Recent Court Decisions

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Injury Incurred During Post-Meeting Informal Company Recreation Is Not Subject to Workers' Compensation Coverage Despite Employee's View That Participation Was Encouraged and Important to Career

Appeal of Kraft Foods, Inc., 147 N.H. 572, 794 A.2d 779, 2002 N.H. LEXIS 28 (New Hampshire Supreme Court, April 15, 2002)

The New Hampshire Supreme Court recently issued an opinion that serves as an advisory to employees who feel that company outings are "command performances" and undoubtedly spurs a sigh of relief from employers, who frequently sponsor or support sporting events or other recreational outings that are thought to build team spirit or serve as perquisites of the job but are not closely supervised by the company.

Kraft sponsored a company outing in early 1999 at the Waterville Valley Conference Center. Kraft employee Claire Connors attended several mandatory meetings on Friday, January 15 and during the morning of Saturday, January 16. Beginning Saturday afternoon, the respondent was free to attend several optional seminars, go on a sleigh ride, or enjoy free time with her family. On Saturday evening, the petitioner (Kraft) provided several optional recreational events for its employees. On Sunday, the respondent (Connors) had her choice of "winter entertainments" provided by the petitioner, including sleigh rides, skating, and downhill or cross-country skiing. The respondent was also free to do nothing or to leave once Saturday's mandatory meetings concluded. The respondent opted for cross-country skiing on Sunday and a sleigh ride on Monday with her regional director. The respondent broke her right fibula while cross-country skiing on Sunday. *See* 2002 N.H. LEXIS 28 at *1-*2.

Connors missed two months of work and applied for workers' compensation benefits. A state Department of Labor hearing officer rejected her claim, but on appeal to the hearing board, benefits were awarded. The Supreme Court reversed, finding that the skiing injury was too attenuated from the employee's job responsibilities. The Court based its finding on what it regarded as fairly clear statutory guidance from the state legislature, which provided:

> Notwithstanding any law to the contrary, "injury" or "personal injury" [within the meaning of the workers' compensation law] shall not mean accidental injury, disease, or death resulting from participation in athletic/

> recreational activities, on or off premises, unless the employee reasonably expected, based on the employer's instruction or policy, that such participation was a condition of employment or was required for promotion, increased compensation, or continued employment.

See 2002 N.H. LEXIS 28 at *4, quoting New Hampshire Rev. Stat. Ann. 281-A:2.

Connors contended that she thought her employment career at Kraft would be enhanced by participation in the recreational activities. Although the hearing officer rejected this argument, the Review Board accepted it. The Court reversed, despite the standard administrative law canon that courts grant substantial deference to the reviewing agency charged with implementing and enforcing a statute. The Court found the Board's view of the statute clearly erroneous, enabling it to reverse the board without violating the standard deference accorded an administrative agency.

According to the Court, the statute requires more than an employee's reasonable belief that participation in recreational activity would be helpful to the employee's career. Rather, the employee must have a reasonable belief that participation in the activity is a condition of employment. Based on the facts of the incident, the Court found that Connors simply was not sufficiently coerced into participating in the cross-country ski outing to make it a condition of employment ("[t]here is no evidence in the record to indicate that participation in recreational activities was a condition of employment, promotion, increased compensation or continued employment"). *See* 2002 N.H. LEXIS 28 at *7.

The *Kraft* case makes sense not only from a statutory interpretation standpoint but also from an insurance efficiency standpoint. The U.S. insurance system is arranged so that employers must provide protection for workers injured on the job. This makes sense both as a matter of prudent paternalism (if left to their own devices, workers would fail to insure themselves) and also in terms of efficiency and responsibility. The worker is often not in a good position to control workplace risk. The employer is. Making the employer procure workers' compensation insurance both seems fair and creates an incentive for the employer to operate a safer workplace.

By contrast, the risk of injury during recreation surrounds the typical employee all the time, regardless of whether the recreation is work-connected or purely personal. To protect against injury, disability, and economic loss as a result of recreational injury, the employee will ordinarily be protected by insurance products other than workers' compensation insurance: health insurance, life insurance, disability insurance, and perhaps even auto insurance and homeowner's insurance. Although some of these products are often employer provided, they are insurance products designed to cover the individual without regard to the place of injury or its particular circumstances (subject of course to certain exclusions such as suicide or a pre-existing condition).

For the most part, then, it makes sense for a person to manage the risk of a broken leg from a skiing incident through some vehicle other than the workers' compensation insurance. However, as the Connors–Kraft dispute shows, this can leave the average person with gaps in coverage. Claire Connors was apparently unable to work for two months because of the injury and was not covered under her employer's workers' compensation policy. Even if she had a personal or group disability policy, it probably

had a 90-day waiting period, leaving her uninsured for the two months away from work. This leaves a practical problem for most employees that can probably only be effectively handled by individual savings sufficient to fill any gaps in coverage.

Although Connors' situation invites sympathy, the facts of the case do not suggest that Kraft was twisting employee arms to participate in the group recreational activities. If sufficient evidence of this type had existed, activity would appear to be a condition of employment and the employee would appear to meet the statute's definition of coverage. However, in murky factual situations, it may be difficult to assess the degree of employer coercion surrounding an activity.

The continuum ranges from express mandatory attendance to merely making the activity available. In between, a range of compulsion is at work as well as a range of employer involvement. Most of us have worked in places where it was obvious that missing the firm's holiday party earned you the ire of the boss. Whether this sort of informal coercion ("Joe, we all missed you at the firm picnic. Was there a death in the family?") brings the matter within the scope of assigned employment duties is a question of fact.

Similarly, firm subsidized or directed activities may make an injury sufficiently job-related. For example, if the firm sponsors bungee jumping as a recreational activity or sponsors a "Race Across Lake Champlain Canoe Rally" (perhaps in November), it would not seem improper to consider any injuries resulting from firm-encouraged hazardous activity to be sufficiently work-related to qualified for workers' compensation coverage.

More difficult issues arise where the activity is not necessarily hazardous, participation is voluntary, but the firm encourages and administers the activity. For example, what if the firm softball team is on the way to a Fortune 500 tournament with firm-provided transportation and accommodations and the squad is in an accident or suffers food poisoning? Has the injury occurred on the job? What if the firm has made the softball team a point of prominence in its morale-building or has lobbied the better athletes in the workforce to participate? These situations may present sufficient facts to qualify for coverage. But according to the New Hampshire Supreme Court, cross-country skiing the day after a firm meeting does not, a result that seems clearly correct on the facts of the case.

ACTIONS BY COUNSEL RETAINED BY INSURERS MAY LEAD TO LIABILITY OF COUNSEL OR INSURER

Givens v. Mullikin, 75 S.W.3d 383, 2002 Tenn. LEXIS 153 (Tennessee Supreme Court, March 25, 2002)

Trau-Med of America, Inc., v. Allstate Ins. Co., 71 S.W.3d 691, 2002 Tenn. LEXIS 154 (Tennessee Supreme Court, March 25, 2002)

In a pair of opinions, the Tennessee Supreme Court has addressed the thorny questions of the relative responsibilities of insurers and retained counsel in connection with the defense of liability claims. The Court's opinions provide some solace for insurers but in the main should act as a warning to carriers. Although the lawyer retained by the insurer largely is the representative of the policy holder, the lawyer's conduct

may subject the insurer to liability if the insurer is sufficiently involved in directing counsel's behavior.

In *Givens*, a third-party plaintiff (Connie Jean Givens) sued an Allstate policy holder, Larry McElwaney, in connection with a 1988 automobile accident. Givens alleged that Allstate initially retained "a highly competent and effective Memphis attorney" to represent McElwaney in connection with Givens' lawsuit against him, and discovery in the dispute was substantially complete. At that juncture, according to Givens, Allstate switched the counsel representing its policy holder. According to Givens, the new law firm (the Richardson firm) engaged in a calculated pattern of repetitive, unnecessary, and harassing discovery directed at Givens, including more than 70 subpoenas directed toward records custodians,[1] all designed to harass Givens and prolong the litigation or force Givens to accept a settlement lower than merited by her claim.

Givens, however, did not sue the second offending law firm but "instead sued [the policy holder] and Allstate, alleging that each was vicariously liable for the tortious actions of the Richardson Firm." *See* 2002 Tenn. LEXIS 153 at *8. Allstate and its policy holder moved to dismiss, arguing that Givens had not stated a legally cognizable claim against them for the purported misconduct of the law firm. The Court defined the issued before it as:

> (1) whether Allstate, as the insurance company that hired the Richardson Firm to defend McElwaney, may be held vicariously liable for that firm's alleged tortious conduct, and (2) whether McElwaney, as the insured and the sole client of the attorney, may also be held vicariously liable for the firm's alleged tortious actions.

[1] Plaintiff Givens and the Court both appeared to be particularly offended by the manner in which the second law firm attempted to use the subpoenas to obtain excessively broad discovery without providing Givens a meaningful opportunity to object or otherwise protect her rights.

> In no case, however, did the Richardson firm actually depose a records custodian. Instead, all but six of the discovery subpoenas stated that the custodian could send a copy of the plaintiff's "entire file" to the Richardson firm "in lieu of personal appearance." The Richardson firm also notified the plaintiff's attorney that depositions of records custodians would not be taken unless the plaintiff objected. After receiving this notice, the plaintiff's attorney wrote letters to these custodians directing them not to comply with the subpoenas.
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> [P]laintiff filed a separate action alleging that the Richardson Firm's discovery practices constituted an abuse of process, and (2) that its practice of obtaining her medical records through use of the defective subpoenas invaded her right to privacy and induced the medical practitioners to breach their confidential relationships with her. The plaintiff also alleged that the Richardson Firm induced her treating physician to breach express and implied contracts of confidentiality with her by privately speaking with him outside a deposition. *See* 2002 Tenn. LEXIS 153 at *6,*7.

See 2002 Tenn. LEXIS 153 at *10. The *Givens* Court held that:

> an insurer and an insured may be held vicariously liable for the tortious acts or omissions of an attorney hired to defend the insured, if the attorney's tortious actions were directed, commanded, or knowingly authorized by the insurer or the insured. We further hold that the complaint in this case states a claim of vicarious liability against the insurer alone for abuse of process.

See 2002 Tenn. LEXIS 153 at *2.

Although the policy holder represented by the attorney is the "client," and counsel owes the policy holder a primary duty of confidentiality, the insurer typically controls the bulk of defense and settlement in the case. This is the case in Tennessee as well as in most states. *See In re Youngblood,* 895 S.W.2d 322, 328 (Tenn., 1995). However, because of the need to protect the lawyer's professional judgment in representing the policy holder/client, "the insurer 'cannot control the details of the attorney's performance, dictate the strategy or tactics employed, or limit the attorney's professional discretion with regard to the representation of the insured.'" *See* 2002 Tenn. LEXIS 153 at *12-*13 (quoting *Youngblood* and citing to Tenn. Bd. of Prof. Responsibility, Formal Op. 88-F-113 (August 2, 1988). Consequently, the *Givens* Court considered counsel retained to defend the policyholder to be an independent contractor retained by the insurer but a lawyer owing professional responsibility duties to the policyholder (in this case, auto accident defendant McElwaney).

But despite the status of the lawyer as independent contractor, the lawyer remains an agent and the insurer a principal (although a principal with limited control over the attorney because of the lawyer–client relationship between counsel and policy holder). Consequently, if the principal directs or orders the agent to act or fail to act in a manner that improperly injures a third party to whom a legal duty is owed, the principal may be liable in tort to the third party. See 2002 Tenn. LEXIS 153 at *14-*17.

By contrast, although the policy holder is the client of counsel, the policy holder generally has far less control over the actions of counsel. Consequently, absent unusual circumstances, the policy holder cannot be held responsible for improper actions taken by counsel in connection with a case, particularly if those actions are taken at the behest of the insurer. However, if the policy holder is responsible in significant part for misconduct, the policy holder may be held liable. Counsel is also independently responsible under the law if improper conduct causes injury to a third party. *See* 2002 Tenn. LEXIS 153 at *20-*22.

However, mere employment of counsel that acts improperly will not subject the insurer to liability. The third-party plaintiff must present sufficient evidence that the insurer exercised actual control over counsel in connection with the actions giving rise to liability. *See* 2002 Tenn. LEXIS 153 at *29. Applied to the allegations of the instant case, the Court found that Givens had stated a legally sufficient claim for proceeding further against Allstate but not against the policyholder. *Id*. at *30. The Court also found that the Givens complaint sufficiently stated a claim of abuse of process against the Richardson firm because the complaint adequately alleged lawyer conduct that had

the primary purpose of harassment rather than proper defense of the litigation. *Id.* at *38.

In *Trau-Med v. Allstate*, the same insurer faced a variant third-party complaint. *Trau-Med* was a "physician practice management" company that stated its primary purpose as "to make medical care more accessible to the public, especially to uninsured and indigent personal injury victims." According to the Court,

> Trau-Med contracts to provide administrative services to licensed medical doctors who treat such "indigent victims of trauma with meritorious claims for personal injury." Trau-Med is then compensated for its services after the victims either settle their claims or receive the proceeds of a judgment following litigation.

See 2002 Tenn. LEXIS 154 at *3.

According to Trau-Med, it was the target of unfair and defamatory criticisms by Allstate "for the purpose of ruining its reputation in the legal community."

Specifically, the complaint avers that Allstate, "wishing to control the activity of claimants with legitimate personal injuries and without the intervention of licensed attorneys, devised a scheme with its agents/employees ... to limit access to health care for injured persons in Memphis and Shelby County, Tennessee, and thus control and limit their claims expenses." *See* 2002 Tenn. LEXIS at *4.

Trau-Med's implicit theory of the case was that Allstate disliked it for making more comprehensive medical care available to persons claiming coverage by Allstate. Allstate most likely viewed Trau-Med as more of a personal injury mill than an Albert Schweitzer for the American working class. Regardless of which view is cosmically more accurate, the Tennessee Court found that Trau-Med had stated a legally cognizable claim for relief and could obtain relief if it in fact proved defamatory conduct by Allstate. According to Trau-Med, Allstate's effort to discredit it included

> accusing Trau-Med of following unlawful conduct: practicing medicine in violation of Tennessee law, administering physical therapy services in violation of Tennessee law, and employing unlicensed physical therapists [as well as a conspiracy] to destroy Trau-Med, as well as other similar clinics and medical organizations [including placing Trau-Med on a purported] "hit list" of these targeted clinics. . . . Moreover, Allstate's agents are alleged to have implied that all claimants who do receive medical treatment from Trau-Med can expect to be "embroiled in unnecessary and expensive litigation."

See 2002 Tenn. LEXIS 154 at *4-*5.

The *Trau-Med* Court found that if the facts as alleged were proven, Allstate could be held liable for controlling or dictating wrongful actions of attorneys retained by Allstate to represent policy holders defending actions by third-party claimants. As in *Givens*, the Court found that although the policyholder/defendant is the client of counsel, the insurer has significant contractual control over counsel and may be held

responsible if that control is misused and causes counsel to violate the law. *See* 2002 Tenn. LEXIS 154 at *10-*11.

In addition, the *Trau-Med* Court found that Trau-Med had stated an arguable claim for intentional interference with business relationships under Tennessee law:

> [W]e expressly adopt the tort of intentional interference with business relationships .... We also hold that liability should be imposed on the interfering party provided that the plaintiff can demonstrate the following: (1) an existing business relationship with specific third parties or a prospective relationship with an identifiable class of third persons; (2) the defendant's knowledge of that relationship and not a mere awareness of the plaintiff's business dealings with others in general; (3) the defendant's intent to cause the breach or termination of the business relationship; (4) the defendant's improper motive or improper means, and finally (5) damages resulting from the tortious interference.

See 2002 Tenn. LEXIS 154 at *20 (emphasis in original; footnotes omitted).

In both *Givens* and *Trau-Med*, the Court was required to meld tort law concepts with issues of lawyer professional responsibility, the insurer–policyholder relationship (or "tripartite relationship," as it is called in some states), and the dictates of the adversary system of dispute resolution that prevails in the United States. When a third party makes a claim against a policyholder, there will be litigation if the insurer cannot successfully settle the matter. Under the accepted ground rules of litigation, the attorney represents the policyholder and is to be a zealous advocate of the policy holder in defending against the third-party claim. Consequently, counsel for the policy holder/defendant must be given some leeway in the representation. It could chill effective advocacy and defense of claims (which may be unmeritorious or exaggerated) if counsel or the insurer faced tort liability (or even defense of a tort claim) simply because the third party wished counsel would have mounted a less effective defense of the policy holder.

However, neither is the adversary system a license for attorneys to abuse third-party claimants or vendors used by third-party claimants. The Tennessee Supreme Court appears to appreciate the balance involved and will permit claims such as *Givens* and *Trau-Med* only if the plaintiff alleges facts sufficient to satisfy the elements of the relevant tort. Further, permitting the claim to go forward does not necessarily mean it will succeed. In order to prevail, Givens and Trau-Med will need to introduce admissible evidence at trial sufficient to prove that Allstate did the awful things of which it is accused.

Of course, nothing can prevent a dissatisfied or angry third party from alleging wrongdoing even if it has no case. However, *Givens* and *Trau-Med* suggest that insurers, policy holders, and counsel would be wise to evaluate their defense strategies and that insurers and policyholders should think twice before "ordering" questionable conduct by counsel. Further, counsel should remember its obligations under the Rules of Professional Conduct and be willing to refrain from following instructions that may make counsel or its principals a litigation target.

PENNSYLVANIA COURT REJECTS DOCTORS' VIEW THAT PROVIDER CONTRACTS WITH HEALTH INSURER REQUIRE PAYMENT TO PHYSICIANS WITHIN REASONABLE TIME

Solomon v. United States Healthcare Systems of Pennsylvania, Inc., 797 A.2d 346, 2002 Pa. Super. LEXIS 691 (Pennsylvania Superior Court, April 16, 2002)

The Pennsylvania Superior Court recently provided ammunition to critics of the U.S. legal system. In an opinion that can only be described as shallow, superficial, ridiculously formal, unrealistic, and too clever by half, the Court held that health insurers are under no obligation to reimburse medical service providers within a reasonable time. In fact, under the reasoning of *Solomon v. U.S. Healthcare,* a contract obligor could presumably take forever before paying for services (provided the contract is silent on the time for payment) and not be in breach.

Dr. Mark Solomon and his practice group, Regional Neurosurgical Associates, P.C., had an agreement with U.S. Healthcare (U.S. Healthcare is now part of Aetna/U.S. Healthcare) to provide medical services to Aetna subscribers. As with most such health insurance-medical care agreements, the physician provides services to patients and then is to be paid a set reimbursement rate that varies by the type of service provided.

According to the *Solomon* complaint, U.S. Healthcare was slow to pay. According to the complaint, U.S. Healthcare was"improperly denying some claims and unreasonably delaying payment on others." The plaintiffs sought declaratory relief requiring that they be reimbursed within a reasonable time—which plaintiffs defined as 30 days—after providing service and also sought interest on late payments. The trial court rejected their claims and the Superior Court, Pennsylvania's intermediate appellate court, affirmed on appeal.

Payment within a reasonable time? Sounds reasonable, at least in the abstract. Thirty days as a reasonable time? Again, sounds pretty reasonable. The obvious comparison is ordinary household bills. Most consumers are expected to pay within 30 days to the electric company, the phone company, the gas company, the cable television company, and the credit card company. Some of these vendors, particularly the credit card company, will charge a significant late fee and substantial interest rates if the consumer's payment is late. Against this backdrop, the *Solomon* complaint hardly seems an outlandish request, even if the contract itself is silent about reimbursement deadlines, although a "reasonable" person may argue that 60 or even 90 days is an acceptably reasonable time for payment in light of the review and verification functions that a health insurer must shoulder.

No matter, the *Solomon* Court cut through any potential Gordian knot as to the exact time parameters that might constitute a "reasonable" time for payment. Instead, the Court simply held that where a contract is silent regarding time for payment, the obligor is subject to no time constraints in making a required payment. According to the Court, where a time of payment is not specified, a court may not "rewrite that agreement and supply the missing term." 2002 Pa. Super. LEXIS 691 at *8. Further,

> [plaintiffs] have not established that an injustice would be prevented by inserting a "reasonable time" term into the parties' agreement, nor are we persuaded that there is any clear intent by the parties to be bound by such

> a term. Moreover, we do not perceive that imposition of a thirty day time period for payment of claims as suggested by Appellants is "essential to a determination of the parties rights and duties."

2002 Pa. Super. LEXIS 691 at *9 (quoting *Hodges v. Pennsylvania Millers Mutual Ins. Co.*, 449 Pa. Super. 341, 673 A.2d 973 (Pa. Super. 1996).

In making this assessment, the Superior Court is talking gibberish. Courts construing contracts constantly fill gaps in contracts, as well as resolve conflicting language or interpretations and render an interpretation of ambiguous (or purportedly ambiguous) terms. This is not "rewriting" the contract. It is interpreting the contract. Further, a basic axiom of contract interpretation is that the contract is to be interpreted in a manner that vindicates the intent of the parties and the purpose of the contract. These factors would seem to suggest that it is perfectly proper for a court to fill the textual gap in the contract regarding time of payment and set ground rules for time of payment. Thirty days may not be the right number. But it is not improper judicial activism to give the parties some guidance on this point. Thereafter, the time of payment term can be renegotiated by the parties from whatever "default" rule is set down by the court.

The *Solomon* Court had an additional, and in my view, better argument for ruling against the plaintiffs. As the court noted, the plaintiffs and the insurer had done business together for 15 years without a specific time for payment set forth in the contract, and the insurer had not paid interest on reimbursement, no matter how delayed. "Certainly the parties' long-standing course of performance was relevant to a determination of whether the parties intended to impose such an obligation." *See* 2002 Pa. Super. LEXIS 691 at *10.

Although this is a pretty good argument for the insurer, it is not necessarily persuasive. The arrangement probably lacked a set time for reimbursement because the insurer (the party with considerably greater bargaining power) wanted it that way. During the prior 15 years, relatively little friction may have existed between the parties as to time of payment. The *Solomon* opinion does not state the historical average length of time for payment and whether this lengthened over time. It is possible, even probable, that the insurer's delay in payment gradually became worse to the point of intolerable, prompting the lawsuit. The suit itself serves as evidence that the doctors were not acquiescing to very late payments.

The *Solomon* Court also rejected plaintiffs' claims pursuant to the Pennsylvania Health Care Act and rejected the allegation that a court could find the insurer's delayed payment to constitute bad faith. Title 40, §991.2166 of Pennsylvania Statutes, entitled "Prompt Payment of Claims," provides that

> (a) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.[2]

[2] A "clean claim" under the statute is defined as "a claim for payment for a health care service which has no defect or impropriety." *See* 40 Penn. Stat. §991.2102.

> (b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim.

Although the statute would seem to impose something close to the relief sought by the plaintiffs, the *Solomon* Court held that there was no private right of action for medical service providers under the statute. Rather, the prompt payment provisions of the law can be enforced only by the State of Pennsylvania. In making this determination, the *Solomon* Court applied applicable Pennsylvania precedent (which referenced older U.S. Supreme Court precedent) for determining whether a regulatory statute creates a private right of action for members of the public. The *Solomon* Court concluded that no private right of action was created under the Pennsylvania Health Care Act.

Although the Court may be correct in this assessment, *Solomon* can be criticized for failing to consider the declaration of Pennsylvania public policy expressed in the Health Care Act. Even if the Act is not strictly enforceable against an insurer by a doctor (as opposed to the insurance commissioner or attorney general), the prompt payment provisions of the Act are proper for a court to consider in construing a contract with an absent or ambiguous term regarding time of payment. The *Solomon* Court would have been well within its perogatives to use the prompt payment provisions of the Act to establish a yardstick for payment under the contract between the plaintiff doctors and the insurer. However, the Court apparently did not even consider this an option because of its misplaced phobia about "rewriting" the contract between the doctors and the insurer.