

1991

Jackie Robertson, Craig Robertson v. Gem Insurance Company : Brief of Appellant

Utah Supreme Court

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IN THE SUPREME COURT OF UTAH

JACKIE ROBERTSON and
CRAIG ROBERTSON,

Plaintiffs/Appellants,

vs.

GEM INSURANCE COMPANY,
Defendant/Appellee.

Case No. ~~91-0214~~

91-0214-CA

BRIEF OF APPELLANT

APPEAL FROM THE FINAL JUDGMENT
OF THE FOURTH JUDICIAL DISTRICT,
UTAH COUNTY, STATE OF UTAH
HONORABLE BOYD L. PARK, JUDGE

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**JACKIE ROBERTSON and
CRAIG ROBERTSON,**

Plaintiffs/Appellants,

vs.

GEM INSURANCE COMPANY,
Defendant/Appellee.

Case No. 900472

BRIEF OF APPELLANT

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OF THE FOURTH JUDICIAL DISTRICT,
UTAH COUNTY, STATE OF UTAH
HONORABLE BOYD L. PARK, JUDGE

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STATEMENT OF JURISDICTION

This is a civil action for insurance benefits, damages and attorney's fees resulting from wrongful denial of a health insurance claim.

Jurisdiction of the court appealed from is based on Utah Annotated Section 78-3-4(1) (1953).

Jurisdiction of the Utah Supreme Court to hear this appeal is based on Utah Code Annotated Section 78-2-2(3)(j). This case has been certified by the Utah Court of Appeals to the Utah Supreme Court pursuant to Rule 43 of the Utah Rules of Appellate Procedure.

Judgment of the trial court was entered September 5, 1990. Appellants' Notice of Appeal was served and filed on September 18, 1990.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

Two issues are raised on this appeal. First, whether the court properly granted appellee's Motion for Summary Judgment on the basis that appellants' causes of action are governed by the Federal Employee Retirement Income Security Act (ERISA). Secondly, whether the court erred in limiting appellantss award of attorney's fees solely to those issues upon which they had prevailed.

DETERMINATIVE STATUTES

Federal Employee Retirement Income Security Act of 1974, 29 U.S.C.A. 1001 et. seq. (ERISA).

STATEMENT OF THE CASE

On or about December 25, 1988 plaintiff/appellant, Jackie Robertson, injured her neck. Jackie Robertson submitted claims for the medical care she received to Gem Insurance Company. Defendant/Appellee, Gem Insurance Company denied coverage alleging that Jackie Robertson's injury was a pre-existing condition. On July 20th 1989, appellants initiated suit for wrongful denial of the insurance claim in the Fourth Judicial District Court of Utah County, State of Utah. On September 11, 1989 defendant/appellee filed a Motion to Dismiss on the basis that ERISA governed the case at bar and therefore preempted Utah state law which allowed for claims such as breach of implied covenant of good faith and fair dealing, intentional infliction of emotional distress and punitive damages. On November 6th 1989, the trial court granted the defendant's/appellee's Motion to Dismiss, allowing trial on only the issue of plaintiffs/appellants claim for policy benefits and attorney fees. Trial was held and final judgment was entered on August 24, 1990 for the appellants, Robertson, and against Gem Insurance Company. Plaintiffs/Appellants submit that the trial court erred in granting the defendant's/appellee's Motion for Summary Judgment, in ruling that ERISA governed the case at bar and in dismissing the appellants' claims for breach of implied covenant of good faith and fair dealing, intentional infliction of emotional distress and punitive damages.

STATEMENT OF FACTS

1. On or about October 26, 1988, Mountain States Steel, appellant Craig Robertson's employer, applied for membership in the Intermountain Employers Trust (IMET) a multiple employers trust which had contracted for group health insurance with appellee, Gem Insurance Company, for purposes of allowing employees to acquire group health insurance. (See Statement of Facts in defendant/appellee Gem Insurance Company's Memorandum in Support of it's Motion to Dismiss, R. 35) Mountain States Steel was accepted by IMET on November 1, 1988 (See R. 36)

2. Appellants Jackie Robertson and Craig Robertson became beneficiaries under the Gem Policy of Insurance also effective November 1, 1988. (See R. 36)

3. During the relevant policy period appellant Jackie Robertson incurred certain medical expenses. Notice and proof of loss was given to appellee Gem Insurance Company. (See plaintiff's complaint below R. 1, 2, and Memorandum Decision R. 239)

4. Benefits were denied appellants by appellee. (See plaintiff's complaint R. 2, 3 and Memorandum Decision R. 239)

5. On or about July 20, 1989, appellants initiated the present action alleging that appellee wrongfully denied coverage, breached the relevant terms of the insurance policy, and breached an implied covenant of good faith and fair dealing. Appellant further alleged that appellee Gem Insurance Company made representations to appellants that were known to be false or misleading and at the time that such representations were made that

Gem Insurance knew or should have known such representations would cause appellants emotional distress. Appellants further plead for punitive damages based on Gem Insurance Company's alleged conduct. Appellants further prayed for all direct and consequential damages incurred as a result of appellee's breach and other conduct. (See plaintiff's complaint R. 1-4)

6. Appellee subsequently made a motion to dismiss all of appellants' causes of action with the exception of an action for policy benefits only. The basis of such motion was that appellants' causes of action are preempted by the Federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. 1001 et. seq. (R. 35). After written memoranda parties were filed and oral arguments were held. The Court held that appellants' causes of action were governed by ERISA and dismissed appellants' causes of action with the exception of that for policy benefits. (R. 84, 85)

7. A non-jury trial was held on the 25th day of June 1990, regarding the issues of policy benefits and attorney's fees.

8. Findings of Fact and Conclusions of Law and Judgment were entered by the Court on the 5th day of September 1990. The Court found that policy benefits had been wrongfully denied appellant Jackie Robertson and that appellants were entitled to attorney's fees in the amount of \$65 an hour for time spent by appellants' attorneys regarding such issues upon which appellants prevailed, (particularly a question of whether policy benefits had been wrongfully denied in the amount of benefits due under the policy)

(R. 252-258)

9. Appellee tendered judgment in the amount of \$13,764.22, such sum representing the amount of policy benefits due and such attorney's fees as awarded by the Court. Such amount was accepted by appellants and satisfaction of judgment was entered. (R. 260, 261)

10. This appeal was then taken by appellants Robertson (See Notice for Appeal R.262)

11. Prior to trial of the matter but after the incurrence and submission of medical bills by appellant Jackie Robertson, Gem Insurance Company unilaterally terminated its agreement to provide insurance to Mountain States Steel. (R. 119, 232, (Def's exhibit No. 1.))

ARGUMENT

POINT I

BECAUSE APPELLANTS APPEAL FOR THE GRANTING OF A MOTION FOR SUMMARY JUDGMENT BELOW, ALL QUESTIONS OF FACT MUST BE RESOLVED IN APPELLANTS' FAVOR.

Appellants challenge the Court's entry of Summary Judgment particularly holding that appellants' causes of action are preempted by the Employment Retirement Income Security Act of 1974, 29 U.S.C.A. 1001 et. seq. (ERISA). As will be pointed out below whether or not the relevant policy of insurance falls under ERISA is a question of fact. Any questions of fact must be resolved in favor of appellants. (See eg. Themy v. Seagull Enterprises Inc.

595 P.2d 526 (Utah 1979); Briggs v. Holcomb, 740 P.2d 281 (Utah App. 1987); Copper State Leasing Company v. Blacker Appliance and Furniture Company, 770 P.2d 88 (1988); Reeves v. Geigy Pharmaceutical Inc. 764 P.2d 636 (Utah App. 1988)).

Likewise, in considering an appeal from a granting of Summary Judgment, the Appellate Court must view the facts in the light most favorable to a losing party below. See eg., Blue Cross and Blue Shield v. State, 779 P.2d 634 (Utah 1989).

The Employee Retirement Income Security Act of 1974 governs "employee welfare benefit plans" (See 29 U.S.C.A. Section 1002 (3) and Section 1003(a)).¹ ERISA provides for pre-emption of state law insofar as it purports to apply to "employee benefit plans" (See 29 U.S.C.A. Section 1144).² The Supreme Court of the United States in Pilot Life Insurance Company v. Dedeaux, 107 S.Ct. 1549 (1987), held that ERISA preempts all state law causes of action stemming from a failure to pay benefits under an ERISA-covered plan. Hence in order for appellee Gem Insurance Company to claim that its

¹29 U.S.C.A. 1002 (3) provides: "The term 'employee benefit plan' or 'plan' means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." Also 29 U.S.C.A. 1003 (a) (1) provides: "Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained- (1) by any employer engaged in commerce or in any industry or activity affecting commerce;.."

²29 U.S.C.A. 1144 (a) provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title...."

insurance policy is governed by ERISA it must show that the policy of the insurance of which appellants Jackie and Craig Robertson are beneficiaries, is part of a "employee benefit plan" under ERISA. Whether or not an employee benefit plan exists "is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person", Kanne v. Connecticut General Life Insurance Company, 859 F.2d 96, 98 (9th.Cir. 1988); See also, Sayble v. Blue Cross of S. Cal., 256 Cal. Rptr. 820 (1989); Taggart Corp. v. Life and Health Benefits Admin., 617 F.2d 1208 (1980); Donovan V. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

POINT II

APPELLEE GEM INSURANCE COMPANY'S POLICY OF HEALTH
INSURANCE WAS NOT A PART OF A "EMPLOYEE BENEFIT PLAN"
AND HENCE IS NOT COVERED BY ERISA.

Appellants do not dispute the fact that, if the insurance policy question constituted a "employee benefit plan" under ERISA, the provisions in applicable law regarding ERISA bar State Law claims as applied to this case. (See Pilot Life, supra) However, appellants maintain that the bare purchase of health insurance through an employer in order to take advantage of group rates does not constitute an "employee benefit plan" and therefore ERISA is unapplicable.

This point was made clear by the United States Court of Appeals for the Fifth Circuit in the case of Taggart Corp. v. Life and Health Benefits Administration, 617 F.2d 1208 (1980). In

Taggart, the Fifth Circuit held that where health insurance is purchased through an employer solely for the purpose of receiving group rates, and the policy is not owned, controlled or administered by the employer, such insurance does not constitute an employee benefit plan invoking jurisdiction under ERISA. Speaking of such health insurance policies, the Fifth Circuit stated:

Considering the history, structure and purposes of ERISA, we cannot believe that the Act regulates bare purchases of health insurance whereas here the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits. . . . [emphasis added]

Taggart supra, at 1211. The record below reflects only that Mountain States Steel, appellant Craig Robertson's employer, joined Intermountain Employers Trust in order to achieve group status for its employees so that they could enter into an insurance agreement with appellee Gem Insurance Company and become beneficiaries of the Gem Insurance policy. Appellee provided no information or any reason to believe that Mountain States Steel either owned, controlled, or administered the relevant insurance policy or had any control over the submission, adjustment and payment of claims thereunder.³

Furthermore, in order for an "employee benefit plan" to exist, the employer must intend to create an ERISA governed employee benefit plan, beyond mere application for insurance and payment of premiums. The United States Court of Appeals for the Seventh

³Appellants conceded at Oral Argument that Mountain States Steel's sole involvement with appellee Gem Insurance Company was its payroll deductions for premiums and a partial contribution to the premium.

Circuit has had occasion to hold:

An employer does not become a participant in, or establish or maintain, a plan by applying for insurance and paying premiums for what it understands to be insurance without any knowledge that the plan exists. Establishing, maintaining, or participating in a plan requires an intent, which presupposes an awareness of the existence of the plan. . .

Wayne v. Columbus Agency Service Corp., 657 F.2d 692, 699 (7th Cir. 1977). The Supreme Court of Nevada in Turnbow v. Pacific Mutual Life Insurance Company, 765 P.2d 1160 (Nev. 1988), addressed a factually similar case to the one at bar.

In Turnbow the plaintiff was a beneficiary of a group health insurance policy (specifically purchased through a multi-employer trust (Beneficial Employees Security Trust (BEST))). BEST in turn acquired coverage through defendant Pacific Mutual Life Insurance Company. Like appellants Robertson in the present action, plaintiff, Turnbow, sued Pacific Mutual for breach of contract, bad faith, affliction of emotional distress and punitive damages. Pacific Mutual claimed that their policy was an "employee benefit plan" under ERISA and hence state law causes of action were preempted. The Supreme Court of Nevada reviewed Federal law and determined that:

Unless there is some indication that an employer is committed to or has guaranteed the continuation of such benefits, nothing is created for ERISA to protect and no plan exist. Appellant did not purchase the health insurance for her employees pursuant to a collective bargaining agreement or a practice of providing such benefits. Nor is there any indication that the appellant intended to guarantee the continued furnishing of the benefits. ERISA does not regulate the bare purchase of health insurance where, as here, there is no indication that the employer intended to guarantee the continued furnishing of the benefits.

Turnbow, supra, at 1161.

As noted above in appellants' Statement of Facts, appellant Craig Robertson's employer Mountain States Steel, was not obligated to continue to provide insurance with IMET or Gem Insurance Company. In fact, Gem Insurance unilaterally terminated the insurance arrangement with Mountain States Steel.

While the Supreme Court of the United States has had a number of occasions to address the scope of ERISA preemption and the possible remedies available under ERISA when an "employee benefit plan" is found to exist,⁴ appellants are aware of only one U.S. Supreme Court case where the factual existence of an "employee benefit plan" was discussed. The United States Supreme Court in the case of Fort Halifax Packing Co. Inc. v. Coyne, 107 S.Ct. 2211 (1987) stated:

Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employers obligation. It is for that reason that Congress preempted the state laws relating to *plans*, rather than simply to *benefits*. [emphasis in original]

Id. at 2217.

In another case virtually identical to the one at bar, the California Court of Appeal, 2nd District, applied the rationale set forth by the United States Supreme Court in Fort Halifax, specifically, what the California Court labeled an "administrative scheme test" regarding what constitutes an "employee benefit plan".

In Sayble v. Blue Cross of S. Cal., 256 Cal. Rptr. 820 (1989),

⁴See eg., Pilot Life Ins. Co. v. Dedeaux, 107 S.Ct. 1549 (1987) and Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. 1542 (1987).

the plaintiff Sayble was employed by Swiss American Credit Jewelers (Swiss American). Swiss American applied to a multiple employer trust (National Employers Security Trust (NEST)). NEST in turn issued a group health insurance policy through Blue Cross of Southern California. A dispute regarding policy benefits arose and plaintiff Sayble filed a complaint against Blue Cross seeking declaratory relief as well as alleging breaches of duty of good faith, fair dealing, fiduciary statutory duties and a further plead for compensatory and punitive damages. Blue Cross filed a Motion for Summary Judgment alleging ERISA preemption. The trial court, like the trial court in the case at bar, found that the policy of insurance constituted an "employee benefit plan" and that the plaintiff's causes of action were preempted under ERISA. The case was appealed on a virtually identical procedural and factual posture as the case at bar. The Sayble court first notes that "the preemptive aspect of ERISA protects employers from conflicting an inconsistent state and local regulations of employment benefit plans." Citing Shaw v. Delta Airlines Inc., 463 U.S. 85, 99 1983); Fort Halifax Packing Co. v. Coyne, supra. Further and with specific reliance on Fort Halifax the Sayble Court held:

ERISA preempts only plans, not benefits, and nowhere in the statute are said terms treated as the equivalent of one another. 'Employee benefit plan' and 'plan' are defined only tautologically in [29 U.S.C. Section 1002(3)], each being described as an 'employee welfare benefit plan or employee pension plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan'. . . [The] United States Supreme Court observed that under the administrative realities of employee benefit plans, 'an employer makes a commitment systematically to pay certain benefits, undertakes a host of obligations, such as determining the eligibility of claimants, calculating the

benefit levels, making disbursements, monitoring the availability of funds for benefit plans, and keeping appropriate records in order to comply with applicable reporting requirements. . . ' [T]hus, the existence of an ERISA plan depends on the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA. . .

Sayble, supra at 823, 824.

The Sayble court goes on to note again quoting Fort Halifax "to do little more than write a check hardly constitutes the operation of a benefit plan." The Sayble court reversed the trial court; holding that no employee benefit plan existed and hence, ERISA was not applicable.

In summary, in order to qualify as an "employee benefit plan" under ERISA, appellee Gem Insurance Company, must show that:

(1) Mountain States Steel intended to create an employee benefit plan; (2) That the group health insurance policy purchased was part of an ongoing obligation to provide employee benefits; and, (3) That the employer, Mountain States Steel, had an ongoing administrative duty regarding the plan. None of these elements were established in appellee's Motion for Summary Judgment below.

The whole scope and thrust of ERISA itself deals with the regulation of the employer/employee relationship and ongoing fiduciary obligations. The intent of Congress in enacting ERISA was to provide a sword for employees in dealing with the preservation of their rights under employee benefit plans. Congress specifically stated:

It is hereby declared to be the policy of this chapter to protect interstate commerce in the interest of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries

of financial and other information with respect thereto, by establishing standards of conduct, responsibility conduct, and obligations for fiduciaries of employee benefit plans, and by providing for appropriate remedies sanctions, and ready access to the Federal Courts.

Three years after the enactment of ERISA Congress evidenced its legislative intent regarding preemption and particularly whether insurance products marketed to employers and employees at large could claim employee benefit status under ERISA and achieve preemption of state control. The 94th Congress Second Session noted by way of House Report:

It has come to our attention. . . that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. . . the entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision from state regulation. We are concerned with this type of development, but on the basis of the facts provided us, we are of the opinion that these programs are not "employee benefit plans" as defined in [29 U.S.C.A. Section 1002 (3)]. As described to us, these plans are established and maintained by entrepreneurs for the purposes of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the act. They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan. . . We are mindful of the potentially harmful effects of an overly broad interpretation of the 'employee benefit plan' when coupled with the policy of [29 U.S.C.A. Section 1144]. As we have already noted, we do not believe that the statute and legislative history will support the conclusion of what amounts to commercial products within the umbrella of the definition. Where a 'plan' is, in affect, an entrepreneurial adventure, it is outside the policy of [29 U.S.C.A. Section 1144] for reasons we have already stated. In short, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional requirement of [29 U.S.C.A. Section 1002 (3)] in both form and substance.

In conclusion, in support of its Motion for Summary Judgment regarding ERISA preemption below, appellee, Gem Insurance Company,

showed only that the Gem Insurance policy was purchased through an employer who had taken advantage of Intermountain Employers Trust to gain group status and achieve the benefit of group policy rates. There was no evidence nor do the facts suggest that the Gem Insurance policy is an "employee benefit plan" under ERISA triggering ERISA preemption. Hence, the lower court's granting of Summary Judgment must be reversed and appellants should be allowed to proceed on all causes of action as articulated in their complaint.

POINT III

THE LOWER COURT ERRED IN REFUSING TO ALLOW PLAINTIFF ALL ATTORNEY'S FEES REASONABLY INCURRED IN PROSECUTING THE ACTION.

As is set forth in the lower court's Findings of Fact and Conclusions of Law, appellee wrongfully denied appellants policy benefits under the Gem Insurance policy. The Court awarded appellants attorney's fees for time spent by their counsel upon such issues for which they prevailed. The Court did so as a matter of state law citing the Utah case of Mountain States Broadcasting Co. v. Neale, 776 P.2d 643 (Utah 1989). (See Memorandum Decision R. 243).

The lower court however, had held that the matter is preempted by ERISA. Any award for attorney's fees should have been granted under ERISA and not as a matter of state law. 29 U.S.C.A. Section 1132(g)(1) provides:

In any action under this subchapter. . . by a

participant, beneficiary, or fiduciary, the court in its discretion may allow reasonable attorneys fee and costs of action to either party.

A five factor test has been developed by the Tenth Circuit in Eaves v. Penn, 587 F.2d 453 (10th Cir. 1978). The Tenth Circuit announced five factors relevant to an award of attorney's fees under ERISA:

(1) The degree of the offending parties' culpability or bad faith; (2) the degree of the ability of the offending parties to personally satisfy an award of attorneys fees; (3) whether or not an award of attorneys fees against the offending parties would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on the member of the pension plan as a whole; and, (5) the relative merits of the parties' position.

Eves supra, at 465.

"[C]ourts apply the Eves factors to every ERISA suit where parties request attorneys fees." *Attorney's Fees Under ERISA: When Is An Award Appropriate?* 71 Cornell L. Rev. 1037, 1043 (1986). If indeed ERISA applies to appellants causes of action as maintained by appellees, then the lower court erred in not applying the provisions of ERISA and applicable case law in considering appellants' claim of attorney's fees below.

Of course, appellants maintain that ERISA does not preempt appellants causes of action. Appellants maintain (See Point II above) that the lower court's granting of Summary Judgment should be reversed and appellants should be allowed to proceed on their independent causes of action. In that event appellants should be entitled to a full award of attorneys fees for prevailing in an insurance contract dispute as set forth in Canyon Country Store v. Bracey, 781 P.2d 414 (Utah 1989).

CONCLUSION

In conclusion, appellants maintain that the lower court erred in granting appellee's Motion for Summary Judgment, particularly finding that, as a matter of law, relevant policy of health insurance was an "employee benefit plan" for purposes of ERISA. Appellee failed to show that the insurance policy was intended by the employer to constitute an "employee benefit plan," that the insurance policy was part of an ongoing obligation by the employer to provide employee benefits, nor show that the employer took any part whatsoever in the administration and ongoing operation of what is claimed to be an ERISA plan. Therefore, under the authority cited above, including the actual intent expressed by Congress, the mere purchase of an insurance policy through an employer who has joined a multi-employer trust in order to achieve group and membership status does not constitute an ERISA plan.

The court below further erred in limiting appellants' award to attorney's fees, solely to those issues upon which plaintiffs prevailed and in not analyzing appellants' request for attorney's fees under the provisions of ERISA as the court had ruled that ERISA governed the action. For these reasons, appellants respectfully request that the court's Order of Summary Judgment be reversed and the appellants be allowed to proceed on their common law claims. Further, that the court be instructed to award all reasonable attorney's fees pursuant to Canyon Country Store v. Bracey, supra, or in the alternative, consider appellants' request for attorney's fees under ERISA.

DATED AND SIGNED this 4th day of February, 1991.

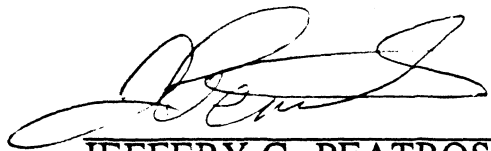
A handwritten signature in cursive script, appearing to read "Jeffery C. Peatross", written over a horizontal line.

JEFFERY C. PEATROSS
IVIE & YOUNG
Attorneys for Appellants

CERTIFICATE OF SERVICE

I, Jeffery C. Peatross, hereby certify that on the 5th day of February, 1991, I served four (4) copies of the foregoing Brief of Appellants, upon Jeffrey R. Oritt, counsel for the appellee in this matter, by mailing to him by first class mail with sufficient postage prepaid to the following address:

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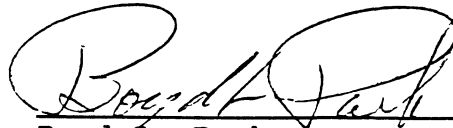


JEFFERY C. PEATROSS
Attorney of Record

IT IS HEREBY ORDERED that Gem's Motion to Dismiss plaintiffs' causes of action for breach of implied covenant of good faith and fair dealing, misrepresentation, intentional infliction of emotional distress and punitive damages shall be and are hereby dismissed, with prejudice and on the merits. Plaintiffs' remaining claim of breach of insurance policy remains to be litigated.

DATED this 5 day of December, 1989.

BY THE COURT:

A handwritten signature in cursive script, appearing to read "Boyd L. Park", written over a horizontal line.

Boyd L. Park
District Judge

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375-3000

IN THE FOURTH JUDICIAL DISTRICT COURT OF UTAH COUNTY
STATE OF UTAH

JACKIE ROBERTSON	:	FINDINGS OF FACT
and CRAIG ROBERTSON,	:	CONCLUSIONS OF LAW
	:	AND JUDGMENT
Plaintiffs,	:	
vs.	:	
GEM INSURANCE COMPANY,	:	Civil No. CV891505
Defendant.	:	Judge Boyd L. Park

The above-entitled matter having come before this Court for non-jury trial on the 25th day of June, 1990, plaintiffs having been represented by Jeffery C. Peatross of Ivie and Young, and defendant having been represented by Jeffrey R. Oritt of Tibbals, Howell, Wilkins & Oritt, the Court having fully considered the testimony presented and the arguments of counsel hereby make the following Findings of Fact and Conclusion of Law:

FINDINGS OF FACT

1. Plaintiff Craig Robertson had group health insurance provided by defendant Gem Insurance Company through Craig Robertson's employer Mountain States Steel.

2. The effective date of the health insurance policy was November 1, 1988.

3. Plaintiff Jackie Robertson is the spouse of Craig Robertson and a beneficiary under the health insurance policy.

4. In 1985, Jackie Robertson suffered a herniated cervical disk at the C6-7 level. Surgery was performed.

5. Mrs. Robertson injured another cervical disk at the C4-5 level while shoveling snow on December 25, 1988. Such injury resulted in a surgery performed by Dr. Adams in March of 1989.

6. Mrs. Robertson submitted claims to Gem Insurance Company requesting coverage for the medical care she received associated with the C4-5 injury.

7. Gem Insurance Company initially denied the coverage alleging Mrs. Robertson had other insurance coverage through her own employer. This matter was later resolved as Mrs. Robertson did not have other coverage.

8. Gem Insurance Company subsequently denied coverage alleging that the C4-5 disk injury was a pre-existing condition.

9. Gem Insurance Company they did so upon reliance of medical records received from Mountain View Hospital.

10. Dr. James Adams sent a letter to Gem Insurance

Company on June 6, 1989, attempting to clarify the misunderstanding of Gem Insurance regarding their claim of pre-existing injury. In such letter Dr. Adams stated that Jackie Robertson had received surgery on the C6-7 cervical level on August 21, 1985. He stated that he performed an anterior discectomy at the C4-5 level. Dr. Adams stated particularly as follows:

Both procedures are separate. One is not related to the other and they are both at different levels in the cervical spine. I hope this will clarify any misunderstanding which your office may have regarding any pre-existing or similar disease pattern.

11. Gem Insurance Company admits receiving Dr. Adams letter but continued to rely upon the hospital records and continued to maintain that Mrs. Robertson's condition was pre-existing.

12. The discrepancy between the hospital records and Dr. Adams' letter was explained by Dr. Adams. He stated that when he dictated the hospital records upon which Gem Insurance Company relied upon, he did not have the proper summary of his office notes, including his own hand written notes which his nurse prepares and keeps on file for him. Such summary takes the form of a "white card, such "white card" was not available when Dr. Adams dictated the records relied upon by Gem Insurance Company.

13. The hospital records relied upon by Gem

Insurance Company where therefore not accurate. The "white card" accurately reflects Mrs. Robertson's relevant medical history and the section on history states:

Neck pain. Four years ago anterior fusion C6 with remission of symptoms.

12-25-88 Shoveling snow with restricted movements and pain, cervical spine, numbness left thumb and pain left arm.

14. The Gem Insurance policy expressly excludes coverage of any pre-existing condition for nine months from the effective date of the policy, in this case November 1, 1988.

15. A pre-existing condition is defined by the policy as:

Pre-existing condition:

The manifestation of symptoms of a medical condition and/or injury or disease for which medical advice, treatment, services, medication or drugs was recommended or received within a twelve month period prior to the effective date.

16. Jackie Robertson received no medical advice, treatment, services, medication or drugs, nor was any recommended within the relevant twelve month period prior to the effective date of the policy (November 1, 1987 to November 1, 1988).

17. Jackie Robertson had no symptoms of the C4-5 disk injury until December 25, 1988.

18. Gem Insurance Company did not conduct further investigation after receiving the June 6, 1989 letter of

Dr. Adams. Specifically they did not call or communicate with Dr. Adams regarding plaintiff's condition.

19. Plaintiffs Craig and Jackie Robertson and defendant Gem Insurance Company have stipulated that the amount of benefits disputed under the policy are \$8,092.46. That they have further stipulated that in the event plaintiffs are awarded policy benefits they shall be entitled to interest at the rate of 10% per annum from April 1, 1989.

20. Plaintiffs have incurred attorney's fees as a result of prosecuting this matter, the Court finds reasonable attorney's fees to be \$4,192.50. Such fees are based upon a per hourly rate of \$65.00 per hour and upon hours spent by plaintiffs' counsel on such issues prevailed upon by plaintiffs.

CONCLUSIONS

FINDINGS OF LAW

1. The relevant policy provision defining pre-existing condition sets forth an objective standard. That standard is whether medical treatment was recommended or received for the relevant medical condition within twelve months before the effective policy date.

2. That the plaintiff Jackie Robertson's C4-5 cervical condition is not a "pre-existing condition" under the terms of the Gem Insurance Company's policy.

That defendant Gem Insurance Company had a

duty to properly investigate the Robertson's pending claims, including an investigation of the apparent conflict of the medical history of Jackie Robertson as seen from Mountain View Hospital's history and physical examination, Mountain View Hospital's discharge summary and Dr. Adams June 6, 1989 letter.

4. That as a result of defendant's failure to conduct such an investigation to pay benefits due to plaintiffs under the policy, plaintiffs have incurred costs and reasonable attorney's fees in such issues resolved in their favor.

JUDGMENT

Based upon the foregoing findings of Facts and Conclusions of Law it is hereby order, judged and decreed as follows:

That the plaintiffs are entitled to judgment and hereby award a judgment in the amount of \$8,092.46 together with interest on such amount at the rate of 10% per annum from April 1, 1989 to date of judgment for a total award of prejudgment interest of \$1,160.01. Plaintiffs are hereby

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awarded judgment for attorney's fees in the amount of \$4,192.50 together with costs in the amount of \$319.25, for a total judgment including interest, attorney's fees and costs in the amount of \$13,764.22.

DATED AND SIGNED this 5 day of September, 1990.


JUDGE BOYD L. PARK


Approval as to form, including interest and cost amounts:

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Jeffrey R. Oritt

MAILING CERTIFICATE

I hereby certify that I mailed a true and correct copy of the foregoing Finding of Facts, Conclusions of Law and Judgment with postage prepaid thereon this 31st day of August, 1990 to the following:

Jeffrey R. Oritt
TIBBALS, HOWELL, WILKINS & ORITT
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257 East 200 South-2
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Secretary