

STATE OF SOUTH CAROLINA)
)
 COUNTY OF CHARLESTON)
)
 Christopher Holroyd, Gillian Holroyd)
 and American AVK Co.,)
)
 Plaintiffs,)
)
 v.)
)
 Michael R. Requa,)
)
 Defendant.)

IN THE COURT OF COMMON PLEAS

ORDER
 Civil Action No. 99-CP-10-30

BY _____
 JUDGE J. [unclear]
 CLERK OF COURT
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ORDER DENYING DEFENDANT'S POST-TRIAL MOTION

This matter came before me for a jury trial on December 17, 2001. Trial lasted for four days, after which the jury rendered a verdict against the Defendant under the causes of action for negligence, negligent misrepresentation and breach of fiduciary duty in favor of the Plaintiffs in the amount of \$365,000.00 in actual damages and \$180,000.00 in punitive damages. This matter now comes before the Court on the Defendant's post-trial motion.

Background

The Defendant Michael R. Requa, d/b/a Requa Financial Group, (hereinafter "Defendant") is a licensed insurance agent in the state of South Carolina. In 1996, Defendant sought to be and became an approved agent for a company called The Fidelity Group located in Great Neck, New York, to sell its insurance product. (The "Fidelity" company referenced herein is not the same entity most people identify with the trade name that is know throughout the world or its financial and investment services.).

On December 17, 1996, Defendant directly solicited Plaintiffs by way of facsimile for

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the purpose of selling the Fidelity insurance product. The letter which was written by Defendant specifically identifies the Fidelity product as insurance. The letter contained several negligent misrepresentations including the affirmative statement that Fidelity was reinsured by Reliance. The December 17, 1997, letter containing the negligent misrepresentations, which was relied upon by Plaintiffs in purchasing the subject insurance, predates any other errors or omission of Defendant or claim arising in favor of Plaintiffs.

After several meetings with Defendant and based on the representations made by Defendant about the Fidelity product, American AVK (hereinafter "AVK") entered into a contract for health care coverage for its South Carolina employees. On or about March, 1997, AVK employees became covered under the insurance offered by Fidelity and sold by Defendant.

On June 19, 1997, the South Carolina Department of Insurance issued to Defendant a Cease and Desist Order, advising him that Fidelity was under investigation and directing that he no longer sell the Fidelity product. Before and after this order, Defendant learned that others were experiencing difficulties with payment of claims. Defendant failed to inform the Plaintiffs that he was served with the Cease and Desist Order or its contents or that others were having difficulty with their claims being paid.

On July 8, 1998, Plaintiff Christopher Holroyd was admitted to the hospital and underwent a heart catheter. As required by Fidelity, the Plaintiffs sought and obtained pre-certification for surgery and the required stay at the hospital after surgery. The Plaintiffs and AVK paid all premiums due under the contract from February 1, 1997 to December 1998. The Plaintiffs incurred certain medical expenses during this time which included Plaintiff Christopher Holroyd's hospitalization and surgery. Claims for the medical costs were submitted to Fidelity for coverage under the terms of the coverage. Despite Fidelity's payment of other claims of

other insureds during the same time period, it failed to pay Plaintiffs' medical bills and costs.

At the trial of the case, Plaintiffs produced overwhelming testimony as to the Defendant's duties to the Plaintiffs, the breach of his duties to the Plaintiffs, the proximate causation of damages and the amount thereof. Plaintiffs' very convincing case resulted in a rather convincing jury verdict in the amount \$365,000.00 actual damages and \$180,000.00 in punitive damages against Defendant as a result of his acts, errors or omissions in rendering or failing to render professional services to Plaintiffs.¹

With regard to duties, Plaintiffs thoroughly established that the Defendant owed the Plaintiffs numerous duties. First and foremost was the Defendant's professional duty as an insurance agent. Not only did this duty extend directly to the employer who was purchasing the insurance product, but also to the employees who Defendant met with and who relied upon his professional advice. As testified by the Defendant, he considered each one of the insureds under every policy his "client."

Plaintiffs established as part and parcel of Requa's professional duty a duty by the Defendant to act competently, to provide truthful and accurate information, not to be reckless with information provided, to use due diligence in investigating and recommending products to his clients and to keep his clients advised of material events after the clients were enrolled. The product we are concerned herewith is "insurance" as specifically represented by the Defendant in his solicitation letter to the Plaintiffs, and as previously determined by this Court. (Order Granting Partial Summary Judgment, filed April 16, 2001).

¹There was no evidence at trial of an intentional act or malicious purpose on the part of the Defendant and in fact the Plaintiffs, through their counsel, acknowledged that no one was accusing him of intentionally harming them.

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Plaintiffs clearly established a violation of the Defendant's duties, for instance:

1. Defendant's failure to adequately investigate the Fidelity product during 1996;
2. Defendant's failure to procure the bond information pertaining to the IWG trustees in both 1996 and 1997;
3. Defendant's failure to adequately investigate the information represented to the Plaintiffs in the December 17, 1996 solicitation letter;
4. Defendant's failure to advise his clients after they subscribed to the insurance product that serious questions were being raised about the product by the South Carolina Department of Insurance;
5. Defendant's failure to advise the Plaintiffs that the Department of Insurance had stopped the sale of the insurance product in South Carolina;
6. Defendant's failure to advise the clients in 1997 that he had notice of a claims processing problem at Fidelity; and
7. Defendant's acceptance of Fidelity's representations that the claims processing problems were being solved without investigating the basis for these representations.

Each and every one of these acts, errors or omissions by the Defendant to properly carry out his professional duties proximately caused the Plaintiffs' damages.

1. The Plaintiffs' claims are not pre-empted by ERISA.

The Defendant's assertion that ERISA preempts the Plaintiffs' state claims for insurance agency malpractice is completely groundless. First it must be noted that the Defendant is incorrect in asserting that the Plaintiffs' argued and the Court found the product sold to Plaintiffs was "an employer-sponsored group health benefit plan." The Order granting partial summary judgement to the Plaintiffs clearly and simply held that the product sold to the Plaintiffs was insurance. No determination was made that the product was "an employer-sponsored health benefit plan," nor are those words contained in the Order. (See Order Granting Partial Summary Judgment, filed April 16, 2001). The determination that the product is insurance is preclusive of

this argument.²

Notwithstanding, Defendant bears the burden of proving its' defenses. In order for Plaintiffs' claims to fall within the ambit of ERISA preemption, the Defendant must prove that the "plan" at issue is an ERISA employee benefit plan as ERISA defines that term. See International Association of Entrepreneurs v. Foster, 883 F. Supp. 1050 (E.D. Va. 1995); Elco Mechanical Contractors, Inc. v. Builders Supply Association of W. Va., 832 F. Supp. 1054 (S.D. W. Va. 1993); Atlantic Health Care Benefits Trust v. Foster, 809 F. Supp. 365 (M.D. Pa. 1992); and Corbett v. Elmer Stone, CA #4:99-1241-23, Unpublished Op. (D.S.C. , October 15, 1999)(the Honorable Patrick Michael Duffy held that the Fidelity product in issue was not an bona fide ERISA plan and therefore ERISA preemption did not apply). The Defendant made no effort to assert or introduced any evidence that would be essential to the determination that the product in question was an employee benefit plan. The mere bald assertion that a product is an ERISA plan is insufficient, therefore, Defendant completely failed in his burden of proving this affirmative defense.

Moreover, the preemption issue has been conclusively resolved by the Fourth Circuit Court of Appeals in the case of Cayne & Delany Co. v. Selman, 98 F. 3d 1457 (4th Cir. 1996) and the District Court of South Carolina in the case of Luck v. Coastal Insurance Group, Unpublished Opinion 4:99-978-22 (D.S.C. June 17, 1999). In Delany the Fourth Circuit was asked to

²Furthermore, the Order Granting Partial Summary Judge is also determinative of whether or not the product constitutes a Multiple Employer Welfare Arrangement (MEWA) as defined by the Employee Retirement Income Security Act of 1974. During the course of the trial mention was made of a MEWA. The Defendant failed to offer any proof that the IWG was maintained by a bona fide association of employers or employee organization, an essential and critical element of a MEWA. Therefore, Defendant failed to prove the existence of a MEWA which serve to once again confirm that the product in question was insurance.

consider whether an employer's malpractice claim against an insurance professional for actions taken as an insurance professional was preempted by ERISA. The employer sued the insurance professional under Virginia malpractice law. The plaintiff alleged that the insurance professionals had misadvised it about the benefit plan and had designed an unsuitable plan. In concluding that the plaintiff's malpractice claim did not fall within any of the three recognized categories of laws preempted by ERISA, the court opined:

We believe that [plaintiff's] malpractice claim against insurance professionals is a "traditional state-based law [] of general applicability [that does not] implicated the relations amount traditional ERISA plan entities," including the principals, the employer, the plan, the plan fiduciaries and the beneficiaries. There is no question that [plaintiff's] malpractice claim is rooted in a field of traditional state regulation. Common law professional malpractice, along with other forms of tort liability, has historically been a state concern. Moreover, a common law professional malpractice claim is "a generally applicable [law] that makes no reference to, or functions irrespective of, the existence of an ERISA plan. The state law at issue in this case imposes a duty of care on all professionals, including all insurance professionals. Common law imposes a duty of care regardless of whether the malpractice involves an ERISA plan or a run-of-the-mill automobile insurance policy. Thus, the duty of care does not depend on ERISA in any way. Finally, the state law malpractice claims does not affect the relations among the principal ERISA entities.

Delaney, at 1471.

Likewise, in the Luck case, the South Carolina District Court, relying on the rationale of Delany and finding it determinative, held that the state claims of breach of fiduciary duty and malpractice brought against an insurance agency as a result of it selling the Fidelity product were not preempted by ERISA. Notwithstanding, Defendant's failure to attempt to introduce any evidence that the subject product fell within the ambit of ERISA, Delany and Luck are determinative of the issue and Plaintiffs' state law claims for professional negligence, negligent misrepresentation and breach of fiduciary duty are not preempted by ERISA.

2. **The Defendant's second exception, that the Court erred by allowing Plaintiffs' counsel to question the Defendant regarding the \$1,000,000.00 in unpaid claims by**

Defendant's other customers as a result of his selling the Fidelity product, is without merit.

This exception must fail for a number of reasons. First of all, Defendant claimed that he did his due diligence, did a proper investigation, and timely notified all of his clients of problems with Fidelity once he learned of them. The existence of \$1,000,000.00 in unpaid medical claims just on this agent's customers is evidence that the Defendant did not adequately investigate this insurance product and did not timely notify his clients of problems. Secondly, the existence of the other claims indicates a pattern and practice. Third, the existence of the other claims is relevant to the repetitive requirement under the South Carolina Unfair Trade Practices Act, a cause of action asserted by the Plaintiffs. (This cause of action was withdrawn after trial.) The existence of the other claims, i.e., the extent of the Defendant's wrongdoing, is also relevant to the jury's consideration of punitive damage award requested by the Plaintiffs.

Moreover, this issue actually came up twice at trial; once when the Plaintiff examined the Defendant in cross-examination; and secondly during closing arguments. When the issue came up at closing argument, at the request of the Defendant's counsel, this Court instructed the jury to ignore the comments made about the total of unpaid medical bills for Defendant's client base. After closing arguments, the parties revisited the portion of the transcript where this information was adduced. The review of the transcript evidenced that the Defendant did not timely object to this evidence and that the Court had overruled the objection. Thus, a note was submitted to the jury while in deliberation correcting the incorrect instruction made during closing. The evidence was not only relevant but the only prejudicial effect was that to the Plaintiffs when the incorrect instruction occurred during closing argument.

3. **Plaintiffs were entitled to put on evidence of both the unpaid medical bills and the**

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premiums paid.

The Plaintiffs in this action consist of two essential groups: (1) AVK, the employer; and (2) the Holroyds. The original and amended Complaint asserted a number of causes of action against the Defendant, including negligence, negligent misrepresentation and breach of fiduciary duty. Each of these causes of action were asserted on behalf of both groups of Plaintiffs. The premiums were paid on the professional advice of Defendant. The premiums continued to be paid because the Defendant failed to inform the Plaintiffs of the Cease and Desist Order issued by the South Carolina Department of Insurance. Premiums were paid as a direct result of Defendant's negligence in failing to properly investigate the product; Defendant's negligent misrepresentation due to the inaccurate and incorrect information contained in his solicitation materials sent to the Plaintiffs; and Defendant's breach of his fiduciary to his clients, AVK and the Holroyds. The premiums paid are actual damages suffered by the Plaintiffs due to his negligence, negligent misrepresentation and breach of fiduciary duty.

Upon hearing this issue at trial, the Court limited the Plaintiffs' claim to unpaid premiums for those which related to Mr. Holroyd. These were in the approximate amount of \$7,000.00. While the Court disagrees with Defendant's position, even if Defendant were correct, this would be a very small part of the damages considered by the jury, as evidence by their verdict. Further, given the general verdict by the jury, it is impossible to determine whether or not the jury actually awarded these damages.³

4. There was no error in allowing Gillian Holroyd to testify as to credit damages.

Long before Gillian Holroyd testified as to damages to her credit, Defendant himself

³ The verdict form was agreed to by the parties.

admitted that unpaid medical bills such as those which occurred in this case damages people's credit and that he is familiar with these types of situations. He further conceded that he believed the situation had damaged the Holroyd's credit. Therefore, any testimony by Mrs. Holroyd as this matter is cumulative to that which was already testified by Defendant and cannot constitute error. Defendant further argues that it had been denied access to the Plaintiffs' credit reports during pre-trial discovery and that this should be a reason to exclude this testimony. Without going to the merits of this assertion, the Court will note that this reasoning was not brought to the Courts attention during the trial and it is not proper to raise it for the Court's consideration for the first time after trial and ask the Court to undo the trial.

5. The Court did not err in not allowing cross-examination regarding allegations in the original Complaint.

As became apparent during trial, there had been a scrivener's err in the original Complaint in this matter. Plaintiffs' counsel had copied certain allegations from an earlier filed complaint on a similar action. One of the allegations was that the Defendant had noticed all parties on May 29, 1998, that there were problems with the insurance company. The Plaintiffs in this case later denied ever getting this letter and amendment to the complaint - and so the existence of the letter came into issue.

While the Court agrees that the attorney is the party's agent and would generally allow such examination, the Court does not believe it is fair where it is clearly shown to be a scrivener's error. The Defendant was unable to produce any evidence that it was anything but a scrivener's error and in fact did not dispute that it was a scrivener's error.

Moreover, the Court believes that even if this were error, it would be harmless. It was the Plaintiffs' contention at trial that any notice in 1998, even if received, would be too late; the

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Defendant should have notified his clients of the problems in 1997. Given that this was a thrust of evidence at trial, the Court does not believe that any err here would be material. Finally, it must be noted that all of the Defendant's own witnesses testified that they had not received a March 1998 letter and failed to support Defendant's claim that he sent letters to all of his clients.

6. The Court did not err in qualifying John O'Brien as an expert.

The admission or exclusion of expert testimony is a matter within the sound discretion of the trial court. See Pavton v. Kearse; 329 S.C. 51, 495 S.E. 2d 205 (1998); Creed v. City of Columbia, 310 S.C. 342, 426 S.E. 2d 785 (1993); Gazes v. Dillard's Dep't Store, Inc., 341 S.C. 507, 534 S.E. 2d 306 (Ct. App. 2000). Mr. O'Brein was well qualified to be an expert in this case. He possesses several certifications in the field of insurance. He has authored several books in the field of insurance. As noted by Defendant he taught classes to insurance agents and has represented insurance agents in his law practice. Clearly, Defendant's arguments herein are misplaced and summarily denied.

7. The Court did not err in allowing Christopher Holroyd and John O'Brein to testify regarding increased premiums.

Similar to section four above, the testimony by Mr. Holroyd and Mr. O'Brein on this subject matter was only after the Defendant himself conceded that the problems caused the Plaintiffs by the Fidelity plan had resulted in increased premiums for Mr. Holroyd. Any testimony by Mr. Holroyd and Mr. O'Brein on these issue is only cumulative to that which the Defendant himself testified. As such, this testimony cannot constitute error.

Secondly, the Defendant's reliance on HIPAA in this argument is misplaced. First Defendant's argument is based on the assumption that Mr. Holroyd's present insurance constitutes a "group health plan." A "group health plan" means "an employee welfare benefit

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plan." 18 U.S.C. §1191b. An "employee welfare benefit plan" is only covered by HIPAA if it is an employee pension benefit plan or is determined by the Secretary of the Treasury to be, a plan described in section 401(a) of title 26, or which meets, or has been determined by the Secretary of the Treasury to meet, the requirements of section 404(a)(2) of title 26. 29 U.S.C. §1321. Defendant failed to offer or even elicit any information regarding the Holroyds present type of insurance coverage. Defendant has baldly asserted HIPAA applies without establishing the prerequisite type of insurance coverage or plan. Thus, Defendant's argument of HIPAA's application is misplaced.

Over objection of Plaintiffs' counsel, the Court allowed the Defendant to read the HIPAA statute to the jury in closing argument. It was apparent to all that HIPAA is a complex regulation. If Defendant was intending for HIPAA to be a substantial part of their case it was incumbent upon the Defendant to present an expert to the jury to explain the effect of this legislation, if any, on this case.

8. The Court did not err in charging future damages and morality tables.

As discussed above, the future damages pertaining to the increased premiums for Christopher Holroyd was first brought into evidence by Defendant himself. Once properly into evidence, it was incumbent on the Court to give the jury the tool in which to properly evaluate future damages. One such tool is the morality table. It was properly charged. Further, no exception was taken by either party to the charge as given.

9. The Court did not err in failing to grant a change of venue.

The Master-In-Equity properly concluded a change of venue was inappropriate. A defense of improper venue is waived if not made by motion under Rule 12 SCRPC or included in a responsive pleading. See Rule 12(h) SCRPC; Henley v. North Trident Regional Hospital, 275

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S.C.193, 269 S.E. 2d 328 (1980). The Defendant did not assert the defense in his pleadings. The issue came before the Court for hearing in April of 2001, two years after the case had been commenced. The Defendant did not actively pursue the issue until the case appeared on an active jury docket. As properly held by the Master-In-Equity, the Defendant waived any issue and to improper venue. Furthermore, the Defendant failed to raise the issue during the course of trial. Thus, the issue was not properly preserved for consideration by way of a post trial motion.

10. As first discussed above regarding the evidence introduced to trial, the greater weight of the evidence supported Plaintiffs' case, not the Defendant's affirmative defenses of comparative negligence and assumption of the risk.

Defendant had the burden of proving his defenses. As evidenced by the jury verdict and the overwhelming evidence at trial, the Defendant failed to do so. The Court has not been given any reason to disagree with the jury's finding.

11. The damages are not grossly disproportionate.

The jury's determination of damages is entitled to substantial deference. Rush v. Blanchard, 310 S.C. 375, 379, 426 S.E.2d 802, 805 (1993). When a party moves for a new trial based on a challenge that the verdict is either excessive or inadequate, the trial judge must distinguish between awards that are merely unduly liberal or conservative and awards that are actuated by passion, caprice or prejudice. Allstate Ins. Co. v. Durham, 314 S.C. 529, 431 S.E.2d 557 (1993). The trial court must set aside a verdict only when it is shockingly disproportionate to the injuries suffered and thus indicates that passion, caprice, prejudice, or other considerations not reflected by the evidence affected the amount awarded. Vinson v. Hartley, 324 S.C. 389, 477 S.E.2d 715 (Ct. App. 1996). In other words, to warrant a new trial absolute, the verdict reached must be so "grossly excessive" as to clearly indicate the influence of an improper motive on the jury. Rush v. Blanchard, 310 S.C. 375, 426 S.E.2d 802 (1993).

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Plaintiff put in evidence, much with the Defendant's testimony, that the Plaintiffs' damages not only included unpaid medical bills, but also included embarrassment, humiliation, credit problems, increased future insurance premiums, stress, premiums paid, and decreased coverage due to preexisting conditions in a new policy. Given the damage evidence introduced at trial, the Court cannot say that the damages are disproportionate to the evidence.

12. The damages awarded by the jury were not unduly liberal.

Pursuant to Gamble v. Southern Bell, 305 S.C. 104, 406 S.E. 2d 350 (S.C. 1991), the Court has reviewed the jury's award of punitive damages and sustains same. The Court finds:

1. Defendant's degree of culpability to be substantial. Defendant's initial inaccurate, unsupported and misleading contact, his failure to make proper inquiry concerning the product he sold AVK, and his failure to adequately inform AVK and the Holroyds, clearly were the cause of Plaintiffs problems. Defendant is 100 percent culpable in causing injury and damage to Plaintiffs.
2. The Defendant's culpability lasted throughout his dealings with Plaintiffs; from his initial contact through his failure to timely notify and warn Plaintiffs of the gargantuan problems with the product he sold them.
3. Defendant had knowledge which, if it had been timely and properly transmitted to Plaintiffs, would have afforded them to make informed intelligent decisions regarding their health insurance coverage.
4. The amount of the punitive damages award is such that it should deter Defendant and others from like conduct in the future.
5. The amount of the punitive damages award is reasonably related to the harm likely to result from Defendant's conduct. The award is slightly less than one-half of the award of actual damages.
6. While there is no direct evidence of Defendant's ability to pay, there was evidence of the amounts Defendant made annually from just the premiums paid on the product.
7. Overall, the case supports an award of punitive damages, Defendant's omissions, his misleading (and inaccurate) initial correspondence with AVK, his blind acceptance of unfounded information from third persons, his lack of diligence when alerted to the problems the product was experience in both claims payment

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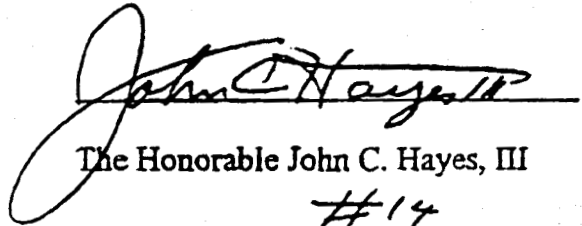
and investigation by The South Carolina Insurance Commission, and his failure to accord due diligence to his clients are all factors supporting an award of punitive damages. The Defendant's conduct was in reckless disregard of Plaintiffs' rights. (See also items 1 through 7 on page 4).

The award is proportionate to the severity of Defendant's misconduct. The Holroyds were (and still are) unable to pay medical bills in excess of \$60,000. More than \$1,000,000.00 in Defendant's clients claims remain unpaid. Defendant's misconduct affected the Holroyds' credit, caused them extreme embarrassment and has affect their futures both financially and emotionally.

Assessing the award of punitive damages under the criteria of Gamble, supra, the undersigned finds the award within constitutional restraints and supported by the

NOW THEREFORE, the reasons set forth above, Defendant's motion for judgment notwithstanding the verdict and for new trial are denied.

AND IT IS SO ORDERED.


The Honorable John C. Hayes, III
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January 24th, 2002

ATTEST: A TRUE COPY
JULIE J. ARMSTRONG (SEAL)
CLERK, C.P. & G.S.

By 
DEPUTY CLERK