

2010

# Mellor v. Wasatch Crest Mutual Insurance : Brief of Appellant

Utah Court of Appeals

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Brian S. King; Attorney for Appellant.

John P. Harrington; Holland and Hart; Attorney for Appellees.

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IN THE SUPREME COURT OF UTAH

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CHRIS ANN MELLOR, individually and  
as guardian of HAYDEN MELLOR,

Appellant,

vs.

WASATCH CREST MUTUAL INSURANCE  
and WASATCH CREST INSURANCE,

Respondent.

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**OPENING BRIEF OF  
APPELLANT CHRIS ANN  
MELLOR**

Case No. 20100952 SC

Brian S. King, #4610

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**FILED  
UTAH APPELLATE COURTS  
MAY 17 2011**

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## **PARTIES TO THE PROCEEDING**

The parties to this proceeding are:

1. Chris Ann Williams (“Mellor”), as guardian of Hayden Williams (deceased minor); and
2. Wasatch Crest Mutual Insurance and Wasatch Crest Insurance Company (collectively “Wasatch Crest.”
3. While not named as parties in this matter, Utah Life & Health Insurance Guaranty Association (“ULHIGA”) and the Liquidator for Wasatch Crest (“Liquidator”) are integrally involved in the matter.

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## **STATEMENT OF JURISDICTION**

This Court has jurisdiction under Utah Code Ann §78A-3-102(3)(j) and Utah R. App. P. 4(a). Judge Toomey entered a Memorandum Decision and Order denying Plaintiff Chris Ann Mellor's ("Mellor") Motion for Summary Judgment and granting the Defendants' Motion to Stay on November 1, 2010. Mellor filed her Notice of Appeal on December 1, 2010.

## **STATEMENT OF THE ISSUES PRESENTED FOR REVIEW**

ISSUE: The Insurers Rehabilitation and Liquidation Act ("the Act"), U.C.A. §31A-27-301 *et seq.*, provides class three distribution priority for losses incurred by insureds and federal and state governments. Mellor and the Utah Office of Recovery Services ("ORS") asserted claims for medical expenses against Wasatch Crest in liquidation but the Liquidator ruled that those claims had class six distribution priority because they were not classified elsewhere in the statute. Does the class three language include the claims of Mellor and ORS?

## **CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES, RULES AND REGULATIONS WHOSE INTERPRETATION IS DETERMINATIVE OF THE APPEAL OR OF CENTRAL IMPORTANCE TO THE APPEAL**

The following is central to Mellor's appeal:

- U.C.A. §31A-27-301 *et seq.*

## **STATEMENT OF THE CASE**

This is a case brought for recovery of wrongfully denied health insurance benefits which should have been provided for Hayden under a group health benefits plan

sponsored by his father's employer and governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 *et seq.* The insurer for that employer-sponsored plan, Wasatch Crest, terminated Hayden's coverage after he became eligible for coverage from Utah State Medicaid following his catastrophic drowning accident in 2001 and denied coverage for Hayden's medical expenses. Wasatch Crest subsequently was declared insolvent and ongoing administration was appointed to the Liquidator.

Hayden's benefit claim made its way through the district court and the first Supreme Court decision ("Initial Decision") held that Wasatch Crest was required to provide COBRA continuation coverage for up to 36 months after Hayden's initial qualifying event and that his eligibility for Medicaid did not relieve Wasatch Crest of the obligation to provide that coverage. The Initial Decision further held that Mellor, as Hayden's guardian, had standing to pursue the claim against Wasatch Crest for its wrongful denial of coverage for Hayden's medical expenses. Following the Initial Decision and after a year of inaction by the Liquidator, Mellor requested the district court's ruling on the priority of the claim. Mellor asserted that the claim had a class three distribution priority because it was a claim for health benefits by an insured for which Wasatch Crest had wrongfully denied payment.

The district court erred in accepting the Liquidator's argument that Mellor's claim was not properly included as a class three distribution priority claim but fell under lower priority class six claims. Mellor seeks this Court's order that the claim, based on her own standing and her existing Collection Agreement with ORS, is properly included in class three distribution priority rather than class six.

## STATEMENT OF FACTS

The essential facts in the case are undisputed and the trial court's Order consisted of conclusions of law based on those undisputed facts. Those facts are:

1. Justin Williams ("Williams") was employed by Mellor Engineering and was a participant in the group health benefits plan ("the Plan") provided by Mellor Engineering for its employees. Record, vol. 12, p. 5049.
2. Williams also elected coverage under the Plan for his wife and children. Id.
3. Williams' employment with Mellor Engineering terminated as of August, 2000. Id.
4. Williams elected COBRA continuation coverage for himself and his family after his employment ended. Id.
5. Williams and Mellor were divorced in March of 2001. Id.
6. Hayden's COBRA continuation coverage continued under the Plan following the divorce of his parents. Id.
7. Hayden's coverage under the Plan was in place on the date of his drowning accident, August 4, 2001. Id.
8. Hayden's health care providers submitted claims for payment of his medical expenses after the accident and the Plan paid claims on behalf of Hayden. Id.
9. Following the accident, Mellor applied for Medicaid coverage for Hayden and the application was granted retroactive to August 1, 2001. Id.



10. Mellor applied for Medicaid coverage for Hayden because she anticipated the possibility that the Plan would not provide coverage for all of Hayden's expenses. Record, vol. 12, p. 5189.
11. In addition, Mellor knew that Hayden's COBRA benefit would not continue indefinitely and that when it ended, she would need Medicaid assistance to pay Hayden's medical expenses. Id.
12. The Plan terminated Hayden's coverage as of August 1, 2001, and requested reimbursement of amounts already paid to Hayden's health care providers. Record, vol. 12, 5049.
13. In August, September and October of 2001, premiums continued to be paid for COBRA continuation coverage for Hayden through the Plan. Record, vol. 9, p. 3577.
14. Some time beginning in November of 2001, the Plan, through its reimbursement specialist, AGA, invoked an exclusion in the Wasatch Crest policy, asserting that Wasatch Crest had no obligation to pay for any of Hayden's medical expenses associated with the accident because there was no coverage under the policy for Hayden at any time after August 1, 2001, the date he became eligible for coverage from Medicaid. Record, vol. 9, p. 3741.
15. Wasatch Crest, through AGA, collected reimbursement from healthcare providers that it had previously paid for services provided to Hayden including \$5,987.47 from South Davis Community Hospital and \$23,809 from Primary

- Children's Hospital, and denied any obligation to cover any medical expenses that remained unpaid by the Plan. Record vol. 9, pp. 3741, 3900-04, and 3920.
16. The expenses incurred by Hayden for his medical care from the accident were extensive. The total amount paid by Medicaid paid for Hayden's medical care through October 31, 2003 was \$184,670.06. Record, vol. 11, p. 4607.
  17. Mellor stopped paying Hayden's COBRA premium in November, 2001, based on the Defendants' assertion that he was no longer eligible for coverage. Record, vol. 12, p. 5190.
  18. If Mellor had known that Hayden was, in fact, eligible to continue with COBRA benefits until July 31, 2003, she would have continued to pay his COBRA premiums. Id.
  19. Throughout the time frame at issue – from August 1, 2001 through July 31, 2003, Hayden's medical expenses were submitted to, and paid by, Medicaid. Record, vol. 12, p. 5192.
  20. The total amount of claims paid by Medicaid during the time frame when Hayden should have had COBRA continuation coverage, from August 1, 2001 through July 31, 2003, is \$181,357.51. Id.
  21. In 2002, ORS entered into a Collection Agreement with Mellor which authorized inclusion of ORS's claims for reimbursement with Mellor's claims against Wasatch Crest. Record, vol. 12, 5049.
  22. AGa communicated with ORS, the Utah state agency charged with recovering reimbursement of Medicaid funds, in August and September of 2002, about

whether Wasatch Crest was responsible to pay Hayden's medical expenses.  
Record, vol. 9, p. 3928.

23. In response to ORS's claim, AGA asserted that the claims had been properly denied and that Wasatch Crest was not obligated to reimburse Medicaid. Id.
24. On September 25, 2002, ORS entered into a collection agreement with Mellor's prior counsel, Robert Schumacher, in which ORS authorized Mellor and her counsel to represent the interests of Medicaid, as well as Mellor's and Hayden's, in pursuing payment of the denied medical expenses arising out of Hayden's accident from Wasatch Crest. Record, vol. 11, pp. 4641-4647.
25. On March 10, 2003, Mellor filed suit in the Fourth Judicial District Court for Utah County against Wasatch Crest for its "... unlawful denial of coverage on medical and health care expenses . . ." arising out of Hayden's accident.  
Record, vol. 10, p. 3959.
26. On July 11, 2003, Wasatch Crest was declared insolvent and proceedings were initiated in the Third Judicial District Court for Salt Lake County for its liquidation. Record, vol. 10, p. 3959.
27. On November 5, 2003, Mellor filed a claim in the Wasatch Crest liquidation proceeding on behalf of Hayden for payment of his medical expenses. Mellor included information in that Notice to indicate that ORS had a lien on the claim. Record, vol. 13, p. 5583.

28. In December of 2003, Mellor's attorney wrote to the Liquidator and attached an updated ORS lien to supplement Mellor's November 5, 2003 Notice of Claim. Record, vol. 13, pp. 5602-5603.
29. On September 6, 2006, counsel for ORS, Stephanie Saperstein, submitted a Notice of Representation of Medicaid Claim to the district court to further establish the agreement between ORS and Mellor. Record, vol. 13, pp. 5628-5634.
30. On August 6, 2007, the district court entered an Order Approving Referee's Findings of Fact and Recommendation Regarding Claim No. 300087 – Chris Ann Williams (Mellor); and Denying Motions of Liquidator and ULHIGA Regarding Claimant's Standing. Record, vol. 12, pp. 4939 – 4942.
31. All parties appealed and after briefing their various arguments and presenting oral argument before the Supreme Court of Utah, the Supreme Court entered its Initial Decision on January 8, 2009. Record, vol. 12, pp. 5048 – 5056.
32. The Initial Decision held that Hayden was an insured under the Wasatch Crest insurance policy at the time of his accident and during the time frame at issue in the case and that Mellor had standing to pursue the claim. Record, vol. 12, pp. 5055.
33. The matter was remitted to the district court on February 20, 2009. Record, vol. 12, pp. 5075 – 5076.

34. After Mellor's attempts to resolve the claim with the Liquidator were unsuccessful, she filed her Motion for Summary Judgment and Memorandum in Support on January 21, 2010. Record, vol. 12, pp. 5141 – 5187.
35. Concurrently with her Motion and Memorandum, Mellor prepared and submitted her own Affidavit and the Affidavit of Carrie Worthen. Record, vol. 12, pp. 5188 – 5190 and pp. 5191 – 5325 respectively.
36. Early in 2010, Wasatch Crest and the Liquidator began distribution and payment of various class two and class three claims. Mellor received no notification of any payments by Wasatch Crest or the Liquidator. *See, e.g.*, Record, vol. 12, pp. 5326 – 5327.
37. The Liquidator periodically submitted reports on the status of the liquidation to the district court. A Report on Status of Liquidation Estate for Period Ending December 31, 2009 was submitted on February 16, 2010. Record, vol. 12, pp. 5333 – 5337.
38. The Liquidator referred in his report to the Initial Decision and Mellor's recently filed Motion for Summary Judgment. The report stated that the Initial Decision had "... found in favor of the claimant on a narrow issue not necessarily dispositive of the case." Record, vol. 12, p. 5335.
39. Wasatch Crest filed its Memorandum in Support of (1) Liquidator's Motion to Dismiss, or in the Alternative, (2) Motion to Stay Claimant's Motion for Summary Judgment, or in the Alternative, (3) Memorandum in Opposition to

Claimant's Motion for Summary Judgment on April 27, 2010. Record, vol. 13, pp. 5564 – 5603.

40. Wasatch Crest continued to argue that Mellor lacked standing and the real party in interest was Medicaid. Record, vol. 13, p. 5567.
41. Wasatch Crest also argued that because Medicaid had provided payment for Hayden's medical expenses, Mellor's claim, at best, was a class six claim rather than a claim for coverage of an insured under the policy which would be classified as a class three claim. Record, vol. 13, pp. 5577 – 5579.
42. Mellor filed her Consolidated Response Memorandum in Support of her Motion for Summary Judgment and in Opposition to Defendants' Motion to Dismiss on Jun 1, 2010. Record, vol. 13, pp. 5615 – 5634.
43. Wasatch Crest filed its Reply Memorandum in Support of its various Motions on June 29, 2010. Record, vol. 13, pp. 5641 – 5653.
44. Wasatch Crest argued that Utah statute prohibited equitable restoration of Mellor's claim from a class six to a class three claim. Record, vol. 13, pp. 5647 – 5649.
45. Wasatch Crest attached as Exhibit A to its Reply Memo a "Second Amended Notice of Determination to Claimant" ("2<sup>nd</sup> Notice") dated June 29, 2010. Record, vol. 13, p. 5653.
46. The 2<sup>nd</sup> Notice was prepared and provided as an exhibit to Wasatch Crest's Reply Memo and was never formally served on Mellor or her counsel at a notification of a decision by the Liquidator. Id.

47. Oral argument was held on August 31, 2010. Record, vol. 13, p. 5689.
48. The Court issued its Memorandum and Order on November 1, 2010 (“11/1/10 Order”), granting Wasatch Crest’s Motion to Stay and denying Mellor’s Motion for Summary Judgment. Record, vol. 13, pp. 5702 – 5709.
49. The 11/1/10 Order agreed with Wasatch Crest that Mellor’s claim was a class six claim because Mellor’s claim fell outside the scope of class three status. Record, vol. 13, p. 5708.
50. Mellor filed her Notice of Appeal on December 1, 2010, Record, vol. 13, pp. 5714 – 5715.

### **SUMMARY OF ARGUMENT**

The Initial Decision is clear and unambiguous in holding that Hayden was a beneficiary of the Wasatch Crest insurance policy and that Mellor has standing both for herself and ORS, to pursue reimbursement of Hayden’s claim from Wasatch Crest. The district court’s 11/1/10 Order errs because Mellor’s claim is for losses incurred under Hayden’s health insurance policy with Wasatch Crest. Whether those claims are asserted by Mellor on her own behalf or on behalf of ORS, they should be treated as class three rather than class six priority claims.

### **ARGUMENT**

#### **Mellor’s Claims Fall Within Class Three Distribution Priority Under the Act**

The Liquidator claims that because Medicaid relieved Mellor of the financial responsibilities associated with Hayden’s medical treatment, Mellor’s claims for payment under the policy are transmogrified from class three to class six claims. The Liquidator is

wrong. Class three claims are:

- (i) . . . all claims under policies for losses incurred **including:**
  - (A) **Claims of the federal, state, or local government;**
  - (B) Third party claims; . . .
- (ii) **All claims under life and health insurance and annuity policies shall be treated as loss claims.**
- (iii) That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant are not included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support, by way of succession at death, as proceeds of life insurance, or as gratuities . . . (emphasis added)

U.C.A. §31A-27-335(2)(c). Class six claims are:

- (A) Any person, including claims of state or local governments, **except those specifically classified elsewhere in this section;** . . . (emphasis added)

U.C.A. §31A-27-335(2)(f).

The claims presented by Mellor in her Proof of Claim dated November 5, 2003, and in her “Supplemental Exhibit” to her proof of claim dated December 8, 2003, make clear that both she and ORS asserted claims against Wasatch Crest for losses incurred. Under the terms of U.C.A. §31A-27-335(c)(1)(A), those claims included losses incurred and claims paid by the federal and state government. ORS’ Notice of Representation of Medicaid Claim, filed on September 7, 2006, also gave clear and unequivocal notice to the Liquidator of Medicaid’s interest in the Mellor claim and its right to be reimbursed under both the Utah State Medical Benefits Recovery Act, U.C.A. §26-19 et. seq., and under U.C.A. §31A-27-335(2)(c). The claim by Mellor, and the interest of ORS in that



claim, were known by the Liquidator for years before the final adjudication of class three claims began in January of 2010. In light of these facts, it is not credible for the Liquidator to argue that he had no timely notice of both Mellor's and Medicaid's claims.<sup>1</sup>

The Liquidator argued, and the district court ruled, that class three claims do not include "that portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant" under U.C.A. §31A-27-335(2)(c)(iii). Record, vol. 13, p. 5707 (11/1/10 Order, p. 6). However, this general language is insufficient to override the explicit reference in U.C.A. §31A-27-335(2)(c)(i)(A) to claims of the federal and state government for losses incurred being class three claims. If indemnification had already been provided to ORS from some other source for the amounts it paid out on Hayden's claim, perhaps the Liquidator's argument would be more persuasive. But Utah's Medicaid program is simply out-of-pocket the money it has paid for Hayden's medical bills. U.C.A. §26-19-5 makes clear that the lien ORS has for repayment of Hayden's expenses ". . . has priority over all other claims to the proceeds . . ." except claims for attorney fees and costs as authorized under U.C.A. §26-19-7(2)(c)(ii).

The Liquidator also asserts, and the 11/1/10 Order agreed, that Mellor's and ORS's claim ". . . may not be permitted to circumvent the priority classes through the use of equitable remedies," U.C.A. §31A-27-335(1)(d), and that "obligations to insurers . . . and their claims for contribution, indemnity, or subrogation, equitable or otherwise . . .,"

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<sup>1</sup> It is particularly difficult to accept the Liquidator's argument that he had no notice of Medicaid's interest in Mellor's claim in light of the fact that the very reason Wasatch Crest cut off Hayden's coverage in 2001 was because Medicaid had begun to cover Hayden's expense arising out of his accident.

U.C.A. §31A-27-335(2)(c)(iv)(C), are excluded from class three claims. Record, vol 13, pp. 5707-5708 (11/1/10 Order, pp. 6-7). But Mellor’s claims against the Liquidator are claims on the Wasatch Crest insurance policy, a written contract, rather than equitable claims. Indeed, in 2001 Wasatch Crest initially paid, and then clawed back, medical expenses for Hayden in substantial amounts. Record, vol. 9, pp. 3741, 3900-04, and 3920.

In addition, the claims are not equitable in light of the terms of U.C.A. §26-19-7(2)(c)(ii) and the language of the United States Code mandating that, as a condition of receipt of federal dollars, the Utah state Medicaid program must maintain a program to pursue reimbursement of funds paid out by Medicaid but for which third parties are later determined to be responsible. Medicaid was designed to be the “payer of last resort” for individuals who have no other resources for payment of medical bills. Rehabilitation Association of Virginia, Inc. v. Kozlowski, 42 F.3d 1444, 1447 (4<sup>th</sup> Cir. 1994). To, among other things, ensure that Medicaid does not become a target of cost shifting by for-profit insurers, state agencies charged with implementing the program are required to “take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan.” 42 U.S.C. §1396a(a)(25)(A). Federal statute also requires that the Utah State Medicaid program put in place a mechanism to actively pursue and collect from these third party payment sources: “in any case where such a legal liability is found to exist after medical assistance . . . [has been provided], the State or local agency will seek reimbursement for such assistance to the extent of such legal liability” (emphasis added). 42 U.S.C. §1396a(a)(25)(B). In the face of such clear

statutory directives, Mellor's and ORS's claims are not equitable.

It is true that the legal effect of Hayden's qualification for Medicaid coverage was to eliminate any ability of his health care providers to bill Hayden or his mother, Mellor, for any expenses associated with Hayden's medical treatment above and beyond the amount paid under the Medicaid payment schedules in place at the time. However, in light of the Initial Decision in this case, Medicaid should never have stepped in and paid Hayden's medical expenses at all. The Initial Decision establishes that Wasatch Crest, rather than Medicaid, should have paid Hayden's medical expenses. Had Wasatch Crest acted as they should have in 2001, Mellor and Hayden would not have been shielded from receiving bills for the full cost of Hayden's medical treatment. Wasatch Crest would have received those bills and would have paid them as required under the insurance policy regardless of any involvement by Medicaid.

Adopting Wasatch Crest's argument goes beyond simply ignoring the Initial Decision. It allows Wasatch Crest to receive a windfall due to its own bad act in refusing to pay a valid claim. Giving Wasatch Crest a monetary advantage arising out of the financial stress Wasatch Crest itself caused by refusing to pay Hayden's medical claims circumvents the express language of the statutes governing the relationship between federal and state taxpayers funding Medicaid and private insurers such as Wasatch Crest. Wasatch Crest, through its own improper refusal to pay Hayden's claims, caused Medicaid to step up to the plate and pay Hayden's medical expenses. Shifting the costs of valid claims from Wasatch Crest to taxpayers is expressly prohibited by federal statute. Record, vol. 12, pp. 5053-5054 (Initial Decision, ¶17).

Simply put, but for its improper denial of Hayden's claims in November, 2001, Wasatch Crest would have paid Hayden's claims in the ordinary course of its claims processing activities in a manner no differently than the processing and payment of any other claims. Its actions in violation of the terms of the policy, federal, and state statute created the facts that it now asserts justify Mellor's claims being treated as class six rather than class three claims.

There are additional reasons to deny Wasatch Crest's attempt to bootstrap its way into treating Mellor's claims as class six rather than class three claims. Wasatch Crest is wrong when it asserts that "the real party in interest is the actual payor [Medicaid], not Mellor." Record, vol. 13, p. 5577 (Wasatch Crest Memorandum, p. 14). In fact, the Collection Agreement attached as part of Exhibit A to that Memorandum, and included as part of the Notice of Representation of Medicaid Claim filed on September 7, 2006, makes clear that ORS, Mellor and her counsel agree to include ORS's claim as a part of the claim Mellor is pursuing. The claim Mellor asserts is larger than the amount Medicaid has paid. In all likelihood, the amount Wasatch Crest is obligated to pay under the terms of its insurance policy will be significantly greater than the amount the providers were paid under the relatively low Medicaid fee schedules. While Wasatch Crest asserts that Mellor has been relieved of any obligation to the healthcare providers, this was true only so long as Medicaid was properly the payer of Hayden's bills. But in light of the Initial Decision, it's evident that Medicaid never should have paid Hayden's bills and his providers should never have been precluded from submitting their full billed charges to Wasatch Crest for processing and payment.

Wasatch Crest asserts that Mellor has been paid for her policy losses by receiving Medicaid benefits. But this is simply not accurate. Mellor received welfare benefits from taxpayers in light of her own lack of resources and the immensity of the past and prospective medical expenses from Hayden's catastrophic accident. The only reason the taxpayers stepped up to the plate was because Wasatch Crest wrongly dodged its own obligation to do so. The amount Mellor seeks in this lawsuit is not simply the amount Medicaid paid for Hayden's expenses. It is an amount above and beyond that figure and represents what Wasatch Crest should have paid for Hayden's medical expenses but, thus far, has not.

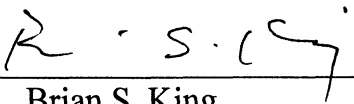
Finally, even if Mellor was acting purely as agent for recovery of Medicaid funds, the claims at issue in this case properly fall under class three priority distribution for another independent reason: they are claims for losses under the Wasatch Crest policy to reimburse the Utah State Medicaid program. That Utah state government program, funded through federal and state taxpayer dollars, is asserting through Mellor a claim for a loss under the Wasatch Crest policy. The Medical Benefits Recovery Act authorizes payment of benefits directly to ORS that would otherwise be payable to Mellor. U.C.A. §26-19-4.5. As such, these claims fall under the express language of U.C.A. §31A-21-335(2)(c)(i)(A).

### **CONCLUSION**

Mellor and ORS have presented claims to the Liquidator for losses incurred by them relating to Hayden's medical expenses. Those claims fall squarely within the language of class three distribution priority in U.C.A. §31A-21-335(2)(c). The district

court erred in ruling that Mellor's claims were class six rather than class three claims. The district court ruling should be reversed and the case should be remanded with instructions to the district court to calculate the amount that should have been paid by Wasatch Crest under the policy on Mellor's claims.

DATED this 17 day of May, 2011.

  
\_\_\_\_\_  
Brian S. King  
Attorney for Appellant/Plaintiff

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing document has been delivered via first class U.S. mail, postage prepaid, to the following:

John P. Harrington  
HOLLAND & HART  
222 South Main Street, Suite 2200  
Salt Lake City, UT 84101-2001

DATED this 17 day of May, 2011.

  
\_\_\_\_\_

## **APPELLANT'S ADDENDUM**

Supreme Court Decision – January 27, 2009

District Court Memorandum Decision and Order – November 1, 2010

Statutes:

- 42 U.S.C. §1396a(a)(25)(A)
- 42 U.S.C. §1396a(a)(25)(B)
- U.C.A. §26-19-5
- U.C.A. §26-19-7(2)(c)(ii)
- U.C.A. §26-19-4.5
- U.C.A. §31A-27-335(c)
- U.C.A. §31A-27-335(c)(1)(A)
- U.C.A. §31A-27-335(1)(d),
- U.C.A. §31A-27-335(2)(c)(i)(A)
- U.C.A. §26-19-7(2)(c)(ii)
- U.C.A. §31A-27-335(2)(c)(iii)
- U.C.A. §31A-27-335(2)(c)(iv)(C)
- U.C.A. §31A-27-335(f)
- U.C.A. §78A-3-102(3)(j)

Rules:

- Utah R. App. P. 4(a)



**Chris Ann Williams Mellor, individually and as guardian of Hayden Williams, Appellant, and Cross-Appellee, v. Wasatch Crest Mutual Insurance Company, in Liquidation, Wasatch Crest Mutual Insurance Company in Liquidation, and Utah Life and Health Insurance Guaranty Association, Appellees, and Cross-Appellants.**

No. 20070763

**SUPREME COURT OF UTAH**

**2009 UT 5; 201 P.3d 1004; 622 Utah Adv. Rep. 20; 2009 Utah LEXIS 9**

**January 27, 2009, Filed**

**SUBSEQUENT HISTORY:** Rehearing denied by *In re Crest*, 2009 Utah LEXIS 25 (Utah, Mar. 5, 2009)

**PRIOR HISTORY:** [\*\*\*1]

Third District, Salt Lake. The Honorable Kate A. Toomey. No. 030915527.

**COUNSEL:** Brian S. King, James L. Harris, Bradley R. Sidle, Salt Lake City, for appellant.

J. Ray Barrios, Jr., Salt Lake City, for appellee, Wasatch Crest Mutual Insurance Company.

Maxwell A. Miller, Randy M. Grimshaw, Salt Lake City, for appellee, Utah Life and Health.

**JUDGES:** WILKINS, Justice. Chief Justice Durham, Associate Chief Justice Durrant, Justice Parrish, and Justice Nehring concur in Justice Wilkins' opinion.

**OPINION BY: WILKINS**

**OPINION**

[\*\*1006] *WILKINS, Justice:*

[\*P1] Appellant Chris Ann Williams Mellor appeals from an adverse order of the district court which held that her minor son, Hayden Williams, was not covered by a Wasatch Crest Mutual Insurance Company health plan when he suffered a near drowning accident on August 3, 2001. Appellees Wasatch Crest and Utah Life and Health Insurance Guaranty Association cross-appeal the district court's holding that Ms. Mellor

has standing in this case to bring an action on behalf of her minor son. We affirm the district court's holding as to standing but reverse on the issue of coverage.

**BACKGROUND**

[\*P2] Hayden Williams' father, Justin Williams, was employed by Mellor Engineering. During his employment, Mr. Williams participated [\*\*\*2] in Mellor Engineering's employee welfare benefits plan, which was provided through Wasatch Crest Insurance Company (Wasatch Crest). Both Ms. Mellor and Hayden were beneficiaries under the Wasatch Crest plan. When Mr. Williams' employment with Mellor Engineering terminated in August 2000, he elected to continue health coverage for himself and his family through the Wasatch Crest plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Mr. Williams and Ms. Mellor divorced in March 2001. COBRA premiums continued to be paid for Hayden, and Wasatch Crest continued to accept them, through November 7, 2001.

[\*P3] On August 3, 2001, Hayden suffered a near drowning accident which resulted in catastrophic, permanent injuries. Because of the overwhelming medical expenses and the prospect of ongoing expenses for Hayden's future care, Ms. Mellor applied for Medicaid coverage for Hayden two weeks after the accident. The application was approved in September 2001. Under Medicaid guidelines, and because of the need to ensure coverage for Hayden's past and future medical expenses, Hayden's effective coverage date was backdated to August 1, 2001.

[\*P4] The Wasatch Crest plan continued to make [\*\*\*3] payments for Hayden's medical care until No-



venember 2001. At that time, Wasatch Crest asserted that under language of the plan, it had no obligation to continue coverage for Hayden after Medicaid coverage began on August 1, 2001. Wasatch Crest requested reimbursement from Hayden's health care providers and collected from many of them. In August of 2002, the Utah State Office of Recovery Services (ORS) began an effort to collect money from Wasatch Crest which it alleged had been improperly paid by Medicaid and should have been paid by the Wasatch Crest plan. A month later, ORS entered into a Collection Agreement with Ms. Mellor which authorized Ms. Mellor to include ORS's claim for reimbursement with her civil claims against Wasatch Crest, with ORS as an assignee of her rights of recovery.

[\*\*1007] [\*P5] On July 11, 2003, Wasatch Crest was declared insolvent. The district court set July 31, 2004 as the deadline for filing a proof of claim against the Wasatch Crest estate in liquidation. Ms. Mellor filed a timely claim. The claims in liquidation are being administered by Utah Life and Health Insurance Guaranty Association (ULHIGA), which thus became a party to this action.

[\*P6] A referee appointed to adjudicate [\*\*\*4] disputes between claimants and Wasatch Crest's liquidator ruled that, under the language of the Wasatch Crest Plan, Wasatch Crest had no obligation to pay any of Hayden's medical expenses as of August 1, 2001. Ms. Mellor filed an objection with the Third District Court. At the subsequent hearing, Wasatch Crest and ULHIGA alleged that Ms. Mellor did not have standing to file a claim in the liquidation proceeding. The court agreed that Ms. Mellor did not have standing in her own right, but ruled that Ms. Mellor did have standing to file a claim on behalf of Hayden. The court further determined that while some of the documents that had been generated in connection with the claim had not always clearly designated that Ms. Mellor was acting in Hayden's behalf, it had been understood since the time that Ms. Mellor first initiated civil action that she was acting for Hayden. Nevertheless, the court approved the referee's findings as to Wasatch Crest's liability, ruling that Hayden had not been covered by the Wasatch Crest plan at the time of his accident. Ms. Mellor appealed the ruling on coverage to this court, and Wasatch Crest and ULHIGA cross-appealed on the issue of standing.

#### STANDARD [\*\*\*5] OF REVIEW

[\*P7] An insurance policy is a contract between the insured and the insurer. *Saleh v. Farmers Ins. Exch.*, 2006 UT 20 P 14, 133 P.3d 428. Questions of contract interpretation which are confined to the language of the contract itself are questions of law, which we review for correctness. *Fairbourn Commer., Inc. v. Am. Hous.*

*Ptnrs., Inc.*, 2004 UT 54, P6, 94 P.3d 292. Likewise, a determination of standing is generally a question of law, which we review for correctness. *Kearns-Tribune Corp. v. Wilkinson*, 946 P.2d 372, 373 (Utah 1997); see also *State v. Pena*, 869 P.2d 932, 936 (Utah 1994).

#### ANALYSIS

##### I. MS. MELLOR HAS STANDING ON BEHALF OF HER MINOR SON HAYDEN

[\*P8] As an employer sponsored welfare benefits plan, the Wasatch Crest insurance plan at issue is governed by the Employee Retirement Income Security Act (ERISA). See 29 U.S.C. § 1003(a) (2008). ERISA contains a specific provision governing standing. It provides, "A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights to future benefits under the terms of the plan, or to clarify his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (2008).

[\*P9] [\*\*\*6] Thus, the issues in this case are interdependent; if Hayden is "a participant or beneficiary" under the Wasatch Crest plan, he has standing to bring an action in this case. *Id.* As we discuss in detail below, we hold that Hayden was a participant or beneficiary under the Wasatch Crest plan, a status which entitles him to pursue recovery of any benefits which may be owing to him under the plan through the courts. Given Hayden's status as a minor child, it follows that his mother, Ms. Mellor, has standing to bring an action on his behalf. See *Utah R. Civ. P. 17(a)-(b)*.

[\*P10] Appellees have made much of the fact that Ms. Mellor has assigned all rights of recovery in this case to ORS through a Collection Agreement. They argue that because of this assignment Hayden is not the real party in interest in this case and that he therefore does not have standing to pursue a cause of action. On the contrary, the assignment has no effect on the standing of Hayden, or through Hayden, Ms. Mellor. The Collection Agreement does nothing more than place a lien in favor of ORS on any reimbursement for medical expenses that may be recovered from Wasatch Crest. Thus, beyond its function of routing any potential [\*\*1008] [\*\*\*7] recovery, the Collection Agreement has no relevance to the case before us.

##### II. HAYDEN HAD COVERAGE UNDER THE WASATCH CREST PLAN ON THE DATE OF HIS ACCIDENT

[\*P11] The COBRA modifications to ERISA require that "an employer who sponsors a group health plan . . . give the plan's 'qualified beneficiaries' the opportunity to elect 'continuation coverage' under the plan

when the beneficiaries might otherwise lose coverage upon the occurrence of certain 'qualifying events,' including . . . the termination of the covered employee's employment . . . ." *Geissal v. Moore Med. Corp.*, 524 U.S. 74, 79-80, 118 S. Ct. 1869, 141 L. Ed. 2d 64 (1998) (quoting 29 U.S.C. § 1163). When Mr. Williams' employment with Mellor Engineering terminated, Mr. Williams elected continuation coverage for himself and his dependents, including Hayden, pursuant to this statute. No responsible party subsequently took any affirmative action to remove Hayden from the Wasatch Crest plan. Appellants nonetheless argue that, under the language of the plan, Hayden's coverage terminated on August 1, 2001 when Hayden became covered by Medicaid. We therefore must determine whether coverage was terminated by operation of law.

*A. Exclusion 4 and Exclusion 17 Create an Inconsistency [\*\*\*8] in the Wasatch Crest Plan and Are Therefore Ambiguous*

[\*P12] At issue is the interplay between two exclusions to coverage in the Wasatch Crest plan as outlined in "Part 7 - Exclusions" of the plan:

4. Expenses covered by programs created by the laws of the United States, any state, or any political subdivision of a state.

17. Services, supplies, or treatment for which Benefits are provided under Medicare or any other government program, except Medicaid.

We have previously held that an insurance contract must communicate its terms with sufficient clarity that it can be understood by a reasonable purchaser of insurance. *Farmers Ins. Exch. v. Versaw*, 2004 UT 73, P 8, 99 P.3d 796. The test for clarity in an insurance contract is as follows:

[W]ould the meaning be plain to a person of ordinary intelligence and understanding, viewing the matter fairly and reasonably, in accordance with the usual and natural meaning of the words, and in the light of existing circumstances, including the purpose of the policy[?]

*Auto Lease Co. v. Cent. Mut. Ins. Co.*, 7 Utah 2d 336, 325 P.2d 264, 266 (Utah 1958). "Whether an ambiguity exists in [an insurance] contract is a question of law." *Saleh v. Farmers Ins. Exch.*, 2006 UT 20, P 14, 133 P.3d

428 [\*\*\*9] (internal quotation marks omitted). We therefore review for correctness. *Id.*

[\*P13] We have observed that "ambiguities typically appear in two forms: 'An ambiguity in a contract may arise (1) because of vague or ambiguous language in a particular provision or (2) because two or more contract provisions, when read together, give rise to different or inconsistent meanings, even though each provision is clear when read alone.'" *Farmers Ins. Exch.*, 2004 UT 73, P 9, 99 P.3d 796 (quoting *U.S. Fid. & Guar. Co. v. Sandt*, 854 P.2d 519, 523 (Utah 1993)).

[\*P14] The ambiguity in the present case is of the second variety. Medicaid is clearly a "program created by the laws of the United States, any state, or any political subdivision of a state." See 42 U.S.C. §§ 1396-1396w-1 (2008). Therefore, exclusion 4 indicates that expenses covered by Medicaid, as are the disputed expenses in this case, are not covered by the Wasatch Crest plan. However, exclusion 17 indicates exactly the opposite--that while "services, supplies, or treatment" covered by "Medicare or any other government program" will not also be covered by the Wasatch Crest plan, "services, supplies, or treatment" covered specifically by Medicaid are not excluded [\*\*\*10] from plan coverage.

[\*P15] Appellees attempt to read these two provisions consistently by arguing that "services, supplies, or treatment" in exclusion 17 represent a small, covered exception carved out of the larger category of excluded "expenses" in exclusion 4. However, Appellees are unable to provide us with a single example of an "expense" that could not also be categorized as a "service, supply, or treatment." [\*\*1009] Such a distinction is surely equally beyond the understanding of a reasonable purchaser of insurance. We therefore hold that the two provisions when read together give rise to inconsistent meanings and that the language of the Wasatch Crest plan is consequently ambiguous.

[\*P16] Insurance contracts are generally drafted by the insurance companies and allow no opportunity for negotiation of the terms by the insured. *Farmers Ins. Exch.*, 2004 UT 73, P 24, 99 P.3d 796. In light of this fact, and in order to assure that the purpose for which the policy was purchased and the premiums were paid is not defeated, we interpret insurance policies liberally in favor of the insured. *U.S. Fid. & Guar. Co.*, 854 P.2d at 521. We have therefore held that when an ambiguity exists in an insurance contract, that ambiguity [\*\*\*11] is interpreted in favor of coverage. *Id.* at 522-523. More specifically, "[I]f an insurance contract has inconsistent provisions, one which can be construed against coverage and one which can be construed in favor of coverage, the contract should be construed in favor of coverage." *Id.* at 523 (internal citations omitted). Thus, we construe the

ambiguities in the Wasatch Crest policy in favor of coverage and therefore reverse the decision of the district court.

*B. Federal and State Law Prohibit Wasatch Crest from Terminating Coverage Because Hayden Became Covered by Medicaid*

[\*P17] Both federal and state law evidence a clear policy of prohibiting insurance companies from shifting their obligation for medical expenses to the taxpayer-funded Medicaid program. ERISA, as amended by COBRA, provides that COBRA coverage cannot be limited by a plan beneficiary's eligibility for or participation in Medicaid:

A group health plan shall provide that, in enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary, the fact that the individual is eligible for or is provided medical assistance under a State plan [\*\*\*12] for medical assistance approved under title XIX of the Social Security Act<sup>1</sup> . . . will not be taken into account.

29 U.S.C. § 1169(b)(2) (2008).

<sup>1</sup> Title XIX of the Social Security Act creates the Medicaid program. 42 U.S.C. § 1396-1396w-1 (2008).

[\*P18] ERISA generally preempts state law. *See* 29 U.S.C. § 1144(a) (2008). An exception exists for state laws created to aid in recovering state Medicaid funds from employee welfare benefit plans. *Id.* § 1144(b)(8)(B). Therefore, Utah employee benefit plans must comply with *Utah Code section 26-19-9* which prohibits employer sponsored health insurance plans from excluding from coverage health care expenses that are also eligible for coverage under Medicaid:

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan

based on the fact that the individual is eligible for or is provided services under the state plan.

*Utah Code Ann. § 26-19-9* (2007).

[\*P19] Appellees argue that the Wasatch Crest plan complies with [\*\*\*13] the Utah statute because it specifies in exclusion 17 that "services" covered by Medicaid are not excluded. However, this argument fails because regardless of whether the Wasatch Crest plan nominally complies, if exclusion 4 precludes coverage for any expenses covered by a government program, it "has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the . . . plan." *Id.*

[\*P20] In order to interpret the Wasatch Crest plan in conformity with the relevant federal and state statutes, we read exclusions 4 and 17 to operate in such a manner that they do not preclude coverage for medical [\*\*1010] expenses which are also covered by Medicaid. Indeed, we find additional justification for this reading in the Wasatch Crest plan itself, which states, "If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform thereto." Therefore, we hold that the terms of the Wasatch Crest plan did not operate to terminate Hayden's coverage as a matter of law when Hayden became eligible for Medicaid coverage.

## CONCLUSION

[\*P21] At best, exclusion [\*\*\*14] 4 and exclusion 17 create an ambiguity in the Wasatch Crest policy. At worst, they evidence an attempt to comply with the nominal requirements of the law while at the same time circumventing the actual requirement of providing coverage regardless of whether a beneficiary is also covered by Medicaid. Under either scenario, we interpret the Wasatch Crest plan in favor of coverage. Since Hayden is a beneficiary of the Wasatch Crest plan, he, and through him his mother Ms. Mellor, have standing to pursue an action for recovery of benefits owing to Hayden under the plan.

[\*P22] Affirmed in part and reversed in part.

[\*P23] Chief Justice Durham, Associate Chief Justice Durrant, Justice Parrish, and Justice Nehring concur in Justice Wilkins' opinion.

4  
FILED DISTRICT COURT  
Third Judicial District

NOV - 1 2010

IN THE DISTRICT COURT OF THE THIRD JUDICIAL DISTRICT  
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH

SALT LAKE COUNTY

Deputy Clerk

In re:

MEMORANDUM DECISION AND  
ORDER

WASATCH CREST INSURANCE  
COMPANY IN LIQUIDATION

CASE NO. 030915527

Judge Kate A. Toomey

This matter is before the Court on Chris Ann Mellor's Motion for Summary Judgment, dated January 21, 2010, and Wasatch Crest Insurance Company in Liquidation's (WCICIL) Motion to Dismiss or Stay the Motion for Summary Judgment, filed April 27. Both motions were briefed. The Court held a hearing on August 31, 2010, after which it took the matters under advisement. The motions are now ready for decision.

BACKGROUND

Hayden Williams's father terminated his employment with a company in August 2000. Mr. Williams elected COBRA coverage to continue his family's health policy through Wasatch Crest Insurance Company ("Wasatch Crest"). The policy was still in place on August 4, 2001 when Hayden had a near-drowning accident. Hayden's mother, Chris Ann Mellor, sought and received Medicaid coverage for Hayden, granted retroactively to August 1, 2001 – just prior to his accident. Ms. Mellor was still paying the COBRA premiums for Hayden, but when Wasatch Crest learned that Hayden was receiving Medicaid coverage, it terminated Hayden's policy and sought reimbursement for the medical claims it had paid since August 1, 2001, the date Hayden began receiving Medicaid benefits. Ms. Mellor, acting on Wasatch Crest's statement that Hayden was no longer eligible for coverage under COBRA, stopped paying the premiums in November, 2001. Meanwhile, Medicaid paid out \$181,357.51 in reimbursements to Hayden's doctors.

Ms. Mellor sued Wasatch Crest, arguing that the insurance company unlawfully terminated Hayden's coverage. She claims that Hayden was eligible for COBRA coverage through July 31, 2003.<sup>1</sup> Ms. Mellor argues that if Wasatch Crest had not wrongfully terminated Hayden's coverage, she would have continued paying the COBRA premiums for the full period of eligibility.

In 2003 Wasatch Crest was declared insolvent. The Court appointed a liquidator, Wasatch Crest Insurance Company in Liquidation ("WCICIL"), to assess and pay valid claims filed against Wasatch Crest, including Ms. Mellor's November 2003 claim on behalf of her son Hayden. WCICIL denied Ms. Mellor's claims via Notices of Determination dated October 2005 and December 2005. This Court upheld WCICIL's decision.<sup>2</sup> On appeal the Utah Supreme Court reversed, holding that the "terms of the Wasatch Crest Plan did not operate to terminate Hayden's coverage as a matter of law when Hayden became eligible for Medicaid coverage." *Id.* at ¶ 20. On June 29, 2010, WCICIL issued a Second Amended Notice of Determination in which it again denied Ms. Mellor's claim, this time reasoning that "the Claimant has been indemnified by a third party [Medicaid] and thus has suffered no unreimbursed loss[.]"

In 2002, Ms. Mellor and the Utah Office of Recovery Services ("ORS") entered into a contract authorizing ORS as an assignee of Ms. Mellor's rights of recovery against Wasatch Crest.<sup>3</sup> See *Mellor v. Wasatch Crest Mut. Insur. Co.*, 2009 UT 5, ¶ 4, 201 P.3d 1004.

---

<sup>1</sup> Hayden was eligible for coverage under COBRA for three years, from August 1, 2000 through July 31, 2003. COBRA allows for the extension of the standard time frame of coverage for "qualifying events." Here, Mr. Williams's employment termination and his divorce from Hayden's mother served as two qualifying events; as such, Hayden was eligible for thirty-six months of coverage.

<sup>2</sup> Judge Timothy R. Hanson originally was the assigned judge on this case. In January, 2007 the case was assigned to Judge Kate A. Toomey.

<sup>3</sup> ORS is the agency implementing Medicaid.

## DISCUSSION

Ms. Mellor moves this Court for summary judgment, requesting that she be reimbursed for claims submitted by Hayden's health care providers and paid by Medicaid between August 1, 2001 and July 31, 2003. She also requests that the Court determine the amount she should be reimbursed by WCICIL. Summary judgment "shall be rendered if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Utah R. Civ. P. 56(c). "A trial court is not authorized to weigh facts in deciding a summary judgment motion, but is only to determine whether a dispute of material fact exists, viewing the facts and all reasonable inferences to be drawn therefrom in a light most favorable to the nonmoving party." *Pigs Gun Club, Inc. v. Sanpete County*, 2002 UT 17, ¶ 24, 42 P.3d 379 (citation omitted). "'A genuine issue of fact exists where, on the basis of the facts in the record, reasonable minds could differ' on any material issue." *Ron Shepherd Ins. Inc. v. Shields*, 882 P.2d 650, 655 (Utah 1994) (citation omitted). WCICIL moves the Court to deny or stay the motion.

### Estoppel

Ms. Mellor argues that WCICIL should be required to grant her claim for reimbursement of expenses from August 1, 2001 through July 31, 2003, the period Hayden would have been eligible for COBRA had Wasatch Crest not terminated his policy prematurely and unlawfully. Ms. Mellor claims that she detrimentally relied on Wasatch Crest's statement that Hayden was no longer eligible for COBRA benefits as of the date he became eligible for Medicaid, August 1, 2001. She argues that if Wasatch Crest had not cancelled the policy she would have continued paying the monthly premiums through the last date of his eligibility for COBRA coverage. She asks the Court to estop WCICIL from denying the benefits Wasatch Crest would have had to pay if it had not led her to believe that her son's

policy was terminated so that she stopped making payments. *See Bowerman v. Wal-Mart Stores, Inc.*, 1998 U.S. Dist. LEXIS 23325, \*42 (it is unreasonable to expect a policy holder to make further inquiries after having been given certain advice); *National Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc.*, 929 F.2d 1558, 1566 (11th Cir. 1991) (when a provider misinforms a policy holder about her ability to continue coverage and the policy holder relies to her detriment, equitable estoppel may hold the provider liable).

A party asserting a claim for estoppel, must demonstrate: "(1) an admission, statement, or act inconsistent with the claim afterwards asserted, (2) action by the other party in reliance on the admission, statement, or act, and (3) injury to such other party resulting from allowing the first party to contradict or repudiate such admission, statement, or act." *Plateau Mining Co. v. Utah Div. of State Lands & Forestry*, 802 P.2d 720, 728 (Utah 1990) (citation omitted), *overruled in part* on other grounds by *State v. Mathis*, 2009 UT 85, 223 P.3d 1119. Estoppel is a doctrine of equity "to prevent one party from deluding or inducing another into a position where he will unjustly suffer loss." *FMA Fin. Corp. v. Hansen Dairy, Inc.*, 617 P.2d 327, 330 (Utah 1980) (citation omitted).

Ms. Mellor meets the first two elements for estoppel. Wasatch Crest informed her around September or October 2001 that Hayden was no longer eligible for COBRA coverage. Consequently, Ms. Mellor stopped paying the monthly premiums. She has a more difficult task demonstrating that she or Hayden was injured by Wasatch Crest's actions. Hayden's expenses were covered by Medicaid, so she was not forced to pay for expenses due to Wasatch Crest's denial of the policy. Ms. Mellor argues that she was harmed because Hayden was denied insurance coverage for which her ex-husband had contracted with Wasatch Crest. Ultimately it is not important whether Ms. Mellor can prove grounds for estoppel because the Court denies her Motion for Summary Judgment on other grounds.

### **Standing**

WCICIL argues that Ms. Mellor's motion for summary judgment should be denied or at least set aside at this time. On July 31, 2003, the Court declared that Wasatch Crest was insolvent, ordered liquidation of Wasatch Crest, and stayed further proceedings in this lawsuit. Ms. Mellor filed a timely claim against with WCICIL pursuant to section 31A-27-328, Utah Code Annotated. WCICIL denied her claim in October and December of 2005. It recently issued a Second Amended Notice of Determination, again denying Ms. Mellor's claim. WCICIL argues that its determination is essentially the law of the case because Ms. Mellor's claim in the liquidation proceedings superceded this lawsuit. WCICIL did not issue the last denial until it filed a Reply in Support of its Motion to Stay or Dismiss Ms. Mellor's motion for summary judgment. Ms. Mellor, therefore, did not have an opportunity to challenge WCICIL's denial of her claim. Ms. Mellor has the option of challenging the latest Notice of Determination, but WCICIL is correct that this case is currently about WCICIL and not Wasatch Crest anymore.

WCICIL further claims that Ms. Mellor is no longer the proper claimant, Medicaid is. Ms. Mellor has been reimbursed for her medical expenses and Medicaid is the party seeking to recover reimbursement of the money paid out during the period Hayden should have been eligible for COBRA coverage, but Medicaid failed to file a claim with the liquidation estate by the 2004 deadline. WCICIL's argument is not well taken. The Collection Agreement between Ms. Mellor and Medicaid "does nothing more than place a lien in favor of ORS or any reimbursement for medical expenses that may be recovered from Wasatch Crest." *Mellor*, 2009 UT 5 at ¶ 10. The Collection Agreement obligates Ms. Mellor to reimburse ORS for the amount it paid out in Medicaid claims during that time; any additional recovery would remain Ms. Mellor's. Ms. Mellor is the proper party.



### **Class of Claim**

WCICIL implies that even if Ms. Mellor could advance her claim for reimbursement of Hayden's medical expenses, she would be so far down the list of recipients of Wasatch Crest's creditors as to practically guarantee no compensation. Utah's Insurers Rehabilitation and Liquidation statute sets forth six levels of distribution of a liquidated company's assets. After the liquidator and guaranty associations are paid, Class Three provides reimbursement for "all claims under policies for losses incurred" but excludes "[t]hat portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant" and also excludes "obligations to insurers . . . and their claims for contribution, indemnity, or subrogation, equitable or otherwise." Utah Code Ann. § 31A-27-335(2).

WCICIL points out that Ms. Mellor is prohibited from a Class Three claim because she was indemnified by Medicaid for Hayden's medical expenses. It argues that Ms. Mellor has a Class Six claim instead. Class Six covers "any person, including claims of state or local governments, except those specifically classified elsewhere in this section[.]" *Id.* Because Ms. Mellor is excluded from Class Three, WCICIL argues, she is relegated to the catch-all of Class Six.


Ms. Mellor acknowledges that Medicaid paid her son's medical expenses, but that they did so only because of Wasatch Crest's bad acts. If Wasatch Crest had not wrongfully terminated Hayden's COBRA coverage and Medicaid stepped in, Ms. Mellor would have been a Class Three claimant. The fact that Medicaid did step in, however, renders Ms. Mellor's claim a Class Six. Ms. Mellor points to public policy suggesting that taxpayers are harmed when a private insurer wrongfully withholds benefits, thereby putting the burden on publicly funded programs such as Medicaid. *See Mellor*, 2009 UT 5 at ¶ 17 (noting that federal and state laws "evidence a clear policy of prohibiting insurance companies from shifting their obligation for medical expenses to the taxpayer-funded Medicaid

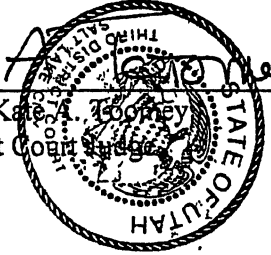
program”); *Rehabilitation Ass’n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994) (Medicaid is the payer of last resort). By misleading Ms. Mellor into terminating her son’s insurance under COBRA, Wasatch Crest shifted the burden to the taxpayers while saving itself significant amounts of money for Hayden’s care over the next two years. In this case, the Insurers Rehabilitation and Liquidation statute contravenes an equitable outcome for Ms. Mellor and ORS and consistent with the public policy against burdening the taxpayers. Utah’s Insurers Rehabilitation and Liquidation statute specifically provides that “a claim may not circumvent the priority classes through equitable remedies.” Utah Code Ann. § 31A-27-335(1)(d). The Court must administer the laws as written (*Morris v. Salt Lake City*, 35 Utah 474, 483 (Utah 1909)), and an attempt to equitably return Ms. Mellor to a Class Three, where she would have been if Medicare had not stepped in, is prohibited.

### CONCLUSION

For the foregoing reasons, the Court denies Ms. Mellor’s Motion for Summary Judgment. Ms. Mellor also requests prejudgment interest and attorney fees. The Court is not determining any judgment in favor of Ms. Mellor, so interest and fees are not appropriate. The Court grants WCICIL’s Motion to Stay because when the Court declared Wasatch Crest insolvent, it stayed further proceedings in the underlying lawsuit.

DATED this 29 day of October, 2010.

  
Judge Kate A. Toomey  
District Court Judge



CERTIFICATE OF NOTIFICATION

I certify that a copy of the attached document was sent to the following people for case 030915527 by the method and on the date specified.

MAIL: JOHN P HARRINGTON 222 SOUTH MAIN SUITE 2200 SALT LAKE CITY,  
UT 84101-2001

MAIL: BRIAN S KING 336 S 300 E STE 200 SALT LAKE CITY UT 84111

Date: Nov 1, 2000

[Signature]  
Deputy Court Clerk



2 of 100 DOCUMENTS

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\*\*\* CURRENT THROUGH PL 112-12, APPROVED 4/25/2011 \*\*\*

TITLE 42. THE PUBLIC HEALTH AND WELFARE  
CHAPTER 7. SOCIAL SECURITY ACT  
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

**Go to the United States Code Service Archive Directory**

*42 USCS § 1396*

**§ 1396. Medicaid and CHIP Payment and Access Commission**

(a) Establishment. There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) Duties.

(1) Review of access policies for all States and annual reports. MACPAC shall--

(A) review policies of the Medicaid program established under this *title* [42 USCS §§ 1396 et seq.] (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI [42 USCS §§ 1397aa et seq.] (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed. Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies. Payment policies under Medicaid and CHIP, including--

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) Eligibility policies. Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) Enrollment and retention processes. Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible

for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) Coverage policies. Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) Quality of care. Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) Interaction of Medicaid and CHIP payment policies with health care delivery generally. The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI [42 USCS §§ 1396 et seq. or 1397aa et seq.] and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) Interactions with Medicare and Medicaid. Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII [42 USCS §§ 1395 et seq.], including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) Other access policies. The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) Recommendations and reports of State-specific data. MACPAC shall--

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) Creation of early-warning system. MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) Comments on certain secretarial reports and regulations.

(A) Certain secretarial reports. If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) Regulations. MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) Agenda and additional reviews. MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI [42 USCS §§ 1396 et seq. or 1397aa et seq.] as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) Availability of reports. MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) Appropriate committee of Congress. For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) Voting and reporting requirements. With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) Examination of budget consequences. Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) Consultation and coordination with MedPAC.

(A) In general. MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") established under section 1805 [42 USCS § 1395b-6] in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII [42 USCS §§ 1395 et seq.], adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) Information sharing. MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) Consultation with States. MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) Coordinate and consult with the Federal Coordinated Health Care Office. MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 [2602] of the Patient Protection and Affordable Care Act [42 USCS § 1315b] before making any recommendations regarding dual eligible individuals.

(14) Programmatic oversight vested in the Secretary. MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) Membership.

(1) Number and appointment. MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) Qualifications.

(A) In general. The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) Inclusion. The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) Majority nonproviders. Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) Ethical disclosure. The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 [5 USCS Appx. §§ 101 et seq.] (Public Law 95-521).

(3) Terms.

(A) In general. The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) Vacancies. Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) Compensation. While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, *United States Code*; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, *United States Code*, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment bene-

fits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman. The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) Meetings. MACPAC shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants. Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may--

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (*41 U.S.C. 5*));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) Powers.

(1) Obtaining official data. MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a) [*42 USCS §§ 1396b(a)* and *1397ee(a)*], from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) Data collection. In order to carry out its functions, MACPAC shall--

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) Access of GAO to information. The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) Periodic audit. MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) Funding.

(1) Request for appropriations. MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) Authorization. There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) Funding for fiscal year 2010.

(A) In general. Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$ 9,000,000.

(B) Transfer of funds. Notwithstanding section 2104(a)(13) [*42 USCS § 1397dd(a)(13)*], from the amounts appropriated in such section for fiscal year 2010, \$ 2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) Availability. Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

## HISTORY:

**26-19-1. Short title.**

This chapter shall be known and may be cited as the "Medical Benefits Recovery Act." 1981

**26-19-2. Definitions.**

As used in this chapter:

(1) "Annuity" shall have the same meaning as provided in Section 31A-1-301.

(2) "Claim" means:

(a) a request or demand for payment; or

(b) a cause of action for money or damages arising under any law.

(3) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.

(4) "Estate" means, regarding a deceased recipient:

(a) all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201;

(b) the decedent's augmented estate as defined in Section 75-2-203; and

(c) that part of other real or personal property in which the decedent had a legal interest at the time of death including assets conveyed to a survivor, heir, or assign of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5) "Insurer" includes:

(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(b) a health maintenance organization; and

(c) any entity offering a health service benefit plan.

(6) "Medical assistance" means:

(a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

(7) "Office of Recovery Services" means the Office of Recovery Services within the Department of Human Services.

(8) "Provider" means a person or entity who provides services to a recipient.

(9) "Recipient" means:

(a) a person who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of a person under Subsection (9)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection (9)(a) if the person is deceased.

(10) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(11) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

(12) "Trust" shall have the same meaning as provided in Section 75-1-201. 1985

**26-19-3. Program established by department — Promulgation of rules.**

(1) The department shall establish and maintain a program for the recoupment of medical assistance.

(2) The department may promulgate rules to implement the purposes of this chapter. 1984

**26-19-4. Repealed.**

1984

**26-19-4.5. Assignment of rights to benefits.**

(1) (a) To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.

(b) The assignment:

(i) authorizes the department to submit its claim to the third party and authorizes payment of benefits directly to the department; and

(ii) is effective for all medical assistance.

(2) The department may recover the assigned benefits or payments in accordance with Section 26-19-5 and as otherwise provided by law.

(3) The assignment of benefits includes medical support and third party payments ordered, decreed, or adjudged by any court of this state or any other state or territory of the United States. That assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.

(4) When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department. 1998

**26-19-5. Recovery of medical assistance from third party — Lien — Notice — Action — Compromise or waiver — Recipient's right to action protected.**

(1) (a) When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance directly from that third party.

(b) Any claim arising under Subsection (1)(a) or Section 26-19-4.5 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for attorney's fees and costs authorized under Subsection 26-19-7(2)(c)(ii).

(2) (a) The department shall mail or deliver written notice of its claim or lien to the third party at its principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.



(3) The department may commence an action on its claim or lien in its own name, but that claim or lien is not enforceable as to a third party unless:

- (a) the third party receives written notice of the department's claim or lien before it settles with the recipient; or
- (b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

(4) The department may:

- (a) waive a claim or lien against a third party in whole or in part; or
- (b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) The department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

2005

#### **26-19-6. Action by department — Notice to recipient.**

(1) (a) Within 30 days after commencing an action under Subsection 26-19-5(3), the department shall give the recipient, his guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:

- (i) personal service or certified mail to the last known address of the person receiving the notice; or
- (ii) if no last-known address is available, by publishing a notice once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides.

(b) Proof of service shall be filed in the action.

(c) The recipient may intervene in the department's action at any time before trial.

(2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:

- (a) the right to intervene in the proceeding;
- (b) the right to obtain a private attorney; and
- (c) the department's right to recover medical assistance directly from the third party.

2004

#### **26-19-7. Notice of claim by recipient — Department response — Conditions for proceeding — Collection agreements — Department's right to intervene — Department's interests protected — Remitting funds — Disbursements — Liability and penalty for noncompliance.**

(1) (a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).

(b) For purposes of Subsection (1)(a), consent may be obtained if:

- (i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within ten days of making his claim or commencing an action; or
- (ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:

(A) within 30 days after being retained by the recipient for that purpose; or

(B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.

(c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.

(d) The notice of claim shall include the following information:

- (i) the name of the recipient;
- (ii) the recipient's Social Security number;
- (iii) the recipient's date of birth;
- (iv) the name of the recipient's attorney if applicable;
- (v) the name or names of individuals or entities against whom the recipient is making the claim, if known;
- (vi) the name of the third party's insurance carrier, if known;
- (vii) the date of the incident giving rise to the claim; and
- (viii) a short statement identifying the nature of the recipient's claim.

(2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the following:

(i) if the department has a claim or lien pursuant to Section 26-19-5 or has become obligated to provide medical assistance; and

(ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).

(b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:

- (i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or
- (ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

- (A) failing to comply with the notice provisions of this section;
- (B) failing or refusing to enter into a collection agreement;
- (C) failing to comply with the terms of a collection agreement with the department; or
- (D) failing to disburse funds owed to the state in accordance with this section.

(c) (i) The collection agreement shall be:

- (A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and
- (B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.

(ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay attorney's fees at the rate of 33.3% of the department's total recovery and shall pay a propor-

tionate share of the litigation expenses directly related to the action.

(d) The department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

(3) (a) If the department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim:

(i) any medical expenses paid by the department; or

(ii) any medical costs for which the department is obligated to provide medical assistance.

(b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

(4) If the department receives notice pursuant to Subsection (1), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

(5) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

(6) (a) If the recipient proceeds without complying with the provisions of this section, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department may recover in full from the recipient or any party to which the proceeds were made payable all medical assistance which it has provided and retains its right to commence an independent action against the third party, subject to Subsection 26-19-5(3).

(7) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

(8) (a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient's attorney must be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds must be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(9) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (5);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney's fees and litigation expenses related to recovering the department's claim. 2005

**26-19-8. Statute of limitations — Survival of right of action — Insurance policy not to limit time allowed for recovery.**

(1) (a) An action commenced by the department under this chapter against a health insurance carrier or employee welfare benefit plan must be commenced within:

(i) two years after the date of the injury or onset of the illness; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable must be commenced within:

(i) four years after the date of the injury or onset of the illness; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(2) The death of the recipient does not abate any right of action established by this chapter.

(3) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.

(4) The provisions of this section do not apply to Section 26-19-13.5.

(5) The provisions of this section supercede any other sections regarding the time limit in which an action must be commenced, including Section 75-7-509. 2004

**26-19-9. Employee benefit plans.**

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for or is provided services under the state plan. 1993

**26-19-9.5. Availability of insurance policy.**

If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:

(1) provide a written explanation if the claim is denied;

(2) specifically describe and request any additional information from the department that is necessary to process the claim; and

(3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy. 2004

**26-19-9.7. Legal recognition of electronic claims records.**

Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

(1) a claim submitted to the department for payment may not be denied legal effect, enforceability, or admissibility as evidence in any court in any civil action because it is in electronic form; and

(2) a third party shall accept an electronic record of payments by the department for medical services on behalf of a recipient as evidence in support of the department's claim. 2004

**26-19-10 to 26-19-13. Repealed.**

1984, 1998

**26-19-13.5. Estate and trust recovery.**

(1) Upon a recipient's death, the department may recover from the recipient's estate and any trust, in which the recipi-

ditor. Any excess received by the creditor shall be held in trust for the other person. As used in this section, "another person" or "other person" does not apply to a guaranty fund or association. 1986

#### 1A-27-334. Secured claims.

1) An allowed claim of a creditor that is secured by a lien property in which the insurer who is subject to a liquidation has an interest, or that is subject to setoff under Section 1A-27-323, is a secured claim to the extent of the value of the creditor's interest in the insurer's interest in the property or to the extent of the amount subject to setoff.

2) The value of any security for a claim is determined under the supervision and control of the court:

(a) by converting it into money according to the terms of the agreement under which the security was granted to or retained by the creditor; or

(b) by agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

3) The net amount received under Subsection (2)(a) or the amount determined under Subsection (2)(b) shall be credited to the secured claim, and any deficiency shall be allowed as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim shall be allowed as if unsecured. 1986

#### 1A-27-335. Priority of distribution.

(a) Every claim in each class of claims from the insurer's estate shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment.

(b) Once the funds are retained by the liquidator and approved by the court, the insurer's estate shall have no further liability to members of that class except to the extent of the retained funds and any other undistributed funds.

(c) Subclasses may not be established within any class.

(d) A claim by a shareholder, policyholder, or other creditor may not be permitted to circumvent the priority classes through the use of equitable remedies.

The classes and order of distribution are as described in Sections (2)(a) through (i).

(a) Class one is the costs and expenses of administration expressly approved by the liquidator, including:

(i) the actual and necessary costs of preserving or recovering the assets of the insurer;

(ii) compensation for all authorized services rendered in the supervision, rehabilitation, or liquidation;

(iii) any necessary filing fees;

(iv) the fees and mileage payable to witnesses; and

(v) reasonable attorney's fees and other professional services rendered in the supervision, rehabilitation, or liquidation.

(b) (i) Class two is the administrative expenses of guaranty associations.

(ii) For purposes of this section, "administrative expenses of a guaranty association" means the reasonable expenses incurred by a guaranty association:

(A) when the expenses are not payments or expenses that are required to be incurred as direct policy benefits in fulfillment of the terms of the insurance contract or policy; and

(B) that are of the type and nature that, but for the activities of the guaranty association, otherwise would have been incurred by the liquidator, including:

(I) evaluations of policy coverage;

(II) activities involved in the adjustment and settlement of claims under policies, in-

cluding those of in-house or outside adjusters; and

(III) the reasonable expenses incurred in connection with the arrangements for ongoing coverage through transfer to other insurers, policy exchanges, or maintaining policies in force.

(iii) The liquidator may in the liquidator's sole discretion approve as an administrative expense of a guaranty association any other reasonable expenses of the guaranty association if the liquidator finds:

(A) the expenses are not expenses required to be paid or incurred as direct policy benefits by the terms of the policy; and

(B) the expenses were incurred in furtherance of activities that provided material economic benefit to the estate as a whole, irrespective of whether the activities resulted in additional benefits to covered claimants.

(iv) The court shall approve the expenses approved by the liquidator under Subsection (2)(b)(iii) unless the court finds the liquidator abused the liquidator's discretion in approving the expenses.

(c) (i) Class three is all claims under policies for losses incurred including:

(A) claims of the federal, state, or local government;

(B) third party claims;

(C) claims for unearned premiums; and

(D) claims of a guaranty association, other than those included in class two, including claims for payment of covered claims or covered obligations of the insurer.

(ii) All claims under life and health insurance and annuity policies shall be treated as loss claims.

(iii) That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant are not included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support, by way of succession at death, as proceeds of life insurance, or as gratuities. A payment made by an employer to the employer's employee may not be treated as a gratuity.

(iv) Notwithstanding Subsections (2)(c)(i), (ii), and (iii), the following claims shall be excluded from class three priority:

(A) obligations of the insolvent insurer arising out of reinsurance contracts;

(B) obligations incurred after:

(I) the expiration date of the insurance policy;

(II) the policy has been replaced by the insured;

(III) the policy has been canceled at the insured's request; or

(IV) the policy has been canceled as provided in the chapter;

(C) obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(D) any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer;

(E) any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy; and

- (F) tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices.
- (v) Notwithstanding Subsection (2)(c)(iv)(B), unearned premium claims on policies, other than reinsurance agreements, may not be excluded.
- (d) Class four is claims of the federal government other than those claims included under class three.
- (e) (i) Class five is debts due employees for services, benefits, contractual or otherwise due, arising out of reasonable compensation to employees for services performed:
- (A) to the extent that they:
    - (I) do not exceed two months of monetary compensation; and
    - (II) represent payment for services performed within six months before the filing of the petition for liquidation; or
  - (B) if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation.
- (ii) Principal officers and directors are not entitled to the benefit of class five priority except as otherwise approved by the liquidator and the court.
- (iii) Class five priority shall be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.
- (f) (i) Class six is claims of:
- (A) any person, including claims of state or local governments, except those specifically classified elsewhere in this section; or
  - (B) attorneys for fees and expenses owed them by a person for services rendered in opposing a formal delinquency proceeding.
- (ii) To prove the claim for attorneys' fees and expenses, the claimant shall show that:
- (A) the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information, and belief, formed after reasonable inquiry indicating opposition was:
    - (I) in the best interests of the person;
    - (II) well grounded in fact; and
    - (III) warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and
  - (B) opposition was not pursued for any improper purpose, such as to:
    - (I) harass;
    - (II) cause unnecessary delay; or
    - (III) cause needless increase in the cost of litigation.
- (g) (i) Class seven is claims of any state or local government for a penalty or forfeiture, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, including the reasonable and actual costs incurred from the act, transaction, or proceeding.
- (ii) The remainder of the claims shall be postponed to class eight claims.
- (h) Class eight is:
- (i) surplus or contribution notes or similar obligations;
  - (ii) premium refunds on assessable policies;
  - (iii) interest on claims of classes one through seven; and
  - (iv) any other claims specifically subordinated to this class.
- (i) Class nine is claims of shareholders or other owners, including policyholders of a mutual insurance corporation within the limits of Subsection 31A-27-337(4)(b) except as they may be qualified in class three or four.
- (3) (a) If the liquidator determines that the assets of the estate will be sufficient to pay all class one claims in full, class two claims shall be paid currently, only after the liquidator secures from each of the guaranty associations receiving disbursements under this section an agreement to return to the liquidator the disbursements, together with investment income actually earned on the disbursements, as may be required to pay class one claims.
- (b) A guaranty association entering into an agreement under Subsection (3)(a) may not be required to post a bond.
- (4) As to a nonprofit corporation organized and operating under Chapter 7 with assets not fully liquidated under Subsections (1) and (2), the remaining assets shall be distributed under Subsections 16-6a-1405(1)(b) and (c) and Subsection 16-6a-1405(2).
- (5) (a) If any claimant of this state, another state, or foreign country is entitled to or receives a distribution upon the claimant's claim out of a statutory deposit or the proceeds of any bond or other asset located in another state or foreign country, unless the deposit or proceeds shall have been delivered to the domiciliary liquidator the claimant is not entitled to any further distribution from the liquidator until and unless all other claimants of the same class, irrespective of residence or place of the acts or contracts upon which their claims are based, shall have received an equal distribution upon their claims.
- (b) After the equalization under Subsection (5)(a), the claimants of the same class are entitled to share in the further distributions by the liquidator, along with and like all other creditors of the same class, wherever the claimants reside.
- (6) Upon the declaration of a distribution, the liquidator shall apply the amount of the distribution against any indebtedness owed to the insurer by the person entitled to the distribution. There shall be no claim allowed for and deductible charged by a guaranty association or entity performing a similar function.
- (7) This section applies retrospectively to any proceeding under this chapter initiated after January 1, 1992. 199
- 31A-27-335.5. Health maintenance organization claims.**
- In the liquidation of a health maintenance organization claims for uncovered expenditures have priority over the third class of claims as provided for in Section 31A-27-335. All other claims shall follow the priority of distribution outlined in Section 31A-27-335. 199
- 31A-27-336. Liquidator's recommendations to the court.**
- (1) The liquidator shall review all claims duly filed in the liquidation and shall make any further investigation as he considers necessary. He may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court, except where the liquidator is required by law to accept claims as settled by another person including a guaranty fund or association. Unresolved dispute shall be determined under Section 31A-27-332. As soon as practicable, the liquidator shall present to the court the reports of claims against the insurer with the liquidator's recommendations. The liquidator shall notify claimants of these recommendations. The report shall include the name and address of each claimant, the particulars of the claim, and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the

- (b) (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the board at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.
- (ii) State government officer and employee members may decline to receive per diem and expenses for their service.
- (c) Legislators on the committee shall receive compensation and expenses as provided by law and legislative rule.

2008

## PART 6

### COURT SECURITY

#### 78A-2-601. Security surcharge — Application and exemptions — Deposit in restricted account.

- (1) In addition to any fine, penalty, forfeiture, or other surcharge, a security surcharge of \$33 shall be assessed in all courts of record on all criminal convictions and juvenile delinquency judgments.
- (2) The security surcharge may not be imposed upon:
  - (a) nonmoving traffic violations;
  - (b) community service; and
  - (c) penalties assessed by the juvenile court as part of the nonjudicial adjustment of a case under Section 78A-6-602.
- (3) The security surcharge shall be collected after the surcharge under Section 51-9-401, but before any fine, and deposited with the state treasurer. A fine that would otherwise have been charged may not be reduced due to the imposition of the security surcharge.
- (4) The state treasurer shall deposit the collected security surcharge in the restricted account, Court Security Account, as provided in Section 78A-2-602.

2009

#### 78A-2-602. Court Security Account established — Funding — Uses.

- (1) There is created a restricted account in the General Fund known as the Court Security Account.
- (2) The state treasurer shall deposit in the Court Security Account:
  - (a) collected monies from the surcharge established in Section 78A-2-601;
  - (b) monies from the portion of filing fees established in Subsections 78A-2-301(1)(j)(iv) and (v); and
  - (c) amounts designated by Subsection 78A-7-122 (3)(b)(ii).
- (3) The Administrative Office of the Courts shall use the allocation to contract for court security at all district and juvenile courts throughout the state.

2009

## CHAPTER 3

### SUPREME COURT

Section	
78A-3-101.	Number of justices — Terms — Chief justice and associate chief justice — Selection and functions.
78A-3-102.	Supreme Court jurisdiction.
78A-3-103	Supreme Court — Rulemaking, judges pro tempore, and practice of law.
78A-3-104.	Appellate court administrator.
78A-3-105.	Service of sheriff to court.

#### 78A-3-101. Number of justices — Terms — Chief justice and associate chief justice — Selection and functions.

- (1) The Supreme Court consists of five justices.
- (2) A justice of the Supreme Court shall be appointed initially to serve until the first general election held more than three years after the effective date of the appointment. Thereafter, the term of office of a justice of the Supreme Court is ten years and commences on the first Monday in January following the date of election. A justice whose term expires may serve upon request of the Judicial Council until a successor is appointed and qualified.
- (3) The justices of the Supreme Court shall elect a chief justice from among the members of the court by a majority vote of all justices. The term of the office of chief justice is four years. The chief justice may serve successive terms. The chief justice may resign from the office of chief justice without resigning from the Supreme Court. The chief justice may be removed from the office of chief justice by a majority vote of all justices of the Supreme Court.
- (4) If the justices are unable to elect a chief justice within 30 days of a vacancy in that office, the associate chief justice shall act as chief justice until a chief justice is elected under this section. If the associate chief justice is unable or unwilling to act as chief justice, the most senior justice shall act as chief justice until a chief justice is elected under this section.
- (5) In addition to the chief justice's duties as a member of the Supreme Court, the chief justice has duties as provided by law.
- (6) There is created the office of associate chief justice. The term of office of the associate chief justice is two years. The associate chief justice may serve in that office no more than two successive terms. The associate chief justice shall be elected by a majority vote of the members of the Supreme Court and shall be allocated duties as the chief justice determines. If the chief justice is absent or otherwise unable to serve, the associate chief justice shall serve as chief justice. The chief justice may delegate responsibilities to the associate chief justice as consistent with law.

2008

#### 78A-3-102. Supreme Court jurisdiction.

- (1) The Supreme Court has original jurisdiction to answer questions of state law certified by a court of the United States.
- (2) The Supreme Court has original jurisdiction to issue all extraordinary writs and authority to issue all writs and process necessary to carry into effect its orders, judgments, and decrees or in aid of its jurisdiction.
- (3) The Supreme Court has appellate jurisdiction, including jurisdiction of interlocutory appeals, over:
  - (a) a judgment of the Court of Appeals;
  - (b) cases certified to the Supreme Court by the Court of Appeals prior to final judgment by the Court of Appeals;
  - (c) discipline of lawyers;
  - (d) final orders of the Judicial Conduct Commission;
  - (e) final orders and decrees in formal adjudicative proceedings originating with:
    - (i) the Public Service Commission;
    - (ii) the State Tax Commission;
    - (iii) the School and Institutional Trust Lands Board of Trustees;
    - (iv) the Board of Oil, Gas, and Mining;
    - (v) the state engineer; or
    - (vi) the executive director of the Department of Natural Resources reviewing actions of the Division of Forestry, Fire, and State Lands,
  - (f) final orders and decrees of the district court review of informal adjudicative proceedings of agencies under Subsection (3)(e);
  - (g) a final judgment or decree of any court of record holding a statute of the United States or this state

unconstitutional on its face under the Constitution of the United States or the Utah Constitution;

(h) interlocutory appeals from any court of record involving a charge of a first degree or capital felony;

(i) appeals from the district court involving a conviction or charge of a first degree felony or capital felony;

(j) orders, judgments, and decrees of any court of record over which the Court of Appeals does not have original appellate jurisdiction; and

(k) appeals from the district court of orders, judgments, or decrees ruling on legislative subpoenas.

(4) The Supreme Court may transfer to the Court of Appeals any of the matters over which the Supreme Court has original appellate jurisdiction, except:

(a) capital felony convictions or an appeal of an interlocutory order of a court of record involving a charge of a capital felony;

(b) election and voting contests;

(c) reapportionment of election districts;

(d) retention or removal of public officers;

(e) matters involving legislative subpoenas; and

(f) those matters described in Subsections (3)(a) through (d).

(5) The Supreme Court has sole discretion in granting or denying a petition for writ of certiorari for the review of a Court of Appeals adjudication, but the Supreme Court shall review those cases certified to it by the Court of Appeals under Subsection (3)(b).

(6) The Supreme Court shall comply with the requirements of Title 63G, Chapter 4, Administrative Procedures Act, in its review of agency adjudicative proceedings. 2009

#### **78A-3-103. Supreme Court — Rulemaking, judges pro tempore, and practice of law.**

(1) The Supreme Court shall adopt rules of procedure and evidence for use in the courts of the state and shall by rule manage the appellate process. The Legislature may amend the rules of procedure and evidence adopted by the Supreme Court upon a vote of two-thirds of all members of both houses of the Legislature.

(2) Except as otherwise provided by the Utah Constitution, the Supreme Court by rule may authorize retired justices and judges and judges pro tempore to perform any judicial duties. Judges pro tempore shall be citizens of the United States, Utah residents, and admitted to practice law in Utah.

(3) The Supreme Court shall by rule govern the practice of law, including admission to practice law and the conduct and discipline of persons admitted to the practice of law. 2008

#### **78A-3-104. Appellate court administrator.**

The appellate court administrator shall appoint clerks and support staff as necessary for the operation of the Supreme Court and the Court of Appeals. The duties of the clerks and support staff shall be established by the appellate court administrator, and powers established by rule of the Supreme Court. 2008

#### **78A-3-105. Service of sheriff to court.**

The court may at any time require the attendance and services of any sheriff in the state. 2008

### **CHAPTER 4**

#### **COURT OF APPEALS**

##### **Section**

78A-4-101. Creation — Seal.

78A-4-102. Number of judges — Terms — Functions — Filing fees.

78A-4-103. Court of Appeals jurisdiction.

78A-4-104. Location of Court of Appeals.

##### **Section**

78A-4-105. Review of actions by Supreme Court.

78A-4-106. Appellate Mediation Office — Protected records and information — Governmental immunity.

#### **78A-4-101. Creation — Seal.**

There is created a court known as the Court of Appeals. The Court of Appeals is a court of record and shall have a seal. 2008

#### **78A-4-102. Number of judges — Terms — Functions — Filing fees.**

(1) The Court of Appeals consists of seven judges. The term of appointment to office as a judge of the Court of Appeals is until the first general election held more than three years after the effective date of the appointment. Thereafter, the term of office of a judge of the Court of Appeals is six years and commences on the first Monday in January, next following the date of election. A judge whose term expires may serve, upon request of the Judicial Council, until a successor is appointed and qualified. The presiding judge of the Court of Appeals shall receive as additional compensation \$1,000 per annum or fraction thereof for the period served.

(2) The Court of Appeals shall sit and render judgment in panels of three judges. Assignment to panels shall be by random rotation of all judges of the Court of Appeals. The Court of Appeals by rule shall provide for the selection of a chair for each panel. The Court of Appeals may not sit en banc.

(3) The judges of the Court of Appeals shall elect a presiding judge from among the members of the court by majority vote of all judges. The term of office of the presiding judge is two years and until a successor is elected. A presiding judge of the Court of Appeals may serve in that office no more than two successive terms. The Court of Appeals may by rule provide for an acting presiding judge to serve in the absence or incapacity of the presiding judge.

(4) The presiding judge may be removed from the office of presiding judge by majority vote of all judges of the Court of Appeals. In addition to the duties of a judge of the Court of Appeals, the presiding judge shall:

(a) administer the rotation and scheduling of panels;

(b) act as liaison with the Supreme Court;

(c) call and preside over the meetings of the Court of Appeals; and

(d) carry out duties prescribed by the Supreme Court and the Judicial Council.

(5) Filing fees for the Court of Appeals are the same as for the Supreme Court. 2008

#### **78A-4-103. Court of Appeals jurisdiction.**

(1) The Court of Appeals has jurisdiction to issue all extraordinary writs and to issue all writs and process necessary:

(a) to carry into effect its judgments, orders, and decrees; or

(b) in aid of its jurisdiction.

(2) The Court of Appeals has appellate jurisdiction, including jurisdiction of interlocutory appeals, over:

(a) the final orders and decrees resulting from formal adjudicative proceedings of state agencies or appeals from the district court review of informal adjudicative proceedings of the agencies, except the Public Service Commission, State Tax Commission, School and Institutional Trust Lands Board of Trustees, Division of Forestry, Fire, and State Lands actions reviewed by the executive director of the Department of Natural Resources, Board of Oil, Gas, and Mining, and the state engineer;

(b) appeals from the district court review of:

(i) adjudicative proceedings of agencies of political subdivisions of the state or other local agencies; and

**le 4. Appeal as of right: when taken.**

a) *Appeal from final judgment and order.* In a case in which appeal is permitted as a matter of right from the trial court, the appellate court, the notice of appeal required by Rule 3 shall be filed with the clerk of the trial court within 30 days after the date of entry of the judgment or order appealed from. However, when a judgment or order is entered in a statutory voidable entry or unlawful detainer action, the notice of appeal required by Rule 3 shall be filed with the clerk of the trial court within 10 days after the date of entry of the judgment or order appealed from.

b) *Time for appeal extended by certain motions.*

b)(1) If a party timely files in the trial court any of the following motions, the time for all parties to appeal from the judgment runs from the entry of the order disposing of the motion:

b)(1)(A) a motion for judgment under Rule 50(b) of the Utah Rules of Civil Procedure;

b)(1)(B) a motion to amend or make additional findings of fact, whether or not an alteration of the judgment would be required if the motion is granted, under Rule 52(b) of the Utah Rules of Civil Procedure;

b)(1)(C) a motion to alter or amend the judgment under Rule 59 of the Utah Rules of Civil Procedure;

b)(1)(D) a motion for a new trial under Rule 59 of the Utah Rules of Civil Procedure; or

b)(1)(E) a motion for a new trial under Rule 24 of the Utah Rules of Criminal Procedure.

b)(2) A notice of appeal filed after announcement or entry of judgment, but before entry of an order disposing of any motion listed in Rule 4(b), shall be treated as filed after entry of the order and on the day thereof, except that such a notice of appeal is effective to appeal only from the underlying judgment. To appeal from a final order disposing of any motion entered in Rule 4(b), a party must file a notice of appeal or an amended notice of appeal within the prescribed time measured from the entry of the order.

c) *Filing prior to entry of judgment or order.* A notice of appeal filed after the announcement of a decision, judgment, order but before entry of the judgment or order shall be treated as filed after such entry and on the day thereof.

d) *Additional or cross-appeal.* If a timely notice of appeal is filed by a party, any other party may file a notice of appeal within 14 days after the date on which the first notice of appeal was filed, or within the time otherwise prescribed by paragraphs (a) and (b) of this rule, whichever period last expires.

e) *Extension of time to appeal.* The trial court, upon a showing of excusable neglect or good cause, may extend the time for filing a notice of appeal upon motion filed not later than 30 days after the expiration of the time prescribed by paragraphs (a) and (b) of this rule. A motion filed before expiration of the prescribed time may be ex parte unless the trial court otherwise requires. Notice of a motion filed after expiration of the prescribed time shall be given to the other parties in accordance with the rules of practice of the trial court. No extension shall exceed 30 days past the prescribed time or 10 days from the date of entry of the order granting the motion, whichever occurs later.

f) *Motion to reinstate period for filing a direct appeal in criminal cases.* Upon a showing that a criminal defendant was deprived of the right to appeal, the trial court shall reinstate the thirty-day period for filing a direct appeal. A defendant seeking such reinstatement shall file a written motion in the sentencing court and serve the prosecuting entity. If the defendant is not represented and is indigent, the court shall appoint counsel. The prosecutor shall have 30 days after service of the motion to file a written response. If the prosecutor opposes the motion, the trial court shall set a hearing at

which the parties may present evidence. If the trial court finds by a preponderance of the evidence that the defendant has demonstrated that he was deprived of his right to appeal, it shall enter an order reinstating the time for appeal. The defendant's notice of appeal must be filed with the clerk of the trial court within 30 days after the date of entry of the order.

(g) *Appeal by an inmate confined in an institution.* If an inmate confined in an institution files a notice of appeal in either a civil case or a criminal case, the notice of appeal is timely filed if it is deposited in the institution's internal mail system on or before the last day for filing. Timely filing may be shown by a notarized statement or written declaration setting forth the date of deposit and stating that first-class postage has been prepaid. If a notice of appeal is filed in the manner provided in this paragraph (f), the 14-day period provided in paragraph (d) runs from the date when the trial court receives the first notice of appeal.

**Rule 5. Discretionary appeals from interlocutory orders.**

(a) *Petition for permission to appeal.* An appeal from an interlocutory order may be sought by any party by filing a petition for permission to appeal from the interlocutory order with the clerk of the appellate court with jurisdiction over the case within 20 days after the entry of the order of the trial court, with proof of service on all other parties to the action. A timely appeal from an order certified under Rule 54(b), Utah Rules of Civil Procedure, that the appellate court determines is not final may, in the discretion of the appellate court, be considered by the appellate court as a petition for permission to appeal an interlocutory order. The appellate court may direct the appellant to file a petition that conforms to the requirements of paragraph (c) of this rule.

(b) *Fees and copies of petition.* For a petition presented to the Supreme Court, the petitioner shall file with the Clerk of the Supreme Court an original and five copies of the petition, together with the fee required by statute. For a petition presented to the Court of Appeals, the petitioner shall file with the Clerk of the Court of Appeals an original and four copies of the petition, together with the fee required by statute. The petitioner shall serve the petition on the opposing party and notice of the filing of the petition on the trial court. If an order is issued authorizing the appeal, the clerk of the appellate court shall immediately give notice of the order by mail to the respective parties and shall transmit a certified copy of the order, together with a copy of the petition, to the trial court where the petition and order shall be filed in lieu of a notice of appeal.

(c) *Content of petition.*

(c)(1) The petition shall contain:

(c)(1)(A) A concise statement of facts material to a consideration of the issue presented and the order sought to be reviewed;

(c)(1)(B) The issue presented expressed in the terms and circumstances of the case but without unnecessary detail, and a demonstration that the issue was preserved in the trial court. Petitioner must state the applicable standard of appellate review and cite supporting authority;

(c)(1)(C) A statement of the reasons why an immediate interlocutory appeal should be permitted, including a concise analysis of the statutes, rules or cases believed to be determinative of the issue stated; and

(c)(1)(D) A statement of the reason why the appeal may materially advance the termination of the litigation.

(c)(2) If the appeal is subject to assignment by the Supreme Court to the Court of Appeals, the phrase "Subject to assignment to the Court of Appeals" shall appear immediately under the title of the document, i.e. Petition for Permission to