

# 21<sup>ST</sup> CENTURY LAW

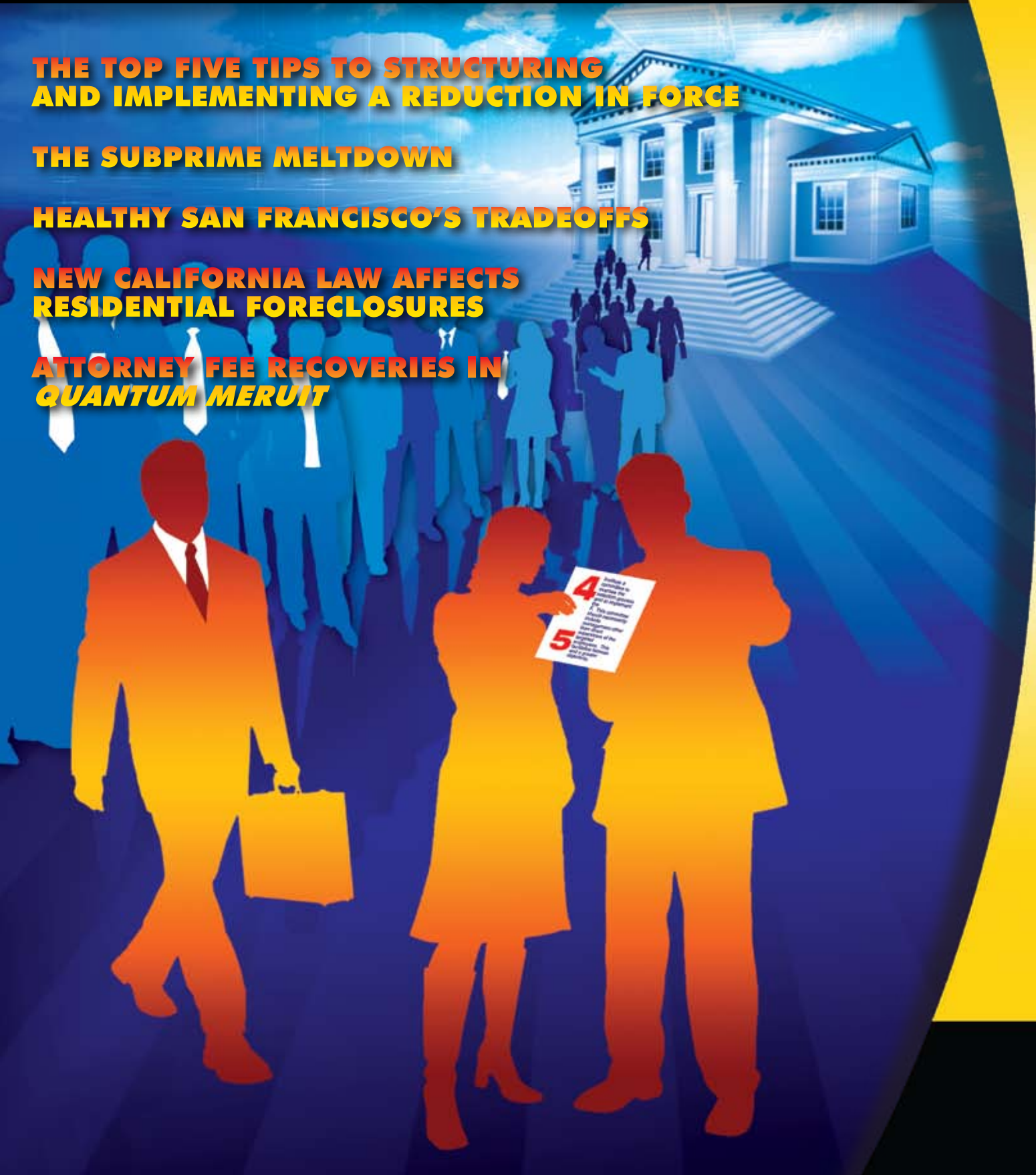
**THE TOP FIVE TIPS TO STRUCTURING  
AND IMPLEMENTING A REDUCTION IN FORCE**

**THE SUBPRIME MELTDOWN**

**HEALTHY SAN FRANCISCO'S TRADEOFFS**

**NEW CALIFORNIA LAW AFFECTS  
RESIDENTIAL FORECLOSURES**

**ATTORNEY FEE RECOVERIES IN  
*QUANTUM MERUIT***





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May 2009

Dear Friends and Colleagues:

There's no doubt that these are tough economic times. With the state of the financial industry and tightening of the credit markets, the bottoming out of the real estate sector, and a climbing unemployment rate, there continues to be cause for concern for all of us. As the new administration takes shape and policies are put in place to secure our country's recovery, our team at RMKB looks to the future with a continued focus on the needs and well-being of our clients.

This edition of *21st Century Law Magazine* provides relevant and timely topics on some of the pressing issues businesses are facing across a wide range of industries. Steve Erigero examines the sub-prime market and its ongoing effects on the insurance industry while Elise Vasquez delves into reduction-in-force issues in light of the current economy. Stephen Lightfoot explores the affects of a new California law on foreclosures and Kim Karelis addresses the topic of attorneys' fees.

The following pages also highlight significant deals and decisions in which our firm attorneys were involved and the featured "In-Box" columns showcase some of RMKB's unique practice areas and capabilities.

Finally, as our country embarks on a path toward economic recovery, we here at RMKB can help you navigate any of the legal or business issues that may arise. We hope you find this latest edition useful and please don't hesitate to call on us should you need assistance with any of your pressing legal matters.

Sincerely,

Richard Wilson  
Managing Partner  
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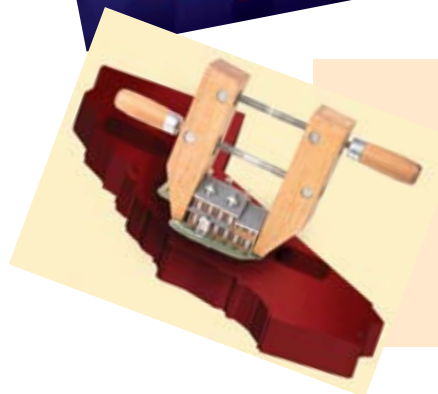
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# THE SUBPRIME



# MELTDOWN

## **Claim Implications After the Crisis**

*by Stephen J. Erigero*

*Unprecedented banking and financial company failures and hastily arranged buyouts by regulators to avoid insolvencies have left the financial markets reeling. The Federal Reserve and the Treasury Department formulated bailouts of companies once thought solid. Congress wrangled with the \$700 billion rescue package to avert further disaster. Stockholders of once-steady entities such as Washington Mutual, Wachovia, or AIG find investments lost, and some on the brink of retirement discover that their nest eggs have shrunk by 25 percent or more. As the affected masses search for people to blame and assets to tap, suits against directors, officers, accountants, and even loan agents and appraisers continue to mount.*

Given the more than \$230 billion in write-downs from the subprime mortgage crisis in the first half of 2008, an inevitable barrage of litigation ensued. During the first three months of 2008 alone, 170 subprime-related lawsuits were filed in Federal Court. Nearly half of these suits were filed in New York and California. One half of the lawsuits involved putative class actions by borrowers versus lenders and mortgage brokers alleging (among other things) discriminatory lending practices, improper charges, and inadequate disclosures.

In January 2008, Bear Stearns estimated that directors and officers (D&O) insurers may face \$9 billion in claim-related costs. Bear Stearns' own officers and directors were subject to a suit against them, which was filed within hours of the announced bailout sale to J. P. Morgan (*Eastside Holdings, Inc. v. Bear Stearns*). Other subprime-related securities lawsuits have been brought against AIG, Citigroup E-Trade Financial Corp., HSBC Holdings, Movies Company, Toll Brothers, and Washington Mutual, Inc. Of the many cases filed in the past year, almost all of them name individual directors or officers as defendants.

But are the insurers taking note of the burgeoning litigation? Have the underwriters anticipated such claims with policy language that excludes claims arising out of fraud, dishonest acts, or improper personal profit? Are claim professionals ready to investigate the facts to make the proper coverage determinations? Will other insurers face the same fate as AIG?

When faced with a D&O claim made against a director or an officer of a Fortune 500, a small privately held firm, or an errors and omissions (E&O) claim against a loan broker, insurers must be prepared to apply policy language and investigate the

facts. This can be accomplished by answering simple questions.

### **Does the Policy Language Limit Coverage?**

D&O and E&O policies contain "dishonesty exclusions." The related policy language may resemble the following: a) The gaining of any profit, remuneration, or advantage to which the insured was not legally entitled; or b) any criminal or deliberately fraudulent act, error or omission by an insured, if evidenced by any judgment, final adjudication, alternative dispute resolution proceeding, or a document or written statement by an insured.

**In January 2008, Bear Stearns estimated that directors and officers (D&O) insurers may face \$9 billion in claim-related costs**

Many policies do not include the qualifying phrase, "or a document or a written statement by an insured." Instead, numerous policies contain language that the exclusion only applies, "if a judgment or other final adjudication adverse to the insured establishes such act, omission, or willful violation."

A secondary issue arises where the policy provides that no fact pertaining to, knowledge possessed by, or conduct by any insured individual shall be imputed to any other insured individual. Essentially, this means that if one director or officer commits a wrongful act resulting in an illegal profit, then the innocent directors or officers are not subject to a loss of coverage.

An insurance company may be defending D&O litigation — or reimbursing an insured for the defense and potential indemnity payments in litigation — until there

is a final adjudication establishing the application of the dishonesty exclusion.

Many D&O policies also contain language excluding "personal profit." The language usually states that such losses are excluded arising out of the gaining "in fact" of any personal profit or advantage to which the insured is not legally entitled.

Some courts have interpreted this "in-fact" requirement as meaning a final adjudication. (*PMI Mortgage Ins. Co. v. American International Specialty Lines Ins. Co*). In *PMI Mortgage*, the insurance company was required to reimburse an insured's defense costs and amounts paid to settle an underlying D&O lawsuit brought about by consumers against a mortgage insurer, even though the allegations of the complaint sought recovery of profit to which the insured was not legally entitled. During the trial, the insurer could not produce evidence of the coverage action to establish that the insured paid a settlement amount allocated to an excluded personal profit. Other jurisdictions have not required a final adjudication to satisfy the "in-fact" requirement.

Therefore, the application of the exclusions related to dishonest acts or personal profit require that the insurer alter the evidence to establish that defense and indemnity reimbursement sought by the insured is excluded. Depending on the policy language, this may require a final adjudication in the underlying action against the insured. Waiting for the underlying action to go to final judgment could be a costly proposition for an insurer. As such, the claim professional needs to investigate to obtain the evidence to determine if the insurer can establish "in fact" an illegal personal profit or establish in a

## Andy Margulis and Eric Weissman Secure Three Insurance Decisions

### *H. Wayne White and Associates, Inc. and National Health Plans Plus, Inc. v. Continental Casualty Company*

Andy Margulis along with Eric Weissman represented Continental Casualty Company in the defense of coverage and bad faith litigation in the U.S. District Court for the Middle District of Florida. The suit arose out of denial of coverage for three claims against the insured. The matter involved coverage for complex underlying claims stemming from the sale of a group health insurance plan to thousands of people that were employed by different companies and who banded together to form a group for the sole purpose of obtaining health insurance (a Multiple Employer Welfare Plan or “MEWA”). The insured was an insurance agent selling health coverage under the group plan to his clients. The issuer of the health insurance was investigated by various state insurance departments nationally and was found to be illegally issuing health insurance. The insured agent and his company sought coverage, and Continental refused to provide a defense or cover the settlements entered into with the clients. Margulis and Weissman were successful in obtaining a summary judgment resulting in the dismissal of both the coverage and bad faith claims.

### *Richard A. Gamin, Jr. v. Columbia Casualty Company*

This case involved the defense of coverage and bad faith litigation in the U.S. District Court for the Northern District of Ohio arising out of denial of coverage to a registered representative. The registered securities representative was sued by a client and former business partner over the parties’ attempt to start their own financial services business. Complicating the situation was the fact that Columbia had defended the initial state court action against the insured, but after that case was voluntarily dismissed and an arbitration was commenced, Columbia refused to defend or indemnify the insured in connection with that arbitration.

Margulis and Weissman were successful in obtaining a favorable interpretation of Columbia’s policy language concerning the types of activities covered by its policy and obtained a summary judgment finding that Columbia correctly refused to defend the insured in the underlying matter dismissing the bad faith claim. The case is currently on appeal before the United States Court of Appeals for the Sixth Circuit.





*Stacey Smith, et. al. v. Continental Casualty Company*

In another defense of coverage and bad faith litigation claim, Margulis and Weissman were successful in securing a summary judgment in favor of Continental Casualty Company in the U.S. District Court for the Middle District of Pennsylvania. The case involved denial of coverage to a securities registered representative sued by a client over the insured’s advice to invest in an offshore asset protection trust and then invest those funds in Evergreen Securities. Evergreen was investigated by law enforcement authorities and ultimately filed for bankruptcy. The client sued the investment advisor for recommending the investment, and denied coverage to the claim on multiple grounds, including the nature of the investment. The client settled with insured and then sued the insurance company for bad faith and loss of investment. The case is currently on appeal before the United States Court of Appeals for the Third Circuit.

For additional information, please contact Andy Margulis at 646.454.3242 or [amargulis@rmkb.com](mailto:amargulis@rmkb.com).

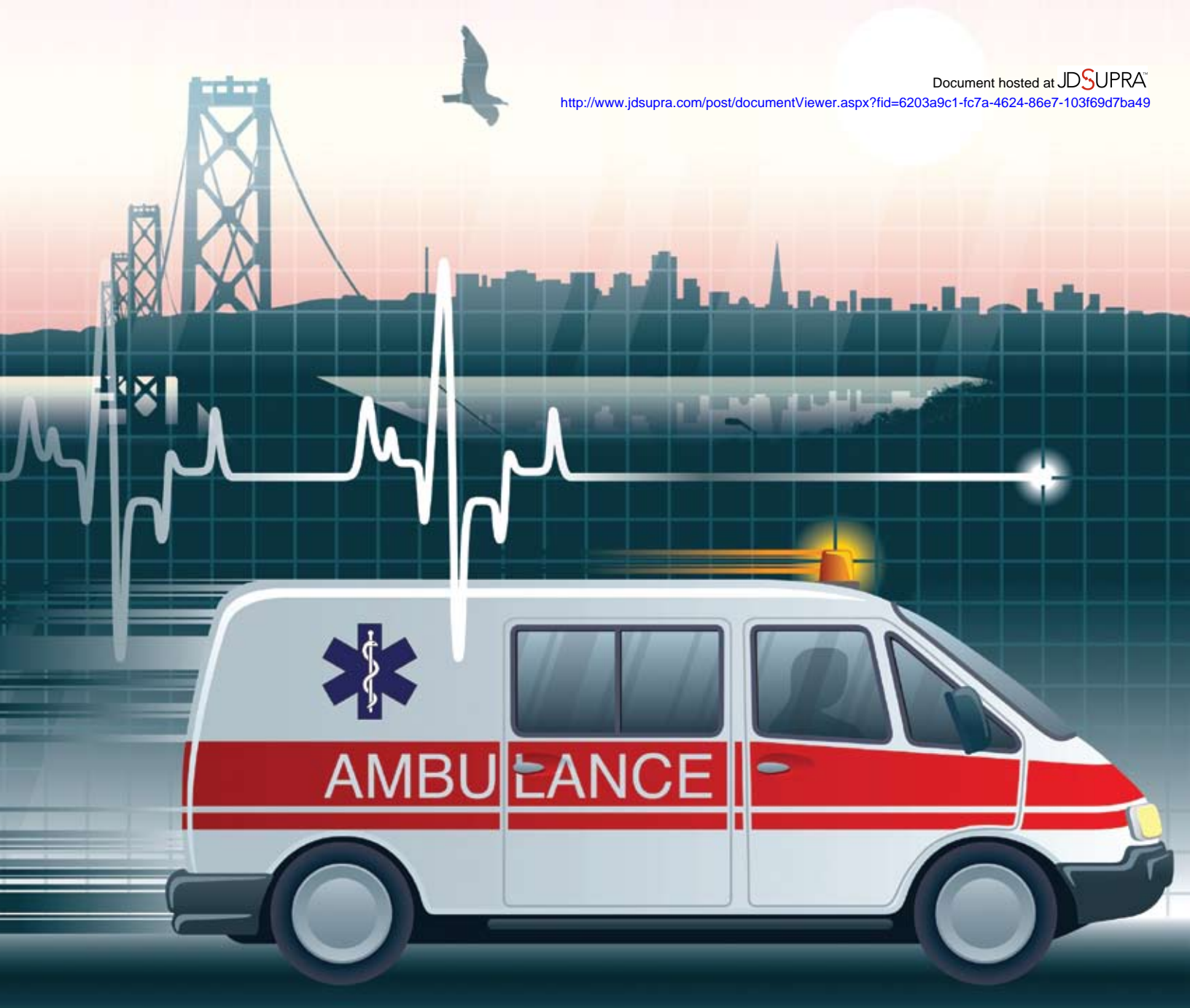
**Partner François Laugier Handles International Technology Deal**

François Laugier, a corporate transactions and international business partner at RMKB, represented privately-held, France-based Trango Virtual Processors in its sale to Palo Alto, California-based business software maker VMware, Inc. (NYSE: VMW). The all cash deal enables VMware, the global leader in virtualization solutions from the desktop to the datacenter, to bring its new VMware Mobile Virtualization Platform (MVP) to mobile phones utilizing innovative technology developed by Trango. The acquisition of Trango’s technology helps VMware handset vendors reduce development time and get mobile phones with value-added services to the market quickly. End users also benefit by being able to run multiple profiles on the same phone.

“As virtualization continues to grow in the mobile industry, Trango’s technology gives VMware a strong competitive foothold and provides numerous applications and benefits to handset manufacturers and end users,” said Laugier.

For more information, please contact François Laugier at 650.780.1691 or [francois@rmkb.com](mailto:francois@rmkb.com).





## HEALTHY SAN FRANCISCO'S TRADEOFFS

*by Robert M. Forni Jr.*

The Ninth Circuit U.S. Court of Appeals recently upheld the San Francisco Health Care Security Ordinance. The cornerstone of the ordinance is Healthy San Francisco, an entitlement program administered by the Department of Public Health. At the time San Francisco enacted the ordinance in 2006, U.S. health care spending peaked at \$2.1 trillion, roughly \$7,026 for every person in the nation. Despite the trillions of dollars spent on health care, an estimated

47 million people in this country are uninsured. In San Francisco alone, there are an estimated 73,000 uninsured residents.

Healthy San Francisco promises to reduce the ranks of the uninsured by delivering services to them through a network of care providers. Persons who already have health insurance, exceed maximum income thresholds or who live outside San Francisco are not eligible to receive services.

However, nonresidents who work in San Francisco may still establish medical spending accounts with the city, through which they may be reimbursed for medical expenses. To date, more than 30,000 city residents have enrolled in Healthy San Francisco, just half of the approximately 60,000 residents expected to enroll eventually.

To pay for this program, the city imposes a tax on employers that do not

reimburse employee medical expenses or pay medical benefits meeting a certain threshold. Under this “pay or play” system, businesses with 20 or more workers currently provide an estimated \$12 million of the program’s \$200 million annual cost. For the same amount, based on the average cost of premiums for private HMO policies in 2008, the city could pay premiums for such policies covering more than 27,000 individuals or 9,700 families, without incurring additional costs to administer its program.

### GGRA's Lawsuit

In November 2006, the Golden Gate Restaurant Association filed suit against the city in the U.S. District Court for the Northern District of California, challenging the ordinance’s spending requirements. Last December, the district court granted the association’s motion for summary judgment, and enjoined the city from collecting employer contributions, on the grounds that the Employee Retirement Income Security Act of 1974 pre-empted the ordinance’s employer spending requirements.

A three-judge panel of the Ninth Circuit reversed the district court on Sept. 30, holding ERISA does not pre-empt the ordinance’s spending requirements because the ordinance does not expressly require employers to establish ERISA plans or make any changes to existing ones. The association filed a petition for rehearing en banc, to which the court denied on March 9, 2009 in a split decision, with eight Circuit Judges dissenting.

### Mandatory Expenditures

Although the ordinance is similar to the 98 other pay-or-play bills introduced since 2006 in 36 state legislatures in that it increases costs of doing business

and imposes administrative burdens, the ordinance is unique in other respects. For instance, the ordinance mandates only that “medium” and “large” businesses, engaging in business within San Francisco, make quarterly “health care expenditures” to or on behalf of certain employees. Specifically, a private employer with between 20 and 99 employees and a nonprofit with 50 or more employees must spend \$1.17 per hour on behalf of “covered employees.” A private employer with 100 or more employees must spend \$1.76 per hour on behalf of each covered employee. The required health care expenditure is calculated by multiplying the total number of hours for which each covered employee is paid, or is entitled to be paid, wages for work performed within San Francisco each quarter by the applicable health care expenditure rate. If an employer does not make the required health care expenditures, it must make payments directly to the city.

A “health care expenditure” is defined under the ordinance to mean any amount paid by a covered employer to its employees, or to a third party on behalf of its employees for the purpose of providing health care services to

them or reimbursing the cost of such services for its employees. Qualifying expenditures include contributions to health savings accounts, reimbursement

to employees for expenses incurred to obtain health care services, payments to third parties for health care services, costs incurred in the direct delivery of health care services, or payments to the city to fund Healthy San Francisco.

**Despite the trillions of dollars spent on health care, an estimated 47 million people in this country are uninsured. In San Francisco alone, there are an estimated 73,000 uninsured residents**

### Covered Employees

The ordinance attempts to limit the scope of employees on whose behalf employers must make such payments. Covered employees are individuals who work in the city at least 10 hours per week on average, and have worked for the employer for at least 90 days. However, the following persons are generally not covered employees under the ordinance: (1) persons who are managerial, supervisory, or confidential employees, unless they earn less than \$72,450; (2) persons who are eligible to receive benefits under Medicare; (3) persons who are employed by a nonprofit corporation for up to one year as trainees in a bona fide training program; and (4) persons whose employers verify that they are receiving health care services through another employer, and they have voluntarily waived any right to receive benefits under the ordinance.

A covered employer that provides health benefits to its covered employees through a self-insured plan complies with the spending requirement if the preceding year’s average expenditure rate per employee meets the applicable





expenditure rate for that employer. The average expenditure rate is calculated by dividing the total amount of health care expenses paid to or on behalf of covered employees by the total number of hours for which they have been, or were entitled to be, paid wages for work performed within San Francisco.

However, the ordinance forbids employers from satisfying their spending requirements by averaging health care expenses paid to their employees. Payments to or on behalf of one covered employee that exceed the required expenditure for that employee will not be considered in determining whether an employer has met its total required expenditures for all employees. If, over the course of a year, an employer that provides health coverage to its covered employees through a self-insured plan pays little or no expenses in some quarters, but large amounts in others that exceed the minimum health care expenses required by the ordinance, then the employer may not satisfy its spending requirements even if the average costs paid over the course of the year exceed the required expenses. For

each quarter in which its health care expenses falls below the mandatory minimum, the employer would have to satisfy the ordinance by some other means, such as by paying the difference between actual and required health care expenditures to the city. Thus, during some quarters, an employer that provides health coverage to all of its covered employees through a self-insured plan may end up paying as much to the city as an employer that provides no health care benefits at all.

### Options for Compliance

The ordinance attempts to skirt ERISA's pre-emption rule by affording employers discretion in complying with its spending requirements. An employer is exempt from making payments to the city if it spends at least \$1.17 or \$1.76 per hour (depending on the number

of employees), and it is partially exempt to the extent that it spends less. An employer may satisfy its spending requirement by, for example, purchasing health insurance for its full-time employees, and paying the city to fund part-time employees' membership in Healthy San Francisco.

Employers that have no health care plan may continue operating without one, but must make their required health care expenditures directly to the city. Alternatively, they may establish a health care plan. If they do so, the ordinance requires that they make the required level of health care expenditures by paying the full amount to fund the plan, or by paying part to fund the plan and part to the city.

Employers that have health care plans that cover some employees, and that spend at least as much as the required health care expenditure for each employee covered by the plan, may choose to maintain their existing plans or amend them to cover any employees excluded from coverage. If they fail to do so, employers may comply with the ordinance by making the required health care expenditures to the city for each employee not covered by their plans.

An employer that spends less than the required health care expenditure for each covered employee under a plan may comply with the ordinance by

**An employer is exempt from making payments to the city if it spends at least \$1.17 or \$1.76 per hour (depending on the number of employees), and it is partially exempt to the extent that it spends less**

paying the city the difference between the amount that the employer pays in premiums and other health care expenses for covered employees enrolled in the plan and the required health care expenditures under the ordinance. To

separate declaratory relief action that the dishonesty exclusion applies.

### What Lies Beneath

An insurer's investigation entails a thorough analysis of the operations of its insured. This begins with a complete review of the underwriting materials from the company and documents from the insurance agent or surplus lines broker that contain all the facts about the insured's operations.

Next, the claim professional will need to analyze the laws governing the particular industry. If there is an allegation of predatory lending practices, then the professional will need to determine what, if any, regulations the insured has allegedly violated. One should also consider the common industry practice as to the application of fees or the duties of disclosure. Do the damages seek excluded fines and penalties? What is the maximum penalty and how is this calculated? The claim professional needs to be able — at an early stage — to allocate the potentially sought damages to amounts covered under a policy, and to amounts excluded as the product of a dishonest act, a personal profit, or a fine or penalty.

Insurers must not overlook easy information sources, such as a company web site or company marketing material for a closely held company like a local mortgage broker. For a large enterprise, pay attention to annual reports or other publicly filed documents. Interviews of company employees may fill in the gaps where documents leave off. Depending on the complexity

of the case and on the policy limits exposure, carriers should also consider forensic accounting experts to assist in understanding the exposure. It may be prudent to ask the expert to assist in a damage analysis for the potential application of policy exclusions to a settlement demand, settlement payment, or a judgment against an insured.

### Duty of the Insurer

The insurer needs to respond to a tender from a policyholder in an expeditious manner. Some state-specific claim regulations establish time periods that a carrier must follow when responding to an insured and making an initial coverage determination. Preliminarily, the insurance company's response will depend on whether the policy is a straight reimbursement policy and if the policy contains a "duty-to-defend" provision.

Where the policy contains a duty to defend — as is often the case in D&O policies specifically tailored to closely held companies — the

insurer would do best to defend <sup>JD SUPRA</sup> <http://www.ldsupta.com/post/documentViewer.aspx?fid=6203a9c1-fc7a-4624-86a7-103f69d7ba49> it investigates the claim. A letter specifically tailored to set forth the coverage position of the insurance company should be formulated. This should include the pertinent

**An insurer's investigation entails a thorough analysis of the operations of its insured**

exclusions, the conditions and provisions of the policy, the definition of loss, and the requirements that the underlying suit must seek damages as opposed to fines or penalties. The carrier can then request the insured's cooperation in providing information, books, records, and other documents from the company that relate to the underlying suit. It can also ensure that its employees are available for interviews and can opt to correspond with its insured via coverage counsel. This will insulate the insurance company through the attorney/client privilege from the thoughts, comments, and opinions of its coverage counsel. It is important to note that the nature and extent of the attorney/client privilege varies from jurisdiction.

In limited circumstances, depending upon the lack of cooperation from the policyholder, it may be necessary to file a specifically tailored complaint for declaratory relief. When the policyholder will not communicate with the insurer, the only remaining option may be seeking court assistance. Filing a declaratory relief action allows the carrier to obtain facts through the litigation process where the policyholder was unwilling or unable to provide the necessary documentation for the carrier to



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In the case of workers making the minimum wage, however, employers could not reduce their wages beneath the statutory minimum to offset the cost of medical insurance or mandatory spending. Thus, if workers' total compensation (wages plus insurance or mandated spending) exceeds their productive value, employers may be forced to lay them off, relocate their businesses outside the city, or drop health insurance benefits altogether, leaving employees to fend for themselves in the private insurance market or participate in Healthy San Francisco, if they're eligible.

This is not an idle possibility in the current economy. The number of small employers with 10 to 199 employees offering health insurance has already fallen nationwide from 69 percent in 2001 to 61 percent in 2007, without the threat of employer mandates. With them, the ordinance may force employers to depress wages and decrease employment and health insurance options for its intended beneficiaries, the working poor.

**Despite its best intentions, the ordinance's spending requirements may adversely affect employment in the city, particularly for low-income workers**

This article first appeared in the November 19, 2008, issue of *The Recorder*. Robert M. Forni Jr. is a senior associate at Ropers, Majeski, Kohn & Bentley in Redwood City, and specializes in the representation of insurance carriers in bad faith and ERISA litigation and appeals involving employment benefits. Robert can be reached at: [rforni@rmkb.com](mailto:rforni@rmkb.com).

*Cont. from pg 12*

satisfy its health care expenditures for covered employees not enrolled in their plans, employers may pay to the city the full amount of the required health care expenditures.

### **Unintended Consequences**

Despite its best intentions, the ordinance's spending requirements may adversely affect employment in the city, particularly for low-income workers. Employers may respond to the mandate by passing the cost of health insurance on to workers in the form of reduced wages.

One recent study by the National Bureau of Economic Research found

that the average cost of a health insurance plan providing family coverage between 2000 and 2006 was \$9,000, or \$3.66 per hour for a full-time worker — well above the spending requirements imposed by the ordinance. The study concluded that wages would need to fall by \$3 per hour to offset fully the cost of a mandate requiring employers to provide coverage similar to the average plan.

This estimate may be conservative in light of current health care expenses.



determine coverage. The carrier does not want to be in a position where there is a demand to indemnify from the policyholder for a questionably covered claim, and the carrier has no facts to evaluate its coverage or to challenge the demand.

### The Power of Exclusion

The impact of a subprime crisis on insurance companies will likely be minimized by the effect of exclusions based on the fraud of the insured — whether the dishonest-acts exclusion or the personal-profit exclusion applies. Insurers have drafted this language anticipating E&O and D&O claims. However, the need for a final adjudication of the facts to apply the exclusions requires the insurer to be vigilant in its investigation from the onset.

The insurer will be required to either wait for the conclusion of an expensive underlying action or be prepared to litigate coverage in a coverage action. The insurer will then need to establish the evidence to allocate the damages sought to the exclusion. A thorough and early investigation will allow the insurer to meaningfully discuss apportionment of loss with its insured while underlying action proceeds along, rather than wait until the insured settles or faces a final judgment that may or may not be sufficiently particular to allow the application of exclusion.

Finally, conducting a thorough investigation will permit an insurer to properly reserve the losses and allow actuaries to price premiums moving forward to maintain the financial solvency of the insurance company.

Stephen Erigero is a partner in the Los Angeles office of Ropers Majeski Kohn & Bentley. He practices in areas of insurance coverage and professional liability. Erigero may be reached at 213-312-2000, serigero@rmkb.com, www.rmkb.com

# RMKB IN BOX



**Warning: Failure to Warn Can Cause Your Company Significant Harm!**

The following are actual warning labels.....

**“Do not use in the shower.”**  
– On a curling iron

**“Do not use with sunshield in place.”** – On a cardboard sunshield that keeps the sun off the dashboard

**“Warning: knives are sharp.”**  
– On the packaging of a sharpening stone



Seem obvious? Even the General Motors Handbook has approximately 29 pages dedicated to how to wear a seatbelt.



In today's litigious environment, manufacturers of consumer products must be hyper diligent with their approach to warning the public of potential product hazards otherwise they might find themselves involved in very expensive lawsuits. (Think McDonald's hot coffee case). RMKB's team of products liability specialists work with companies to provide advice on sensitive product liability issues ranging from defects to warning labels. The firm represents insureds in industries as diverse as chemical manufacturing, recreational products, aircraft, food and beverage, automotive parts, consumer electronics, and industrial equipment.



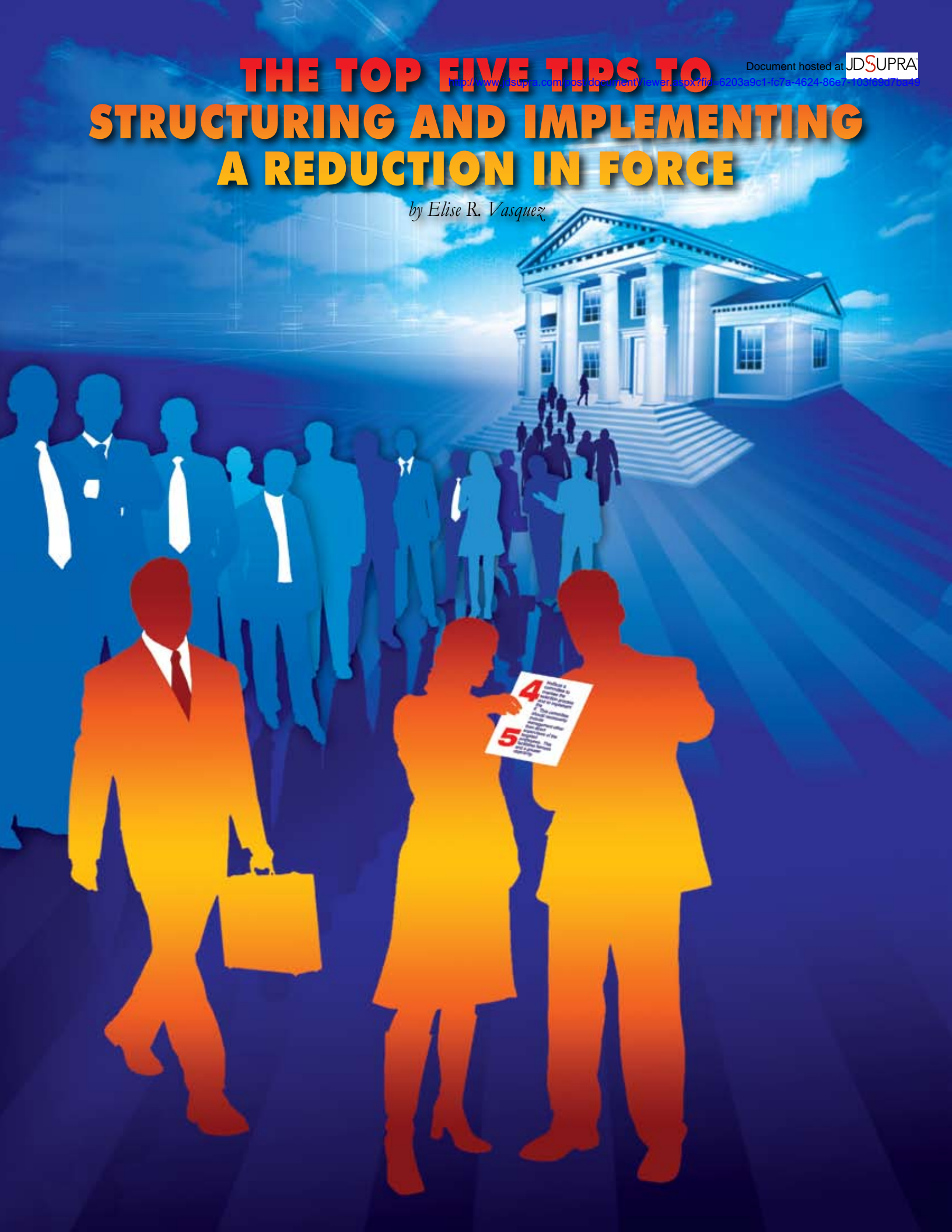
For more information on our firm's capabilities in this area, please contact Partner James "Chuck" Hyde at [jhyde@rmkb.com](mailto:jhyde@rmkb.com) or at 408.918.4538.

# THE TOP FIVE TIPS TO STRUCTURING AND IMPLEMENTING A REDUCTION IN FORCE

by Elise R. Vasquez

Document hosted at JDSUPRA

<http://www.jdsupra.com/post/documentViewer.aspx?fid=6203a9c1-4c7a-4624-86e7-100100d7ba16>



**4** Analyze a company's financial performance to determine the need to implement a RIF. This analysis should include a review of the company's financial statements, a comparison of the company's performance to industry peers, and a review of the company's strategic plan.

**5** Develop a RIF plan that includes a clear definition of the RIF, a list of the employees to be affected, and a plan for the implementation of the RIF.

Reductions in Force must be well-thought out and uniformly executed to minimize the threat of litigation. Here are the top five tips to structuring and implementing a Reduction in Force (“RIF”).

## 1 ESTABLISH AN OBJECTIVE REASON FOR THE RIF

An employer must first establish an objective, business related reason or reasons for deciding to reduce its workforce. For example, economic necessity, loss or downturn of business and reorganization. The reason or reasons given, should be well-supported and documented.

## 2 CONSIDER ALTERNATIVES TO A WORKFORCE REDUCTION

There is no requirement that an employer consider alternatives to a RIF. An employer, however, who shows that it considered alternatives to a RIF, prior to its decision, can better support that its RIF was done out of necessity.

*Alternatives to a RIF may include:*

- *Pay freezes or reductions*
- *Shorter work weeks or workdays*
- *Modified vacation and other paid time off benefits*
- *Reductions in authorized overtime*
- *Voluntary leaves of absence*
- *Temporary shutdown*
- *Reduction in the numbers of temporary or contract personnel*

- *Hiring freezes*
- *Voluntary Separation Programs*
- *Early Retirement Programs*

The two most commonly used alternatives to a RIF are Voluntary Separation Programs (“VSP”) and Early Retirement Programs (“ERP”). Each program is governed by specific Federal and State laws.

### A. Voluntary Separation Programs (VSP)

If there is no established policy or practice, the amount of severance and eligibility criteria for a VSP can be established by the employer. Important laws affect severance benefit plans, release agreements, and potential notice obligations.

A VSP must not suggest to any employee that her refusal to accept the VSP, will result in a subsequent involuntarily termination. Such a suggestion will expose an employer to liability. The employee who accepts the “voluntary” separation will argue she was actually constructively discharged. Her voluntary release of claims, therefore, was not truly voluntary and as such, not enforceable.

The monetary portion of the VSP can be made in either a lump sum payment or in installments. It can also offer a continuation of benefits. It is recommended that the VSP benefits be conditioned upon her execution of a release of employment related claims. Employees must be given a time period upon which to consider such a release and to terminate their employment. Under the Older Worker Benefits Protection Act (“OWBPA”), employees must be given at least 45 days to review any release agreement upon which VSP benefits may be

conditioned. If less than 45 days is given for the employee to review the VSP and the employee accepts the VSP an employer can expect challenges by the employee to the voluntariness of the released claims.

### B. Early Retirement Programs (ERP)

To encourage voluntary retirement, ERPs generally include incentives that are not ordinarily offered to retiring employees. Incentives may include continuation of company-paid medical insurance, continuation of salary, severance payments in excess of those already provided or increased pension benefits.

An ERP must use non-discriminatory criteria in determining eligibility for the plan. An ERP’s offer of early retirement must be presented as a strictly voluntary option available to eligible employees in order to prevent claims under the Age Discrimination in Employment Act. The program must also have an expiration date before which the employee must accept the offer.

## 3 USE AN OBJECTIVE SELECTION PROCESS

The selection process must be based on objectively determined criteria, consistently executed and well-documented.

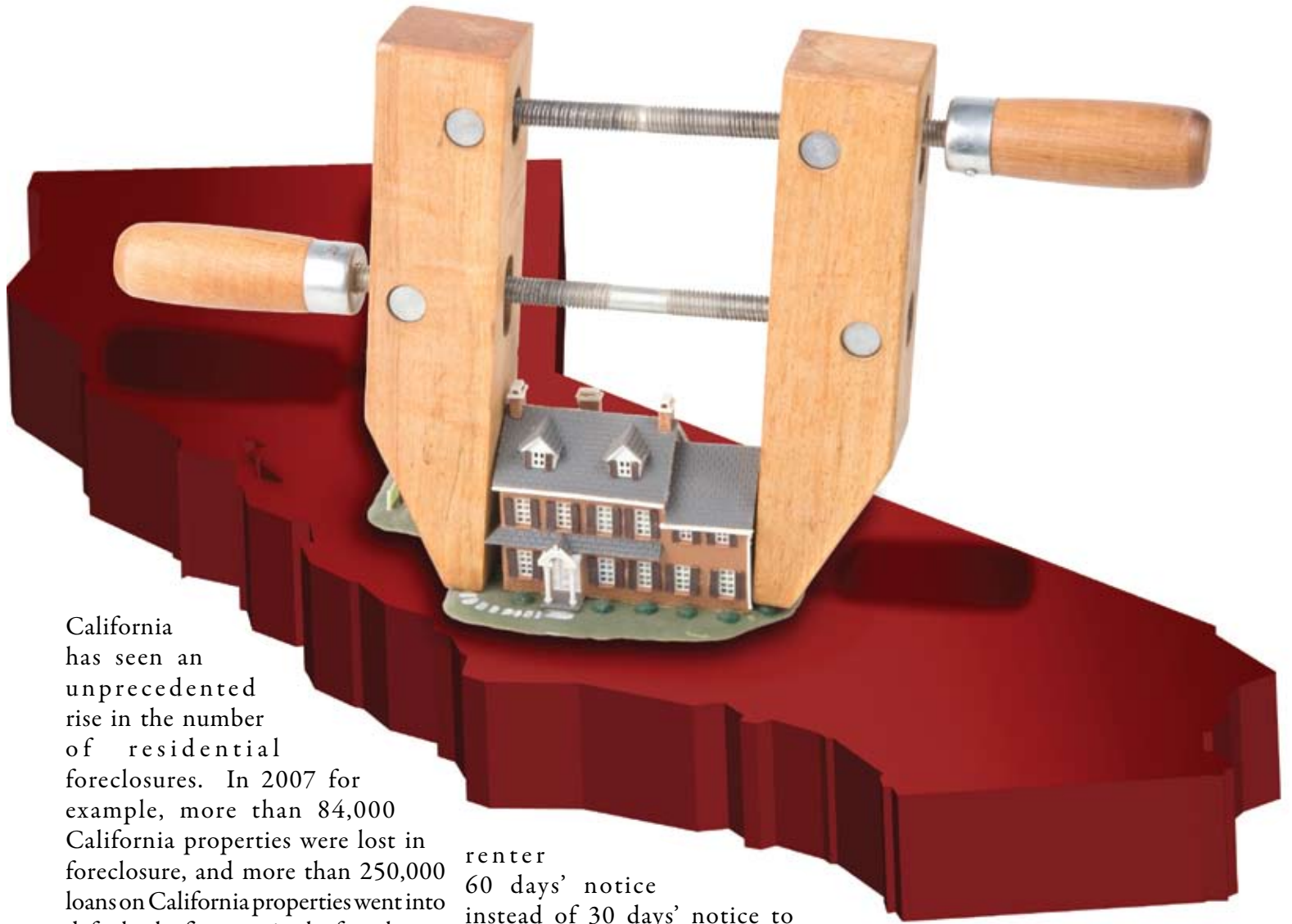
The most commonly challenged part of a RIF is the selection process the employer uses to determine which employees will be included in the RIF. Absent a requirement under a collective bargaining agreement, the law does not require employers to give employees selected for layoff an opportunity to transfer or “bump” other employees.

*Cont. on pg 26*

# New California Law Affects Residential Foreclosure

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by Stephen K. Lightfoot, II



California has seen an unprecedented rise in the number of residential foreclosures. In 2007 for example, more than 84,000 California properties were lost in foreclosure, and more than 250,000 loans on California properties went into default, the first step in the foreclosure process. To address this extraordinary threat to the state and local economies, the California State Legislature started working on legislation in early 2008. The result was Senate Bill 1137, signed into law on July 8, 2008 by Governor Arnold Schwarzenegger as emergency legislation. The new law makes major changes to non-judicial residential foreclosures in California by: (1) establishing additional, detailed procedures for lenders to follow in the foreclosure process; (2) requiring a purchaser to maintain vacant residential property purchased through foreclosure or be subject to monetary penalties; and (3) giving a

renter 60 days' notice instead of 30 days' notice to vacate a property which has been foreclosed. The new law applies only to loans made between January 1, 2003 and December 31, 2007 for owner-occupied residential properties. Further, all provisions of the new law sunset by January 1, 2013, unless a later enacted statute extends or deletes that date.

## **New Requirements for Lenders in the Foreclosure Process**

Most lenders in California use mortgages and deeds of trust which contain a power of sale clause. The lender initiates the non-judicial

foreclosure process by recording and serving a Notice of Default, after the borrower fails to meet their loan obligations. Prior to SB 1137, lenders were not obligated to notify borrowers of their intent to commence a foreclosure. Under the new law however, a lender may not record a Notice of Default until 30 days after the lender contacts the borrower or 30 days after satisfying specific "due diligence" requirements. Furthermore, a Notice of Default must now include a declaration from the lender or its agent that the lender 1) has contacted the borrower; 2) tried with due diligence to contact the borrower; or

3) the borrower has surrendered the property.

However, as with most laws, there are exceptions. Under SB1137, the lender is not required to contact the borrower, delay recording the Notice of Default, include additional contact information in the Notice of Sale or even exercise “due diligence” if: 1) the borrower has surrendered their property and confirmed same in writing or delivered up the keys; 2) the borrower has contracted with an organization or person whose primary business is advising people on how to extend the foreclosure process and avoid their loan obligations; or 3) the borrower has filed for bankruptcy, and the proceedings have not been finalized.

Another section of the new law requires lenders to offer loan modifications to borrowers who are in default, or whose default is foreseeable, if the lender’s anticipated recovery under the loan modification exceeds the anticipated recovery through foreclosure on a net present value basis.

If the default is not cured, or a loan modification is not effected, the next step in the foreclosure process is for the lender to record and serve a Notice of Sale. The Notice of Sale can be recorded three months after the Notice of Default is recorded. The Notice of Sale contains the auction details, including the sale amount and the date, time and place of the sale. The Notice of Sale must be posted and published in specific places at least 20 days before the sale date.

If a lender had already filed a Notice of Default prior to the enactment of the new law, and did not subsequently file a notice of rescission, then the lender must include a declaration in the Notice of Sale: 1) that the borrower was contacted to assess the borrower’s financial situation and to explore

options for the borrower to avoid foreclosure; or 2) listing the efforts made, if any, to contact the borrower in the event no contact was made.

The new law also imposes an additional requirement for Notices of Sale in cases where the billing address for the borrower is different than the subject property address. At the same time the Notice of Sale is recorded and posted, the lender must also post at the property and mail to the borrower a specifically worded, additional notice advising that the foreclosure process has commenced and the property may be sold. It also advises the tenant

that they are entitled to a JD SUPRA<sup>™</sup> termination notice. The notice must be printed in six different languages: English, Spanish, Chinese, Tagalog, Vietnamese and Korean.

### **New Requirements for Purchasers of Foreclosed Properties**

The new law also requires the owner of a vacant residential property purchased or acquired through foreclosure to maintain the subject property. At a minimum, the owner must care for the exterior of the property; prevent

*Cont. on pg 25*

RMKB IN BOX

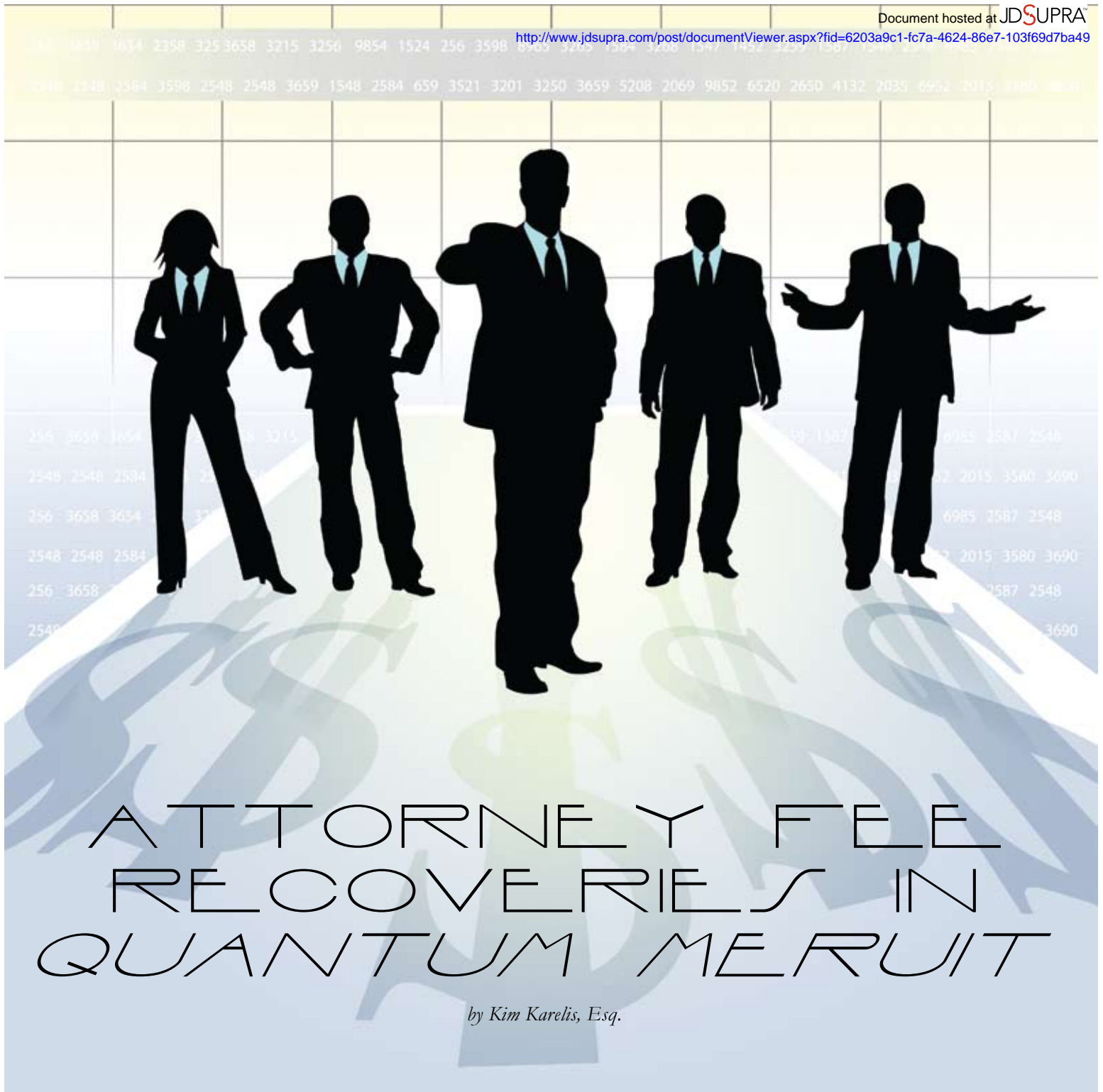
## RMKB’S APPELLATE PRACTICE “APPEALS” TO CLIENTS BEFORE THE VERDICT

In business litigation, appellate lawyers are increasingly being brought in to the mix before the jury deliberates. This new model is a departure from how appellate attorneys have traditionally worked – getting hired once the verdict was announced. RMKB’s team of seasoned specialists work in tandem with the firm’s litigators on a regular basis to provide valuable, ongoing guidance during trial – an effective strategy for winning cases on appeal.

RMKB’s expertise in appellate law stems back more than 50 years and its lawyers have been involved in thousands of cases resulting in hundreds of published decisions in state and federal courts. The firm maintains a strong presence in appellate courts throughout the country and has handled cases in virtually every area of civil litigation, including commercial law, product liability, tort litigation, insurance coverage and bad faith, civil procedure, intellectual property and discrimination.

For more information on RMKB’s appellate practice, contact Sue Handelman, a partner and certified appellate specialist in the firm’s Redwood City office at 650.780.1759 or shandelman@RMKB.com.





# ATTORNEY FEE RECOVERIES IN QUANTUM MERUIT

by Kim Karelis, Esq.

## Introduction

When an attorney's fee agreement with a client is either nonexistent or unenforceable, the attorney's recovery in any subsequent fee dispute is limited to the reasonable value of the legal services rendered. "*Quantum meruit*" is a Latin phrase meaning "as much as he has deserved." Until recently it was an open question as to whether there was the right to a trial by jury with respect to such *quantum meruit* actions. That issue has now been answered affirmatively by the California Court of Appeal. This article will also discuss the statute of limitations applicable to *quantum meruit* claims, the elements that must be satisfied in order for an attorney to prevail on this theory of recovery, the factors that the courts consider in reaching a decision as to the amount that the attorney is entitled to recover, and *quantum meruit* claims arising from unenforceable fee-splitting agreements.

## Plaintiff has the right to a trial by jury

On August 1, 2008, the California Court of Appeal handed down its decision in *Jogani v. Superior Court* (2008) 165 Cal. App. 4th 901, which found that plaintiffs seeking to recover under a *quantum meruit* theory are entitled to a jury trial. In *Jogani*, the trial court had denied a business manager's jury trial demand for a *quantum meruit* claim, finding that no such right existed. Of course, the right to a trial by jury exists for a civil action "at law," but not with respect to equitable actions. On appeal, the Court reasoned that the right to a trial by jury was guaranteed by the California Constitution to the extent that such a right existed at common law in the year the Constitution was adopted, which was 1850. The Court further found that a "common count" for *quantum meruit* is a form of the common law action of *assumpsit*, which was historically an action "at law" that carried with it the right to a jury trial well before 1850.

In opposing plaintiff's demand for a jury trial, defendants relied on *C & K Engineering Contractors v. Amber Steel Co.* (1978) 23 Cal. 3d 1, in which the California Supreme Court stated: "In determining whether the action was one triable by a jury at common law, the court is not bound by the form of the action but rather by the nature of the rights involved and the facts of the particular case—the gist of the action." (*Id.* at 9 (internal quotes and citation omitted).) The defendants therefore argued that the "gist" of an action is equitable if it requires the consideration of equitable doctrines, even if the form of the action was considered to be "at law" in the past. The defendants therefore contended that because a claim in *quantum meruit* requires the application of

equitable principles, no right to a jury trial attaches. (*Jogani*, at 907.)

However, the Court of Appeal rejected this argument, finding that it was "based on a misreading of *C & K Engineering*, concerning the 'gist' of an action." (*Id.* at 908.) The Court held that "in determining whether an action was triable by a jury at common law, a court is not bound by the form of the action but rather looks to its substance, the gist of the action." (*Id.* at 908 (quotations and citations omitted).) The Court therefore looked to "the nature of the rights at issue and the remedy sought." (*Id.*) In performing that analysis, the Court held that the "fact that equitable principles are applied in the action does not necessarily identify the resultant relief as equitable," and that equitable principles "are a guide to courts of law as well as of equity." (*Id.* at 909 (citations omitted).) Therefore, this factor is not determinative.

The Court proceeded to distinguish other cases cited by defendants on the grounds that they clearly sought equitable remedies, not monetary recoveries. In *Jogani*, by contrast, plaintiff simply sought to recover the reasonable value of legal services rendered. Because such monetary claims represented remedies available "at law," the Court concluded that the plaintiff was entitled to a trial by jury.

### The statute of limitations is generally 2 years

An action based upon a *quantum meruit* theory has long been held to be subject to a two-year statute of limitations pursuant to Code of Civil

Procedure § 339, as amended. <sup>1</sup> *Id.* <sup>2</sup> *Id.* <sup>3</sup> *Id.* <sup>4</sup> *Id.* <sup>5</sup> *Id.* <sup>6</sup> *Id.* <sup>7</sup> *Id.* <sup>8</sup> *Id.* <sup>9</sup> *Id.* <sup>10</sup> *Id.* <sup>11</sup> *Id.* <sup>12</sup> *Id.* <sup>13</sup> *Id.* <sup>14</sup> *Id.* <sup>15</sup> *Id.* <sup>16</sup> *Id.* <sup>17</sup> *Id.* <sup>18</sup> *Id.* <sup>19</sup> *Id.* <sup>20</sup> *Id.* <sup>21</sup> *Id.* <sup>22</sup> *Id.* <sup>23</sup> *Id.* <sup>24</sup> *Id.* <sup>25</sup> *Id.* <sup>26</sup> *Id.* <sup>27</sup> *Id.* <sup>28</sup> *Id.* <sup>29</sup> *Id.* <sup>30</sup> *Id.* <sup>31</sup> *Id.* <sup>32</sup> *Id.* <sup>33</sup> *Id.* <sup>34</sup> *Id.* <sup>35</sup> *Id.* <sup>36</sup> *Id.* <sup>37</sup> *Id.* <sup>38</sup> *Id.* <sup>39</sup> *Id.* <sup>40</sup> *Id.* <sup>41</sup> *Id.* <sup>42</sup> *Id.* <sup>43</sup> *Id.* <sup>44</sup> *Id.* <sup>45</sup> *Id.* <sup>46</sup> *Id.* <sup>47</sup> *Id.* <sup>48</sup> *Id.* <sup>49</sup> *Id.* 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<sup>711</sup>

(California Jury Instructions, Civil, No. 371.)

In *Fergus v. Songer* (2007) 150 Cal. App.4th 552, 561, the Court of Appeal cited with approval the following nine factors relevant to deciding a legal fee *quantum meruit* claim: 1) The amount of the fee in proportion to the value of the services performed; 2) The novelty and difficulty of the questions involved and the skill necessary to perform the legal services properly; 3) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the attorney; 4) The amount involved and the results obtained; 5) The time limitations imposed by the client or by the circumstances; 6) The nature and length of the professional relationship with the client; 7) The experience, reputation, and ability of the attorney performing the services; 8) The time and labor required; and 9) The informed consent of the client to the fee.

All of these factors address the value of the legal services to the client, the client's consent to the fee, and the cost to the attorney of providing the requested legal services. For example, factors (1), (4) and (9) deal with the economic value of the services provided, the results obtained, and whether the client gave informed consent regarding the fee. Factor (6) also addresses the client's consent to the fee based on his or her experience in employing the attorney. Factors (2), (3), (5), (7), and (8) address the skill level required of the attorney, the cost to the attorney of taking on the work, time restrictions placed on the attorney, and the amount of work

involved. Taken together, these nine factors provide a very good roadmap for the application of the equitable principles that guide a court's decision based on the attorney's *quantum meruit* claim.

### Where the fee agreement is unenforceable

A common situation involving unenforceable fee agreements is where an attorney refers a case to another attorney in return for a percentage of the ultimate fee recovery. For example, in *Chambers v. Kay* (2002) 29 Cal. 4th 142, one attorney sued another for breach of contract and *quantum meruit*. The plaintiff rented an office from the defendant, but they maintained separate law practices. The defendant wrote a letter to plaintiff confirming their fee-splitting agreement and copied the client, but neither attorney obtained the client's written consent to this arrangement. The trial court granted summary judgment for the

defendant because this agreement was unenforceable as it did not comply with the California Rules of Professional Conduct, Rule 2-200, which requires that the client's informed written consent be obtained.

The Court of Appeal reversed the judgment on plaintiff's *quantum meruit* claim, but otherwise affirmed. The California Supreme Court agreed with the Court of Appeal, holding that plaintiff's breach of contract claim was barred by Rule 2-200, and that plaintiff's *quantum meruit* claim could not include legal fees due under the fee-splitting agreement.

However, in *Huskinson & Brown v. Wolf* (2004) 32 Cal.4th 453, the California Supreme Court held that plaintiff could seek to recover legal fees and costs in *quantum meruit* that were incurred independently of such an unenforceable agreement. The plaintiffs sought to recover for legal services and an expert witness fee that were not a part of the unenforceable fee sharing agreement. Under such facts, the Court concluded that the plaintiffs could recover in *quantum meruit* because such a recovery would not constitute the sharing of fees

An attorney pursuing a *quantum meruit* claim is entitled to a trial by jury





or costs under the unenforceable agreement.

Furthermore, a referring attorney may be able to recover in *quantum meruit* against the client if the client requested that the work be performed. For example, in the very recent case *Strong v. Beydoun* (September 19, 2008) 2008 Cal. App. LEXIS 1445, the plaintiff and defendant entered into a fee-sharing agreement that was unenforceable because they failed to obtain the client's informed written consent. When the defendant attorney refused to pay, plaintiff sued both the defendant and the client. However, in order to recover in *quantum meruit* against the client, plaintiff had to prove that the legal services had been performed at the request of the client. Here, the clients had made no such request. Therefore, the claim was barred because the attorneys' fee-splitting agreement was unenforceable. However, practitioners should be aware that *quantum meruit* recoveries against the clients are permitted in situations where the clients have requested the attorney to perform legal services.

## Conclusion

An attorney pursuing a *quantum meruit* claim is entitled to a trial by jury. However, such claims are generally subject to a 2 year statute of limitations, and may not recover fees under an unenforceable fee-sharing agreement. But a *quantum meruit* claim can enable an attorney to recover the reasonable value of legal services performed at the request of clients or other attorneys.

About the Author

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<http://www.jdsupra.com/post/documentViewer.aspx?fid=6203a9c1-fc7a-4624-86e7-103f69d7ba49>

**Under the new law the notice period required to terminate a tenancy at a foreclosed property is increased from 30 days to 60 days (this extended notice period does not apply if a borrower remains in the property as a tenant, subtenant, or occupant)**

excessive foliage growth that diminishes the value of surrounding properties; prevent trespassers or squatters from remaining on the property; and prevent mosquito larvae from growing in standing water or other conditions that create a public nuisance. If the owner fails to maintain the property, a governmental entity may, after 30 days' written notice to the owner and an opportunity to abate the condition, impose a fine of up to \$1,000 per day (less notice may be given if there are public health and safety violations).

### **New Notice Period for Terminating Tenancies in Foreclosed Properties**

Under the new law the notice period required to terminate a tenancy at a foreclosed property is increased from 30 days to 60 days (this extended notice period does not apply if a borrower remains in the property as a tenant, subtenant, or occupant). However, the new law does not affect a local just cause eviction ordinance (e.g., San Francisco, Oakland, Berkeley). So if the foreclosed property is located in a city with a just cause eviction ordinance, the new owner (including a lender) must have just cause (one of several, specific reasons) to evict the tenant from the foreclosed property. This can create numerous hurdles to an eviction and may even prevent an eviction if there is no just cause. It also increases the costs of maintaining and

carrying the subject property. **JD SUPRA**  
new owner by at least one month.

### **Impact of New Requirements**

The new legislation seeks to avoid unnecessary foreclosures of residential properties and thereby provide stability to California's state and local economies (and housing markets) by requiring early contact and communications between lenders and borrowers to explore options that could avoid foreclosure and by facilitating loan modification or restructuring. The practical effect of the new legislation is that it extends the timeline for non-judicial foreclosures and extends the time under which a tenancy can be terminated in a foreclosed property. It increases costs to lenders by requiring lenders to take additional steps in the foreclosure process. It also increases costs to new owners by imposing maintenance obligations and extending the time for a tenancy to be terminated.

However, the new legislation may also foster additional mortgage-related litigation. Specific areas where new litigation may arise include lawsuits against lenders for failing to adhere to the statutory requirements of the non-judicial foreclosure process; borrowers suing to challenge a foreclosure if the lender has not complied with the new requirements; and tenants seeking to delay evictions and/or sue for wrongful eviction in cases where new owners served improper notices of termination.

Only time will tell if SB 1137 has any impact on the California foreclosure crisis.

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This article is for informational purposes and does not contain or convey legal advice. The information in this article should not be used or relied upon in regard to any particular facts or circumstances without first consulting a lawyer.

An employee's wrongful termination claim arising out of a RIF allege that the employer discriminated against them in selecting them for layoff. Another common claim arising from a RIF, is a challenge by the employee that the true reason for the RIF was to get rid of employees in a protected class.

In either case, unless the reductions can be justified as being job-related and consistent with business necessity, discrimination can be established if facially neutral procedures have an adverse impact on a protected class. An employee can establish a prima facie case of discrimination by showing a statistical adverse impact.

An objective selection process must be developed to avoid discrimination claims under equal employment opportunity laws:

- ♦ *The RIF must be based on nondiscriminatory factors,*
- ♦ *The RIF must be based on facially neutral factors do not have a disparate impact; and*
- ♦ *The determined criteria and process to be used must be consistently applied.*

Two commonly used criteria for the selection process is seniority and performance.

Seniority is the most commonly used criteria. The employees with the least length of service with the company are selected for the RIF. It is also better accepted by employees involved and, therefore, less subject to claims of discrimination.

Performance, however, as a selection process is difficult to objectively execute. If written performance

evaluations have not been consistently given and are not well-documented, they cannot provide the necessary objectivity.

**4 INSTITUTE A MANAGEMENT COMMITTEE TO OVERSEE THE SELECTION PROCESS**

Institute a committee to oversee the selection process and to implement the RIF. This committee should necessarily include management other than direct supervisors of the targeted employees. This facilitates fairness and a greater objectivity.

The committee should receive copies of the written selection criteria. The committee need only receive employee data relevant to the selection process. The committee should include Human Resources professionals. All members should be educated to ensure consistent and uniform application and administration of the RIF.

**5 COMPLY WITH ALL THE LEGAL REQUIREMENTS FOR NOTICE, COMPENSATION PAYMENTS AND CONTINUATION OF BENEFITS**

RIF affected employees must receive all entitlements required by law and company policy. For example:

**A.** Advance Notice of Closing/ Mass Layoff. The Worker Adjustment and Retraining Notification Act (the "WARN Act") and similar state statutes require employers to provide advance notice in the event employees are terminated due to the closing of a facility or due to a significant reduction in the workforce. Such statutes set minimum thresholds and can have a significant effect on the timing of a layoff.

**B.** Severance Benefits. If a company policy or practice for the payment of severance to laid off employees exists, this must be followed. Absent any policy that conditions the payment of severance upon the signing of a release, further consideration must be paid to the employee to enforce any release of employment related claims. If, however, a release is sought a waiver of an age discrimination claim will not be valid unless it is in writing and understood by the employee. It must include a specific reference to the rights and claims under the Age Discrimination in Employment Act (ADEA) and the employee must be given at least 21 days to consider the agreement and 7 days to revoke the agreement.

**C.** Wages and Vacation Pay. All applicable State wage payment laws that govern payment of final wages should be followed upon termination.

**D.** Insurance Continuation and Conversion Privileges. Employers now face a significant communications and administrative challenge to comply with the COBRA portions under President Obama's economic stimulus bill. Employees are now entitled to more generous benefits.

There is no exact science to the avoidance of RIF related employment actions. A well-structured, well-documented and consistently applied RIF, however, can minimize the exposure to employment related litigation.

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