

INSURANCE DEFENSE TIPS

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CURRENT STATE OF THE LAW RE: ADMISSIBILITY OF THE PROPER AMOUNT OF MEDICAL BILLINGS IN A PERSONAL INJURY ACTION

By Matthew J. Trostler

RELEVANT CASE LAW

The question of how much one can recover for past medical expenses in a tort suit is not a novel one. California's old jury instruction allowed a plaintiff to recover "the reasonable value of medical care, services and supplies reasonably required and actually given in the treatment of the plaintiff." The new California jury instruction (3903A) allows a plaintiff to recover "damages for past medical expenses ... plaintiff ... must prove the reasonable cost of reasonably necessary medical care that he has received." The question becomes, what amount is considered reasonable, and what evidence may be admitted at the time of trial to determine reasonableness.

The case of *Hanif v. Housing Authority* (1988) is the seminal case discussing reasonableness when a portion of the medical bills has been paid prior to trial. In the *Hanif* case, a child was struck by an automobile and the trial court ordered as special damages the reasonable value of medical care and services, even though the court's award exceeded the amount paid by Medi-Cal on plaintiff's behalf for that care. On appeal, the Court of Appeal modified the judgment by reducing the special damages award. The Court held that the minor was entitled to recover as special damages for past medical care only the amount actually paid by Medi-Cal on plaintiff's behalf. The rationale for the modification of awarded medical

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Matthew has significant experience in arbitrations, mediations and jury trials. Some of his verdicts have been published statewide and nationally. His aggressive applicational style is tempered by his sense of fairness and compassion.

STEALTH RECORDS DISCOVERY MEANS ADVANTAGE

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damages is that in tort actions, damages are normally awarded for the purpose of compensating the plaintiff for injuries suffered, i.e., restoring the plaintiff as nearly as possible to his former position, or giving him some pecuniary equivalent. The Court noted: “The primary object of an award of damages in a civil action, and the fundamental principle on which it is based, is just compensation or indemnity for the loss of injuries sustained by the complainant, and no more ... A plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done.” *Id.* at 641, citing previous case law. Accordingly, an award of damages for past medical expenses in excess of what the medical care and services cost constituted over compensation. (The noted exception to this rule is whether the low rate of the treatment was intended as a gift; certainly, by filing subrogation and lien rights, Medi-Cal’s benefits could not be considered a gratuity).

In 2001, the case of *Nishihama v. City and County of San Francisco* confirmed the *Hanif* rule and rationale. In the *Nishihama* case, the plaintiff injured herself while stepping from a bus platform and into a pothole in a crosswalk maintained by the city. A jury awarded the plaintiff \$99,064, but the award included \$17,168 in medical costs even though her health insurance paid \$3,600 to plaintiff’s medical provider as full payment for its services. On appeal, the Court held that plaintiff was only entitled to the \$3,600 actually paid for her medical care, reducing her award from \$99,064 to \$85,496.

The key exception to this rule is the collateral source rule which is distinguishable from this holding. Prior payments made by a wholly independent source are made inadmissible by the collateral source rule, thus a plaintiff could recover the full amount of the medical billings even though the amount may have been compromised prior to trial under those circumstances. This judicially-created rule reflects the state’s important policy of encouraging “prudent investment of insurance.”

A recent case has impliedly expanded the collateral source rule while diluting the *Hanif* rule. Decided in August 2006, the case of *Greer v. Buzgheia* involved an auto versus auto collision. Defendant filed a motion in limine, based on the *Hanif* case, that plaintiff’s

economic damages of \$211,000 should be reduced to \$132,984.92 based upon the compromise agreement reached with plaintiff’s medical providers prior to trial. Defense counsel further argued that the jury should be precluded from hearing evidence that the reasonable value of the medical services exceeded the amount actually paid, since that sum is not recoverable. The trial court disagreed with defense counsel and allowed the jury to hear evidence of the total amount of the medical bills before the compromise, \$211,000. The jury also heard testimony that this amount was reasonable. The jury determined that total past economic loss, including medical expenses and lost earnings totaled \$260,000. It is important to note that defense counsel, when submitting the special verdict form, did not segregate between lost earnings and medical specials in terms of recoverable past economic damages.

The Court of Appeal affirmed the trial court’s decision to allow the jury to hear evidence that the total amount of the medical bills was in excess of the amount actually paid and that the total amount of the medical bills was reasonable. The Court of Appeal also chastised defense counsel for failing to segregate the economic damages on the special verdict form. The Court of Appeal affirmed the trial court’s decision in not reducing the verdict in light of the faulty special verdict form

which did not contain a separate entry for plaintiff’s past medical expenses.

“Counsel should anticipate, however, expert testimony confirming that the higher amount of medical billings is reasonable.”

HOW TO LIMIT GREER’S HOLDING

The defense attorneys in the *Greer* case have requested that the Supreme Court de publish this opinion. If so, the *Hanif* ruling and rationale remain. If *Greer* remains published, however, defense counsel should still bring a motion in limine under the *Hanif* and *Nishihama* cases. Counsel should anticipate, however, expert testimony confirming that the higher amount of medical billings is reasonable. This can be countered with the appropriate defenses: plaintiff is malingering, unproven treatment methods, failure to obtain prompt treatment, etc. Counsel should also request a special verdict which segregates the amount of past medical expenses so that a trial judge can reduce the verdict to the amount of medical bills actually paid by a third party.



NEW CASE LAW EXCLUDING COVERAGE FOR CONTRACTUAL DISPUTES

By Matthew J. Trostler

Oak Park Calabasas Condominium Association v. State Farm (2006) is a case which arose out of Los Angeles County. State Farm Fire & Casualty Company denied insurance coverage to the Oak Park Calabasas Condominium Association when a construction company (ECC) sued Oak Park for failing to pay its bills after the construction company made repairs to damaged structures in the association.

This case involves over a decade of litigation. In January 1994, the Northridge Earthquake caused significant structural damage in the Oak Park community. As a result, Oak Park made agreements with the construction company to repair the damaged structures. Following several contractual modifications, Oak Park refused to pay amounts owed under the contract. ECC recorded a lien on June 1, 1995. By July 1995, ECC sued Oak Park and the owners of the condominiums for breach of contract, foreclosure of a mechanic's lien and other causes of action.

Oak Park then tendered the ECC complaint to its insurance carrier State Farm. State Farm, which provided a Directors and Officers policy (D&O), questioned whether there was any coverage and denied a defense for the ECC litigation to Oak Park and its owners, claiming that liability coverage under the D&O policy was limited to tort liability, and not contractual obligations. In 2002, ECC obtained a judgment against Oak Park in an amount in excess of \$7 million. By 2003, Oak Park sued State Farm.

The case went to trial in late 2004 and the trial court found that there was no potential for coverage

for the ECC action, and the judge entered judgment for State Farm.

Oak Park appealed in 2005. The appellate court agreed with the trial court. The appellate court noted that the insurance policy in question expressly defined "wrongful acts" as conduct sounding in negligence, i.e., negligent acts, errors, omissions or breach of duty. The court analyzed these words to determine if these words "cumulatively referred to coverage for torts and thus are covered under the policy as contended by Oak Park, or whether these words were exclusive to breach of contract indemnification as contended by State Farm and thus not covered under the policy." The appellate court ultimately held that Oak Park wanted to "enrich itself by forcing State Farm to pay for the property loss which Oak Park simply chose not to pay due and owing to ECC.

This case is a prime example of a situation where a D&O policy was strictly construed. Although

the association may have been "negligent" in not paying ECC, the court held that the dispute essentially rested upon breach of contract, which was not covered under the D&O insurance policy.

Coverage questions such as these can create litigation which lasts over a decade. Insurers and coverage counsel need to focus on the true issues surrounding the dispute rather than forcing common terms such as "negligence" into a constrained construction. The Oak Park case is a class example of a lack of ambiguity in the terms of the policy.



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