NORMAN, HANSON & DETROY, LLC

newsletter

Current developments in Maine law

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Law Court Refuses to Blend Contract and Tort Causes of Action

BY DAVID L. HERZER

In August, the Law Court issued its decision in *Alexander v. Mitchell*, 2007 ME 108, and answered a question that one would think it would have addressed decades ago, given Maine winters. In the opening paragraph, the Law Court stated the question succinctly: "Does a person or company that has contracted with a municipality to plow, salt, and sand the Town's roads owe a general duty of care to all members of the public using those roads based on the terms of the contract?" In short, the Court answered that question with a resounding and unanimous "no."

The accident in this case occurred on December 16, 2003, on the Pushaw Road in Glenburn, Maine, and resulted in the tragic death of Michelle Alexander, who was 37 years old. Several inches of snow had fallen the night before the accident, and the roads were slushy and slippery. The road conditions caused an unidentified vehicle to careen out of control on the Pushaw Road just moments before Mrs. Alexander arrived. Mrs. Alexander had her 11-month-old son, Camden, in the car when she lost control of her vehicle and collided with an approaching Adelphia Cable van.

Norman, Hanson & DeTroy represented Philip Mitchell, who contracted with the Town of Glenburn to remove snow and to provide sanding and salting services on all public roadways, including Pushaw Road. Unfortunately, the severe storm arrived at a time when Mr. Mitchell was in the process of acquiring the full fleet of trucks specified in the contract. To that point, he was provided with substandard, nonfunctional equipment through his supplier and, therefore, only had one useable truck on December 16. Although he negotiated with the Town for another contractor to take over the contract, the transition was not complete when the storm hit.

To understand the reasons behind the Law Court's decision, a brief discussion of the history of Maine law is enlightening. The Law Court historically has been reluctant to assign open-ended responsibility for accidents caused by snow-related conditions. For instance, in *Denman v. Peoples Heritage Bank, Inc.*, 1998 ME 12, 704 A.2d 411, a pedestrian who was injured after slipping and falling on a city sidewalk sued Peoples Heritage Bank, which owned the building adjacent to the sidewalk, and the maintenance company who contracted with the Bank to remove snow and ice from the Bank's property. As a result of a City of Portland ordinance, the Bank was required to clear ice and snow from the sidewalk adjacent to the Bank's property.

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Denman was not a party to the contract between the Bank and its maintenance company and was not a third-party beneficiary to the contract, either. The Law Court concluded that neither defendant owed her any contractual duties. The Court also decided that neither the Bank nor the maintenance company owed a tort-based duty to passers-by to maintain the sidewalk free from snow and ice. Given the mandatory nature of the City ordinance, the Bank did not voluntarily assume the obligation of maintaining the sidewalk or otherwise exhibit an intent to control the

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sidewalk, which ordinarily would carry with it the duty to exercise reasonable care. The maintenance company owed no tort-based duty because it was merely discharging the mandatory legal obligation of the Bank for maintaining the sidewalk.

The *Alexander v. Mitchell* case presented analogous facts. The Town of Glenburn had a statutory obligation to maintain state aid highways within its boundaries in the winter months. Consequently, like Peoples Heritage Bank, the Town did not voluntarily assume the duty for maintaining the roadways during the winter, nor did it intend to control such highways. By extension, Philip Mitchell, who contracted with the Town to plow the roadways, did not assume a duty voluntarily, but was merely discharging the Town's statutory obligation. As such, no tort duty could be imposed on either Philip Mitchell or the Town.

The Court's decision required it to distinguish its recent decision in *Budzko v. One City Center Associates Limited Partnership*, 2001 ME 37, 767 A.2d 310. In *Budzko*, the Law Court put to rest the commonly believed notion that a land owner has no obligation to remove snow and ice as it falls during the course of a storm. The Law Court held that business owners could be liable for injuries that occurred during a snow storm if they did not take reasonable steps to address accumulating snow and ice from the storm during business hours when they invite hundreds of people to enter their premises.

The factors distinguishing the *Budzko* case and the *Alexander* case include the fact that, in *Budzko*, the duty was imposed on the business owner to keep its own premises reasonably safe. In *Alexander*, neither the Town nor Philip Mitchell owned, occupied, or intended to control the state aid highway in question. Furthermore, the Court pointed out that the *Budzko* decision did not impose an open-ended duty on the business owner. *Budzko* merely extended already existing land owner liability for hazardous conditions to a small and manageable part of the property at a time of foreseeable need. Consequently, both the ownership component and the circumspect application of the tort duty in *Budzko* meant that the decision gave "very little guidance" to the Law Court in the *Alexander* case.

The Court noted that the Plaintiff in *Alexander*, on the other hand, called upon it to impose a previously unrecognized common law tort duty based solely on the contractual obligations Mr. Mitchell assumed with the municipality. The Plaintiff did not press the claim that the decedent was a third-party beneficiary to the contract based on Mrs. Alexander's status as a resident and taxpayer of the Town of Glenburn, but instead argued that Mr. Mitchell's failure to abide by the contractual duty he assumed should be deemed actionable negligence. The Law Court explained that a cause of action for breach of contract and a cause for the tort of negligence are separate and distinct and should remain so. An alleged breach of the contractual duties one individual might owe to another does not mean that the individual should answer in tort to people who are not parties to the contract.

In *Alexander v. Mitchell*, the Law Court resisted a trend that is evolving across the nation, whereby tort and contract law is conflated into one cause of action that ends up looking more like tort than contract. The difference can be significant in terms of the parties who can be held liable and the damages that can be awarded. Tort law generally provides more far-reaching and lucrative remedies than does contract law. The Court distinguished Maine — and other jurisdictions like Colorado, where significant snowfall is a part of daily living in the winter — from the rest of the country by observing that "creating a new duty is disfavored because of the pervasiveness of the annual risk caused by ice and snow on Maine roads." ☐

NH&D Engineers Milestone for Maine's Credit Unions

Adrian Kendall successfully argued a case before the Maine Supreme Judicial Court on behalf of the Maine Credit Union League this summer. As a result, the Court ruled in favor of the Maine Credit Union League's position (which was also fully supported by the Maine Bureau of Financial Institutions) by allowing all federally insured credit unions to offer Interest on Lawyers Trust Accounts (IOLTA). An IOLTA is part of a program where lawyers holding clients' funds that are too small or short-term for an individual interest-bearing account, deposit those funds into a special account containing similar funds from other clients. The interest generated from the pooled account helps fund legal programs for the needy. The Maine Bar Foundation had proposed a revised Maine Bar Rule regarding IOLTA accounts, which categorically denied Maine's credit unions the right to participate in the state's IOLTA program. ☐

NORMAN, HANSON & DETROY, LLC
newsletter
is published quarterly to inform you of recent developments in the law, particularly Maine law, and to address current topics of discussion in your daily business. These articles should not be construed as legal advice for a specific case. If you wish a copy of a court decision or statute mentioned in this issue, please e-mail, write or telephone us.

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A Legislative Solution to the Medicare Set Aside Requirement?

By Robert W. Bower, Jr.

As all of us involved in handling workers' compensation claims know that the Medicare Secondary Payer Law, 42 U.S.C. §1395y, and the agency that enforces that law, the Center for Medicare and Medicaid Services ("CMS"), have created a monumental barrier to the efficient settlement of workers' compensation claims. CMS has offered written "guidance" that has been interpreted by some to require the creation and funding of Medicare set-aside arrangements in many, if not most, workers' compensation settlements. Those of you who have been reading this publication for a few years, and those of you who have attended our seminars on this issue will recall that our firm takes a more nuanced view on this issue. However, the fact remains that the Medicare Secondary Payer Law and the guidance offered by CMS has created a huge headache for employers and insurers in the form of long delays while parties await pre-approval from CMS, and increased costs of settlement caused by the frequent demands of claimants and their counsel that the set-aside "trusts" be funded 100% by employers and insurers.

Now, HR 2549, a bill introduced in the United States House of Representatives on May 24, 2007, offers some hope that the uncertainty and expense of the Medicare set-aside problem will be resolved. The "Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2007" offers the promise of safe harbors and reduced administrative difficulty when employers and insurers seek to comply with the Secondary Payer Law.

First, the bill provides five distinct categories of cases that are not "primary plans" pursuant to section 1395y. Only a "primary plan" owes Medicare a duty to protect its interests. Effectively, this category of cases is exempt from compliance with the Secondary Payer Law.

The five categories include:

1. A case with a settlement present value of less than $250,000.
2. A compromise settlement agreement that has a present value "not more than 20% of the present value of the total amount that could have been payable under the applicable workers' compensation law . . . if the claim involved had not been subject to a compromise agreement."
3. The settling claimant is not eligible for Medicare benefits as of the date of settlement and is unlikely to become so eligible within thirty months after such effective date.
4. Any settlement agreement in which the claimant "is not eligible for payment of medical expenses incurred after the effective date of such agreement that are available under the workers' compensation law or plan of the jurisdiction in which such agreement will be effective."
5. Any settlement agreement that does not limit or extinguish the right of the claimant involved to payment of medical expenses incurred after the effective date of such agreement.

The bill provides a methodology for calculating the present value of the settlement agreement. The present value includes any cash provided at the time of settlement, and the cost to purchase any annuity for a structured settlement. The present value does not include any payments made to satisfy previously unpaid medical expenses, and any payments made to satisfy any third party claim for liens including Medicare payments for past due benefits. Attorney's fees are not included in the calculation of "present value."

The bill also provides a mechanism for determining whether someone is

ROBERT W. BOWER, JR.

"likely" to become a Medicare recipient within thirty months. The bill provides that a claimant is presumed to be unlikely to become eligible within thirty months unless one of the following is true:

1. He has been awarded Social Security Disability benefits or is appealing a denial of such benefits;
2. The claimant is at least 62 years and 6 months of age; and
3. The claimant is suffering from end stage renal disease.

As can be readily observed, this bill, if enacted as currently written, will largely eliminate the Medicare set-aside problem for most cases. However, the bill goes further to provide compliance safe harbors for those cases still considered "primary plans" under Section 1395y.

First, this part of the bill provides that no set-aside meeting the safe harbor requirements identified in the bill must be submitted to Medicare for pre-approval. Second, it provides that any party to a set-aside meeting the safe harbor thresholds is completely immune from recourse either directly or indirectly by Medicare. A Medicare set-aside arrangement automatically qualifies as a "qualified" set-aside arrangement if the amount of the set-aside is at least 10% of the present value of the settlement agreement.

The bill provides for an "optional"

process to seek Medicare pre-approval of the set-aside amount. Presumably a set-aside meeting the safe harbor definition of 10% of the present value of the settlement would not need to seek out this optional pre-approval process. If the pre-approval process is selected the bill provides that the set-aside proposal is automatically approved unless Medicare provides notice to the parties that it is not a qualified Medicare set-aside within sixty days of its submission to Medicare.

The bill also resolves the long festering question of whether Medicare's decision with regard to set-asides is subject to appeal in any form. The bill provides for an appeal for any party dissatisfied with Medicare's determination. The appeal takes the form of first a reconsideration by Medicare, then a hearing before an administrative law judge, and finally judicial review after the administrative law judge issues a ruling.

The statute provides for an optional direct payment of the set-aside amount to Medicare which avoids the problem of the employee managing a self-administered trust, or paying for a third party to administer the trust.

The bill also provides for a mechanism for modifying or terminating the qualified Medicare set-aside in the case of a change in the claimant's circumstances (death, improvement, etc.).

A final, but intriguing provision of this bill provides that Medicare is not authorized to take action against parties to settlement agreements that were in place prior to the effective date of this bill (assuming it is enacted) "that is additional to the liability in effect on the date of the enactment of this Act . . . ." Should this clause be enacted with the bill, this means that agreements that have already been finalized will be deemed to have complied with the law if they meet the terms of this bill even though it will be enacted in some cases long after those settlements were approved.

As you can see from the above summary of this bill, somebody in Congress "feels our pain." We urge our readers to contact your representatives in Congress to encourage them to work quickly to enact HR 2549. With one stroke of the pen the President could eliminate the extensive delays and increased costs occasioned by the Medicare Secondary Payer Law. Most importantly enactment of this bill will provide all of us with the certainty that our settlement agreements are in fact final. We will keep you posted on the progress of this bill as it works its way through Congress. ☐

KUDOS

AARON BALTES and his wife Katherine became proud parents for the third time with the birth of their son Matthew J. Baltes on June 20, 2007. Congratulations to the new parents!

On July 9, 2007 **NICOLE BOTTS** and her husband Phil also become parents for the third time welcoming to their family Paige Nicole Botts.

ROD ROVZAR presented a seminar on business lending and regulatory examinations to officers and directors of Maine credit unions at a program sponsored by the Maine Credit Union League on September 20, 2007.

ANN FREEMAN competed in two Olympic distance triathlons this summer (1.5K swim, 40K bike, 10K run) – The Zone/Urban Epic in her hometown of Portland and the Lobsterman up the road in Freeport. She placed second and first in her age group (30-34) respectively and was in the top 10 overall for women in each race.

DAVID HERZER was featured on the front page of The Maine Lawyer's Review relating to a recent Law Court decision in a case he defended in which a snow plower was sued for a fatal traffic accident. The decision established that entities who plow roads for municipalities are not liable to drivers for accidents caused by snow and ice conditions, even when the plower may have breached its contract with the municipality.

DORIS CHAMPAGNE presented a program on the shifting of burdens of proof at the recent Comp Summit Seminar at Sugarloaf. **STEVE MORIARTY** served as moderator of a panel presentation of three hearing officers of the Board.

ADRIAN KENDALL recently returned from a meeting of the ALFA International Law Practice Group in Brussels, Belgium. The conference included seminars on cutting edge issues such as effective strategies for the protection of intellectual property, cross-border employment practices, and international arbitration and enforcement of judgments. He had the opportunity to share his experience at the conference with Maine businessmen and women at the Maine International Trade Center's Essentials of Exporting seminar just two days following his return from Brussels. This was Adrian's second invitation to speak at this annual seminar. Adrian serves as the German Honorary Consul for Maine and New Hampshire, the first ever to be appointed in New England.

STEVE MORIARTY and seven teammates successfully defended their championship in the men's 50+ division at the recent Lake Winnipesaukee Race Relay. The team also placed 7th overall out of 86 participating teams. ☐

Two Recent Law Court Decisions

BY DAVID P. VERY

DAVID P. VERY

Award of attorney fees in a duty to indemnify action

Is an insured entitled to an award of attorney fees because he prevailed in a declaratory judgment action brought by his insurance company to determine whether the insurance company had a duty to indemnify the insured? In *Foremost Insurance Company v. Levesque*, 2007 ME 96 (July 26, 2007), the Law Court answered that question in the affirmative.

In *Gibson v. Farm Family Mut. Ins. Co.*, 673 A.2d 1350 (Me. 1996), the Law Court had held that an insurer may be liable for an insured's attorney fees in an unsuccessful declaratory judgment action seeking to establish the insurer's duty to defend. The Maine Legislature later codified the Court's holding. The statute enacted by the Legislature states that when there is a declaratory judgment action, "to determine an insurer's contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney's fees." 24-A M.R.S.A. § 2436-B(2)(2006).

The Law Court noted that it had not previously determined whether an insurer is liable for the insured's attorney fees when the insured has to defend against the insurer's suit seeking a declaration that there is no duty to indemnify. The Court acknowledged that the aforementioned statute does not answer the question because it speaks only to actions to determine an insurer's contractual duty to defend.

The Law Court noted that in *Gibson*, it held that there was a "special relationship between insurer and insured" and the heavy burden that can fall on an insured when the insurer unsuccessfully forces the insured to defend a declaratory judgment action. The Court noted that it had previously stated that the insured should be placed in a position equally as good as the insured would have occupied had the insurance contract been fully and properly performed from the beginning. The Law Court found that the same reasons that support the assessment of attorney fees in a duty to defend action also support the assessment of fees in a duty to indemnify action.

The Law Court noted that unsuccessful litigation filed by an insurer against its insured subjects the insured to significant costs that may render victory for the insured on the indemnification issue meaningless. The Court stated that when an insured prevails after incurring legal fees to defend a suit brought by its insurer, policy reasons support the allowance of attorney fees to the insured. The Law Court therefore held that because Levesque had incurred attorney fees when he successfully defended against Foremost's declaratory judgment action on the duty to indemnify, the Superior Court properly awarded Levesque attorney fees.

Of interest, Foremost Insurance Company had filed its declaratory judgment on the issue of its duty to indemnify while the underlying action was pending. It had also retained an attorney to defend the insured in the underlying action. The Court admonished the insurer and stated that duty to indemnify actions should not be brought until the underlying action is completed in order to avoid duplicative litigation and to spare insureds the cost of declaratory judgment actions. Although it is unclear whether Foremost's decision to bring the declaratory judgment while the underlying action was pending had an effect on the Court's ultimate decision, the holding of the case does not in any way state that an award of attorney fees would only be awarded in an action filed while the action was pending, as opposed to an action filed following a resolution of the underlying case.

As a final note, Justice Mead dissented. He noted that the majority of jurisdictions in this country do not award attorney fees to an insured in these situations. He also found that duty to indemnify actions are fundamentally different from the duty to defend cases and that attorney fees should only be awarded in situations where the insurer acts in bad faith.

Sufficiency of evidence to survive summary judgment

In *Reid v. Town of Mount Vernon, et al.*, 2007 ME 125 (September 4, 2007), the Court addressed, in part, the sufficiency of evidence needed to survive a motion for summary judgment.

The case involved the death of James Reid. James and his brother, Clayton Reid, had traveled to the Town of Mount Vernon's transfer station in Clayton's pickup truck to dispose of a television set. The Town had a number of trash dumpsters at the transfer station which were almost flush with the ground.

James Reid got out of the truck and motioned to Clayton to back the truck up to the dumpster so that they could push the television set from the truck into the dumpster. At the time Clayton began backing up, the tailgate of the pickup truck was up. James motioned for Clayton to stop the truck. Clayton stopped the truck and shut off the engine. As Clayton was exiting the vehicle, he heard two thumps from the rear of the truck. He believed the thumps were the tailgate dropping down and James falling into the dumpster.

Clayton walked to the rear of the truck and observed that the tailgate was now down and that his brother was lying at the bottom of the dumpster face down. James died as a result of striking his head. There were no eyewitnesses to the accident.

Previously, the Town of Mount Vernon had placed chains attached to and running the length of the dumpster to prevent people from falling in. The chains had broken and were not present for several months. At the time of the accident, Clayton was aware that there were no safety chains or other devices in front of the dumpster. He had experience using the Town's transfer station and knew the danger in backing up his truck to the dumpster.

James' widow, Priscilla Reid, filed a complaint against her brother-in-law, Clayton Reid, as well as the Town of Mount Vernon and Waste Management. Clayton Reid had filed a motion for summary judgment on the grounds that there was insufficient evidence of negligence. The Superior Court granted the motion and Priscilla Reid appealed.

On appeal, Priscilla Reid argued that Clayton owed a duty of care to his brother. This duty stemmed from his knowledge that there was an open dumpster that posed a hazardous condition and from his backing up while James was positioned between the vehicle and the dumpster.

The Law Court reiterated that "the mere fact of the happening of an accident is not evidence of negligence." The Court noted that in the present case, there were no eyewitnesses. The Court stated that the plaintiff had failed to present evidence as to how James' fall occurred. The Court noted that James could have placed himself in a precarious position behind the truck, he could have accidentally let down the tailgate, Clayton could have backed up too close, or the tailgate could have fallen down by itself, knocking James into the dumpster. The Court stated that whether the facts presented show that any duty was violated when James' accident occurred was no better than speculation.

As a result, the Law Court held that the facts did not establish a prima facie case for liability and it therefore affirmed summary judgment in favor of Clayton Reid. This case will obviously be helpful in successfully defending an unobserved fatal accident with multiple potential causes of the accident. □

2007 Fall Forum and Client Reception

November 16, 2007

Portland Regency Hotel • 20 Milk Street

The Fall Forum 2 - 4 PM

Annual Client Reception 4 - 7 PM

The 11th annual Norman, Hanson & DeTroy, LLC, Fall Forum for our clients will be held in Portland on Friday, November 16, 2007, at the Portland Regency Hotel.

The Forum will be followed by our annual client reception at the hotel, and we cordially invite all interested clients to join us. Please mark your calendars, and look for your invitation and topic announcements in the mail.

We hope to see you there!

New MHRA Definition of "Disabled"

By Anne M. Carney

Who is "disabled" under the Maine Human Rights Act has shifted dramatically in the last one and one-half years. This major change in the legal landscape began with the April 11, 2006 Law Court decision *Whitney v. Wal-Mart Stores, Inc.*, 2006 ME 37, 895 A.2d 309. *Whitney v. Wal-Mart* rejected the Maine Human Rights Commission regulation interpreting the Maine Human Rights Act (MHRA) definition of "disability" to be consistent with the federal Americans with Disabilities Act (ADA) definition. The MHRC adopted a new regulation consistent with *Whitney v. Wal-Mart* on March 21, 2007. On June 21, 2007, the Legislature amended the MHRA by enacting a completely new definition of "physical or mental disability." The legislation incorporates some familiar scenery, but also introduces innovative concepts. The new definition is intended to bring clarity and predictability to Maine's disability discrimination laws.

The MHRA established protection for disabled individuals in 1975. The protection extends to employment, housing, public accommodations, credit, and education. 5 M.R.S.A. §4551 *et seq.* The MHRA defined physical or mental disability broadly to include:

> any disability, infirmity, malformation, disfigurement, congenital defect or mental condition . . . and includes the physical or mental condition of a person that constitutes a substantial disability as determined by a physician, or in the case of mental disability, by a psychiatrist or a psychologist, as well as any other health or sensory impairment that requires special education, vocational rehabilitation or related services.

5 M.R.S.A. §4553(7)(A). The Act's definition of "physical or mental handicap" remained substantively the same for over 30 years.

When the Maine Human Rights Commission adopted enforcement regulations in 1985, it utilized the federal Rehabilitation Act of 1973 as a guide to clarify the MHRA definition. The Rehabilitation Act defines a disability as a condition that "substantially limits one or more . . . major life activities." 29 U.S.C. §705(2)(B)(i). The ADA, enacted in 1990, also utilized the Rehabilitation Act definition. 42 U.S.C. §12102(2)(a). The standard incorporated in the Rehabilitation Act, the Maine Human Rights Commission regulations, and the ADA, was at odds with the MHRA statutory definition. For over 20 years, disabled individuals, employers, public accommodations, schools, and courts tried to resolve complex questions of reasonable accommodation and disability discrimination in the face of a statute and regulation that appeared to establish different legal standards.

Whitney v. Wal-Mart highlighted this conflict because it involved both ADA and MHRA disability discrimination claims brought by a Wal-Mart manager who formerly worked six days and 70 hours per week. Mr. Whitney could only work nine hours per day, 45 hours per week, and required two consecutive days off per week due to high blood pressure and heart disease. Wal-Mart did not accommodate Mr. Whitney's work restrictions, and the central issue in the ensuing litigation was whether Mr. Whitney was "disabled" under the MHRA standard. Because he could work a standard work week, Mr. Whitney did not satisfy the ADA 'substantial limitation of a major life activity' standard. A majority of the Law Court held that the MHRA definition of "disability" did not require a showing of "substantial limitation," and that the conflicting regulation adopted by the Maine Human Rights Commission was invalid. *Whitney*, 2006 ME 36, ¶30-33.

ANNE M. CARNEY

For almost a year following the Whitney decision, the controlling legal standard was the 1975 statutory definition widely recognized to be abstruse:

> Section 4553(7)(A) is not a model of legislative clarity. It consists of a single, seventy-seven word run-on sentence that contains 13 commas and employs the disjunctive "or" eight times.

Id., ¶46.

The Maine Human Rights Commission adopted a new regulation on March 21, 2007 that parsed the 1975 MHRA definition in order to render it capable of application. The regulation addressed the problem, in part, by separately defining each of the statute's six terms for health limitation. It was not an ideal solution.

On June 21, 2007, the Legislature enacted the new statutory definition of "physical or mental disability." Recognizing the uncertainty generated by invalidation of the prior Maine Human Rights Commission regulation and the "challenging" 1975 statutory definition, the Legislature categorized the new definition as emergency legislation so that it went into effect immediately.

The new definition creates three methods of establishing disability. First, a physical or mental impairment could qualify as a "disability" if it "substantially limits one or more of a per-

son's major life activities." 5 M.R.S.A. §4553-A(1)(A)(1). This method tracks the language of the ADA so that individuals who are able to satisfy that narrow standard need not develop evidence that also satisfies the broader MHRA standard. Second, an impairment is a "disability" if it "significantly impairs physical or mental health" because it has "an actual or expected duration of more than six months" and "impair[s] health to a significant extent as compared to what is ordinarily experienced in the general population." 5 M.R.S.A. §4553-A(1)(A)(2) and §4553-A (2)(B). This second method is consistent with the legislative intent expressed in the 1975 statute, to extend the protection of the MHRA to more individuals and a greater range of conditions. Third, an impairment is a "disability" when it "requires special education, vocational rehabilitation or related services." 5 M.R.S.A. §4553-A(1)(A)(3). This method incorporates another aspect of the 1975 statute.

Totally new, and superimposed on the three-method framework, are *per se* disabilities and *per se* exclusions. "Disability" now includes certain physical or mental impairments regardless of significance:

> Without regard to severity unless otherwise indicated: absent, artificial or replacement limbs, hands, feet or vital organs; alcoholism; amyotrophic lateral sclerosis; bipolar disorder; blindness or abnormal vision loss; cancer; cerebral palsy; chronic obstructive pulmonary disease; Crohn's disease; cystic fibrosis; deafness or abnormal hearing loss; diabetes; substantial disfigurements; epilepsy; heart disease; HIV or AIDS; kidney or renal disease; lupus; major depressive disorder; mastectomy; mental retardation; multiple sclerosis; muscular dystrophy; paralysis; Parkinson's disease; pervasive developmental disorders; rheumatoid arthritis; schizophrenia; and acquired brain injury.

5 M.R.S.A. §4553-A(1)(B).

Excluded from the definition of "disability," regardless of severity, are pedophilia, exhibitionism, voyeurism, sexual behavior disorders, compulsive gambling, kleptomania, pyromania, tobacco smoking, psychoactive substance use disorders resulting from current illegal use of drugs, and actual or perceived heterosexuality, bisexuality, homosexuality, or gender identity or expression (which are protected under Maine's sexual orientation provision). 5 M.R.S.A. §4553-A(3).

The new definition carries over from the previous statute the requirement that mitigating measures such as medication, aids and prosthetic devices not be taken into account when evaluating whether a "disability" "substantially limits" a major life activity or "significantly impairs . . . health." 5 M.R.S.A. §4553-A(2)(A). This is a major deviation from federal law. The new statute does carry over from the ADA the concept that a person satisfies the statutory definition if he or she has a record of a disabling condition, or is regarded as having or likely to develop a "disability." 5 M.R.S.A. §4553-A(1)(C)(D).

The new MHRA definition of "disability" has the potential to clarify and make predictable the rights and obligations of disabled individuals, employers, public accommodations, schools and others. The new definition was crafted by a committee of labor representatives, representatives from major businesses, advocacy groups, and lawyers who advise clients and litigate claims in the disability discrimination area. The committee's objective was to streamline the analysis in some cases by agreeing that certain conditions are disabling without undertaking extensive analysis of the severity of an individual's impairment. Careful consideration was given to identifying conditions that are truly disabling. For example, while the definition includes "absent . . . limbs, hands, feet or vital organs," it does not include missing digits which are somewhat common and, for certain individuals, not a significant impairment.

Another benefit is the guidance the new definition provides with regard to "significant impairment," the second method of proving "disability." While the 1975 statute placed no limitation on what might constitute "a substantial disability," the new definition creates a two-part test. The impairment must last more than six months, and it must be "significant" compared to "what is ordinarily experienced in the general population." Finally, the new definition eliminates litigation over certain conditions that the Legislature and the general public would not want protected, such as pedophilia.

Maine will be traveling through unfamiliar terrain for several years, as the new definition is applied in the workplace, the courts and elsewhere. The extensive body of federal caselaw formerly relied upon to predict the outcome of disability issues will not apply to Maine's restructured statute. Maine's unique approach to defining "disability" may ultimately bring consistency to this complex area of the law. ☐

Workers' Compensation Law Court Decisions

By Stephen W. Moriarty

Benefits for Presumed Total Incapacity

Section 212(2) of the Act creates a conclusive presumption of 800 weeks of total incapacity following certain catastrophic personal injuries resulting in permanent blindness, the actual loss of two or more extremities, or the permanent paralysis of two or more extremities. In addition, the presumption of total incapacity applies to the "permanent and total loss of industrial use of both legs or both hands or both arms or one leg and one arm". The concept of "loss of industrial use" has been an enduring mystery since the adoption of the Act, and for the first time the statute was interpreted by the Law Court in a recent decision.

In *Saucier v. Nichols Portland*, 2007 ME 132 (September 18, 2007), Ms. Saucier had sustained a gradual bilateral hand injury in 1997, and evidently retired later that year and began to receive non-disability pension benefits. In a 2000 decree the employee's claim for workers' compensation benefits was denied based upon the retirement presumption set forth in §223. She was, however, awarded the protection of the Act for the bilateral hand injury. In the years following the decree, her symptoms deteriorated and in late 2005 she filed a Petition for Restoration. In that proceeding, the employee claimed that her condition had progressed to the point where she had permanently lost the industrial use of her hands. The presiding Hearing Officer declined to apply the retirement presumption, and granted the Petition for Restoration, awarding 800 weeks of permanent total incapacity benefits. The Court accepted the case for appellate review.

The Court initially addressed the inter-relationship between the retirement presumption and benefits for presumed total incapacity under §212(2). Earlier, the Court had held in *Costales v. S. D. Warren Company*, 2003 ME 115, 832 A.2d 790 that the retirement presumption can only be rebutted upon a showing of a complete physical inability to perform work suitable to an individual's qualifications. By its express terms, §223 "supersedes other applicable standards used to determine disability under this Act". The Court initially held that the Hearing Officer committed reversible error by failing to apply "the superseding retiree presumption of sections 223". Accordingly, the retirement presumption must be addressed first, if applicable, before the Board can consider a claim for benefits under §212(2). The Court held that the employee could not have rebutted the presumption on the grounds that the evidence disclosed the existence of suitable work that the employee was capable of performing. The award of benefits was vacated and the matter was remanded to the Board with instructions to enter judgment in favor of the employer.

The Court's discussion of the concept of "loss of industrial use" was less clear. Noting that §212(2) is based upon Michigan law, the Court observed that Michigan requires an examination of wage-earning capacity and an ability to function in industry to evaluate permanent and total loss of industrial use. The Court then held that, even if the employee had rebutted the retirement presumption, she would not have qualified for benefits for presumed total incapacity. The Court reasoned that because the employee had been out of the work force for a number of years and had no intention of returning, she had not suffered a loss of industrial use of the hands. Therefore, because the claimant had withdrawn from the workplace years before her condition had significantly worsened, she would have been ineligible for benefits for lost industrial use.

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The *Saucier* decision is significant as it clearly suggests that an intent to return to the workforce is a necessary prerequisite to entitlement to benefits for permanent and total loss of industrial use. It is unclear what the result would have been on these facts if the claimant had not retired. It should be noted that "loss of industrial use" does not require amputations of portions of the body, and that in the event of multiple amputations the *Saucier* analysis would probably not defeat a claim for §212(2) presumed total incapacity benefits.

Retirement Pension Offset

Section 221(3)(A)(4) provides that compensation benefits must be reduced to reflect the after-tax amount of a pension or retirement benefit paid for by the employer. In *Foley v. Verizon*, 2007 ME 128 (September 11, 2007), the employee was paid benefits for total incapacity as the result of a 2003 injury, and retired in the following year. At the time of his retirement he accepted his pension in the form of a single and substantial lump sum payment in excess of $355,000. Neither the Act nor the WCB Rules establish any method for the appropriate treatment of retirement benefits which are paid in a lump sum. The employee argued that the employer should be entitled only to a one-time offset for the week in which the retire-

ment benefits were paid. The employer argued that there should be a payment holiday until the amount of the lump sum payment had been fully depleted by the value of the employee's entitlement to weekly disability benefits.

Noting that the legislative purpose of the coordination of benefits statute is to prevent a double recovery of compensation and retirement benefits, the Court rejected the alternatives offered by the parties and affirmed the method of calculating the offset implemented by the presiding hearing officer. The hearing officer essentially converted the lump sum payment into a weekly amount that the employee would have received if he had not elected to receive the lump sum. The hearing officer then ordered a coordination of benefits based upon the weekly payment that the employee would otherwise have received. In approving the hearing officer's exercise of discretion, the Court noted that the formula was "a common sense and practical method that meets the overall purpose of the coordination of benefits provision", and was not prohibited by statute or rule. The Court also observed that the hearing officer's calculation was "better than any of the alternatives offered by the parties".

In the same decision the Court held that because weekly compensation benefits "must" be reduced in accordance with §221, the employer correctly stopped payment of benefits immediately without filing a 21-day letter or giving any other form of advance notice. In holding that the employer was entitled to an immediate coordination of benefits, the Court in effect ruled that the coordination provisions of §221 stand as an exception to the 21-day notice requirements of §205(9)(B)(1).

Disability Insurance Offset

Section 221(3)(A)(2) of the Act provides that workers' compensation benefits may be offset against payments made pursuant to a disability insurance policy provided by the employer. In *Nichols v. S. D. Warren/Sappi*, 2007 ME 103 (August 7, 2007), the employer had provided a group insurance policy containing multiple coverages, including life insurance, an accelerated death benefit, and personal loss coverage. The policy also contained "a permanent and total disability feature" in an amount equivalent to existing life insurance coverage, which could be elected whenever a covered employee became unable to work due to injury or disease. In this case, the employee applied for and received the permanent total disability feature, and the employer filed a petition to determine the amount of its statutory offset. The presiding hearing officer ruled that the benefit was paid under a disability insurance policy within the meaning of the statute and allowed an offset.

On appeal the employee claimed that the payment was actually made pursuant to a life insurance policy, and therefore was not subject to the coordination provisions of §221. The Court disagreed and held that the policy contained several types of insurance coverage in a single package, and agreed with the hearing officer's "common sense" approach to the issue. The Court specifically held that a disability insurance policy within the meaning of the statute "includes a payment pursuant to a disability feature in a policy that provides multiple coverages", and that accordingly the employer was entitled to an offset.

Work search requirement

In a recent decision the Law Court upheld its long-standing position that partially disabled individuals may be awarded 100% incapacity benefits by establishing that work remains unavailable to them within their community as a result of an occupational injury. In *Monaghan v. Jordan's Meats*, 2007 ME 100 (July 31, 2007), the Court distilled nearly three decades of appellate opinions into a single straightforward decision which thoroughly analyzes the work search requirement and clarifies uncertainties regarding the burdens of proof.

In *Monaghan*, the claimant had injured both knees in 2003 but was able to continue working without wage loss. However, the injury had left her with permanent limitations, and when her employer closed in 2005 she filed a Petition for Award seeking ongoing partial incapacity benefits at a 100% rate. She had full-time work capacity within her restrictions.

In an effort to obtain new employment, the claimant contacted 147 potential employers and also took typing and computer classes to enhance her employability. Her work search was unsuccessful. The employer offered a labor market survey showing that a stable labor market existed for the employee. The presiding hearing officer rejected the claim for partial at a 100% rate, but awarded fixed partial based upon a presumed earning capacity of $300 per week. The Court granted the employee's Petition for Appellate Review.

Noting that the term "work search rule" might be a bit misleading, the Court observed that "any competent and persuasive evidence to show the unavailability of work in his or her local community is acceptable" to establish entitlement to 100% benefits. Such evidence might consist of a labor market survey, but the Court noted that an actual search for work is generally the most persuasive means of demonstrating the availability or unavailability of work. Procedurally, the Court held that the adequacy of work search evidence is a mixed question of fact and law and recognized that a number of factors must be taken into consideration in evaluating the reasonableness of the effort. Citing a series of its past decisions, the Court set forth the following non-exclusive list of factors:

1. The number of inquiries made or applications filed;
2. Whether the search was carried out in good faith;
3. Whether the search was too restrictive;
4. Whether the employee appropriately used classified ads or other sources of available positions.
5. Whether the search focused upon work that the employee is capable of performing;

6. Whether the employee over-emphasized medical restrictions;
7. Whether the employee undertook other efforts to increase employability;
8. Personal characteristics such as age, education, and training;
9. The size of the job market within the employee's area.

The Court emphasized that no single factor was to be given determinative weight, and that the work search evidence had to be considered comprehensively.

The Court granted the employee's appeal and remanded the matter to the Board for further consideration of the work search evidence in light of the factors enumerated. Notwithstanding the remand, the Court made several key rulings of significance to employers. First, the Court rejected the suggestion that a minimum number of job contacts can constitute an adequate work search as a matter of law. As noted, in this case the claimant had contacted 147 potential employers, but on appeal she argued that 25 such contacts should be legally sufficient. Although the number of contacts is a factor to be considered, the Court rejected the call for "a bright line rule" establishing a legally sufficient minimum.

In addition, the Court rejected the employee's argument that an employer must in each case initially establish the existence of work within an employee's restrictions in his or her community. Instead, the Court held that when an employee is the moving party (as with a Petition for Award), the burden of proof rests with the employee to establish the unavailability of work as the result of the occupational injury. By contrast, when an employer is the moving party (as with a Petition for Review of Incapacity), the employer must initially show some level of partial work capacity and must ultimately prove that there is available work within the community within the employee's physical restrictions.

Weight of §312 Exam

Several years ago the Board determined that the claimant had sustained a compensable injury to her right arm, and eventually the employer filed a Petition to Determine Permanent Impairment. A neurologist who at the time was on the Board-approved list of examiners was appointed to assess impairment resulting from the physical component of the injury, and arrived at a 3% assessment. The presiding hearing officer adopted the examiner's findings and on appeal the employee challenged the legal sufficiency and reliability of the underlying opinion.

In *Higgins v. H. P. Hood*, Inc., 2007 ME 94, 926 A.2d 1176, the Court agreed that there were a number of inconsistencies and inaccuracies in the §312 report. However, in rejecting the employee's appeal, the Court underscored the discretion of a hearing officer to weigh and evaluate a §312 report together with all other evidence offered by the parties. The Court found that the errors in the report were predominantly minor and clerical, and observed that the hearing officer was free to independently evaluate the employee's credibility. The Court found that the report, errors and all, was sufficient competent evidence upon which to base the finding of the extent of permanent impairment and refused to substitute its judgment for that of the hearing officer. ☐

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