Westlaw Journal
INSURANCE COVERAGE

Litigation News and Analysis • Legislation • Regulation • Expert Commentary

VOLUME 28, ISSUE 32 / MAY 18, 2018

WHAT'S INSIDE

COLLAPSE COVERAGE

Federal judge asks Connecticut high court to decide 'collapse' coverage issue

By Jason Schossler

A Connecticut federal judge has asked the state's highest court to determine what constitutes a "substantial impairment of structural integrity" for the purpose of applying a homeowners insurance provision.

Karas et al. v. Liberty Insurance Corp., No. 13-cv-1836, 2018 WL 2002480 (D. Conn. Apr. 30, 2018).

In an April 30 ruling, U.S. District Judge Stefan R. Underhill of the District of Connecticut referred the suit against Liberty Insurance Corp. to the state Supreme Court, saying he needed guidance because the issue is unsettled under state law.

Judge Underhill also noted the question is "almost certain" to come up again, given that concrete collapse cases are on the rise.

REUTERS/Molly Riley

MOTTES CONCRETE

According to the judge's certification order, the house owned by plaintiffs Steven and Gail Karas is one of many in northeastern Connecticut built with concrete supplied by J.J. Mottes Concrete Co.

That concrete allegedly contains significant amounts of the mineral pyrrhotite, which reacts with water, oxygen and concrete paste to form expansive secondary minerals that crack and destabilize the concrete.

In October 2013 the Karases learned their basement walls were crackling, crumbling and deteriorating in a manner "typical of Mottes concrete," the order said.

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EXPERT ANALYSIS

The impact of *Cyan* on public companies and the D&O insurance marketplace

Ivan J. Dolowich and Andrew A. Lipkowitz of Kaufman Dolowich Voluck LLP and Kylie Tomas of insurer Sompo International analyze the U.S. Supreme Court's recent decision in *Cyan Inc. v. Beaver County Employees Retirement Fund* and what impact it may have on securities litigation against public companies.

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Westlaw Journal Insurance Coverage

Published since December 1997

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Westlaw Journal Insurance Coverage (ISSN 2155-5915) is published 52 weeks a year by Thomson Reuters.

Thomson Reuters
175 Strafford Avenue, Suite 140
Wayne, PA 19087
877-595-0449
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The impact of *Cyan* on public companies and the D&O insurance marketplace

By Ivan J. Dolowich, Esq., and Andrew A. Lipkowitz, Esq., Kaufman Dolowich Voluck LLP, and Kylie Tomas, Esq.
Sompo International

Blue Apron, the "meal kit" service that delivers prepackaged ingredients and recipes to its customers, went public June 29, 2017, offering 30 million common stock shares on the New York Stock Exchange. By most accounts, its initial public offering grossly underperformed, as its share price fell substantially in the months after it began trading.

In late March 2018, Blue Apron was trading at less than $2 per share, an 80 percent drop from its initial trading price of $10 per share. Predictably, Blue Apron has been hit with multiple securities class action lawsuits alleging that it failed to adequately disclose material information. Among the allegations are claims that Blue Apron violated federal securities laws, including the Securities Act of 1933.

Securities class actions like these are oftentimes expensive to litigate, and they can lead to significant losses for the companies involved. The U.S. Supreme Court's recent decision in *Cyan Inc. v. Beaver County Employees Retirement Fund* is likely to have a significant impact on the targets of these suits — and by extension, their insurers.[1]

In *Cyan*, the high court reaffirmed that state courts have concurrent jurisdiction with federal courts to adjudicate securities class actions brought under the '33 Act. This expert analysis examines the court's rationale in *Cyan*, the impact the ruling is likely to have on securities class actions, and the potential alternatives to litigating a '33 Act case in state court. It also considers the implications of *Cyan* for directors-and-officers insurance providers.

Congress passed the Private Securities Litigation Reform Act in 1995 to limit "perceived abuses of the class-action vehicle" in securities cases.[2] The PSLRA created procedural hurdles to securities class actions filed in federal court.

> The Supreme Court in *Cyan* held that SLUSA does not permit defendants to remove class actions alleging only '33 Act claims from state to federal court.

JURISDICTION FOR SECURITIES LAW CASES

Two federal statutes serve as the framework for governing the sale of securities. The '33 Act regulates the offering of new securities to the public and requires "full and fair disclosure" of relevant information, while the Securities Exchange Act of 1934 regulates the trading of existing securities on securities exchanges.

Congress authorized state and federal courts to have concurrent jurisdiction over suits brought pursuant to the '33 Act. In addition, the '33 Act barred the removal of such actions from state to federal court. The '34 Act, by contrast, grants federal courts exclusive jurisdiction to hear private suits brought under that statute.

It also had the unintended consequence of funneling more securities cases to state court. This prompted Congress to act again by passing the Securities Litigation Uniform Standards Act of 1998.

Two provisions of SLUSA limiting the jurisdiction of state courts over '33 Act cases are relevant to *Cyan*.

First, Section 77p(b) says "covered class actions" (meaning a class action involving more than 50 people) based on alleged violations of state law involving dishonest practices regarding a nationally traded security's purchase or sale may not be brought in any state or federal court.

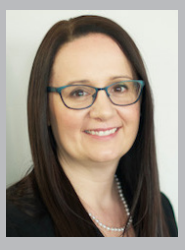
Second, Section 77p(c) provides for the removal of "covered class actions" to federal court so that they can be subject to dismissal based on the bar on state law class actions set forth in paragraph (b).

As the Supreme Court noted in *Cyan*, the point of providing for removal of class actions under paragraph (c) was to "ensure the dismissal of a prohibited state law class action" even where the action was initially brought in state court.[3]

SUPREME COURT'S *CYAN* DECISION

Cyan was initially filed in California state court by a class of investors who purchased shares of Cyan, a telecommunications company, in an IPO. The investors alleged





Ivan J. Dolowich (L) is co-managing partner of **Kaufman Dolowich Voluck LLP** in Woodbury, New York, and co-chair of the firm's insurance coverage and litigation practice group. **Andrew A. Lipkowitz** (C) is an associate at the firm, and his practice focuses on insurance coverage litigation and monitoring. **Kylie Tomas** (R) is a vice president, claims counsel at insurer **Sompo International**.

that Cyan's offering materials contained material misstatements in violation of the '33 Act.

Critically, there were no state law claims alleged in *Cyan*. Instead, all claims in the case were raised under the '33 Act.

The defendants in *Cyan* sought to have the case dismissed, arguing that SLUSA's amendments to the '33 Act stripped state courts of the authority to adjudicate '33 Act claims in "covered class actions."

Eventually, the Supreme Court granted review of the case and rejected the defendants' argument, holding that SLUSA leaves intact the concurrent jurisdiction of state and federal courts to adjudicate '33 Act claims.

At issue in *Cyan* was a "conforming amendment" to the '33 Act that was part of SLUSA. The conforming amendment was drafted as an "exception" to the general rule that authorizes concurrent jurisdiction of '33 Act suits in state and federal court, and provides that state and federal courts have concurrent jurisdiction over '33 Act class actions "except as provided in Section 77p." This is referred to in the decision as the "except clause."

As explained above, Section 77p prohibits class actions involving more than 50 people based on alleged violations of state law, and permits removal of such actions to federal court in order to ensure that the state law class action bar is enforced.

The Supreme Court unanimously held that the except clause does not apply to securities class actions brought solely under federal law because Section 77p only prohibits suits based on state law. Therefore, since the "except clause" does not apply, the general "background" rule permitting concurrent jurisdiction of '33 Act securities class actions governs.

In addition, the Supreme Court in *Cyan* held that SLUSA does not permit defendants to remove class actions alleging only '33 Act claims from state to federal court. The '33 Act expressly prohibits removal of such actions from state to federal court. Again, the Supreme Court interpreted SLUSA as only allowing removal of proposed securities class actions based on state law.

THE POTENTIAL IMPACT

The obvious and most immediate impact of the court's decision is that the plaintiffs' bar will likely file additional '33 Act cases in state court. This could allow plaintiffs to avoid the procedural hurdles for securities class actions in the PSLRA.

One example noted in *Cyan* is the rule that requires a lead plaintiff in any class action brought under the Federal Rules of Civil Procedure to file a sworn certification stating that he had not purchased the security at issue "at the direction of plaintiff's counsel."[4] Such procedural rules obviously would not apply to securities class actions filed in state court. *Cyan* hands the plaintiffs' bar the tactical advantage of being able to choose which forum would be most advantageous for their clients.

> *Cyan* hands the plaintiffs' bar the tactical advantage of being able to choose which forum would be most advantageous for them.

California state courts are a favorite venue of plaintiffs' attorneys partly because they are less vulnerable to dismissal motions there than they are in federal court. According to Cornerstone Research, California state courts dismissed '33 Act claims at a lower rate between 2010 and 2016 (19 percent) than their federal court counterparts (25 percent).

It should be noted that the holding in *Cyan* does not affect '34 Act cases, which involve regulation of securities already trading in the marketplace, because federal courts have exclusive jurisdiction over those cases.

As a result, we could see parallel lawsuits filed in state and federal court in cases where violations of both the '33 Act and '34 Act are alleged, with federal courts adjudicating the '34 Act claims and state courts adjudicating the '33 Act claims. The obvious result of this would be a likelihood of duplicative litigation and an increase in defense costs.

ALTERNATIVES TO REMOVAL

As stated above, SLUSA did not impact the '33 Act's bar on removal of securities class actions brought under the '33 Act from state to federal court. As such, defendants in such cases cannot use either federal question jurisdiction or diversity jurisdiction to remove an action that solely alleges violations of the '33 Act.

There are alternatives, however, that companies may wish to consider.

First, they can adopt bylaws or provisions in their corporate charter designating federal court as the exclusive forum for litigating '33 Act cases. Such forum-selection clauses are the subject of a lawsuit against Blue Apron, Roku and Stitch that is currently pending in Delaware Chancery Court.[5] All three companies included a provision in their certificates of incorporation that says any claim under the '33 Act must be brought in federal court.

The plaintiff in the lawsuit, which was filed as a putative class action on behalf of shareholders of the three companies, is seeking a declaratory judgment that the forum-selection clauses in the corporate charters are invalid under Delaware law.

Of course, if the Chancery Court strikes down these clauses, they will no longer be a viable option for companies seeking to keep '33 Act cases in federal court.

Second, defendants could seek to transfer the case under the doctrine of forum non conveniens. Under this doctrine, courts apply a variety of factors to decide whether to transfer a case to a different court.

These factors include the convenience of the parties and witnesses as well as the strength of the two venues' citizens' interests in the case. There is more uncertainty associated with this option compared to removal, since dismissal based upon forum non conveniens is a matter of the court's discretion.

Third, in matters involving parallel state and federal court litigation, the defendants could seek a stay of the state court case pending the outcome of the federal court case. Again, this decision is left up to the court's discretion.

Of course, as noted above, the ban on removal for '33 Act cases might not apply where a lawsuit alleges some other basis of federal question jurisdiction.

For example, claims brought under the '34 Act would be subject to removal or dismissal for lack of subject matter jurisdiction. Another possible basis for invoking federal question jurisdiction is the existence of a pending federal bankruptcy proceeding.

Finally, *Cyan* could prompt Congress to overturn the Supreme Court's holding by amending SLUSA to expressly bar state-court jurisdiction over '33 Act claims, either

for securities class actions or individual shareholder suits — or both.

IMPLICATIONS FOR D&O INSURERS

If '33 Act cases filed in state court gain traction with the plaintiffs' bar, one potential downside for businesses is a decrease in the ability to obtain dismissal at an early stage in the litigation. As explained above, some state courts, such as those in California, dismiss cases at a lower rate than their federal counterparts.

If more '33 Act cases survive the motion to dismiss stage, defense costs will increase substantially. Faced with the prospect of lengthy, expensive litigation, businesses might consider settling these lawsuits at an earlier stage simply to avoid incurring significant defense costs.

In the face of such trends, D&O insurers should remain proactive in the claims-handling process.

First, they should actively engage with defense counsel to explore avenues for early resolution of such cases in order to minimize the impact on both the insureds and the insurers. While the insureds under D&O policies often control the defense of '33 Act and other securities lawsuits, it is important for D&O insurers to freely discuss strategy with the insureds and have their views heard.

Second, in light of the decision in *Cyan*, D&O insurers should continue to regularly monitor the progress of '33 Act cases from inception through conclusion and share their experiences internally with both underwriting and claims. This will provide valuable insight into how, and if, the *Cyan* decision is impacting the expenses and severity associated with '33 Act cases filed in state court.

Third, D&O insurers should adhere to the basics of carefully reviewing their policies for provisions that grant or exclude coverage for '33 Act claims, and when appropriate, consult with coverage counsel who may have broader experience with the trends developing in this area.

Finally, it is always in the best interest of insurers (and their insureds) to proactively monitor claim trends and collaboratively develop strategies to counter the efforts of the plaintiffs' bar. WJ

NOTES

[1] 138 S. Ct. 1061 (2018).

[2] *Id.* at 1066.

[3] *Id.* at 1068.

[4] *Id.* at 1067.

[5] *Sciabacucchi v. Salzberg,* No. 2018-0931, *complaint filed,* 2017 WL 6815531 (Del. Ch. Dec. 29, 2017).

'Collapse' coverage

CONTINUED FROM PAGE 1

The couple reported the claim under the collapse provision of their Liberty homeowners policy, but the insurer refused to cover it, arguing the damages were not caused by a collapse.

According to the order, the policy does not define "collapse," but it does bar coverage for collapses caused by "settling, cracking, shrinking, bulging or expansion."

The Karases sued Liberty in December 2013 for breach of contract and bad faith, saying the loss qualified as a collapse under the Connecticut Supreme Court's ruling in *Beach v. Middlesex Mutual Assurance Co.,* 532 A.2d 1297 (Conn. 1987).

In that case, the state high court held that absent a policy definition, the term collapse could be interpreted to include a "substantial impairment of the structural integrity of a building," according to the order.

Question certified to Connecticut Supreme Court

What constitutes a "substantial impairment of structural integrity" for purposes of applying the "collapse" provision of this homeowners' insurance policy?

SEEKING A CONCLUSIVE INTERPRETATION

But Judge Underhill said he could not decide the Karas case without additional guidance defining the "substantial impairment" standard. He certified the question to the state Supreme Court.

The judge noted that he had declined to certify questions to the state's high court in prior concrete collapse cases.

But given the frequency with which the collapse issue has recurred, certifying the question would "save time, energy, and resources" by yielding a conclusive interpretation, he said, quoting *Arizonans for Official English v. Arizona*, 520 U.S. 43 (1997).

The District Court will conduct further proceedings after the state Supreme Court has either answered the question or declined to certify it, Judge Underhill concluded. WJ

Attorneys:
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Defendant: Philip T. Newbury Jr. and Kieran W. Leary, Howd & Ludorf, Hartford, CT

Related Filings:
Order: 2018 WL 2002480

See Document Section A (P. 19) for the order.

Insurer asks court to make death determination in no-body suicide case

By Kteba Dunlap, Esq.

Lincoln Benefit Life Co. has amended its federal complaint in a $1 million death benefits case to add a request that the court decide whether the policyholder is in fact dead.

Lincoln Benefit Life Co. v. Fundament, No. 18-cv-260, amended complaint filed, 2018 WL 1998337 (C.D. Cal. Apr. 26, 2018).

Although policyholder Paulo Fundament's wife insists he committed suicide, family members have offered conflicting accounts of his October 2016 disappearance and authorities have failed to fully investigate the case, the insurer says in an amended complaint filed April 26 in the U.S. District Court for the Central District of California.

MISSING PERSON

The case began when Fundament's wife submitted a claim on his life insurance policy, alleging that he walked away from the couple's southern California home Oct. 1, 2016, and never returned.

Lincoln filed a declaratory judgment action in February 2018, claiming that because Fundament's body has never been found, the insurer did not know whether to release the policy proceeds. It asked the court to make the determination.

Paige Fundament told the police she believed her husband had killed himself because he left his wallet and other personal belongings behind and had sent emails that seemed to say goodbye, the insurer's complaint says.

Although Fundament obtained a court order Dec. 6, 2017, declaring her husband dead, it has no effect on her insurance claim because she did not notify Lincoln of the order, the insurer says.

Besides, an order is not conclusive proof and only creates a rebuttable presumption of death, according to the suit. Fundament has presented no direct evidence that her husband is actually dead, Lincoln says.

The insurer says it cannot pay out on the policy based on the little information it has about Paulo Fundament's disappearance and alleged suicide.

Paige Fundament moved for dismissal April 5, arguing that Lincoln has failed to state an actionable controversy.

She asserted that she provided the insurer with enough proof of her husband's death to trigger the benefits payment.

INVESTIGATION, ALLEGED DISCREPANCIES

In its new complaint, Lincoln claims that the Newport Beach Police Department's investigation into Fundament's disappearance lacked key elements. The police did not interview his colleagues or take possession of his electronic devices, nor did they canvass the neighborhood, the suit says.

The officers also did not question either of his teenage sons, one of whom Paige Fundament said was the last to see him, the suit contends. The couple's other son was an apparent witness to Paulo's Sept. 30, 2016, execution of his will, which Paige reported finding "placed conspicuously in an upstairs room" soon after he disappeared, the complaint says.

Other circumstances cause the insurer to question what really happened, the complaint says. For example, there was a change in the narrative of the son who saw him last, and Paige Fundament refuses to produce her husband's passport, according to the suit.

Furthermore, the "goodbye" letter that Paige Fundament says Paulo emailed to her was dated a year before his disappearance, Lincoln contends. And he renewed his engineering license shortly before he went missing, even though it was not due to expire until September 2018.

In light of the amended complaint's submission, which Paige Fundament did not contest, the court denied her motion to dismiss as moot. WJ

Attorneys:
Plaintiff: Jason P. Gosselin, Katherine L. Villanueva and Alexis N. Burgess, Drinker Biddle & Reath, Philadelphia, PA

Related Filings:
Amended complaint: 2018 WL 1998337

Hospital must turn over government, insurer reimbursement rates, Texas high court says

By Thomas Parry

A Texas hospital must disclose its insurance reimbursement rates as part of an uninsured patient's lawsuit alleging the medical center overcharged her for treatment after a car accident, the state's highest court has ruled.

In re North Cypress Medical Center Operating Co., No. 16-0851, 2018 WL 1974376 (Tex. Apr. 27, 2018).

In a 6-3 decision affirming a lower court, the Texas Supreme Court said the rates North Cypress Medical Center would charge an insurance company or the government were relevant to determining whether the rates it charged Crystal Roberts for her treatment were reasonable.

"We fail to see how the amounts a hospital accepts as payment from most of its patients are wholly irrelevant to the reasonableness of its charges to other patients for the same services," Justice Debra H. Lehrmann wrote in an opinion for the majority.

Roberts asked North Cypress to reduce the lien, but the parties could not reach an agreement, and Roberts sued the hospital in the Harris County 234th District Court, alleging that it had overcharged her, the opinion said.

As part of her suit, Roberts requested that North Cypress disclose how much it would charge private insurers and government programs for the same treatment it provided to her.

The trial court ruled that North Cypress had to turn over the information because it was relevant to determine whether the hospital had charged Roberts reasonable rates.

> "It defies logic to conclude that those payments have nothing to do with the reasonableness of charges to the small number of patients who pay directly," Texas Supreme Court Justice Debra H. Lehrmann wrote.

In dissent, Justice Nathan L. Hecht said a more relevant line of discovery would investigate how much other hospitals charged similarly situated patients for those services.

HOSPITAL LIEN

Roberts was injured in an automobile accident June 9, 2015, and received emergency treatment at North Cypress, according to the opinion.

After three hours of care, North Cypress released Roberts, charged her $11,000 for the tests and procedures it had performed, including X-rays, CT scans and lab tests, and later filed a hospital lien in pursuit of the amount, the opinion said.

The insurer of the other driver involved in the accident offered to pay $9,400 of Robert's medical expenses, according to the opinion.

An appeals panel affirmed the trial court's decision. *In re North Cypress Med. Ctr. Operating Co.*, No. 14-16-00671-CV, 2016 WL 6134457 (Tex. App. Oct. 20, 2016).

RELEVANT DISCOVERY

The Texas high court affirmed, finding that Roberts had requested relevant evidence.

The majority noted that the rates hospitals charge patients without insurance, often called "chargemaster" rates, far exceed the rates negotiated by insurance companies and the government.

The majority further noted that the negotiated rates sought from insurers and the government may not settle the question of whether Roberts' bill was unreasonable.

But the rates are at least relevant to the matter, the majority said.

"[C]onsidered together, reimbursements from insurers and government payers comprise the bulk of a hospital's income for services rendered," Justice Lehrmann wrote.

"It defies logic to conclude that those payments have nothing to do with the reasonableness of charges to the small number of patients who pay directly."

DIFFERENT CIRCUMSTANCES

Dissenting, Justice Hecht said the rates North Cypress charged private insurers and the government were not relevant because as an uninsured, solitary patient, Roberts was not like those payers.

Government payers provide between a third and two-thirds of hospital income in the United States, the justice said.

Private insurers bring hospitals a "predictable volume of business" and "ease of payment," according to the dissenting opinion.

The negotiated rates that insurers and the government pay come from a different set of circumstances than a single, uninsured patient, he said.

A relevant investigation would explore what North Cypress and similar hospitals regularly charged patients in the same position as Roberts, he said.

Justices Paul W. Green and Eva M. Guzman joined in the dissent. WJ

Related Filings:
Opinion: 2018 WL 1974376

See Document Section B (P. 24) for the opinion.

Insurer, broker deny background-check company's concealment claims

By Jason Schossler

First Mercury Insurance Co. and an insurance broker are denying claims that they actively concealed an exclusion in an employment screening company's policy that barred coverage for violations of certain federal credit reporting laws.

Investigative Concepts Inc. v. First Mercury Insurance Co. et al., No. 18-cv-311, answer filed (W.D. Okla. Apr. 17, 2018).

Investigative Concepts Inc. sued First Mercury and El Dorado Insurance Agency Inc. after the insurer refused to defend the plaintiff in an underlying lawsuit accusing it of botching a job candidate's background check in violation of the Fair Credit Reporting Act, 15 U.S.C.A. § 1681.

In separate answers filed April 17 in the U.S. District Court for the Western District of Oklahoma, First Mercury and El Dorado are urging the court to toss IC's suit for failure to state a valid cause of action.

The suit, originally filed March 1 in the Oklahoma County District Court, accuses First Mercury of breach of contract, false representation and bad faith.

It also alleges El Dorado is liable for false representation and negligence for failing to ensure IC was issued a policy that provided the type of coverage needed for its business.

The defendants removed the suit to the federal court April 6 on diversity-of-citizenship grounds and because the amount in controversy exceeds the $75,000 threshold for federal jurisdiction.

COVERAGE DENIED

According to its lawsuit, IC conducted a background check on job applicant Justin Norman and erroneously reported that he had a felony conviction.

Norman sued the employment screening company in January 2017 over the inaccurate information, accusing it of violating the FCRA.

IC says it tendered the claim to First Mercury for defense and indemnification under its commercial general liability policy. The insurer, however, denied coverage, citing policy exclusions for any acts involving the FCRA, according to IC's suit.

'SWEEPING' EXCLUSIONARY LANGUAGE

IC alleges that First Mercury breached the insurance contract and the implied covenant of good faith and fair dealing by refusing to cover it against Norman's suit.

The plaintiff also says the insurer and El Dorado are liable for false representation by failing to disclose the "broad sweeping FCRA exclusionary language" of the policy.

According to the suit, the defendants had a duty to inform IC of any policy provisions that eliminated coverage for any part of its investigative services. Instead, the defendants purposely concealed this information, the suit says.

The complaint also asserts a separate count of negligence against El Dorado for failing to make sure the policy provided full errors and omissions coverage.

IC is seeking unspecified compensatory and punitive damages, attorney fees and costs.

CLAIMS REBUFFED

In its answer, First Mercury says it rightly denied coverage in light of the policy's exclusion for any alleged violation of "credit reporting and debt collection act statutes."

Other policy exclusions, including a "knowing violation of rights of another" exclusion, also preclude coverage, according to the insurer.

The insurer also says the plaintiff cannot move forward with the suit because it failed to mitigate its damages.

In its own answer, El Dorado maintains that IC's damages, if any, were caused by "intervening or supervening causes" for which El Dorado was not responsible.

The broker also denies that it made any misrepresentation to IC, saying there is no causal connection between its "actions or inactions" and the plaintiff's alleged damages. WJ

Attorneys:
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Defendant (Ed Dorado Insurance Agency Inc.): Drew A. Lagow and Shawna L. Landeros, Holden & Montejano, Tulsa, OK

Life insurer wins transfer of centenarian's bad-faith action

By Jason Schossler

A Maryland federal judge has ruled that a lawsuit alleging Transamerica Life Insurance Co. unlawfully plans to cut off a 100-year-old man's permanent universal life insurance coverage because of his age must be litigated in Florida.

Lebbin et al. v. Transamerica Life Insurance Co., No. 17-cv-1870, 2018 WL 2013054 (D. Md. Apr. 30, 2018).

Gary Lebbin and the Lebbin-Spector Family Trust sued Transamerica in the U.S. District Court for the District of Maryland in July 2017, alleging the insurer notified Lebbin that it intends to terminate his coverage solely because he is turning 100.

The suit accuses Transamerica of falsely representing that the plaintiffs' policies would insure Lebbin for life. It also says the planned termination of the policies will expose the plaintiffs to adverse tax consequences.

In granting Transamerica's motion to transfer venue, U.S. District Judge Theodore D. Chuang said it would be more convenient for the parties and witnesses to litigate the action in the Southern District of Florida.

All substantive aspects of the life insurance transactions also occurred in Florida, according to the ruling.

'INSURANCE FOR LIFE'

The complaint says Lebbin holds two permanent universal life insurance policies issued by Transamerica in the early 1990s.

The defendant allegedly marketed, sold and represented the policies as permanent coverage and a vehicle to allow the cash value earnings to grow with no tax due on them until they were withdrawn.

The face amounts of the polices are $2 million and $1.2 million, the suit says.

But in marketing its policies as "insurance for life" in the 1990s, Transamerica used outdated mortality tables that did not take into account that Americans are increasingly living to and past the age of 100, according to the suit.

Beginning in the mid-to-late 2000s, Transamerica extended the "policy maturity" in its universal life polices to the terminal age of 121, which effectively guaranteed that the policies would remain in force until the insured's death, the suit says.

The defendant, however, did not amend the terminal age for the older policies it had issued under the outdated mortality tables, the complaint alleges.

Rather, Transamerica chose to terminate the former policies at age 100 even though it had previously guaranteed them for life, according to the plaintiffs.

The suit says that when the plaintiffs learned Transamerica planned to cut off the relevant policies, they urged the defendant to continue honoring its prior commitment to provide coverage for the remainder of Lebbin's life.

The insurer allegedly denied the plaintiffs' request and said it would issue them a taxable distribution instead.

The complaint accuses Transamerica of breach of contract, negligent misrepresentation, fraud, unjust enrichment and violations of the Maryland Consumer Protection Act, Md. Code Ann., Com. Law § 13-101.

The plaintiffs seek compensatory damages, punitive damages and injunctive relief barring Transamerica from terminating the policies.

They also seek reformation of the policies to conform to the original, agreed-upon intentions of the parties in addition to a refund of all premiums the plaintiffs paid.

PROPER VENUE

In a motion filed last fall, Transamerica said the case should be transferred to the Southern District of Florida to promote the convenience of the parties and witnesses.

Judge Chuang agreed. He noted that nearly every party and potential witness reside in the Sunshine State, including Lebbin and his daughter Carole Lebbin, who is one of two trustees of the Lebbin-Spector Family Trust.

The policies' original selling agent, Jack Kay, and their current servicing agent, Lisa Fleming, also are located in Florida, according to the ruling.

The only party currently located in Maryland is the second trustee, Lebbin's son Roger Lebbin, the judge said.

The interests of justice also support transfer, he said, because all of the discussions regarding the policies occurred in Florida.

Further, Florida law most likely applies to the claims at issue in the case because the alleged torts of misrepresentation also appear to have occurred in the state, according to the ruling. WJ

Related Filings:
Opinion: 2018 WL 2013054
Motion to transfer: 2017 WL 4583624
Complaint: 2017 WL 2929324

Builder hits back in coverage row over sports-complex suit

By Jason Schossler

A design and construction firm has countersued Mt. Hawley Insurance Co., claiming it acted in breach of contract by refusing to defend and indemnify the company against a lawsuit accusing it of failing to properly build a municipal sports complex.

Mt. Hawley Insurance Co. v. Slay Engineering, Texas Multi-Chem and Huser Construction LLC, No. 18-cv-252, answer and counterclaims filed, 2018 WL 2110343 (W.D. Tex. Apr. 27, 2018).

The insurer's complaint, filed in the U.S. District Court for the Western District of Texas, seeks a declaration that a breach-of-contract exclusion in the firm's insurance policies bars coverage for the underlying suit.

Slay Engineering, Texas Multi-Chem and Huser Construction LLC, a joint venture of three Texas companies, filed an answer and counterclaims April 27, arguing that the cited exclusion does not apply to all of the underlying suit's claims.

In addition, Mt. Hawley has violated multiple provisions of the Texas Insurance Code by refusing to pay a claim without conducting a reasonable investigation, the defendant says.

SPORTS COMPLEX PROJECT

According to Mt. Hawley's complaint, the city of Jourdanton, Texas, entered into a contract in July 2015 with the defendant for the design and construction of several Little League ballfields, a concession building and a public swimming pool, the complaint says.

The city sued the joint venture in Texas state court in February, alleging it performed substandard work that resulted in deficient site drainage and substantial cracks in the swimming pool, a parking lot and other paved surfaces. *City of Jourdanton v. Slay Eng'g/Tex. Multi-Chem/Huser Constr. LLC*, No. 17-12-1181, *second amended petition filed* (Tex. Dist. Ct., Atascosa Cty. Feb. 26, 2018).

The project also failed to meet accessibility guidelines under Texas law and the federal Americans with Disabilities Act, according to the underlying suit.

The city further alleges that the defendant has failed to remedy the deficiencies and code violations.

The suit seeks more than $1 million in damages for breach of contract, negligence and other causes of action.

DECLARATORY JUDGMENT SOUGHT

Mt. Hawley says the defendant tendered the city's suit for a defense and indemnity under a series of commercial general liability and commercial excess liability policies.

The insurer denied coverage, citing a breach-of-contract exclusion in the firm's policies. Mt. Hawley is now asking the court to confirm its position.

According to the insurer's suit, the exclusion "independently and conclusively" bars coverage for the entire underlying complaint because the city's alleged damages arise from a breach of the project contract.

Other provisions in the policies may also void coverage, the complaint says.

'PREDETERMINED' DENIAL

In its counterclaims, the defendant says Mt. Hawley breached the insurance contract by denying coverage.

The insurer is obligated to cover the suit because the city's property damage claims do not arise from a breach of the construction contract, according to the joint venture.

The defendant also says Mt. Hawley "conducted essentially no investigation" into the specific allegations in the underlying suit.

Additionally, the firm says, Mt. Hawley violated the Texas Insurance Code, Tex. Ins. Code Ann. §§ 541.060 and 541.061, by making false statements about coverage available under the policies.

The insurer also violated Section 542.056 of the state insurance code by failing to promptly pay the joint venture's defense costs for the underlying suit, according to the counterclaims.

The defendant seeks a ruling that Mt. Hawley acted in breach of contract. It also seeks unspecified compensatory and statutory damages, plus pre-judgment and post-judgment interest. WJ

Attorneys:
Plaintiff: Greg K. Winslett and Tammy L. Clary, Quilling, Selander, Lownds, Winslett & Moser, Dallas, TX

Defendant: Travis M. Brown and Patrick J. Wielinski, Cokinos & Young, Irving, TX

Related Filings:
Answer and counterclaims: 2018 WL 2110343
Complaint: 2018 WL 1404445

Known, undisclosed risk leaves law firm without malpractice coverage

By Kteba Dunlap, Esq.

A malpractice insurer can avoid defending a New Jersey law firm because the firm misled the insurer about its knowledge of potential professional liability claims stemming from a client's Ponzi scheme, a state appeals court has ruled.

Ironshore Indemnity Inc. v. Pappas & Wolf LLC et al., No. A-0959-16T1, 2018 WL 2012009 (N.J. Super. Ct., App. Div. May 1, 2018).

A trial judge properly concluded that Hercules Pappas, a partner at Pappas & Wolf, was aware that he might be implicated when the attorney general of New Jersey sued his client in 2010 for securities law violations, a two-judge panel of the New Jersey Superior Court's Appellate Division said.

Thus, the firm's nondisclosure of those potential claims in its 2011 renewal application for professional liability insurance amounted to a material misrepresentation, entitling Ironshore Indemnity Inc. to deny coverage, the panel concluded.

ATTORNEY-CLIENT RELATIONSHIP

According to Ironshore's declaratory judgment action against Pappas & Wolf, Pappas and partner Matthew S. Wolf, the dispute began when newly formed investment company Carr Miller Capital LLC retained Pappas' old firm in 2006. Two years later CMC brought Pappas & Wolf in-house as general counsel, the complaint said.

The law firm shared office space with CMC, but paid no rent or other office expenses, according to the complaint. Ironshore also said that Pappas was a director of Indigo Energy Inc., CMC's biggest investment holding, and that CMC had loaned Indigo $7 million over the course of several years.

Pappas resigned from his position as a CMC employee in 2009, but his firm stayed on as outside counsel, the suit said.

$41 MILLION PONZI SCHEME

At some point the state attorney general began investigating CMC, and sued the company and its President Everett Miller for securities fraud in October 2010.

According to Ironshore's complaint, CMC duped nearly 200 investors into paying more than $41 million into Miller's Ponzi scheme, returning only $11.7 million to investors.

In a deposition regarding the malpractice litigation, Pappas said it was at this point that he became concerned that he and his firm would be implicated in CMC's case, according to the appeals panel's opinion.

> Quoting the trial judge, the panel agreed that "common sense" showed the defendant had prior knowledge of a potential suit.

CMC dissolved in October 2010, and the New Jersey attorney general placed CMC into receivership with Michael P. Pompeo in February 2011.

MALPRACTICE SUIT

Pappas & Wolf renewed its professional liability policy with Ironshore in August 2011, and in response to the question of whether the firm had prior knowledge of any potential claims against it, the attorneys answered "no," the opinion said.

Pompeo sued Pappas, Wolf, and their firm for malpractice in August 2012, alleging that they had failed to advise CMC that it was making investments inappropriate for their clients, among other errors in representation.

Pappas & Wolf tendered the suit to Ironshore, which filed its declaratory judgment action against the firm in the Essex County Superior Court. The insurer alleged that the firm had materially misrepresented a lack of prior knowledge of the potential claim related to CMC.

The Superior Court granted Ironshore summary judgment. Pompeo, to whom Pappas & Wolf had assigned its rights under the policy, appealed.

SUBJECTIVE STANDARD

On appeal, Pompeo challenged the trial court's finding that Pappas' deposition demonstrated he was concerned about a claim nine months before renewing the firm's Ironshore policy.

The receiver argued that the court had misapplied the subjective standard to the question of whether Pappas was aware of a potential malpractice suit. Ironshore could not prove his state of mind at the time he signed the application, Pompeo said.

The appellate panel said that subjective intent did not necessarily control if the totality of the circumstances indicated otherwise.

"Regardless of Pappas' testimony, the subjective standard is overcome by a reasonable analysis of the circumstances," it said.

Pappas may have claimed he did not expect a malpractice suit, but his actions showed otherwise, the panel said, noting the intimate relationship between the law firm and the investment company.

Quoting the trial judge, the panel agreed that "common sense" showed Pappas had prior knowledge of a potential suit. WJ

Attorneys:
Plaintiff-respondent: Matthew P. O'Malley and William C. Kelly, Tompkins McGuire Wachenfeld & Barry, Newark, NJ

Appellant (Pompeo): Jeffrey S. Lipkin, Ramsey, NJ

Related Filings:
Opinion: 2018 WL 2012009
Complaint (Ironshore): 2013 WL 12235097

See Document Section C (P. 36) for the opinion.

5 NYC men charged in $31 million slip-and-fall scheme

By Jason Schossler

Five New York City residents have pleaded not guilty to charges that they bilked businesses and insurance companies out of more than $31 million by staging slip-and-fall accidents.

United States v. Kalkanis et al., No. 18-cr-289, pleas entered (S.D.N.Y. Apr. 23, 2018).

Peter Kalkanis, 70; Bryan Duncan, 30; Kerry Gordon, 34; Robert Locust, 52; and Ryan Rainford, 28, each face charges of conspiracy to commit mail and wire fraud, mail fraud and wire fraud in connection with the alleged scheme, the U.S. Justice Department said in an April 19 statement.

Kalkanis, who the DOJ says was the leader of the purported scheme, is also facing a separate count of aggravated identify theft.

All five defendants pleaded not guilty April 23 before U.S. District Judge Laura Taylor Swain of the Southern District of New York.

According to the indictment, the defendants recruited certain individuals to stage slip-and-fall accidents at various locations throughout New York City.

They also allegedly instructed the individuals to claim injuries and seek medical treatment.

Following the staged accidents, the recruited individuals were referred to specific attorneys who represented them in lawsuits against the owners of the purported accidents' sites and/or their insurers, the indictment says.

The allegedly fraudulent suits did not disclose that the recruited individuals had purposely fallen or, in some cases, not fallen at all, according to prosecutors.

Further, the indictment says, the defendants instructed the recruited individuals to receive ongoing chiropractic and medical care for their allegedly bogus injuries.

In some cases, prosecutors allege, the recruited individuals went as far as to have unnecessary surgery to increase the likelihood they would get a higher settlement payment from their lawsuits.

The indictment says Kalkanis, a former chiropractor, paid his co-defendants to recruit the individuals and transport them to their doctor and attorney appointments. He also helped procure the funding for the individuals' medical care and lawsuits, according to the filing.

During the course of the alleged scheme, the defendants and other unnamed co-conspirators attempted to defraud the businesses and their insurers of at least $31,791,000, the indictment alleges.

If convicted, Kalkanis is facing up to two years in prison on the aggravated identify theft charge.

All five the defendants also face up to 20 years in prison on each of the remaining counts, according to the DOJ. WJ

Related Filings:
Indictment: 2018 WL 2035041

See Document Section D (P. 39) for the indictment.

INSURANCE FRAUD

California woman sentenced to 30 days in jail for disability insurance fraud

By Jason Schossler

A California woman has been sentenced to 30 days in jail and ordered to pay more than $124,000 in restitution for fraudulently collecting disability insurance benefits while working three full-time jobs.

Teresa Baker, 60, of Brawley, received the sentence from an Imperial County Superior Court judge after pleading guilty in January to one count of insurance fraud, the California Department of Insurance said in an April 27 statement.

According to the statement, Baker filed a claim with her insurer in October 1998 stating she was unable to work due to a back injury she suffered while employed at an El Centro bank.

Later, however, the CDI received a tip that Baker had been working full-time while collecting disability benefits, the statement said.

A subsequent investigation revealed that Baker had collected more than $100,000 in disability payments while working for three different employers, according to the statement.

From 2007 to 2013, Baker worked for the Brawley Public Scales, Sun Community Federal Credit Union and as a substitute teacher at the Brawley School District, the CDI said.

In addition to a month in jail, the judge sentenced Baker to 60 days of home detention and three years of formal probation, the statement said. WJ

INSURANCE FRAUD

5 service members indicted in Navy insurance fraud scheme

By Jason Schossler

Five Navy service members have been indicted for filing fraudulent claims to receive unearned benefits under a government insurance program, according to a federal indictment unsealed May 2.

United States v. Cote, No. 18-cr-1674, indictment filed, 2018 WL 2110327 (S.D. Cal. Mar. 29, 2018).

The U.S. Justice Department filed an indictment in the U.S. District Court for the Southern District of California, charging each of the defendants with one count of conspiracy to commit wire fraud, six counts of wire fraud and five counts of making a fraudulent and false claim.

The defendants are Richard Cote, 43, of Oceanside, California; Kelene McGrath, 41, of Jacksonville, Florida; Christopher Toups, 40, of Woodstock, Georgia; Jason Toups, 35, of Gulfport, Mississippi; and Earnest Thompson, 44, of Murrieta, California.

According to the indictment, the defendants filed the bogus claims under the Traumatic Servicemembers Group Life Insurance program. The program, which compensates service members who suffer from debilitating injuries while on active duty, is funded by service members and the U.S. Defense Deparment.

Prosecutors allege that each of the defendants falsely claimed they were entitled to benefits of $100,000 under the TSGLI for serious injuries they said they had suffered but actually did not.

The defendants also submitted fraudulent medical records to substantiate the fraudulent claims, the indictment says.

By the time the government uncovered the purported schemes, four of the five defendants had received the $100,000 payout, the DOJ said in a May 2 statement. WJ

Related Filings:
Indictment: 2018 WL 2110327
DOJ statement: 2018 WL 2042126

Texas court to hear oral argument in Chuck E. Cheese's coverage row

By Jason Schossler

A Texas federal judge will hear opposing motions for summary judgment in a lawsuit alleging an insurer wrongfully refused to defend the operator of pizza chain Chuck E. Cheese's against a shareholder suit.

CEC Entertainment Inc. v. Travelers Casualty & Surety Co. of America, No. 16-cv-2493, oral argument scheduled (N.D. Tex. Apr. 20, 2018).

U.S. District Judge Barbara M.G. Lynn of the Northern District of Texas will hear oral argument June 5 in a suit against Travelers Casualty & Surety Co., which CEC Entertainment Inc. claims broke its contract in refusing to pay for underlying defense costs.

CEC's suit alleges the insurer breached its directors-and-officers liability policy when it did not cover the costs of a shareholder suit that challenged the company's 2014 merger with an Apollo Global Management LLC affiliate.

CEC says Travelers owes it about $4.9 million in actual damages plus 18 percent annual interest.

Travelers says in a brief supporting its motion for summary judgment that CEC has not alleged any plausible basis for coverage under the policy.

No coverage is owed for the underlying action, according to the insurer, because the shareholder plaintiffs did not allege CEC engaged in any "wrongful acts" as defined by the company's D&O policy.

In a brief supporting its own summary judgment motion, CEC disagrees with Travelers' assessment of the underlying allegations.

The company says the court must liberally interpret the shareholders' claims and draw "all inferences in CEC's favor" in determining Travelers' coverage obligations. WJ

Attorney Profiles:
Plaintiff: Amy E. Stewart and Katherine H. Fayne, Amy Stewart PC, Dallas, TX

Defendant: J. Price Collins and Ashley F. Gilmore, Wilson Elser Moskowitz Edelman & Dicker, Dallas, TX

Related Filings:
Plaintiff's brief supporting summary judgment: 2018 WL 1123912
Defendant's brief supporting summary judgment: 2018 WL 1123924
Complaint: 2016 WL 4575700

CASE AND DOCUMENT INDEX

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United States District Court, D. Connecticut.

Steven KARAS, and Gail Karas, Plaintiffs,
v.
LIBERTY INSURANCE CORP., Defendant.
No. 3:13-cv-01836 (SRU)

Signed 04/30/2018

Attorneys and Law Firms

Jeffrey R. Lindequist, Law Office of Michael D. Parker, Lindsay Britton, Springfield, MA, Michael D. Parker, Law Office of Michael D. Parker, Springfield, CT, for Plaintiffs.

Philip T. Newbury, Jr., Kieran W. Leary, Howd & Ludorf, LLC, Hartford, CT, for Defendant.

ORDER CERTIFYING QUESTION TO THE CONNECTICUT SUPREME COURT

Stefan R. Underhill, United States District Judge

***1** Steven and Gail Karas sued their insurer, Liberty Insurance Corp. ("Liberty"), for denying coverage under their homeowners' insurance policy for a loss to their basement walls. The Karases allege that Liberty (1) breached its insurance contract with the Karases; (2) breached the implied covenant of good faith and fair dealing; and (3) committed unfair and deceptive practices proscribed by the Connecticut Unfair Insurance Practices Act ("CUIPA") and the Connecticut Unfair Trade Practices Act ("CUTPA"). Liberty moved for summary judgment on September 5, 2017. Doc. No. 57. At a hearing held on December 14, 2017, Doc. No. 69, I denied Liberty's motion with respect to the breach of contract claim and granted it with respect to the bad faith and CUTPA/CUIPA claim, substantially for the reasons stated in my decision in *Roberts v. Liberty Mutual Insurance Co.*, 264 F. Supp. 3d 394 (D. Conn. 2017).

On December 20, 2017, Liberty moved to certify questions to the Connecticut Supreme Court. Doc. No. 70. The Karases initially opposed certification, but changed their position upon learning that my colleague United States District Judge Robert N. Chatigny was likely to certify questions in another concrete collapse case, *Vera v. Liberty Mutual Fire Insurance Co.*, 3:16-cv-00072 (RNC). All parties to both cases now support certification. Furthermore, the question presented by this case and by *Vera*—whether the definition of "collapse" given in *Beach v. Middlesex Mutual Assurance Co.*, 205 Conn. 246 (1987), requires coverage in the present circumstances—has the potential to resolve a large number of lawsuits pending throughout the state.[1] Therefore, I grant Liberty's motion to certify questions to the Connecticut Supreme Court.

I. Standard of Review

Under Connecticut law, "[t]he Supreme Court may answer a question of law certified to it by a court of the United States ... if the answer may be determinative of an issue in pending litigation in the certifying court and if there is no controlling appellate decision, constitutional provision or statute of this state." Conn. Gen. Stat. § 51-199b(d). When deciding whether to certify a question to the Connecticut Supreme Court, a court should consider, among other factors, "(1) the absence of authoritative state court decisions; (2) the importance of the issue to the state; and (3) the capacity of certification to resolve the litigation." *O'Mara v. Town of Wappinger*, 485 F.3d 693, 698 (2d Cir. 2007). "Where a question ... implicates the weighing of policy concerns, principles of comity and federalism strongly support certification." *Parrot v. Guardian Life Ins. Co. of Am.*, 338 F.3d 140, 144 (2d Cir. 2003).

II. Background[2]

***2** The Karases' house is among many in northeastern Connecticut built with concrete supplied by the J.J. Mottes Concrete Co. ("Mottes"). The stone aggregate used in Mottes concrete contains significant amounts of pyrrhotite (Fe1-xS), a ferrous mineral that reacts with water, oxygen, and concrete paste to form expansive secondary minerals such as gypsum, ettringite, and thaumasite.

The expanding minerals crack and destabilize the concrete, "lead[ing] to [its] premature deterioration." *See generally* Conn. Dep't of Consumer Prot., *Report on Deteriorating Concrete in Residential Foundations*, App'x D, at 52 (2016).

In October 2013, the Karases discovered that their basement walls were cracking, crumbling, and deteriorating in the manner typical of Mottes concrete. On November 15, 2013, the Karases reported a claim under their homeowners' insurance policy to Liberty. Liberty denied the Karases' claim the same day, asserting that the loss described was "deterioration" and was therefore not covered under the policy.

On December 11, 2013, the Karases filed suit against Liberty, contending that the loss was a "collapse" under the construction given in *Beach v. Middlesex Mutual Assurance Co.* The Karases' policy covers "collapse" as follows:

> *Collapse.* We insure for direct physical loss to covered property involving collapse of a building or any part of a building caused only by one or more of the following:
>
> ...
>
> b. Hidden decay;
>
> c. Hidden insect or vermin damage;
>
> d. Weight of contents, equipment, animals or people;
>
> e. Weight of rain which collects on a roof; or
>
> f. Use of defective material or methods in construction, remodeling or renovation.
>
> Loss to an awning, fence, patio, pavement, swimming pool, underground pipe, flue, drain, cesspool, septic tank, foundation, retaining wall, bulkhead, pier, wharf or dock is not included ... unless the loss is a direct result of the collapse of a building.
>
> Collapse does not include settling, cracking, shrinking, bulging or expansion.

In *Beach v. Middlesex Mutual Assurance Co.*, the Connecticut Supreme Court held that the term "collapse" in a homeowners' insurance policy, when otherwise undefined, was "sufficiently ambiguous to include coverage for any substantial impairment of the structural integrity of a building." 205 Conn. at 252. The *Beach* Court specifically rejected the insurer's contention that " 'collapse' ... unambiguously contemplates a sudden and complete falling in of a structure," but did not further define the standard of "substantial impairment of [ ] structural integrity." *Id.* at 250, 252. In the present case—as in many others pending in this district—the parties essentially dispute whether the damage constitutes a "collapse" under *Beach*.

III. Discussion

In previous concrete collapse cases, I have declined to certify state law questions to the Connecticut Supreme Court. I determined that "there were 'several Connecticut state court cases ... applicable to the legal question[s] raised,' " and concluded that "sufficient precedents exist[ed] for me to make a prediction of how the [Connecticut Supreme Court] would decide the question[s]." *Roberts*, 264 F. Supp. 3d at 402 n.4 (quoting *Goodlett v. Kalishek*, 223 F.3d 32, 37 n.4 (2d Cir. 2000); *Karagozian v. Luxottica N. Am.*, 2016 WL 2944149, at *4 (D. Conn. May 20, 2016)). Like my colleague United States District Judge Victor A. Bolden, I continue to think that the standard enunciated in *Beach* is "relatively clear." *See Belz v. Peerless Ins. Co.*, 204 F. Supp. 3d 567, 464 (D. Conn. 2016). Nevertheless, because this "unsettled question of state law raises important issues of public policy," and is "likely"—indeed, almost certain—"to recur," *see In re World Trade Ctr. Lower Manhattan Disaster Site Litig.*, 846 F.3d 58, 69 (2d Cir. 2017) ("*World Trade Ctr.*"), I now deem it advisable to seek direct guidance from Connecticut's highest court.

***3** Conn. Gen. Stat. § 51-199b(d) authorizes "[t]he Supreme Court [to] answer a question of law certified to it by a court of the United States ... if the answer may be determinative of an issue in pending litigation in the certifying court and if there is no controlling appellate decision, constitutional provision or statute of this state." Those criteria are met here. First, appellate guidance with respect to the definition of "collapse" will be "determinative" of not only this case, but also many others pending throughout the state. A final resolution of the issue "will assist the administration of justice in both federal and state courts." *Parrot*, 338 F.3d at 145.

Second, "there is no controlling appellate decision," because *Beach* (though highly instructive) arguably "provides insufficient guidance." *Id.* at 144. No Connecticut appellate decision has squarely applied *Beach* and arrived at a definition of "substantial impairment of structural integrity."[3] Heretofore, I and my colleagues on the federal and state trial courts have felt that "sufficient precedents exist for us to make a prediction of how the [Connecticut Supreme Court] would decide the question." *See Goodlett*, 223 F.3d at 37 n.4. But in light of the frequency with which the collapse issue has recurred, I now conclude that certification would "save time, energy, and resources" by enabling the state's highest court to provide a "conclusive" interpretation of "substantial impairment of structural integrity." *See Arizonans for Official English v. Arizona*, 520 U.S. 43, 77 (1997) (internal quotation marks omitted); *Freedman v. Am. Online*, 412 F. Supp. 2d 174, 191 (D. Conn. 2005). In short, certification "will provide the Connecticut Supreme Court with the opportunity to decide this ... repetitive question and to promote uniformity in its law." *Hume v. Hertz Corp.*, 628 F. Supp. 763, 767 (D. Conn. 1986).

I also think that certification is warranted because the concrete collapse cases "are plainly of great importance to the State." *See World Trade Ctr.*, 846 F.3d at 69. Not only is "[i]nsurance ... an important industry in Connecticut," *Fireman's Fund Ins. Co. v. TD Banknorth Ins. Agency*, 644 F.3d 166, 172 (2d Cir. 2011), but also the concrete collapse issue affects thousands of Connecticut residents and "implicates broad questions of Connecticut public policy."[4] *See Munn v. Hotchkiss Sch.*, 795 F.3d 324, 334 (2d Cir. 2015). Determining the extent to which the substantial loss should fall on homeowners or on their insurers entails "value judgments and important public policy choices that the [Connecticut Supreme Court] is better situated ... to make." *Beck Chevrolet Co. v. GM LLC*, 787 F.3d 663, 682 (2d Cir. 2015).

***4** Liberty has requested that I certify the following three questions:

> 1. Is "substantial impairment of structural integrity" the applicable standard for "collapse" under the provision at issue?
>
> 2. If the answer to question one is yes, then what constitutes "substantial impairment of structural integrity" for purposes of applying the "collapse" provision of this homeowners' insurance policy?
>
> 3. Under Connecticut law, do the terms "foundation" and/or "retaining wall" in a homeowners' insurance policy unambiguously include basement walls? If not, and if those terms are ambiguous, should extrinsic evidence as to the meaning of "foundation" and/or "retaining wall" be considered?

Mot. Certification, Doc. No. 70, at 1.

I conclude that only the second question merits certification. With respect to the first question, there is no dispute that the insurance policy in this case does not define "collapse," which means that *Beach* clearly provides the relevant standard.[5] With respect to the third question, Connecticut courts have "consistently rejected" insurers' arguments concerning the term "foundation," have "determined that th[ose] policy terms were ambiguous," and have "construed them against" the insurers.[6] *Jang v. Liberty Mut. Fire Ins. Co.*, 2018 WL 1505574, at *3 (D. Conn. Mar. 27, 2018); *see also, e.g., Gabriel v. Liberty Mut. Fire Ins. Co.*, 2017 WL 6731713, at *2 (D. Conn. Dec. 29, 2017) (noting prior determination "that the terms 'foundation' and 'retaining wall,' as used in the policy, were ambiguous."); *Belz v. Peerless Ins. Co.*, 46 F. Supp. 3d 157, 164 (D. Conn. 2014); *Karas v. Liberty Ins. Corp.*, 33 F. Supp. 3d 110, 115 (D. Conn. 2014) ("Each party thus has a reasonable but different interpretation of the phrases ['foundation' and 'retaining wall'] supported by dictionaries and case law, so the phrases are ambiguous, and the insurance policy should be construed against Liberty Mutual."); *Bacewicz v. NGM Ins. Co.*, 2010 WL 3023882, at *4 (D. Conn. Aug. 2, 2010) ("[A] reasonab[e] jury could find that the basement walls of the Bacewiczes' house did not constitute the 'foundation' of the house."). I have not found, and Liberty has not cited, any Connecticut case (state or federal) that ruled for an insurer on the basis of the "foundation" exclusion. Therefore, I do not think that the third question presents a sufficiently "[n]ovel" or "unsettled" question to merit certification. *Arizonans for Official English*, 520 U.S. at 79; *see also Metsack v. Liberty Mut. Fire Ins. Co.*, 2015 WL 5797016, at *10 (D. Conn. Sept. 30, 2015) (declining to "certify the question of whether the terms 'foundation' and 'retaining wall' are ambiguous" because "[t]he Connecticut Supreme Court ... has provided the necessary guidance for this Court to determine whether, under Connecticut law, an ambiguity exists in a given contract"); *Gabriel v. Liberty Mut. Fire Ins. Co.*, 2015 5684063, at *4 (D. Conn. Sept. 28, 2015) (declining to certify question whether "the terms 'foundation' and 'retaining wall' ... [are] ambiguous' because court was "capable of making a sound decision, in light of the applicable authorities, that the terms 'foundation' and 'retaining wall' are ambiguous in the context of the policy language at issue in this case").

***5** Liberty's second proposed question does warrant certification, however. In *Roberts*, I "interpret[ed] *Beach* to require that a 'collapse'—in the form of 'substantial impairment of [ ] structural integrity'—be proved by evidence that a building 'would have caved in had the plaintiffs not acted to repair the damage.' " 264 F. Supp. 3d at 407 (quoting *Beach*, 205 Conn. at 249). For the reasons

discussed above, Connecticut's highest court should have the opportunity to decide whether my interpretation of *Beach* was correct. Therefore, pursuant to Conn. Gen. Stat. § 51-199b(d), I certify the following question to the Connecticut Supreme Court:

> What constitutes a "substantial impairment of structural integrity" for purposes of applying the "collapse" provision of this homeowners' insurance policy?

Of course, "[t]he Connecticut Supreme Court may modify th[at] question as it sees fit and add any pertinent questions of Connecticut law ... that the Court chooses to answer." *Fireman's Fund Ins. Co.*, 644 F.3d at 173. I will make available to the Connecticut Supreme Court any part of the record in this case that might assist the Court in its review of the issue. This court "retains jurisdiction over this case," and will conduct further proceedings after "the Connecticut Supreme Court has either provided [me] with its guidance or declined certification."[7] *Id.*

IV. Conclusion

I grant Liberty's motion for certification, Doc. No. 70, and deny as moot its motion to defer ruling, Doc. No. 74. The Clerk shall effect certification to the Connecticut Supreme Court.

So ordered.

All Citations

Slip Copy, 2018 WL 2002480

Footnotes

1 In addition to a dozen or more federal lawsuits, the state "judicial district of Tolland presently has over forty such cases pending." *See Roy v. Liberty Mut. Fire Ins. Co.*, 2017 Conn. Super. LEXIS 506, at *1 n.1 (Conn. Super. Ct. Feb. 22, 2017).

2 Except where otherwise indicated, the facts are taken from the parties' Local Rule 56(a)1 and Local Rule 56(a)2 Statements and their accompanying exhibits.

3 A Superior Court decision, *Sansone v. Nationwide Mut. Fire Ins. Co.*, 47 Conn. Supp. 35, 39 (Conn. Super. Ct. 1999), applied *Beach* and was affirmed and adopted in its entirety by the Appellate Court. 62 Conn. App. 526 (2001) (per curiam). *Sansone* indicated that "whether a plaintiff has proven [a substantial] impairment is a question of fact," 47 Conn. Supp. at 41, which supports my conclusion in *Roberts* that "whether a building has suffered a substantial impairment of [ ] structural integrity is a question ... of fact, not one of law." *Roberts v. Liberty Mut. Fire Ins. Co.*, 264 F. Supp. 3d 394, 410 (D. Conn. 2017) (internal quotation marks omitted). *Sansone* ultimately was decided on other grounds, however. The Superior Court held that there was no coverage because the plaintiffs' loss "was the proximate result of ... [an] excluded" cause—termite damage—and the insurance policy at issue did not "ma[ke] specific reference to collapse that ensues from otherwise excluded activity." 47 Conn. Supp. at 41. Therefore, *Sansone* is "inconclusive" with respect to the question here. *See Parrot v. Guardian Life Ins. Co. of Am.*, 338 F.3d 140, 144 (2d Cir. 2003).

4 As many as 34,000 homes may be affected by collapsing concrete. *See* Lisa W. Foderaro & Kristin Hussey, *Financial Relief Eludes Connecticut Homeowners with Crumbling Foundations*, N.Y. Times, Nov. 14, 2016, https://www.nytimes.com/2016/11/15/nyregion/financial-reliefeludes-connecticut-homeowners-with-crumbling-foundations.html.

5 Liberty asserts that *Beach* "is *not* binding authority with respect to the policy language at issue here," because the policy "define[s] collapse ... [as] not include[ing] settling, cracking, shrinking[,] bulging[,] or expansion." Mem. Supp. Mot. Certification, Doc. No. 70-1, at 6. In fact, though—as I noted in another concrete collapse case—*Beach* "held that an identically worded exclusion could 'reasonably be read to exclude loss related to "settling, cracking, shrinkage, bulging[,] or expansion," only so long as "collapse" d[id] not ensue.' " *Agosti v. Merrimack Mut. Fire Ins. Co.*, 279 F. Supp. 3d 370, 376 (D. Conn. 2017) (quoting *Beach v. Middlesex Mut. Assur. Co.*, 205 Conn. 246, 251 (1987)). Notwithstanding Liberty's reliance on out-of-state cases, *Beach* clearly controls with regard to the undefined term "collapse."

[6] Most persuasively, Judge Susan Quinn Cobb of the Connecticut Superior Court has observed that the "foundation" and "retaining wall" exclusions are located in a "section of the policy [that] appears to exclude items that would be found outside of a building, and not inside a building, such as an awning, fence, patio, pavement, pool, septic tank." *Roy*, 2017 Conn. Super. LEXIS 506, at *19. Under the interpretive canon of *noscitur a sociis*—which provides that "a word is given more precise content by the neighboring words with which it is associated," *United States v. Williams*, 553 U.S. 285, 294 (2008)—the provision as a whole "suggests that what was intended by th[e] ['foundation' and 'retaining wall'] exclusion language includes only items found outside of the home[,] or at a minimum renders [the language] ambiguous." *See Roy*, 2017 Conn. Super. LEXIS 506, at *20.

[7] I note that a case currently pending before the Connecticut Supreme Court, *Jemiola v. Hartford Casualty Insurance Co.*, No. SC 19978, might already provide an opportunity to clearly define "substantial impairment of structural integrity." The policy in *Jemiola*, however, included the qualification that the collapse must be "abrupt," which the trial court interpreted to mean that "a 'collapse' requires a sudden and catastrophic type event." 2017 WL 1258778, at *9 (Conn. Super. Ct. Mar. 2, 2017). Thus, the Connecticut Supreme Court might decide *Jemiola* on the grounds that the loss—regardless of whether it constituted a "substantial impairment"—was not "abrupt." The policy in this case, which does not include an "abrupt" or "sudden" qualifier, more squarely presents the issue of what constitutes a "substantial impairment of structural integrity."

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NORTH CYPRESS

2018 WL 1974376
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Supreme Court of Texas.

IN RE NORTH CYPRESS MEDICAL CENTER OPERATING CO., LTD., Relator
No. 16–0851

Argued November 9, 2017

OPINION DELIVERED: April 27, 2018

Synopsis

Background: Patient, who had been treated in hospital's emergency room following an automobile accident and who lacked health insurance, brought action for a declaratory judgment that hospital's charges were unreasonable and that hospital's corresponding $11,037 lien was invalid to the extent that it exceeded a reasonable and regular rate for services rendered. The 234th District Court, Harris County, Wesley R. Ward, J., granted patient's motion to compel and ordered hospital to produce information regarding its reimbursement rates from private insurers and public payers for the services that it provided to patient. Hospital petitioned for mandamus relief. The Houston Court of Appeals, 14th District, denied petition. Hospital petitioned for mandamus relief.

[Holding:] The Supreme Court, Lehrmann, J., held that the trial court did not abuse its discretion in determining that the requested information was relevant.

Petition denied.

Hecht, C.J., dissented and filed opinion in which Green and Guzman, JJ., joined.

West Headnotes (4)

[1] **Mandamus**
Nature and scope of remedy in general

Mandamus is an extraordinary remedy granted only when the relator shows that the trial court abused its discretion and that no adequate appellate remedy exists.

Cases that cite this headnote

[2] **Pretrial Procedure**
Discretion of court

The trial court abuses its discretion by ordering discovery that exceeds that permitted by the rules of procedure.

Cases that cite this headnote

[3] **Health**
Hospitals

Trial court did not abuse its discretion in concluding that the amounts that hospital was willing to accept as payment for services rendered to the vast majority of its patients were relevant to the reasonableness of its charges for those same services to uninsured patients, and thus trial court could order hospital to produce information regarding its reimbursement rates from private insurers and public payers for the services that it provided to patient who had been treated in hospital's emergency room following an automobile accident, who lacked health insurance, and who had brought an action for a declaratory judgment that charges included in hospital's lien were unreasonable.

Cases that cite this headnote

[4] **Mandamus**
Proceedings in civil actions in general

Allegedly confidential and proprietary information contained in hospital's insurance contracts was not a reason to grant hospital mandamus relief from trial court's decision to order hospital to produce information regarding its reimbursement rates from private insurers and public payers for the services that it provided to patient who had been treated in hospital's emergency room following an automobile accident, who lacked health insurance, and who had brought an action for a declaratory judgment that charges included in hospital's lien were unreasonable.

Cases that cite this headnote

ON PETITION FOR WRIT OF MANDAMUS

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Opinion

Justice Lehrmann delivered the opinion of the Court, in which Justice Johnson, Justice Boyd, Justice Devine, Justice Brown, and Justice Blacklock joined.

***1** Our procedural rules allow broad discovery of unprivileged information that is "relevant to the subject matter of the pending action." TEX. R. CIV. P. 192.3(a). This includes information that may ultimately be inadmissible at trial so long as it "appears reasonably calculated to lead to the discovery of admissible evidence." *Id.* The "subject matter" of the underlying action, which involves the enforceability of a hospital lien securing payment of charges for services rendered to an uninsured patient, encompasses the reasonableness of those charges.

The trial court's order at issue in this mandamus proceeding requires the defendant hospital to produce information regarding its reimbursement rates from private insurers and public payers for the services it provided to the plaintiff. The hospital argues those reimbursement rates are irrelevant to whether its charges to the uninsured plaintiff were reasonable and that the trial court therefore abused its discretion in ordering production of that information. We disagree. The reimbursement rates sought, taken together, reflect the amounts the hospital is willing to accept from the vast majority of its patients as payment in full for such services. While not dispositive, such amounts are at least relevant to what constitutes a reasonable charge. Accordingly, we deny the hospital's petition for writ of mandamus.

I. Background

Crystal Roberts was involved in an automobile accident on June 9, 2015, and was taken by ambulance to the emergency room at North Cypress Medical Center. North Cypress released Roberts approximately three hours later after performing a series of x-rays, CT scans, lab tests, and other emergency services. Because Roberts was uninsured, North Cypress billed her for the services at its full "chargemaster" prices, which totaled $11,037.35. North Cypress also filed a hospital lien for this amount. *See* TEX. PROP. CODE § 55.002(a) ("A hospital has a lien on a cause of action or claim of an individual who receives hospital services for injuries caused by an accident that is attributed to the negligence of another person.").

The liability insurer of the driver at fault offered to settle the case for $17,380, attributing $9,404 to past medical expenses. Roberts sought reduction of North Cypress's bill, and the parties negotiated but could not reach an agreement on the bill's amount.[1] Roberts sued, seeking a declaratory judgment that North Cypress's charges were unreasonable and its lien invalid to the extent it exceeds a reasonable and regular rate for services rendered.[2] North Cypress counterclaimed on a sworn account for $8,278.31, the amount to which it had previously offered to reduce its bill.

***2** Roberts served requests for production and interrogatories on North Cypress, including the following:

> • Please produce all contracts regarding negotiated or reduced rates for the hospital services provided to Plaintiff in which Defendant is a party, including those with Aetna, First Care, United Healthcare, Blue Cross Blue Shield, Medicare, and Medicaid.
>
> ....
>
> • Please produce the annual cost report you are required to provide to a Medicare Administrative Contractor Medicare [sic], as a Medicare certified institutional provider for 2011, 2012, 2013, 2014 and 2015.
>
> ....
>
> • Please state the Medicare reimbursement rate for x-rays, CT scans, lab tests and emergency room services, as you performed on the Plaintiff on June 9, 2015.
>
> • Please state the Medicaid reimbursement rate for x-rays, CT scans, lab tests and emergency room services, as you performed on the Plaintiff on June 9, 2015.

North Cypress objected to these discovery requests and moved for a protective order, asserting that they sought irrelevant information and were overly broad. Roberts filed a corresponding motion to compel. In an oral ruling on the record, the trial court ordered North Cypress to produce the requested information, though the court narrowed the scope to include only contracts "that cover the [time] period at issue in this case."

North Cypress moved for reconsideration, reiterating its relevance objection and adding that it would "suffer irreparable harm" from the disclosure of its "confidential and proprietary" negotiated insurance contracts. The trial court denied the motion, prompting North Cypress to file a petition for writ of mandamus in the court of appeals. The court of appeals denied the petition, and North Cypress now seeks mandamus relief in this Court.

II. Analysis

[1] [2]Mandamus is an extraordinary remedy granted only when the relator shows that the trial court abused its discretion and that no adequate appellate remedy exists. *In re Prudential Ins. Co. of Am.*, 148 S.W.3d 124, 135–36 (Tex. 2004). "The trial court abuses

its discretion by ordering discovery that exceeds that permitted by the rules of procedure." *In re CSX Corp.*, 124 S.W.3d 149, 152 (Tex. 2003). We address North Cypress's two challenges to the discovery order in turn.

A. Relevance

North Cypress first argues that information about reimbursement rates from insurers and government payers is not relevant to Roberts' claims about the enforceability of its hospital lien. *See* TEX. R. CIV. P. 192.3(a) (parties may obtain discovery of information that is "relevant to the subject matter of the pending action"). Evidence is "relevant" if "it has any tendency to make a fact [of consequence to the action] more or less probable than it would be without the evidence." TEX. R. EVID. 401. And as noted, evidence need not be admissible to be discoverable so long as it "appears reasonably calculated to lead to the discovery of admissible evidence." TEX. R. CIV. P. 192.3(a).

Because the subject matter of this action involves a dispute over a hospital lien, in evaluating the relevance of the requested information we must begin with a discussion of Texas's hospital-lien statute, codified in Texas Property Code chapter 55. This statute provides hospitals an additional method of securing payment from accident victims, encouraging their prompt and adequate treatment. *McAllen Hosps., L.P. v. State Farm Cty. Mut. Ins. Co. of Tex.*, 433 S.W.3d 535, 537 (Tex. 2014). Subject to certain conditions, a hospital has a lien on the cause of action of a patient "who receives hospital services for injuries caused by an accident that is attributed to the negligence of another person." *Id.* (quoting TEX. PROP. CODE § 55.002(a)). The lien also attaches to the proceeds of a settlement of the patient's cause of action. TEX. PROP. CODE § 55.003(a)(3). We have noted that the statute "is replete with language that the hospital recover the full amount of its lien, subject only to the right to question the reasonableness of the charges comprising the lien." *Bashara v. Baptist Mem'l Hosp. Sys.*, 685 S.W.2d 307, 309 (Tex. 1985); *see also Daughters of Charity Health Servs. v. Linnstaedter*, 226 S.W.3d 409, 411 (Tex. 2007) (noting that the amount of a hospital lien may not exceed "a reasonable and regular rate").[3]

***3** North Cypress challenges the trial court's order requiring production of (1) its contracts with private insurers regarding the negotiated reimbursement rates it accepts from those insurers for the services provided to Roberts, (2) the reimbursement rates for those services from Medicare and Medicaid, and (3) North Cypress's annual Medicare cost reports for certain years. North Cypress primarily argues that its negotiated reimbursement rates with health insurance carriers are not relevant to its charges to an uninsured patient and therefore are not discoverable. It urges that because Roberts had neither private health insurance nor Medicare or Medicaid coverage when she was treated, she is not entitled to the benefit of those negotiated rates. North Cypress also cites our holding in *Haygood v. De Escabedo* that any billing adjustment reflected in the negotiated rates belongs to the insurance carrier, not the patient. 356 S.W.3d 390, 394–95 (Tex. 2012). According to North Cypress, this further highlights the distinction between billed charges and reimbursement rates.[4]

Roberts responds that the insurance contracts are necessary to establish whether the amount North Cypress charged Roberts for emergency services is excessive in comparison to the rates for the same services provided to other patients in the same hospital. Roberts avers that the contracts will show that North Cypress is customarily and regularly paid significantly less for those services, making the contracts relevant to the reasonableness of the charges.[5]

1. Healthcare Pricing

This case highlights the "two-tiered" healthcare billing structure that has evolved over the past several decades. In *Haygood*, on which North Cypress heavily relies, we described these tiers as encompassing (1) " 'list' or 'full' rates [also described as chargemaster rates] sometimes charged to uninsured patients, but frequently uncollected," and (2) "reimbursement rates for patients covered by government and private insurance." *Id.* at 393 (footnotes omitted). We noted that "[f]ew patients today ever pay a hospital's full charges," *id.* (alteration in original) (citing *Linnstaedter*, 226 S.W.3d at 410), but that hospitals are pressured to set these charges as high as possible because reimbursement rates typically increase along with them, *id.*

Commentators lament the increasingly arbitrary nature of chargemaster prices, noting that, over time, they have "lost any direct connection to costs or to the amount the hospital actually expect[s] to receive in exchange for its goods and services." George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745, 755 (2016) (citing Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 48 (2006)). Yet hospitals have incentive to continue raising chargemaster prices because of the positive correlation between those prices and hospital revenue. *Id.* at 755–56; *see also* George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers*

and Uninsured Patients, 65 BAYLOR L. REV. 425, 454 (2013) ("In one form or another, a hospital's billed (chargemaster) charges are used indirectly to determine the ultimate dollar level of reimbursement payments.").[6] This trend continues notwithstanding the fact that hospitals generally expect to recover far less than they officially "charge." *E.g.*, Tompkins, 25 HEALTH AFF. at 48 ("The gap between charges and actual payments (net patient revenues) now averages about 255 percent and is growing rapidly.").

2. Evaluating Reasonableness of Hospital Charges

***4** Citing *Haygood*, North Cypress notes that its legal right to be paid for Roberts' treatment is not offset by a negotiated agreement with an insurance carrier. *See Haygood*, 356 S.W.3d at 391 (holding that a plaintiff's recovery of medical expenses incurred is limited, as is the evidence at trial, "to expenses that the provider has a legal right to be paid"). The dissent similarly opines that hospitals should not be limited "to charging an uninsured patient insurer-negotiated reimbursement rates." *Post* at ––––. According to North Cypress and the dissent, this renders irrelevant any adjustments that would have been applicable if Roberts were covered by private health insurance, Medicare, or Medicaid.

However, the issue is not whether Roberts may take advantage of insurance she did not have. Rather, because a valid hospital lien may not secure charges that exceed a reasonable and regular rate, the central issue in a case challenging such a lien is what a reasonable and regular rate would be.[7] And because of the way chargemaster pricing has evolved, the charges themselves are not dispositive of what is reasonable, irrespective of whether the patient being charged has insurance.[8] By contrast, a hospital's reimbursements from private insurers and public payers comprise the vast majority of its payments for services rendered. We fail to see how the amounts a hospital accepts as payment from most of its patients are wholly irrelevant to the reasonableness of its charges to other patients for the same services.

Courts in several other jurisdictions agree. In *Bowden v. Medical Center*, 297 Ga. 285, 773 S.E.2d 692 (2015), the Supreme Court of Georgia recently considered the exact issue presented here. That case also involved the validity and amount of a hospital lien for the reasonable charges for an uninsured's patient's care. *Id.* at 693. The patient, Bowden, sought information and documents regarding amounts the hospital charged insured patients for the same type of care during the same time period. *Id.* The court held that such documents were discoverable, concluding:

> The amounts that TMC charged to (*and agreed to accept as payment in full from*) other patients treated at the same hospital for the same type of care during the same general time frame that Bowden was treated may not be dispositive of whether TMC's charges for Bowden's care were "reasonable" under [Georgia's hospital lien statute], to the extent that the other patients were not similarly situated in other economically meaningful ways. But that does not mean that how much TMC charged those other patients is entirely irrelevant—particularly in the broad discovery sense—to the reasonableness of the charges for Bowden's care.

Id. at 696–97 (emphasis added). The court clarified that the hospital would be entitled to present evidence that the different amounts paid by insured patients "reasonably reflected such economic factors as volume discounts or promises of prompt and full payment, or [were] based on the rates that the government was willing to pay." *Id.* at 697. The court also noted that the evidence may or may not ultimately be admissible at trial, confirming that its holding was merely that the discovery sought had "some relevance to the reasonableness of [the hospital's] charges for [Bowden's] care." *Id.*

***5** Other courts have held similarly. In *Parkview Hospital, Inc. v. Frost*, which involved the determination of reasonable charges to an uninsured patient under the Indiana Hospital Lien Act, the Indiana Court of Appeals held that the patient was entitled to discover information about discounted amounts the hospital accepted from patients who had private insurance or were covered by government programs. 52 N.E.3d 804, 805–06, 810 (Ind. Ct. App. 2016).[9]

Appellate courts have also addressed the issue in the context of determining the reasonable value of hospital services provided to patients whose insurers had no contractual relationship with the hospital at the time of emergency treatment. For example, in *Children's Hospital Central California v. Blue Cross of California*, the noncontracting insurer was required by statute to pay the hospital "the reasonable and customary value" of its services, which "embodies the concept of quantum meruit." 226 Cal.App.4th 1260, 172 Cal.Rptr.3d 861, 872 (2014). During discovery, the insurer sought admission from the hospital that all its contracts provided for payment of less than the full billed charges, as well as information regarding the number of patients for whom the hospital had received its full billed charges as payment for similar services. *Id.* at 867. The court noted that, in quantum meruit cases, "a wide variety of evidence" is accepted in determining reasonable value of services, which the court equated with fair market value. *Id.* at

872. While the hospital's full billed charges were relevant to that value, so was "the full range of fees that Hospital both charges and accepts as payment for similar services. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace." *Id.* at 873; *see also Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (holding that the amounts the hospital actually received for its services were relevant to the reasonable value of those services, particularly in light of the fact that the hospital "rarely recovers its published rates").

Finally, the United States District Court for the Southern District of Florida provided helpful analysis in a case involving a motion to dismiss a putative class action complaint challenging the reasonableness of a hospital's charges to uninsured patients. *Colomar v. Mercy Hosp., Inc.*, 461 F.Supp.2d 1265, 1267–68 (S.D. Fla. 2006). The hospital urged that an unreasonable-pricing claim required allegations—which the plaintiff did not make—that the hospital's chargemaster prices "grossly exceed" those of other hospitals in the same market. *Id.* at 1269. The district court rejected that argument, in part because the plaintiff in fact made such allegations and in part because "a market analysis is not the sole measure of evaluating reasonableness." *Id.* at 1270. Another "piece of relevant information in the inquiry," the court held, is "the prices charged to other patients [in the same hospital], and the amounts received from them, [which] may offer some insight into the value of the actual services provided." *Id.* at 1271–72. The court concluded that the plaintiff's allegation that patients with private insurance and government benefits received significant discounts for the hospital's services "suggests that the value of the services charged to Plaintiff may be significantly less than" she was asked to pay, and "if borne out during discovery, would be evidence in support of the conclusion that the charges imposed on Plaintiff [were] unreasonable." *Id.* at 1272. Finally, the court recognized that the hospital's internal cost structure could also play a role in the analysis. *Id.*

***6** These cases demonstrate at least the potential connection between reimbursement rates and the reasonableness of billed charges. *See* TEX. R. EVID. 401 (evidence is relevant if "it has any tendency to make a fact [of consequence to the action] more or less probable than it would be without the evidence"). Roberts does not argue, and we do not conclude, that reimbursement rates standing alone are dispositive of the question of what constitutes a reasonable and regular rate for a hospital's services.[10] And we recognize that many considerations go into negotiated rates that may explain a discount applied to a particular insurer. *See, e.g.*, *Bowden*, 773 S.E.2d at 697 (noting such factors as volume discounts and promises of prompt and full payment). We further recognize that government-payer reimbursement rates are not necessarily a perfect comparator in evaluating the reasonableness of a provider's charges. *See* Nation, 65 BAYLOR L. REV. at 459. But the fact that explanations exist for disparate reimbursement rates does not render them wholly immaterial. As noted, considered together, reimbursements from insurers and government payers comprise the bulk of a hospital's income for services rendered. It defies logic to conclude that those payments have nothing to do with the reasonableness of charges to the small number of patients who pay directly. *See id.* at 461 (suggesting that a good starting point for measuring the fair and reasonable value of medical services is the average of the negotiated private-insurer reimbursement amounts, with adjustments to reflect the value such insurers provide).[11]

[3]The dissent complains that this conclusion contradicts our holding in *In re National Lloyds Insurance Co.* that one party's attorney's fees in a case are generally irrelevant to the reasonableness of the opposing party's fees. 532 S.W.3d 794, 810–12 (Tex. 2017). We summarized our reasoning for that holding as follows:

> (1) the opposing party may freely choose to spend more or less time or money than would be "reasonable" in comparison to the requesting party; (2) comparisons between the hourly rates and fee expenditures of opposing parties are inapt, as differing motivations of plaintiffs and defendants impact the time and labor spent, hourly rate charged, and skill required; (3) "the tasks and roles of counsel on opposite sides of a case vary fundamentally," so even in the same case, the legal services rendered to opposing parties are not fairly characterized as "similar"; and (4) a single law firm's fees and hourly rates do not determine the "customary" range of fees in a given locality for similar services.

Id. at 808 (footnote omitted). The "fundamental" variations affecting the connection between the information sought and the end for which it was sought in *National Lloyds* are not present here. Roberts seeks reimbursement rates only for the specific services she received.[12] Further, Roberts does not argue, and we do not hold, that the rates negotiated between North Cypress and any particular insurer govern the reasonableness of its charges to uninsured patients. Rather, we hold that the trial court did not abuse its discretion in concluding that the amounts North Cypress is willing to accept as payment for services rendered to the vast majority of its patients is relevant to the reasonableness of its charges for those same services to uninsured patients. *See Haygood*, 356 S.W.3d at 393 (noting that few patients pay a hospital's full charges).

***7** Finally, we note that North Cypress does not elaborate in its briefing on its relevance objection to the information contained in its Medicare cost reports. In any event, surely for discovery purposes a hospital's costs have some bearing on the reasonableness of its patient charges. *See Colomar*, 461 F.Supp.2d at 1272 (noting that a hospital's internal cost structure could play a role in evaluating a claim of unreasonable pricing). Accordingly, we hold that the trial court did not order the production of irrelevant information.[13]

B. Confidentiality

[4]In addition to its relevance objection, North Cypress argues the confidential nature of its insurance contracts warrants mandamus relief from the trial court's order requiring their production. North Cypress first raised this argument in its motion for rehearing in the trial court. During the hearing at which the trial court denied the motion, North Cypress sought clarification on whether the court would "be willing to put in place" measures to protect its confidentiality concerns "if ultimately our mandamus is unsuccessful." The court replied that, if the parties were unable to agree on such measures, North Cypress could "file a motion for a confidentiality order" for the court's consideration.

Nothing in the record indicates that the trial court is unwilling to issue a protective order in the event North Cypress requests and demonstrates its entitlement to one. *See* TEX. R. CIV. P. 192.6. Nor does North Cypress explain why, in the event it is entitled to a protective order, such relief would be insufficient to address its concerns. Accordingly, we decline to grant mandamus relief on the ground that the contracts contain confidential and proprietary information.

III. Conclusion

The crux of Roberts' lien claim is whether the amount secured by North Cypress's hospital lien exceeds a reasonable and regular rate for the services provided. The amounts North Cypress accepts as payment for those services from other patients, including those covered by private insurance and government benefits, are relevant to whether the charges to Roberts were reasonable and are thus discoverable. We hold that the trial court did not abuse its discretion in compelling production of this information. Accordingly, we deny North Cypress's petition for writ of mandamus.

Chief Justice Hecht filed a dissenting opinion, in which Justice Green and Justice Guzman joined.

Nathan L. Hecht, Chief Justice, Dissenting

The Court holds that rates used by governmental programs like Medicare and Medicaid and by private insurers to reimburse a hospital for healthcare provided to covered patients—rates no patient ever pays out of her own pocket—are "reasonably calculated to lead to the discovery of admissible evidence" of what a patient reasonably *should* pay for healthcare.[1] How, exactly? Well, the Court says, there is "at least the potential connection"[2] between government-set and insurer-negotiated reimbursement rates and reasonable charges to a self-pay patient. Of course, the Court explains, "many considerations go into negotiated rates",[3] so "reimbursement rates standing alone are [not] dispositive of the question of what constitutes a reasonable and regular rate for a hospital's services"[4] and "are not necessarily a perfect comparator in evaluating the reasonableness of a provider's charges."[5] Agreed. So, then, what is the "potential connection" between reimbursement rates and reasonable charges to self-payers? Here, with dizzying circularity, is the Court's only answer: "It defies logic to conclude that … payments [by the government and insurers] have nothing to do with the reasonableness of charges to the small number of patients who pay directly."[6] Actually, it is the Court's analysis that defies logic.

The Court cannot distinguish this case from our decision last Term in *In re National Lloyds Insurance Co.* that one party's attorney fees in a case are generally irrelevant in determining whether an opposing party's attorney fees are reasonable.[7] Nor does the Court address our concern in that case, raised here as well, that any marginal relevance the requested discovery might have in a particular case is outweighed by the real risks of abuse and confusion of the jury.[8]

For these reasons, I respectfully dissent.

I

Seven years ago in *Haygood v. De Escabedo*, the Court observed that "it has become increasingly difficult to determine what [healthcare] expenses are reasonable."[9] While an individual healthcare provider, like any service provider, must take into account its costs, profit margins, and market—including its experience, expertise, and location—in setting its charges, governmental regulation and private insurance have driven charges for healthcare into a now-familiar, two-tiered structure.[10] The higher tier consists of the "full" or "list" prices set out in a detailed "chargemaster" for each service, similar to the "sticker price" of a new car.[11] The lower tier includes the reimbursement rates set by governmental insurers like Medicare and Medicaid or negotiated with private insurers.[12] Governmental insurers provide one- to two-thirds of most American hospitals' income, and their reimbursement rates, usually based

on patient diagnoses, may not even cover a procedure's cost.[13] The amount a private insurer is willing to pay to a hospital for a particular service—and the amount that a hospital is willing to accept—reflects a number of factors including the volume of patients that the insurer has previously or potentially could direct to that hospital and the insurer's promise of prompt payment.

Because reimbursement rates are often percentages of or influenced by list prices, providers are incentivized to set list prices as high as possible.[14] List prices are usually multiple times reimbursement rates.[15] Each patient is charged the list price.[16] If the patient is insured, the price is reduced to the set or negotiated reimbursement rates.[17] If the patient is not insured, a provider may choose to reduce charges based on the patient's means, and in some instances, provide care free of charge for charity.[18] But it is not required to do so.[19] Healthcare providers generally contend, as does North Cypress, that list prices and reimbursement rates are both reasonable charges *under the circumstances*—that is, depending on whether the patient is or is not insured. There is no demonstrated relationship between reimbursement rates and prices regularly charged to uninsured patients.

It is unreasonable to limit a hospital to charging an uninsured patient insurer-negotiated reimbursement rates. The patient cannot confer on the hospital benefits of a predictable volume of business or ease of payment as an insurer can. As we explained in *Haygood*, the benefit of an insurer's discounted rate belongs to the insurer, not the insured.[20] It certainly does not belong to an uninsured patient. Nor can reimbursement rates, which vary from insurer to insurer, be used to determine reasonable charges for uninsured patients. The Court cannot suggest a formula for doing so. And because governmental reimbursement rates are often below a hospital's costs, they can provide no basis for gauging the reasonableness of charges to uninsured patients. In sum, none of the information at issue that North Cypress has been ordered to produce in discovery can be used to determine whether its charges to Roberts were reasonable.

Rather, a reasonable charge to Roberts would be what North Cypress, and perhaps other similarly situated hospitals, regularly charge uninsured patients. The record indicates that North Cypress based its charges to Roberts on its list prices, reduced by exactly 25%. Roberts does not argue, and there is nothing to indicate, that North Cypress ever gave a different discount to another patient in Roberts' position or that it discriminated against her in any way. Nor does Roberts argue, or anything suggest, that North Cypress based its charges to Roberts or other self-payers on reimbursement rates. To the contrary, the evidence is undisputed that North Cypress charged Roberts 25% of its list prices. Thus, contrary to the Court's "logic", nothing in North Cypress' reimbursement rates can show that the charges to Roberts were either reasonable or unreasonable. The reimbursement rates are purely irrelevant. Suppose North Cypress' list price for a procedure were $200, Medicare would reimburse $25, and 3 private insurers would reimburse $90, $100, and $110, respectively. Would a $150 charge to all uninsured patients be reasonable or unreasonable? There is simply no way to tell. Roberts has not shown that lower reimbursement rates for insured patients can lead to admissible evidence of reasonable charges for uninsured patients. That evidence is of the usual and customary prices regularly charged uninsured patients.

II

We have recently granted mandamus relief from orders requiring discovery of irrelevant information in comparable situations. The Court cannot distinguish those cases.

Just last Term, in *In re National Lloyds Insurance Co.*, insured homeowners suing their insurer for underpaying property-damage claims sought discovery of the insurer's attorney fees to show the reasonableness of their own attorney fees.[21] The trial court ordered production.[22] We held that one party's attorney fees are generally irrelevant in determining the reasonableness of an opposing party's attorney fees.[23] What a lawyer of particular experience and position would charge a client to advance its position in litigation is ordinarily irrelevant in determining what another lawyer would charge a different client to advance the opposing position.[24]

In a similar case identically styled, another homeowner, also suing her insurer for underpaying her property-damage claim, sought discovery of the insurer's claim files for other homes in the same town damaged by the same storm.[25] The homeowner argued that the other claim files could be used to "establish[ ] a baseline" to compare the adjustment of her claim.[26] "[W]e fail[ed] to see how [the insurer's] overpayment, underpayment, or proper payment of the claims of unrelated third parties [was] probative of" whether the plaintiff's claim had been undervalued.[27] We noted "the many variables" that would affect evaluation of a claim, "such as when the claim was filed, the condition of the property at the time of filing (including the presence of any preexisting damage), and the type and extent of damage inflicted by the covered event."[28] And we characterized the plaintiff's proposed strategy of "[s]couring claim files in hopes of finding similarly situated claimants whose claims were evaluated differently" as "an 'impermissible fishing expedition.' "[29]

Evidence of how other property-damage claims were valued does not generally lead to admissible evidence that another claim was undervalued. Evidence of what one party paid its lawyer to take one position in a case does not generally lead to admissible evidence that the attorney fees an opposing party paid her lawyer to take a different position were reasonable. By the same token, evidence of healthcare reimbursement rates set by the government or negotiated by private insurers does not lead to admissible evidence that prices charged a self-paying patient, without reference to reimbursement rates, were unreasonable.

III

In last Term's *National Lloyds* opinion, the Court added that "[e]ven if a party's attorney-billing information were marginally relevant to an opposing party's fee claim, discovery of such information should ordinarily be denied because the 'probative value is substantially outweighed by the danger of ... unfair prejudice, confusion of the issues, misleading the jury, undue delay, or needlessly presenting cumulative evidence.' "[30] The court must limit discovery when its burden outweighs its likely benefit.[31]

North Cypress billed Roberts $11,037.75. The insurer of the man responsible for the auto accident offered to settle Roberts' claim against him for $17,380, of which $9,404 was for past medical expenses. Roberts asked North Cypress to reduce its bill to $3,500, based on her counsel's estimation of "the reasonable and necessary charges ... for the treatment received based on the geographic area and similarly sized facilities." North Cypress agreed to a 25% reduction, to $8,278.31. Roberts asked for a further reduction to $6,269.33, two-thirds of the amount offered by the tortfeasor's insurer. When North Cypress refused to lower its bill by another $2,000, Roberts sued for actual and punitive damages under statutes governing deceptive trade practices, debt collection, and fraudulent liens.[32] The discovery ordered by the trial court has brought the parties to this Court in a dispute over $2,000–$5,000.

North Cypress contends that the information Roberts seeks is proprietary and confidential and should be subject to a protective order. That will add to the expense of the case. Further, amici raise the concern that hospitals, faced with this kind of litigation and concerned that the confidentiality of their negotiations with insurers cannot be protected, will simply cave in to demands of uninsured patients and attempt to shift the costs of their treatment to insured patients or suffer the loss of income. If the confidential information were directly relevant to Roberts' claim, the concerns the amici raise might be unavoidable. But when neither Roberts nor the Court can state how reimbursement rates can be used to show that charges to self-payers are unreasonable, the discovery should not more be allowed than in the *National Lloyds* cases.

* * * * *

Cost and delay are the prevalent criticisms of the American civil justice system, and the main contributor to both is discovery.[33] " 'Discovery is often the most significant cost of litigation' and a potential 'weapon capable of imposing large and unjustifiable costs on one's adversary.' "[34] Discovery is an essential tool in our system for ascertaining the truth in civil cases. But it can also be an abusive weapon to thwart justice. Which one depends entirely on court supervision.

I would grant relief.

All Citations

--- S.W.3d ----, 2018 WL 1974376

Footnotes

1 Roberts initially requested that the bill be reduced to $3,500, which she characterized as "the reasonable and necessary charges ... for the treatment received based on the geographic area and similarly sized facilities." North Cypress offered to reduce the bill to $8,278.31, and Roberts countered with $6,269.33. North Cypress declined. The hospital-lien amount remains $11,037.

2 Roberts also asserted claims for fraudulent lien filing and for violations of the Texas Deceptive Trade Practices Act and the Texas Debt Collection Act. She further claimed that the lien is invalid because she was never formally admitted to the hospital. These claims are not relevant to the instant discovery dispute.

[3] Notwithstanding these statements in *Bashara* and *Linnstaedter*, amici curiae Christus Health and Texas Health Resources argue that the hospital's charges for services rendered, as distinguished from physician charges and "charges for other services," need not be "reasonable" to be covered by a valid hospital lien. *Compare* TEX. PROP. CODE § 55.004(b) ("A hospital lien ... is for the amount of the hospital's charges for services provided ...."), *with id.* § 55.004(c) ("A hospital lien ... may also include the amount of a physician's reasonable and necessary charges for emergency hospital care services provided ...."), *and id.* § 55.004(d) ("A hospital lien ... does not cover ... charges for other services that exceed a reasonable and regular rate for the services [.]"). North Cypress does not make this argument and has consistently taken the position that its charges are reasonable. Accordingly, we do not address the statutory-interpretation argument amici present.

[4] Amici curiae Parkland Health & Hospital System, Hunt Regional Medical Center, Christus Health, Texas Health Resources, and Memorial Hermann Health System submitted briefs in support of North Cypress's petition.

[5] Amici curiae The Alliance of Claims Assistance Professionals, The Fuentes Firm, P.C., and Research & Planning Consultants, LP, submitted briefs in support of Roberts.

[6] The author of these two law review articles, George A. Nation III, is counsel of record for amicus curiae The Alliance of Claims Assistance Professionals.

[7] North Cypress accuses Roberts of utilizing the full amount of the billed charges to negotiate a favorable settlement with the liability insurer and then seeking a windfall by challenging those charges as unreasonable. To the extent North Cypress asserts some sort of estoppel defense in the underlying suit, we fail to see how it forecloses discovery on a central issue.

[8] North Cypress contends that it "charges all patients the same thing for any particular service, regardless of whether the patient has health insurance." This argument reflects the fact that chargemaster prices are technically listed on all patient bills, but ignores the fact that, for insured patients, the amount actually accepted as payment after applying the negotiated discount is typically far lower. *Haygood*, 356 S.W.3d at 391 (noting the "great disparities between amounts billed and payments accepted" from insurers).

[9] Not all courts agree on the relevance of such information. In *Parnell v. Madonna Rehabilitation Hospital, Inc.*, for example, the Nebraska Supreme Court upheld summary judgment for the hospital on the amount of its hospital lien. 258 Neb. 125, 602 N.W.2d 461, 464–65 (Neb. 1999). Noting that the statute at issue provided for a lien on the amount due for the hospital's "usual and customary charges," the court summarily held that consideration of the "amounts actually collected," rather than the amount charged, would contravene the statute's plain language. *Id.* at 464. Importantly, however, the statute at issue in *Parnell* did not contain a reasonableness requirement. And while the court correctly noted the unremarkable proposition that amounts charged and amounts collected are two different things, it failed to explain why they are wholly unrelated.

[10] We express no opinion on the reasonableness of the charges secured by North Cypress's hospital lien in this case, as the merits of Roberts' claims are not before us. The issue presented is limited to whether certain information is discoverable.

[11] The dissent concludes that "a reasonable charge to Roberts would be what North Cypress, and perhaps other similarly situated hospitals, regularly charge uninsured patients." *Post* at ––––. But as we have recognized, in most cases hospitals simply do not expect to collect anywhere close to the amounts they officially charge. *Haygood*, 356 S.W.3d at 393; Tompkins, 25 HEALTH AFF. at 48. We disagree that rates a hospital does not expect to collect are more relevant than amounts they accept.

[12] By contrast, in *In re National Lloyds Insurance Co.*, we held that an insured homeowner suing her insurer for underpayment of her property-damage claim was not entitled to discovery of her insurer's claim files relating to other homeowners who suffered property damage during the same storm. 449 S.W.3d 486, 490 (Tex. 2014). Given the individual nature of the condition of the properties and the damage inflicted, we held that the insurer's "overpayment, underpayment, or proper payment of the claims of unrelated third parties" was not relevant to whether the insurer properly compensated the plaintiff. *Id.* at 489. In this case, Roberts is asking for the amounts North Cypress accepts as payment on behalf of other patients for the exact same services.

[13] With respect to private insurance contracts, Roberts requested North Cypress's "contracts regarding negotiated or reduced rates for the hospital services provided to Plaintiff." We do not read this request to seek the contracts in their entirety. Rather, Roberts requested, and the trial court ordered, production of those portions of the contracts that reflect the specific rate information identified. Roberts does not contend that any other information contained in those contracts is relevant to her claims.

[1] *Ante* at ––– (quoting TEX. R. CIV. P. 192.3(a)).

[2] *Ante* at ––––.

[3] *Ante* at ––––.

[4] *Ante* at ––––.

[5] *Ante* at ––––.

[6] *Ante* at ––––.

[7] 532 S.W.3d 794, 812–813 (Tex. 2017) (orig. proceeding).

[8] *Id.* at 813.

[9] 356 S.W.3d 390, 391 (Tex. 2011).

[10] *Id.* at 393 & n.13.

[11] *Id.* at 393; Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. HEALTH CARE L. & POL'Y 363, 366 (2007).

[12] *Haygood*, 356 S.W.3d at 393.

[13] *See* George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 459 (2013) ("There is a significant body of research suggesting that the reimbursement[ ] rates paid by government insurers such as Medicare and Medicaid are actually below fully allocated cost for most hospitals."); Peters, *supra* note 11 at 367 ("Medicare's reimbursement rates do not typically cover the actual cost of providing health care to a hospital's patients.").

[14] *Haygood*, 356 S.W.3d at 393.

[15] *See* George A. Nation, III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 104 (2005–2006) (stating that a hospital's list prices "are generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services" from a private or governmental insurer), *cited in Haygood*, 356 S.W.3d at 393 n.17.

[16] *Haygood*, 356 S.W.3d at 394.

[17] *Id.* n.20.

[18] *Id.* at 393 n.14.

[19] Of course, a healthcare provider is free to charge whatever it chooses for its services, whether reasonable or not, just as any service provider can, and the consumer is free to choose another healthcare provider that charges less. But patients are not usually in a position to investigate and compare different hospitals' charges, and obviously they cannot do so when they present to the emergency room. Amici curiae Christus Health and Texas Health Resources argue that not all charges secured by a lien under the Hospital Lien Act need be reasonable. They point out that a lien can include only reasonable and necessary charges for a physician's emergency hospital care, TEX. PROP. CODE § 55.004(c), and does not cover charges for emergency medical services or other services that exceed a reasonable and regular rate, *id.* § 55.004(d)(1), (g)(1), but otherwise "[a] hospital lien ... is for the amount of the hospital's charges for services provided", *id.* § 55.004(b). *But see Daughters of Charity Health Servs. v. Linnstaedter*, 226 S.W.3d 409, 411 (Tex. 2007) (stating that "[t]he lien amount cannot be more than 'a reasonable and regular rate' " (quoting § 55.004(d)(1))); *Bashara v. Baptist Mem'l Hosp. Sys.*, 685 S.W.2d 307, 309 (Tex. 1985) (stating that "the statute ... is replete with language that the hospital recover the full amount of its lien, subject only to the right to question the reasonableness of the charges comprising the lien"). North Cypress does not argue that it can charge Roberts unreasonable prices for the services it provided her. Rather, it argues that its charges to her were reasonable.

[20] *See* 356 S.W.3d at 395 ("An adjustment in the amount of [a provider's full] charges to arrive at the amount owed is a benefit to the insurer, one it obtains from the provider for itself, not for the insured.").

21 532 S.W.3d 794, 799–800, 809 (Tex. 2017) (orig. proceeding).

22 *Id.* at 801.

23 *Id.* at 812–813.

24 *See id.* at 810–812.

25 *In re Nat'l Lloyds Ins. Co.*, 449 S.W.3d 486, 487–488 (Tex. 2014) (per curiam) (orig. proceeding).

26 *Id.* at 489.

27 *Id.*

28 *Id.*

29 *Id.* (quoting *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813, 815 (Tex. 1995) (per curiam) (orig. proceeding)); *see, e.g.*, *In re State Farm Lloyds*, 520 S.W.3d 595, 611 (Tex. 2017) (orig. proceeding) ("Reasonable discovery does not countenance a 'fishing expedition.' "); *In re Alford Chevrolet–Geo*, 997 S.W.2d 173, 181 (Tex. 1999) (orig. proceeding) ("[D]iscovery may not be used as a fishing expedition or to impose unreasonable discovery expenses on the opposing party.").

30 *In re Nat'l Lloyds Ins. Co.*, 532 S.W.3d 794, 813 (Tex. 2017) (orig. proceeding) (omission in original) (quoting TEX. R. EVID. 403).

31 TEX. R. CIV. P. 192.4(b); *see also In re State Farm Lloyds*, 520 S.W.3d at 615 ("[P]roportionality is the polestar.").

32 Roberts has pleaded claims under the Texas Deceptive Trade Practices–Consumer Protection Act, TEX. BUS. & COM. CODE § 17.41 *et seq.*, the Texas Debt Collection Act, TEX. FIN. CODE § 392.001 *et seq.*, and the Fraudulent Lien Act, TEX. CIV. PRAC. & REM. CODE § 12.001 *et seq.* She seeks actual and exemplary damages, attorney fees, and declaratory relief. She also claims that North Cypress' lien is invalid because she was never formally admitted for treatment, but this claim does not involve the discovery dispute before us.

33 INST. FOR THE ADVANCEMENT OF THE AM. LEGAL SYS., FINAL REPORT ON THE JOINT PROJECT OF THE AMERICAN COLLEGE OF TRIAL LAWYERS TASK FORCE ON DISCOVERY AND CIVIL JUSTICE AND IAALS 2 (2009).

34 *In re Nat'l Lloyds*, 532 S.W.3d at 813 (quoting *In re Alford Chevrolet–Geo*, 997 S.W.2d at 180).

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IRONSHORE

2018 WL 2012009
Only the Westlaw citation is currently available.

Superior Court of New Jersey,
Appellate Division.

IRONSHORE INDEMNITY, INC., Plaintiff-Respondent,
v.
PAPPAS & WOLF, LLC, HERCULES PAPPAS and MATTHEW S. WOLF, Defendants.
MICHAEL P. POMPEO, As Assignee Of The Claims of PAPPAS & WOLF, LLC and HERCULES PAPPAS, Appellants.
DOCKET NO. A-0959-16T1

Argued April 23, 2018

Decided May 1, 2018

On appeal from Superior Court of New Jersey, Law Division, Essex County, Docket No. L-9918-13.

Attorneys and Law Firms
Jeffrey S. Lipkin argued the cause for appellants.

Matthew P. O'Malley argued the cause for respondent (Tompkins, McGuire, Wachenfeld & Barry, LLP, attorneys; Matthew P. O'Malley and William C. Kelly, of counsel and on the brief).

Before Judges Fasciale and Sumners.

Opinion

PER CURIAM

***1** This is a legal malpractice insurance coverage case. The parties disputed whether the attorney materially misrepresented important information when his firm filled out an insurance renewal application. Specifically, the question is whether – under a totality of the circumstances – the attorney misrepresented that there existed no potential legal malpractice claims, when in fact he knew otherwise. The carrier learned about this misrepresentation and denied insurance coverage.

The case reaches us after the judge entered orders concluding that the misrepresentation justified the denial. The basis of the attorney's knowledge of the potential claims came from his association with a former client. After the carrier filed this complaint, the attorney and his firm assigned their rights to a receiver who was previously appointed in an action against the attorney's former client.

Michael P. Pompeo (the Receiver) – the court appointed receiver for the former client Carr Miller Capital, LLC, (CMC) and Everett Miller (Miller),[1] and as assignee of the claims of Pappas & Wolf, LLC, and Hercules Pappas (Pappas) (collectively Pappas Defendants) – therefore appeals from two October 21, 2016 orders. One order granted the carrier's, Ironshore Indemnity Inc. (Ironshore), motion for summary judgment; and the other order denied the Receiver's cross-motion for partial summary judgment. We affirm.

In December 2013, Ironshore filed this complaint for declaratory judgment against its insureds – Pappas Defendants and Matthew S. Wolf (Wolf)[2] –seeking a judicial determination there was no insurance coverage for an underlying legal malpractice claim due to the misrepresentation. The Receiver, by way of a settlement agreement and consent order that he had entered into with Pappas

Defendants,[3] then filed an answer and counterclaim, which sought a judicial determination that the insurance policy provided coverage for the underlying legal malpractice claim.

On appeal, the Receiver (on behalf of Pappas Defendants) contends the judge erred by determining that Pappas Defendants made the material misrepresentation in the renewal application.

When reviewing an order granting summary judgment, we apply "the same standard governing the trial court." Oyola v. Liu, 431 N.J. Super. 493, 497 (App. Div. 2013). A court should grant summary judgment when the record reveals "no genuine issue as to any material fact" and "the moving party is entitled to a judgment or order as a matter of law." R. 4:46-2(c). We owe no deference to the motion judge's conclusions on issues of law. Manalapan Realty, LP v. Twp. Comm. of Manalapan, 140 N.J. 366, 378 (1995). Both parties moved for summary judgment, but because the judge granted judgment in favor of Ironshore, we consider the facts in a light most favorable to the Receiver. Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 523 (1995).

***2** The Receiver asserts that no reasonable trier of fact could conclude that Pappas was aware of a basis for a potential legal malpractice claim against him. The crux of the issue lies in Pappas & Wolf's assertion in its renewal application with Ironshore for continued professional liability insurance dated August 22, 2011. In the renewal application, Pappas & Wolf responded "no" to the following question (Prior Knowledge Question):

> After inquiry, does any firm member know of any circumstance, situation, act, error or omission that could result in a professional liability claim or suit against the firm or its predecessor firm(s) or any current or former member of the firm or its predecessor firm(s)?

"[I]t is well established in this State that an attorney will not have access to insurance coverage to respond to claims from injured third parties, [or] clients, ... if the professional liability insurance policy has been rescinded due to the attorney's misrepresentations of material fact in the policy application." DeMarco v. Stoddard, 223 N.J. 363, 378 (2015).

The Receiver asserts the judge properly acknowledged that a subjective standard applies when considering a challenge to an insured's prior knowledge representation. The parties agree that the Court adopted such a standard in Liberty Surplus Insurance Corp. v. Nowell Amoroso, PA, 189 N.J. 436 (2007). In Nowell Amoroso, our Supreme Court "upheld the entry of summary judgment in favor of the insurer in a declaratory judgment action seeking rescission ab initio of a legal malpractice liability insurance policy due to misrepresentations of material fact in the policy application." DeMarco, 223 N.J. at 377 (citing Nowell Amoroso, 189 N.J. at 450). But the Receiver maintains that the judge disregarded the subjective standard when making his material factual determination.

The subjective standard examines an individual's state of mind. "Generally, when the 'subjective elements of willfulness, intent or good faith of the moving party are material to the claim or defense of the opposing party, a conclusion from papers alone that palpably there exists no genuine issue of material fact will ordinarily be very difficult to sustain.'" Nowell Amoroso, 189 N.J. at 447 (quoting Judson v. Peoples Bank & Tr. Co., 17 N.J. 67, 76 (1954)). However, "subjective intent may not be controlling when the undisputed facts[, like here,] reveal otherwise." Ibid. This is so because "our courts have determined [a principle in which] the character of the act can be the basis of an inference that the insured intended the injury." Morton Int'l, Inc. v. Gen. Accident Ins. Co. of Am., 266 N.J. Super. 300, 329-330 (App. Div. 1991), aff'd, 134 N.J. 1 (1993).

> This principle makes the actor's testimony about subjective intent less than controlling but allows a judge to conclude, from the circumstances of the act, what the actor's real intent was, despite verbal protestations to the contrary. It restrains the court from "ignor[ing] reality" and accepting "the testimony of the insured" that he "did not intend to injure plaintiff" despite the fact that a "reasonable analysis [of the circumstances] requires the conclusion that from the very nature of the act harm must have been intended."
>
> [Id. at 330 (alterations in original) (quoting State Farm Fire & Casualty Co. v. Victor, 232 Neb. 942, 946 (1989)).]

In applying the subjective standard and this principle, the judge concluded:

> ***3** It thus appears clear that at least by the time the Pappas [D]efendants completed the renewal application for coverage from Ironshore in August 2011, they were actually aware of [the] possibility of a lawsuit. And common sense really supports the [d]eposition testimony of Pappas. That he must have, when you look at that [d]eposition testimony, combined with ... the totality of facts in this case, that he was aware of some claim ... being brought against him in his capacity as an attorney.

Importantly, the judge relied on Pappas' deposition testimony that in December 2010, nearly nine months before Wolf filled out the renewal application, he was concerned about a claim being asserted against him as an attorney because of the New Jersey Bureau of Securities action against CMC.

The Receiver contends that the judge erroneously relied on this portion of Pappas' testimony because Pappas was purportedly concerned in general about any claim being brought against him, not specifically legal malpractice claims, and Pappas later testified that he was not concerned about legal malpractice claims. This distinction is unpersuasive. As the judge noted, Pappas held himself out as an attorney, and in effect CMC's attorney. Any claim against him as an attorney would likely result in a claim with his liability insurance –Ironshore. As Pappas testified that he was concerned about a claim being brought against him as an attorney, any such claim should have been disclosed to Ironshore, and therefore the Prior Knowledge Question required an affirmative response.

Regardless of Pappas' testimony, the subjective standard is overcome by a reasonable analysis of the circumstances. And here, there is overwhelming credible evidence showing Pappas knew of potential relevant claims. At CMC's inception in 2006, it retained Pappas' prior law firm as outside counsel before hiring Pappas as in-house counsel in 2008. As in-house counsel, Pappas accompanied Miller on trips related to CMC projects; worked fourteen-hour days; and served on the board of a corporation that CMC loaned significant funds, in order to protect CMC's interest. When Pappas resigned as CMC's in-house counsel in September 2009, he wrote to Miller stating that, "[a]s of late, I have learned from you that [CMC] is having some solvency issues, as well as some potential legal issues pertaining to the operation of the company." After Pappas resigned, Pappas & Wolf continued to serve as CMC's outside counsel. From the start, Pappas had intimate involvement with CMC and Miller.

When the Attorney General sued CMC and Miller for securities-related fraud in December 2010, Pappas was not named as a defendant, but according to his testimony, he was concerned about claims against him as an attorney because "things happened, lawsuits get filed and people get sued." Looking at the totality of the circumstances, the judge found it "[h]ard to believe" that Pappas felt immune to legal malpractice claims because he hired outside counsel for securities-related advice in January 2009 – nearly two and a half years after he began counseling CMC.

Pappas Defendants, from our de novo review of the record, made a material misrepresentation in the renewal application by responding "no" to the Prior Knowledge Question. Such a misrepresentation justified Ironshore's denial of coverage. Consequently, Ironshore was entitled to summary judgment as a matter of law.

Affirmed.

All Citations
Not Reported in A.3d, 2018 WL 2012009

Footnotes

1 In February 2011, the Receiver was appointed in an action by the Attorney General of New Jersey, on behalf of the New Jersey Bureau of Securities, against Miller and CMC, alleging violations of New Jersey securities laws. In May 2011, a judge entered an order providing for the Receiver's permanent retention as Receiver for Miller and CMC.

2 All claims against Wolf were later dismissed.

3 In August 2012, the Receiver commenced a civil action against Pappas Defendants alleging they committed professional legal malpractice in connection with their representation of CMC.

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KALKANIS

2018 WL 2035041 (S.D.N.Y.) (Trial Pleading)
United States District Court, S.D. New York.

UNITED STATES OF AMERICA,
v.
Peter KALKANIS, Bryan Duncan, Kerry Gordon, a/k/a "Curry," Robert Locust, and Ryan Rainford, a/k/a "Ace", Defendants.
No. 1:18CR00289.
April 17, 2018.

Sealed Indictment

Geoffrey S. Berman, United States Attorney.

COUNT ONE
(Conspiracy to Commit Mail and Wire Fraud)

The Grand Jury charges:

OVERVIEW OF THE SCHEME

1. From at least in or about January 2013, up to and including April 2018, in the Southern District of New York and elsewhere, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, together with others known and unknown, carried out a widespread mail and wire fraud scheme through which the defendants defrauded businesses and insurance companies by staging slip-and-fall accidents and filing fraudulent lawsuits arising from those staged slip-and-fall accidents (the "Fraud Scheme"). The Fraud Scheme generally operated as follows:

a. Fraud Scheme participants recruited individuals (the "Recruited Patients") to stage slip-and-fall accidents at particular locations throughout New York City (the "Accident Sites"). In some instances, the Recruited Patients did not actually stage a slip-and-fall accident but, instead, were provided with an address that they were instructed to claim was the location where they slipped and fell.

b. The Recruited Patients were directed to claim that they had injured themselves and to seek medical treatment. In particular, the Recruited Patients were directed to claim injuries to certain areas of their bodies, including the knees, shoulders, and/or back.

c. The Recruited Patients were then brought to an attorney who represented them in connection with a lawsuit (the "Fraudulent Lawsuits") against the owners of the Accident Sites and/or the insurance company of the owners of the Accident Sites (the "Victims"). The Fraudulent Lawsuits did not disclose that the Recruited Patients had deliberately fallen at the Accident Sites, or that the Recruited Patients had never fallen at the Accident Sites. Instead, the Fraudulent Lawsuits claimed that the Recruited Patients' injuries were solely caused by the negligence of the Victims. During the course of the Fraud Scheme, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, together with others known and unknown, attempted to defraud the Victims of at least $31,791,000.

d. The Recruited Patients were also instructed to receive ongoing treatment from a chiropractor in order to provide medical records in support of the Fraudulent Lawsuits.

e. The Fraud Scheme participants referred the Recruited Patients to a particular MRI facility as well as particular doctors.

f. The Fraud Scheme participants advised the Recruited Patients that if they intended to continue with their Fraudulent Lawsuit, they were required to undergo surgery. As an incentive to undergo surgery, the Recruited Patients were offered a payment after they completed surgery as well as a percentage of any settlement payment from their Fraudulent Lawsuit.

g. The legal and medical fees of the Recruited Patients were usually paid for by legal funding companies.

RELEVANT PERSONS

2. At all relevant times to this Indictment, PETER KALKANIS, the defendant, a former Chiropractor, was the organizer and leader of the Fraud Scheme. Among other things, KALKANIS paid other Fraud Scheme participants, referred to as "Runners," to recruit patients and transport the Recruited Patients to and from their medical and legal appointments. KALKANIS organized the Recruited Patients' legal and medical appointments, and assisted in procuring the funding for the Recruited Patients' medical treatment and Fraudulent Lawsuits.

3. At all relevant times to this Indictment, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, were "Runners." Among other things, they helped recruit patients into the Fraud Scheme, transported patients to medical and legal appointments, identified potential Accident Sites, and coached Recruited Patients on faking their injuries. DUNCAN, GORDON, LOCUST, and RAINFORD, at various times, were paid by PETER KALKANIS, the defendant, for their assistance in the Fraud Scheme. Some of the Runners, including RAINFORD, were responsible for paying the Recruited Patients after they underwent surgery.

STATUTORY ALLEGATIONS

4. From at least in or about January 2013, up to and including the present, in the Southern District of New York and elsewhere, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, together with others known and unknown, willfully and knowingly, did combine, conspire, confederate, and agree, together and with each other, to violate Title 18, United States Code, Sections 1341 and 1343.

5. It was a part and object of the conspiracy that PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, together with others known and unknown, willfully and knowingly having devised and intending to devise a scheme and artifice to defraud, and for obtaining money and property by means of false and fraudulent pretenses, representations and promises, for the purpose of executing such scheme and artifice, would and did place in a post office and authorized depositories for mail matter, matters and things to be sent and delivered by the Postal Service, and did deposit and cause to be deposited matters and things to be sent and delivered by private and commercial interstate carriers, and would and did take and receive therefrom, such matters and things, and would and did cause to be delivered by mail and such carriers according to directions thereon, and at the places at which they were directed to be delivered by the person to whom they were addressed, such matters and things, in violation of Title 18, United States Code, Section 1341.

6. It was further a part and object of the conspiracy that PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, together with others known and unknown, willfully and knowingly, having devised and intending to devise a scheme and artifice to defraud and for obtaining money and property by means of false and fraudulent pretenses, representations, and promises, would and did transmit and cause to be transmitted by means of wire, radio, and television communications in interstate and foreign commerce, writings, signs, signals, pictures, and sounds for the purpose of executing such scheme and artifice, in violation of Title 18, United States Code, Section 1343.

(Title 18, United States Code, Section 1349)

COUNT TWO
(Mail Fraud)

The Grand Jury further charges:

7. The allegations contained in paragraphs 1 through 3 of this Indictment are repeated and realleged as if fully set forth herein.

8. From at least in or about January 2013, up to and including April 2018, in the Southern District of New York and elsewhere, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, willfully and knowingly, having devised and intending to devise a scheme and artifice to defraud, and for obtaining money and property by means of false and fraudulent pretenses, representations, and promises, for the purpose of executing such

scheme and artifice and attempting so to do, would and did place in a post office and authorized depositories for mail matter, matters and things to be sent and delivered by the Postal Service, and did deposit and cause to be deposited matters and things to be sent and delivered by private and commercial interstate carriers, and would and did take and receive therefrom, such matters and things, and did cause to be delivered by mail and such carriers according to the directions thereon, and at the places at which they were directed to be delivered by the person to whom they were addressed, such matters and things, to wit, KALKANIS, DUNCAN, GORDON, LOCUST, and RAINFORD caused legal correspondence to be mailed to attorneys in Manhattan, New York, in furtherance of fraudulent lawsuits against businesses and insurance companies.

(Title 18, United States Code, Sections 1341 and 2.)

COUNT THREE
(Wire Fraud)

The Grand Jury further charges:

9. The allegations contained in paragraphs 1 through 3 of this Indictment are repeated and realleged as if fully set forth herein.

10. From at least in or about January 2013, up to and including April 2018, in the Southern District of New York and elsewhere, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, willfully and knowingly, having devised and intending to devise a scheme and artifice to defraud, and for obtaining money and property by means of false and fraudulent pretenses, representations, and promises, did transmit and cause to be transmitted by means of wire, radio, and television communication in interstate and foreign commerce, writings, signs, signals, pictures, and sounds for the purpose of executing such scheme and artifice, to wit, KALKANIS, DUNCAN, GORDON, LOCUST, and RAINFORD used their cellphones and email accounts to send communications to a litigation funding company located in New Jersey in furtherance of the wire fraud scheme.

(Title 18, United States Code, Sections 1343 and 2.)

COUNT FOUR
(Aggravated Identity Theft)

The Grand Jury further charges:

11. The allegations contained in paragraphs 1 through 3 of this Indictment are repeated and realleged as if fully set forth herein.

12. In or about November 2014, in the Southern District of New York and elsewhere, PETER KALKANIS, the defendant, knowingly did transfer, possess, and use, without lawful authority, a means of identification of another person, during and in relation to a felony violation enumerated in Title 18, United States Code, Section 1028A(c), and aided and abetted the same, to wit, KALKANIS possessed and used the names and identities of other persons to obtain litigation loans, in connection with the offenses Charged in Counts One, Two, and Three of this Indictment.

(Title 18, United States Code, Sections 1028A(a)(1), 1028A(b), and 2.)

FORFEITURE ALLEGATIONS

13. As a result of committing the offenses alleged in Counts One, Two, and Three of this Indictment, PETER KALKANIS, BRYAN DUNCAN, KERRY GORDON, a/k/a "Curry," ROBERT LOCUST, and RYAN RAINFORD, a/k/a "Ace," the defendants, shall forfeit to the United States, pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and Title 28, United States Code, Section 2461(c), any and all property, real and personal, that constitutes or is derived from, proceeds traceable to the commission of said offenses, including but not limited to a sum of money in United States currency representing the amount of proceeds traceable to the commission of said offenses that the defendants personally obtained.

Substitute Assets Provision

14. If any of the above-described forfeitable property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p) and Title 28, United States Code, Section 2461(c), to seek forfeiture of any other property of the defendants up to the value of the above forfeitable property.

(Title 18, United States Code, Section 981; Title 21, United States Code, Section 853; and Title 28, United States Code, Section 2461.)

<<signature>>
Foreperson

<<signature>>
GEOFFREY S. BERMAN
United States Attorney

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