds who have caused damages arising from sexual molestation. However, the opinion opened the door to two significant areas for insurers.

### A. Burden-Shifting

The Court glossed over the burden-shifting feature between a judgment creditor and an insurer in a reach and apply action. Historically the Court has held that the judgment creditor need only satisfy the meager burden that the judgment is within the threshold grant of coverage. The burden then shifts to the insurer to prove the applicability of any one or more exclusions. The *Jacobi* Court held that "although any ambiguities in an insurance contract are construed in favor of coverage, the party seeking to recover pursuant to the reach and apply statute has the burden to demonstrate that awarded damages fall within the scope of an insurance contract. Thus [the judgment creditor] must demonstrate that the damages awarded by the court. . . are covered by the policy despite the existence of any potentially applicable exclusions."

This explication of the burden on the judgment creditor simply is not consistent with Law Court precedent, which favors the burden-shifting analysis described above. Although Justice Alexander's statement of the law is dramatically more favorable to insurers than historically has been the case, I would caution against counting on it in a future reach and apply action in which the burden-shifting feature is central to the Court's analysis. It is doubtful that the Law Court would require the judgment creditor to prove the judgment is within coverage and also prove the inapplicability of the relevant exclusions, despite the language in Jacobi.

### B. Intended Injury, Sexual Molestation and the Duty to Defend

In a perfunctory treatment of the intended injury exclusion, the Court held that the exclusion precludes coverage for Jacobi's IIED because the *allegations* giving rise to that claim demonstrate intentional conduct, the natural object of which is to cause emotional distress. It is true that the Law Court has held that in cases of sexual molestation the Court will presume, as a matter of law, that the particular injury to the minor is certain to follow. That is, it is so highly likely that sexual contact of a minor will cause substantial emotional damage that the law will not entertain an insured's plea that such damages were not subjectively foreseeable by him. *Curtis v. Porter,* 2001 ME 158, ¶ 10, 784 A.2d 18, 22.

However, the Court's language in Jacobi goes one step further by concluding that the *allegations,* giving rise to the claim of emotional distress, which were brought about by the sexual molestation, demonstrate intentional conduct, which is excluded under the policy. Of course, in a reach and apply action the analysis does not involve the allegations in the complaint which gave rise to the judgment but rather involve the actual facts as proven at trial and whether or not those facts support the application of an exclusion. The Court's broader interpretation of the application of the intended injury exclusion as it pertains to *allegations* of sexual molestation invites insurers to decline a defense to insureds against whom such claims, and other claims of intentional conduct, are made. Given the Law Court's historic and dogmatic adherence to the comparison test as a talisman inviolate, I suspect this part of the Court's opinion is attributable to undisciplined judicial writing as opposed to a conscious intent to overrule 35 years of Law Court precedent on the subject. It is typically the case that when the Law Court intends to overrule precedent it does so in a somewhat more conspicuous fashion than the *Jacobi* Court did.

As a more practical matter, it is rare the case where a plaintiff alleges damages only caused by sexual molestation in a single count for intentional infliction of emotional distress. In such cases, it is likely that the guiding principle of *Perreault, Curtis* and *Jacobi* would justify a denial of a defense. Invariably, however, such cases are pled, as was the Jacobi complaint, by alleging other damage causing conduct. Moreover, an insurer who declines a defense based on the intended injury exclusion does so at its own peril if the torts alleged can be satisfied by something other than intentional conduct (e.g. recklessness).

Insurers should be wary that the possibility remains that after a judgment is entered on claims, some of which are covered and some of which are not covered, that the burden is on the insurer to delineate damages caused by each. Given the practical impossibility procedurally and otherwise for the insured to do so, the Law Court likely is going to conclude that a judgment entered against the insured is covered in its entirety.

*Jacobi* was something of an unusual case insofar as plaintiff's counsel was well aware of the relevant coverage problems and tried to circumvent them by characterizing the eviction as somehow wrongful because of its proximity to the allegation of sexual molestation in the winter months. However, as the Court concluded, "poor manners that do

not constitute a violation of a statutory or common law duty do not create an actionable, independent tort of wrongful eviction that can serve as a basis for recovery of damages of NIED." Had Jacobi claimed a separate and actual independent tort which caused separate and independent injuries from that which were caused by the sexual molestation, this would have been a very different outcome.

## Conclusions

Although there is little doubt that the Law Court got it right in Jacobi, its provocative and inconsistent statements regarding the burden-shifting features of the reach and apply action and the duty to defend obligation for intentional conduct create more complex problems than they resolve and invite insurers to make smart challenges in those areas in the appropriate case.

*Jacobi* represents a continuation of a trend that the Law Court's antipathy toward insurance companies is exceeded only by its antipathy toward sexual molesters. Call me Mr. Bright Side, but in a jurisdiction where insurers face increasingly hostile attitudes from the bench, this is a positive development.

*Lance Walker represented MMG in the Jacobi v. MMG case. Please contact Lance with any questions you have. He can be reached by phone at 774-7000 or by email at lwalker@nhdlaw.com.* □

# Law Court Upholds Covenants Not to Compete, Liquidated Damage Provisions In Physician Contracts

By Christopher C. Taintor

Contracts that limit competition are frequently litigated. People often take jobs without thinking, or perhaps caring, about what might happen when their employment ends. Employers, on the other hand, do not want to introduce new employees to their established customers, and nurture those relationships, without some assurance that they will be able to protect their business when the employees depart. When the employees are doctors and the "customers" are patients, unique public interest concerns come into play. Where enforcement of a restrictive covenant would limit the professional practice of a health care provider, courts are often asked to consider the effect enforcement would have on, among other things, consumer access to medical care. Some courts have refused to enforce these agreements when the effect would be to unduly limit access.

In *Sisters of Charity Health System, Inc. v. Farrago,* 2011 ME 62 (May 26, 2011), the Maine Supreme Judicial Court decided a case that presented a variant of that concern. There, the Court upheld enforcement of identical covenants not to compete contained in contracts between Sisters of Charity Health System (SOCHS), an integrated healthcare system which includes St. Mary's Regional Medical Center, and three formerly-employed physicians. Although the decision on one level simply follows well-settled Maine precedent, it is significant both for its rejection of the doctors' public policy challenge to the covenants and for its approval of sizeable liquidated damages provisions in each of the contracts.

Each of the physician-defendants had come to the Lewiston-Auburn area without an existing patient base, and had practiced within the system for several years. Their contracts all contained a provision that prohibited them, for a period of two years after their termination or dismissal, from practicing medicine with Central Maine Healthcare Corporation (CMHC), its affiliates, or its subsidiaries within a twenty-five-mile radius of St. Mary's. The limitation could be avoided if the doctors maintained active admitting privileges at St. Mary's and did not maintain staff or admitting privileges at Central Maine Medical Center (CMMC), part of the CMHC system.

At the end of 2006, all three doctors terminated their employment with SOCHS and became employees of

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CMMC with admitting privileges at that institution. Over time, more than a thousand patients who had received medical services from the doctors while they were employed by SOCHS had their medical records transferred to one of them. Soon thereafter SOCHS sued to recover the liquidated damages stipulated in the contracts. The trial court, following a jury-waived trial, found the covenants enforceable and ordered each doctor to pay the system $100,000 as provided by the liquidated damages clauses in their contracts. On appeal, the doctors argued that the covenants were wholly unenforceable. Alternatively, they argued that the contracts' liquidated damages provisions were unreasonable and therefore unenforceable.

The Law Court first observed that under well-settled Maine law, covenants restricting competition are disfavored. As a threshold matter, therefore, such agreements are enforceable only to protect legally-valid interests. In terms of both geographic and temporal scope, moreover, they must "'sweep no wider than necessary to protect the business interests in issue,'" and they may not "impose an undue hardship on the employee." In the *Farrago* case the employees did not argue that the covenants were either too long in duration or too geographically broad. Rather, they took the position that the covenants were "not designed to protect a legitimate business interest."

Because it has long been established that the benefit conferred by an employee's contact with customers -- or, in the medical context, patients -- has a value that an employer may try to protect through a restrictive covenant, and because the physicians had been afforded "direct contact with [SOCHS's] patients and were in a position to appropriate the good will that SOCHS paid the doctors to help . . . develop," there was no doubt that the health system had a presumptively legitimate, protectable interest in preventing its former employees from raiding important sources of revenue. To avoid enforcement of the covenants, therefore, the physicians were relegated to advancing a public policy argument rooted in the federal statutes (the so-called Stark and anti-kickback laws) which prohibit hospitals from paying doctors for making referrals. They asserted that the covenants should be invalidated because they were intended to serve as tools "to influence patient referrals for hospital services, which they contend contravenes public policy . . . and therefore is not a legitimate business interest."

The Law Court rejected this argument. The Court observed that SOCHS had not actually sought to enjoin the doctors from maintaining staff privileges at CMMC, but had sued only for damages. Therefore, the doctors were free to refer patients wherever they chose; they simply had to compensate SOCHS for the estimated revenue stream the system lost when they left. Although the doctors argued that making them pay for the privilege of admitting patients to CMMC was effectively the same as paying them to refer cases to St. Mary's, the Court dismissed that theory without discussion. Furthermore, the Court reasoned, "[e]ven if we were to conclude that hospital referrals were not a legitimate interest, the employment contracts provide that 'any or all ... invalid or unenforceable provisions shall be amended by [the] court so as to cause [the] restrictive covenant to be valid and enforceable to the fullest extent permitted by law.'"

Finally, the Law Court rejected the physicians' challenge to the reasonableness of the damage award. To be enforceable, the Court said, the liquidated damages clause had to satisfy two criteria: it must have been "very difficult" to estimate the damages caused by the breach accurately, and the amount fixed in the agreement must have been a "reasonable approximation" of the loss caused by the breach. The Court found that SOCHS's proof was sufficient on both counts. The Court reasoned: "At the time that the parties executed their employment contracts, it was not possible to determine how many patients would leave with their doctor or how much revenue those patients would have generated for [SOCHS]." SOCHS had produced evidence at trial establishing that the average net revenue from each patient in 2006 had been roughly $340, that more than a thousand patients had requested that their medical records be transferred following the doctors' move to CMHC, and that "it takes two to three years for a replacement physician to generate income at a level commensurate with that of an established doctor." On this evidence, the Court concluded that "the amount of damages fixed in the contract was a reasonable approximation of the damages that SOCHS would incur if a doctor left . . . to practice within a twenty-five-mile radius."

The *Farrago* decision certainly does not dispose of every issue that might influence the enforceability of covenants limiting competition in the medical profession. There was no contention in *Farrago* that the doctors were the sole providers of a medical service that was desperately needed in the community. In that situation, Maine courts could yet be called upon to weigh that community need against the harm to the health system, which may have invested substantial charitable resources to recruit a physician in the first place. The *Farrago* decision could well have been influenced, moreover, by the defendant-doctors' admission that they had never intended to abide by the restrictive covenant, even when they signed on with SOCHS; in light of that admission, their plight probably did not elicit much sympathy. At a minimum, though, the Law Court has signaled that it will not hesitate to enforce covenants limiting competition that are the product of arm's-length transactions, and that any physician will be well-advised to carefully consider the impact such a covenant will have on his future employability. □

# Workers Compensation: The Reach of Section 206

By Robert W. Bower, Jr. & Katlyn M. Davidson

The reach and limitation of section 206 of the Maine Workers' Compensation Act are questions that employers and insurers should consider when faced with a Petition for Payment of Medical and Related Services, especially for items that are not obvious medical expenses. Section 206 provides "An employee sustaining a personal injury arising out of and in the course of employment or disabled by occupational disease is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer." Subsection 8 addresses the compensability of "physical aids" and provides in pertinent part that "[t]he employer shall furnish artificial limbs, eyes, teeth, eyeglasses, hearing aids, orthopedic devices and *other physical aids* made necessary by the injury . . ." Id. § 206(8) (emphasis added.)

The Law Court first analyzed the scope of compensable medical expenses in the decision of *Cote v. Georgia-Pacific Corp.,* 596 A.2d 1004 (Me. 1991). In that matter, the employee sought payment for weekly housekeeping services. While this decision fell under the former Workers' Compensation Act, 39 M.R.S.A. § 52, current section 206 contains virtually identical language. The Court rejected the compensability of housekeeping services, stating that the purpose of the statute is "to provide payment by the employer for purely medical expenses" and that it would be "inappropriate to expand the scope of the statute to include reimbursement for housekeeping services."

In the decision of *Brawn v. Gloria's Country Inn,* 1997 ME 191, 698 A.2d 1067, the Court addressed the compensability of a van and personal care services. The employee, a quadriplegic as the result of a compensable injury, sought payment of the cost of a van specially adapted to accommodate the employee's wheelchair and reimbursement for the services of

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a part-time personal care assistant who performed housekeeping services in the course of her duties. The employer agreed to pay for the cost of accommodations to the van but disputed the cost of the van itself, as well as the cost of services for the part-time personal care assistant. The Court reversed the hearing officer's decision and granted the employee's petition for the complete cost of the van and personal care assistant. The Court reasoned that a van is a reasonable and proper mechanical or physical aid and that a personal care assistant who performs some housekeeping services during her shift does not make the assistant's presence "unnecessary from a medical perspective." It distinguished this case from the Cote decision on the grounds that the personal care assistant provided both medical and housekeeping services as opposed to the individual in *Cote* who performed no medical functions. In making its decision, the Court further explained that section 206 "is not limited to medical apparatus or aids, but extends to all 'reasonable and proper . . . mechanical . . . aids' and 'physical aids made necessary by the injury.' "

More recently, the Workers' Compensation Board, in the matter of *Masalsky v. State of Maine Corrections Department,* addressed the reach of section 206 and potentially limited its scope. The employee in this matter was seriously injured in a work-related motor vehicle accident and suffered ongoing difficulties as a result. The employee filed a petition for medical expenses, seeking payment for the cost of the construction of a garage and additional bathroom among other expenses. The hearing officer initially granted the employee's petition in total and relied on the opinion of a section 312 examiner who had opined that the bathroom and garage "could be medically necessary."

In response, the employer filed a Petition for Appellate Review with the Law Court on the grounds that the hearing officer erred in his analysis of the claimed expenses under section 206. Specifically, the employer argued that the hearing officer only analyzed whether the garage construction and home improvement expenses were reasonable and necessary and did not consider whether the costs were "medical" expenses as defined in section 206. The employer also argued that the garage and additional bathroom were fixed structures and therefore not "mechanical" in nature in order to qualify as "mechanical aids" under section 206. The Law Court granted the employer's Petition for Appellate Review and, in a highly unusual fashion, summarily vacated the underlying decision of the hearing officer. This action was taken without the benefit of oral argument or a full writ-

ten submission from the employee. In its Order, the Law Court directed the hearing officer to make additional Findings of Fact with respect to both the construction and wiring of the employee's garage and any other home renovations.

Ultimately the hearing officer issued a revised decision in May 2010, and found that the employer was not responsible for any costs associated with construction of a garage or the building of a second bathroom, with the exception of installation of a walk-in shower. In reaching this decision, the hearing officer concluded that a garage was not a mechanical or surgical aid, and therefore was not compensable under the Act. Minor home modifications, such as a raised toilet and installation of a handicap handrail in the bathroom, were found to be the employer's responsibility.

Following this second decision, the employee filed a Petition for Appellate Review with the Law Court and in late December the Court denied the attempt to appeal. In essence, therefore, the Court found that the hearing officer in his second Decree had correctly interpreted section 206 in a manner to deny employer responsibility for major home renovation or constructions costs.

As these decisions highlight, it is important for employers and insurers to be mindful of the limits of section 206 when evaluating an employee's claim for medical or incidental expenses. Section 206 requires a two-pronged analysis. First, the hearing officer must determine whether the expenses being claimed are in fact "medical" within the meaning of section 206. Only when such a finding is made does the hearing officer progress to the second step, which is to determine whether the expenses are reasonable, necessary, and causally related to the employee's occupational injury. If the particular items or services in question are not found to be within the scope of section 206, the hearing officer will have no occasion to evaluate the reasonableness of the claimed expenses.

Robert W. Bower, Jr., Esq., and Lindsey Morrill Sands, Esq., represented the State of Maine in the matter of *Masalsky v. State of Maine Corrections Department.* □

# The Pendulum Continues To Swing In Loss of Consortium Cases

By Mark E. Dunlap

MARK E. DUNLAP

Consortium is defined as comfort, society and companionship of a spouse. Its loss, due to damage to the spouse, can give rise to a claim, pursuant to 14 M.R.S.A. §302, first enacted in 1981. Typically, a loss of consortium claim is brought by the spouse of a person injured or killed by the wrongful acts of a third party. It is principally a claim that the marital relationship has been interfered with by the wrongs done by another. Loss of consortium has been subject to quite a few Law Court case in the past twenty years or so, with the latest being *Eryn Steele v. Botticello*, 2011 ME 72 (June 28, 2011).

## History

Historically, there was no claim for loss of consortium for a wife, although a husband had always been able to bring such a claim. The first case decided by the Maine Law Court regarding a loss of consortium claim brought by a wife was that it such a claim did not exist. *Potter v. Shaffer*, 211 A.2d 891 (Me. 1965). Then the Legislature passed the statute allowing such a claim in 1981 (now 14 M.R.S.A. §302). It simply states: "a married person may bring a civil action in that person's name for loss of consortium of that person's spouse." That simple language has led to much confusion recently.

In a series of decisions involving different factual scenarios between 1993 and 2005 , the Law Court determined the consortium statute meant the spouse's claim was an independent action, fully controllable by the spouse of the injured party. That is, even after the injured spouse has settled or tried his or her claim for the underlying injury, a later, separate claim for loss of consortium could be filed. This led to some problems of potential double recoveries and of the possibility of extended litigation based on a single wrongful act, but everyone knew where they stood.

Then, in December of 2008, the Law Court totally reversed field. *Brown v. Crown Equipment*, 2008 ME 186, 960 A.2d 1188, overruled the previous line of cases from the 1990's and early 2000's and held that the loss of consortium claim was a derivative action, subject to all the defenses in the underlying action. We all thought that meant the loss of consortium claim could not be brought as an independent action. Once the injured spouse's case was over by settlement or trial, so was the loss of consortium claim. Defense firms all over the state presumably sent their clients notification of this change and how the change was going to alter

the practice with respect to the signing of releases. However, Steele changed it all again.

### Eryn Steele v. Botticello

Christopher Steele was Eryn's estranged (now ex) husband when Brown was decided. Before the Brown decision, he had filed suit for the injuries he received in a fight which occurred in Old Orchard Beach in August of 2006. His claim was settled in February of 2009 and he signed the appropriate release then, two months after Brown was decided. In April of 2009, Eryn Steele brought her claim separately for loss of consortium. The defendants obtained summary judgment in their favor based on the Brown decision that Eryn's loss of consortium claim was a derivative claim and Christopher Steele's release of that claim also extinguished her loss of consortium rights.

Eryn Steele appealed the summary judgment grant and the Law Court continued its evolving view of loss of consortium. It overturned the granting of the summary judgment and sent the matter back to the Superior Court for trial on the grounds that Brown did not extinguish Eryn Steele's loss of consortium rights in this case. Loss of consortium, in this case was not a derivative claim, but could be brought independently.

### The Meaning of Steele v. Botticello

As the title of this piece suggests, the law continues to be somewhat unsettled in this loss of consortium area. It is going to be difficult for lawyers and clients to understand exactly what the rules are in any given case. As a result of *Steele*, a loss of consortium claim is partly derivative and partly independent. Future cases with different facts may push the limits in this area again. In the meantime, in an abundance of caution, insurers should take pains to try to get a spouse's signature on any injured spouse's release. Of course, there will be many cases where that will not be possible, especially when the couples are separated or divorced at the time of the injured spouse's release.

If defendants are concerned about double recovery or inconsistent obligations or anticipate not being able to obtain signatures of both spouses on a release, the Law Court suggested they should join the spouse into the injured spouse's litigation so as to deal with the underlying claim and any potential loss of consortium claim all at once. Obviously, joinder is going to present its own problems and added expenses in many cases. *Steele* left this area of the law still somewhat of a moving target. The takeaway from this case is that everyone should be aware that *Brown* no longer is good law for the proposition that loss of consortium is a derivative claim which is extinguished when the injured spouse's claim is resolved. □

# NHD Attorneys Designated as "Lawyer of The Year"

Norman, Hanson & DeTroy is proud to announce that three of its attorneys have been designated by Best Lawyers as the "Lawyer of the Year" for 2011 for the greater Portland area. We congratulate the following attorneys for having achieved this impressive recognition.

Peter J. DeTroy
Criminal Defense:
White Collar –Litigation

Stephen Hessert
Workers' Compensation Law

James D. Poliquin
Insurance Law
Appellate Practice

# KUDOS

**JOHN VEILLEUX** was recently elected as President of the Casco Bay Hockey Association Board of Directors. CBHA is Maine's largest youth hockey program with nearly 900 players and over 150 coaches. This will be John's 6th year on the Board. Back in 1990's **JOHN KING** held the same position.

**MARK LAVOIE** recently delivered a two-part presentation on trial ethics at the Maine College of Trial Advocacy. Mark also spoke at the Houlton Regional Hospital on the role of errors in communication on delivery of quality of patient care.

**STEVE HESSERT**, who is Vice President and Finance Chair of the Board of Directors for the Portland Conservatory of Music, recently assisted with the organization and management of an International Piano Festival involving youth from Russia, Bulgaria, the Netherlands, New York, New Jersey, New Hampshire, and Maine.

**STEVE MORIARTY** moderated and spoke at a program on the essentials of Workers' Compensation practice offered by Lorman Education Services in Portland. Steve and **KEVIN GILLIS** also gave a presentation at the Maine Human Resources Convention summarizing recent changes in the law and updates with the Legislature and Workers' Compensation Board.

**MARK LAVOIE** has been appointed as an inaugural mentor for the Charles H. Harvey Fellow selected from the 2nd year class at the University of Maine School of Law.

**STEVE HESSERT and DORIS CHAMPAGNE** attended the 2011 ALFA International Worker's Compensation Group Seminar in April in New Orleans. Doris presided over the Women's Initiative Luncheon and was a speaker on the panel discussing the Medicare Secondary Payer Laws. Steve was one of the presenters providing legal tips for effective handling of workers' compensation claims.

**DEBRA TRAFTON**, legal assistant to **CHIP HEDRICK**, has been invited to display her paintings at an opening exhibit at the Agora Gallery in New York City in late July. The Agora Gallery is a fine art gallery located in the heart of New York's Chelsea district and is famous for showcasing a spectacular array of talented artists from around the world. □

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