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What's in a Word? The Tortured Life of the Virginia Conspiracy Statute Va. Code §§ 18.2-499 and -500

by J. Scott Sexton

Conspiracy

The Virginia statutory conspiracy statute was once codified as part of the antitrust laws of Virginia. Va. Code §59-21/1 (Cum. Supp. 1962). In 1964, the statute was moved to the criminal code with more severe sanctions. Va. Code §18.1-74.1:1 (superseded). The words of this simple statute have confounded litigants and judges now for more than 40 years, presenting a moving target of judicial interpretation that, even today, makes this perhaps the most misunderstood of all statutes. By all accounts, its use is disfavored by the bench (except when it isn't). The difficulty for litigants is trying to discern those occasions in which the courts will apply the plain meaning of the statute from those where the statute will be interpreted into something else. This article is designed to help the unwary understand this history and to predict success or failure with future cases. Focusing generally on the history of interpretation of the statute, this article highlights two areas that are commonly targets for claims of statutory conspiracy: (1) employment issues; and (2) interference with contract or business relations.

While based on statute, the interpretation and terminology of the statutorily stated requirements

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for a claim under the statute have changed over the years, and a review of that history and the more recent cases is very instructive as to the current state of the law. It begins, however, with the statute itself.

The Conspiracy Statute

18.2-499-500 provides:

Any two or more persons who combine, associate, agree, mutually undertake or concert for the purpose of (i) willfully and maliciously injuring another in his reputation, trade, business or profession by any means whatever...shall be jointly and severally guilty...

Va. Code §18.2-499 (emphasis added)

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Letter from the Chair

The Ombudsman

In the last year or so, there have been some unfortunate exchanges between sitting judges and members of the bar. These matters get picked up by the press, and they get reported in the statewide legal media, if not the general circulation newspapers. It does not reflect well on our profession, especially when tempers are lost and comments are made which all sides later regret.

This series of events brings to mind a conversation I had with an out-of-state attorney a few years ago. At the time, as a relatively new member of the Litigation Section Board of Governors, I surveyed some of our litigating brethren in surrounding states to see what services of interest their state and local bars had developed. One local bar had developed an "Ombudsman" program, with the approval of the local judiciary. The Ombudsman program designates a well-respected attorney in a local area to act as a confidential intermediary

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between lawyers and judges to assist in solving potential problems between the bench and bar. For example, if a judge is developing a habit for failing to make timely rulings, or is becoming mercurial in temperament, upon a request from members of the bar, the Ombudsman might go to the chief judge of the circuit — or to the judge at issue — to try and have the problem addressed. The system is designed to work both ways. If a judge suspects that an attorney who has always had an exemplary practice starts missing deadlines or exhibiting uncharacteristic behavior, the Ombudsman might, at the request of the judge or judges, sit down with the attorney and discuss the court's observations. No subject is off limits, even suspicions of alcohol or substance abuse. The emphasis on the Ombudsman program is on the total confidentiality of the process.

I have not followed up to see how the program has worked over the last several years, but in these days of legislative evaluations, failures to reappoint, and increasing press coverage, one wonders if a program like this might not make sense to help solve problems before they fester. It is a shame when a bench-bar relationship goes sour, and true talent is lost in the process.

This is a program likely best developed at the local bar level, given that local attorneys and judges are most familiar with each other's personalities. Whether a program like this would work in our state, one can only speculate. This is my own personal observation and not that of the Litigation Section. However, it might be worth a try.

Paul M. Black
Chair, Litigation Section

Recent Developments in ERISA Benefits Litigation

by Karl W. Pilger

The last two years have seen significant developments in the area of employee benefits litigation under the Employee Retirement Income Security Act of 1974, Title 29 U.S.C. §§ 1001, et seq. ("ERISA"). This comprehensive statute governs the great majority of private-sector employee benefits, such as pensions, health insurance and disability benefits.

Of importance to litigators, ERISA preempts¹ state law causes of action relating to benefits plans, significantly reducing the types of relief previously available against employers and insurers who deny benefit claims. Employees covered by ERISA plans cannot sue the insurer for breach of contract or bad faith when benefits are denied. Claims must be brought under the civil enforcement provision of ERISA, Title 29 U.S.C. § 1132, and relief is limited to equitable remedies.

Court opinions interpreting the statute require that all claims for benefits must first complete an administrative appeal before suit can be filed to compel payment of benefits.² Recent amendment of the claims regulation³ has changed the timing of the administrative claims procedures, and in some areas has clarified the rights of those seeking benefits.⁴ In most cases, the administrative appeal of the benefits denial is made to the insurer who is responsible for the payment of approved claims.

In the typical benefits case, the court simply reviews the administrative record before the claims administrator⁵ in the context of motions for summary judgment. Actual trials are rare, and when they occur, they are non-jury. Courts grant deference to the decisions of the claims administrator where the benefit plan gives the administrator discretion to determine benefits eligibility or interpret the terms of the plan.⁶ To help compensate for the

conflict of interest inherent in this system of administrative decision-making, the courts give a lesser degree of deference to the claims administrator's decisions when it is the party who is responsible for payment of benefits.⁷

Treating Physician Rule Rejected

In May 2003, the U.S. Supreme Court unanimously ruled that benefit plans are not required to accord special weight to the opinions of treating physicians in disability cases. The opinion in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S. Ct. 1965, 155 L.Ed.2d 1034 (2003), reversed a Ninth Circuit decision applying the rule as developed by caselaw and later codified by regulations adopted by the Social Security Administration for its disability cases. By contrast, the Department of Labor has not incorporated the rule in its regulations, and it opposed adoption of the rule in ERISA cases in its *amicus* brief.

The Court relied on differences between the mandatory Social Security disability program and the optional ERISA plans offered by employers in reaching its decision. It also questioned whether a treating health care provider would necessarily always be in a better position to render a more accurate assessment of disability, given variations in expertise and duration of treatment. The Court did state, however, that the benefit plan "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* at 824 or 1966 or 1038.

In light of this decision, claimants will need to make sure that the administrative record contains copies of the treating health care providers' resumes and other information about such providers' expertise in the relevant health care field. Evidence of the frequency and duration of all contacts between the claimant and such providers should be checked for completeness and accuracy before being submitted to the insurer or other party deciding the administrative appeal. Insurers might be inclined to use better-qualified consultants for claims review to counteract such strategy, but they may elect to forego the additional cost where their decisions on the administrative appeals

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will be governed by the favorable deferential standard when examined by the courts.

An Exception to Preemption Redefined

The scope of ERISA preemption is broad and far-reaching. ERISA supercedes any state laws that "relate to" an ERISA benefit plan. Claims for benefits must be brought under the civil enforcement provision of 29 U.S.C. § 1132. While it is now well-settled that the usual claim for benefits is within the scope of ERISA preemption, much litigation continues concerning the exact limits of preemption as it applies to various state laws and factual situations.

One exception to ERISA preemption is the "insurance clause." State laws are saved from preemption under § 1144(b)(2)(A) when they "regulate insurance." Until recently, the question of whether a practice constituted the business of insurance was determined under the McCarran-Ferguson Act.⁸

That definition was abandoned by the U.S. Supreme Court in *Kentucky Ass'n of Health Plans, Inc., et al., v. Miller*, 538 U.S. 329, 123 S. Ct. 1471, 155 L. Ed. 2d 468 (2003). Affirming a Sixth Circuit ruling, the Court said it was making a "clean break" from the McCarran-Ferguson factors. It announced a new two-factor test in determining if a law regulates insurance: first, the law must "be specifically directed towards entities engaged in insurance," and, second, it must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* at 341, 481, 1479. The state law at issue was an "any willing provider" statute that required health insurers to accept as part of their network any health care provider in the locale who agreed to the insurer's terms. The Court held that the law did regulate insurance under the new test and therefore was not preempted.

Reimbursement Clauses in Doubt

In early 2002, the Supreme Court ruled that a plan could not seek reimbursement from a plan participant who recovered from a third party. While it is common for a plan to require participants and beneficiaries to reimburse the plan if they recover on a claim for which the plan paid benefits, the Court in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708 (2002), ruled that enforcement of the reimbursement clause was not the sort of "equitable relief" available under ERISA. The majority concluded that Great-West's claim for restitution was legal in nature and therefore prohibited under ERISA civil enforcement

scheme; the four dissenters saw the claim as equitable and would have allowed recovery.

The case exemplifies the esoteric distinctions that make ERISA litigation so challenging. The most promising method of avoiding the holding in *Great-West* appears to be characterizing the reimbursement claim as one seeking the imposition of a constructive trust on the funds recovered from the party causing the injury. This equitable theory would be allowed under ERISA, but it would appear to be limited to the factual situation where identifiable funds recovered from a third party are actually in the hands of the plan participant.

The case is instructive in the broader sense that parties bringing ERISA claims of any sort must be certain that the claim and the relief sought are those that are traditionally equitable in nature.

Untimely Administrative Claims Decisions

An emerging trend in the circuit courts should have every claims administrator checking the regulations to make sure its initial claims decisions and administrative appeals are timely decided. The fail-

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ERISA preempts state law
causes of action relating to
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Employees covered by
ERISA plans cannot sue the
insurer for breach of
contract or bad faith when
benefits are denied.**

ure to render a decision on time may well result in the courts giving the matter *de novo* review, rather than the more deferential standard usually given to plans and their insurers.

In *Gritzer v. CBS Inc.*, 275 F.3d 291 (3rd Cir. 2002), the plan administrator failed to respond to the claim for benefits during the required time-frame. The claimants filed suit, the claim having been "deemed denied" by the failure to respond. About five months later, the plan issued its decision denying benefits and sought a deferential standard of review in the court. The district court used an "arbitrary and capricious" standard (because the plan gave the administrator unfettered discretion to interpret the plan) that was modified by the court due to the financial conflict of interest involved in the decision. The Third Circuit determined that the trial court should have used a *de novo* standard, since the plan administrator had not actually exercised its discretion until after the litigation had been filed.

Three recent cases have dealt with the issue of the failure of a plan to issue a final decision after the claimant has filed an administrative appeal from the initial decision denying or terminating benefits. In *Jebian v. Hewlett-Packard Co.*, 310 F.3d 1173 (9th Cir. 2002), the plan did not respond to the claimant's disability benefits appeal on the merits within the required 60 days or advise that additional time would be needed to do so. The appellate court found that the "deemed denial" of the appeal was not an exercise in discretion and was, therefore, undeserving of the deference it otherwise would have been accorded. The decision of the trial court granting summary judgment to the plan was reversed, and the matter was remanded for determination under a *de novo* standard.

The *Jebian* decision was followed by the Tenth Circuit in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003). The plan exceeded the time allowable for the decision on appeal, instead advising the claimant that it was scheduling an independent medical examination ("IME") for her. The claimant canceled the IME and filed in court. The trial court granted summary judgment for the plan using the "arbitrary and capricious" standard, and the appellate court reversed and

remanded for consideration of the case using the *de novo* standard.

The *Gilbertson* court took into consideration earlier decisions of other circuits that had decided the issue differently and also reviewed the many cases standing for the proposition that procedural defects in administering an ERISA plan generally will not upset the decision of the plan's representatives. But the court stressed the importance of deadlines as part of the administrative process and the need on the part of the plan to make timely requests for information from the claimant:

Although plan administrators may believe that they have articulated good reasons for their requests for more records or additional diagnostic tests, from the claimant's perspective these requests are often indistinguishable from pointless stalling. In addition, the costs of delay are generally much higher for claimants, who may need disability benefits to buy their daily bread, than for plans and administrators.

Id. at 636.

The more recent case of *Seman v. FMC Corp. Ret. Plan for Hourly Employees*, 334 F.3d 728, 2003 U.S. App. LEXIS 13280 (8th Cir. July 1, 2003), also applied the *de novo* standard because the plan failed to render a timely decision on review of the administrative appeal. Furthermore, it made a distinction between the failure of a plan to make an initial benefits decision and the failure to make a decision on the appeal:

When a plan administrator fails to render any decision whatsoever on a participant's application for benefits, it leaves the courts with nothing to review under any standard of review, so the matter must be sent back to the administrator for a decision. When a plan administrator denies a participant's initial application for benefits and the review panel fails to act on the participant's properly filed appeal, the administrator's decision is subject to judicial review, and the standard of review will be *de novo* rather than for abuse of discretion if the review panel's inaction raises serious doubts about the administrator's decision.

Id. at 734, 14.

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