

the Firm Inquiry

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Inside this issue...

- 2
Medicare Liens –
An Overview and Update
Part I
- 2
Missouri Bad Faith Law –
The Elements are Watered Down
- 3
Be Careful Where Your Name Appears:
Motor Carriers and Logo Liability
- 3
Workers' Compensation Exclusion
Limits UM Benefits to Statutory
Minimum in Missouri
- 4
Right To Medical Records –
Not Always Automatic
- 4
Fire Spread:
Am I My Neighbor's Keeper?
- 5
Australian Court Allows Service
on Defendant Via Facebook
- 6
Missouri's Partial Loss Statute
Limited to Fire Losses
- 7
Statutory Presumption May Limit
the Recovery of Medical Expenses
in Personal Injury Cases

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The Impact of a Foreclosure on the Mortgagee's Right to Recover Under a "Standard" Mortgage Clause

Robert Brady



Most property insurance policies contain a "standard" mortgage clause. Such a clause protects the mortgagee's right to recover for a loss notwithstanding the insured's intentional acts and breaches of the policy's conditions. These clauses are designed to protect the mortgagee's security interest in the property. As a result of the standard mortgage clause, there is a commonly held view within the insurance industry that the mortgagee "always gets paid." However, this is not always the case.

One very common situation that bars coverage for the mortgagee, and which is often overlooked, is when the insured property has gone into foreclosure and been sold at a trustee's sale. The proceeds from the trustee's sale are applied to the mortgage debt. Often times, the entire mortgage debt is paid off from the proceeds raised at the trustee's sale. Under Missouri law, this "extinguishment" of the mortgage debt terminates any interest the mortgagee has under the policy's standard mortgage clause. This is true even if the named mortgagee on the policy is the purchaser at the trustee's sale.

In *Economy Preferred Ins. v. Schomaker*, 900 S.W.2d 249 (Mo. App. E.D. 1995), the named insured defaulted on the mortgage payments and the mortgagee foreclosed on the property. The mortgagee subsequently purchased the home at a trustee's sale. When the home was destroyed by fire, the mortgagee made a claim for the fire damage under the named insured's policy. The Eastern District of the Missouri Court of Appeals upheld the insurer's denial of

coverage for the mortgagee under the policy, stating "the existence of a standard mortgage clause does not preserve coverage on a policy that is terminated because the entire debt has been extinguished."

The Eastern District in *Economy Preferred* relied upon another Eastern District case, *Northwestern Nat. Ins. Co. v. Mildenberger*, 359 S.W.2d 380 (Mo. App. E.D. 1962). In *Northwestern*, the Eastern District found that the creditor-debtor relationship "serves as the pillar for the whole structure so far as the mortgagee is concerned." This is so because the "true purpose" of the standard mortgage clause is to ensure that the mortgage debt is repaid. *Id.* Once the mortgage debt has been paid in full and the creditor-debtor relationship is terminated, "the reason for any claim on the part of the mortgagee on the insurance proceeds likewise evaporates." It is inconsequential that the mortgagee, as opposed to someone else, paid the indebtedness. *Id.*

The holdings in these cases were recently reinforced by the Western District of the Missouri Court of Appeals in *Countrywide Home Loans v. Allstate Ins. Co.*, 246 S.W.3d 515 (Mo. App. W.D. 2007). In *Countrywide*, the insured property was damaged by fire. Countrywide subsequently purchased the insured property at a trustee's sale for the full amount due on the mortgage loan. Countrywide then attempted to recover insurance proceeds under the Allstate policy for the fire damage to the property. Allstate denied the claim based upon the foreclosure. The Western District upheld Allstate's denial of the claim and held that Countrywide's interest as a mortgagee on the insurance

(continued on page 6)

Medicare Liens – An Overview and Update

Part 1

Christine A. Vaporean



The impact of Medicare liens on litigation will increase with the implementation of new federal mandatory reporting requirements for insurance companies and self-insured organizations this summer.

Beginning on July 1, 2009, all self-insured organizations and insurers that potentially pay bodily injury claims under a workers' compensation, no-fault auto, or liability plan must submit detailed electronic reporting for the purpose of enforcing the Medicare Secondary Payer Act.

Under the new reporting rules, all liability insurers and self-insureds must determine whether a claimant is eligible for Medicare and report that information to the federal government. Congress enacted the new requirements to preserve Medicare's status as a secondary payer and to ensure that Medicare maximizes its recovery rights against any sum recovered by the claimant from a responsible third party.

After July 1, 2009, insurers and self-insureds will be subject to substantial penalties if they fail to comply with these reporting requirements. Any insurer or self-insured failing to meet them will be subject to a penalty of \$1,000 per claimant per day.

Insurers and self-insureds should fully understand their obligations under Medicare and the new reporting requirements to protect themselves from liability for the substantial penalties imposed by the recent enactments. The laws governing Medicare liens and the new reporting requirements are detailed and complex. Part I of this article provides an overview of Medicare lien laws. In the next edition of *The Firm Inquiry*, Part II of this article will address the new reporting requirements.

OVERVIEW

To prevent the depletion of the Medicare Trust Fund, Congress created the Medicare Secondary Payer (MSP) Act. MSP gives Medicare a right to recover the monies that it paid for health care services received by a plaintiff because of a third party's liability to the plaintiff-beneficiary. This law requires a Medicare lien to be satisfied before any other payment on a claim is made. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) imposes an affirmative obligation on primary payers (generally, insurance companies) to notify Medicare of any interest that Medicare may have in a lawsuit.

The MMSEA has also led to a debate over the applicability of the Medicare Set Aside Trust provisions to non-workers' compensation

settlements. Some regional offices of the Centers for Medicare and Medicaid Services (CMS) have taken the position that a Set Aside Trust must be established if a Medicare patient receives payment from a third-party payer for future medical care. In the future, the American Recovery and Reinvestment Act of 2009 (the Stimulus Bill) may be applied to further enhance Medicare's recovery rights against primary payers, but the Stimulus Bill's impact remains unknown at this time.

Medicare's statutory recovery right attaches automatically with the payment for health care services. The failure to satisfy a Medicare lien with the proceeds of a settlement or judgment can result in significant penalties for a defendant or its insurer, including having to pay for the claimant's medical expenses twice, paying double damages to Medicare, and paying interest on the lien amount. The Set Aside Trust provisions further mandate that Medicare is not to make a payment for any care to a plaintiff if the proceeds from any payment by a third-party insurer are available. Thus, an *entire* settlement may be exhausted by the cost of future medical care before Medicare makes another payment to the beneficiary. This provision understandably has members of the plaintiffs' bar concerned, and, thus, impacts defendants, their insurers, and their counsel.

LAWS ESTABLISHING THE LIEN

Medicare provides health insurance to persons over age 65; under age 65 who are disabled; and with end-stage renal disease with certain exceptions. If a covered individual obtains medical care that is also covered by a group health plan, a workers' compensation law, a liability insurance policy, or a no-fault insurance policy ("primary payers"), Medicare will generally not make a payment unless the primary plan cannot be reasonably expected to make a prompt payment. Such payments by Medicare are called "conditional payments." Primary payers with a responsibility to pay for care must reimburse Medicare, as a secondary payer, for conditional payments made. Responsibility of a primary payer to make a payment can be demonstrated by a judgment, a settlement (regardless of whether liability is admitted), "or by other means."

(continued on page 7)

Missouri Bad Faith Law – The Elements are Watered Down

Jackie M. Kinder



Bad faith, as the term is generally used, refers to liability arising out of an insurer's handling of its insured's claim. Under a liability insurance policy, the insurer owes two duties to the insured, the duty to defend and the duty to indemnify. When an insurer breaches either of these duties, a cause of action for bad faith may arise.

The court in *Dyer v. General American Life Ins. Co.*, 541 S.W.2d 702 (Mo. App. 1976), first stated the elements for the tort of bad faith as follows:

1. The liability insurer has assumed control over negotiations, settlement, and legal proceedings brought against the insured;
2. The insured has demanded that the insurer settle the claim brought against the insured;
3. The insurer refuses to settle the claim within the policy's liability limits; and
4. In refusing, the insurer acts in bad faith, as opposed to negligently.

Bad faith is an evolving area of the law and, recently, these elements have been somewhat watered down, if not eliminated

(continued on page 8)

Be Careful Where Your Name Appears: Motor Carriers and Logo Liability

Kurt A. Schmid



Prudent managers of motor carriers recognize the importance of assuring that their company names are not routinely placed on placards on trucks heading across the country. The concept of “logo liability” is well entrenched in transportation law and can lead to consequences never intended by the motor carrier. However, recently in the case of *Horner v. Fedex Ground*, 258 S.W.3d 532 (Mo. Ct. App. W.D. 2008), the Missouri’s appellate court considered again whether a motor carrier is automatically liable for a plaintiff’s injuries simply because the truck that injured the plaintiff bears the motor carrier’s logo. This liability is known as “logo liability”, and it is often taken for granted as the law across the country. On its face, the *Horner* case may appear to be a straightforward application of the traditional strict logo liability rule. However, the *Horner* case actually represents a movement by courts across the country to return to application of traditional agency rules when determining liability.

In *Horner*, a motor vehicle accident occurred while a truck driver was “bobtailing” (not pulling a trailer) to the motor carrier’s hub. The driver was to either pick up a load for delivery or leave the truck at the hub and go home. If the strict logo liability rule were not in effect, there would have been strong arguments to make that the driver was not in the course and scope of employment with the motor carrier when the accident occurred. However, the truck bore the motor carrier’s logo and ICC registration number when it collided with plaintiff’s vehicle.

The *Horner* court recognized that the two Missouri Supreme Court cases addressing logo liability could be read to support two different liability standards: one case appeared to adopt a minority rule that the presence of a logo creates a *rebuttable presumption* of liability instead of automatic liability. That is, a situation could arise where the defendant’s logo on the truck does not automatically create liability. The other case appeared to adopt the majority strict liability standard: if a defendant’s logo is on the truck, the defendant is liable. In the end, the *Horner* court kept

things unsettled. The court held that no matter what the standard actually is, the motor carrier had not offered any evidence supporting its position that it was not liable.

The *Horner* case demonstrates that arguments against the application of the strict liability standard are not futile. In fact, the court’s openness to the application of the

rebuttable presumption standard is in line with recent amendments to applicable federal regulations and other states’ and federal case law. In the future, we may see a bigger move away from strict logo liability in Missouri, a most welcomed departure from the present state of the law. ■

Workers’ Compensation Exclusion Limits UM Benefits to Statutory Minimum in Missouri

Megan K. Dana



In a much welcomed decision, the Missouri Court of Appeals recently gave insurers more room to restrict uninsured motorist coverage where the insured received workers’ compensation or other similar benefits. In *Rice v. Shelter Mut. Ins. Co.*, 2009 WL 585903 (Mo. App. W.D. March 10, 2009), the Western District of the Missouri Court of Appeals upheld an exclusion in a Shelter policy mandating that if the insured received any benefit under a “compensation law,” the insured would automatically receive the statutory-mandated minimum under Missouri’s Motor Vehicle Financial Responsibility Law (“MVFRL”).

The plaintiff in *Rice* was injured while a passenger in a vehicle involved in an accident with an uninsured motorist. It was undisputed that the plaintiff was working at the time of the accident and received workers’ compensation benefits. At the time of the accident, he was insured under three Shelter policies issued to his parents, with \$600,000 of “stacked” uninsured motorist coverage available subject to the terms of the policies.

The plaintiff demanded \$600,000 from Shelter, but Shelter instead paid \$75,000, the statutory minimum (\$25,000) for each of the three policies. The plaintiff brought suit to recover \$525,000 and both parties moved for summary judgment. The trial

court ruled for the plaintiff, holding the Shelter exclusion was illusory and void under Missouri public policy.

On appeal, the Missouri Court of Appeals held the following provisions of the Shelter policy were not illusory and did not violate the Missouri public policy contained in Section 379.203, R.S.Mo. 2000. The first paragraph under the section “Exclusions” is a type of “savings clause,” which by its own terms has application only where some policy provision is rendered unenforceable.

COVERAGE E-UNINSURED MOTORISTS EXCLUSIONS

If an applicable uninsured motorist insurance law or financial responsibility law renders any exclusion provision of this policy unenforceable, we will provide only the minimum limits required by such law. However, if other insurance covers our insured’s claim and provides those required minimum limits, the exclusion provisions of this policy are fully enforceable.

Following the savings clause is the list of exclusions, including the “compensation law” exclusion at issue:

Coverage E does not apply:

(3) To damages sustained by an Insured if benefits are:

a) payable to, or on behalf of, such insured under any compensation law

(continued on page 9)

Right to Medical Records – Not Always Automatic

A. J. Bronsky



Medical records are subject to the physician-patient privilege. Section 491.060(5), R.S.Mo. 2000. In Missouri, as in most states, plaintiffs waive the privilege by putting their physical condition in issue under the pleadings. See *State ex rel. McNutt v. Keet*, 432 S.W.2d 597 (Mo. banc 1968). This waiver permits defendants to secure those medical records that relate to the physical condition at issue under the plaintiffs' pleadings. Typically, where the injuries at issue are straightforward, the defendant has easy and unfettered access to relevant health records by medical authorization.

But what happens in a situation when the medical issues are less clear cut? For example, consider the situation where the medical condition of a young child may have been affected by the child's *in utero* development. Recently, the Missouri Court of Appeals in *State ex rel. Allison v. Mouton*, 2009 WL 765458 (Mo. App. S.D.), addressed this issue.

In 2004, Hunter Allison, a minor, by and through his parents, Lisa and Jeremy, filed suit against several defendants, alleging she had developed lead poisoning due to the defendants' failure to remove or properly abate lead paint from the premises where the Allison family had lived. The parents brought a separate cause of action for recovery of Hunter's loss of services and medical expenses incurred during his minority. The defendants propounded interrogatories to the plaintiffs, requesting information on Lisa Allison's medical care during pregnancy. Plaintiffs objected to this interrogatory and the defendants filed a motion to compel, claiming the information was relevant. The defendants additionally filed a motion requesting the court to order Lisa Allison to execute a medical authorization for the release of her pregnancy health records.

The defendants claimed in their pleadings that the records were relevant because Hunter Allison filed a claim for physical and cognitive injuries; therefore, the defendants contended the mother's medical condition before the child's birth

was relevant to the child's condition. The defendants cited a case from New York, *Lamy v. Pierre*, 818 N.Y.S.2d. 610 (App. Div. 2006), where the court had ordered a mother to execute a medical record release in a factually similar lead paint case. The defendants argued that Hunter Allison's cognitive disorders may have been caused by an *in utero* birth defect or a pre-natal accident. However, the defendants did not file any evidentiary material (affidavit, report, or deposition) explaining how this might be true. Rather, the defendants simply relied on the New York case.

The trial court granted the defendants' motions, finding the records relevant and ordered Lisa Allison to execute a medical authorization within thirty days. Instead, she immediately dismissed her cause of

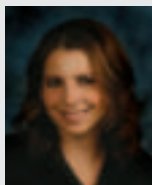
action, leaving only Hunter Allison and Jeremy Allison as parties. An additional hearing was held and the trial court, in light of Lisa Allison's dismissal, ordered Jeremy Allison to execute an authorization for the release of his wife's medical records. In response, the plaintiffs sought immediate appellate review of the trial court's order.

The Missouri Court of Appeals reversed the trial court's decision. The appellate court held the defendants' motion was unsupported by a qualified medical expert to explain how Lisa Allison's medical records were material and necessary to the defense. The court further noted that compelling evidence of the relevance of the medical records is necessary before a court may permit discovery of non-party

(continued on page 10)

Fire Spread: Am I my Neighbor's Keeper?

Irene J. Marusic



A fire starts on one property and spreads onto neighboring property destroying the neighbor's home. Is the owner of the property where the fire originated liable for the damages done to the neighboring property? The surprising answer is generally "No." Several decades have passed since Missouri appellate courts have addressed the fire spread issue in detail. A recent decision by the Missouri Court of Appeals, *Ronald Sherrell v. Brandy Brown*, 2009 WL 531051 (Mo. App. E.D. March 3, 2009), gives affirmation of those prior decisions.

In *Sherrell v. Brown*, the plaintiffs' service station and personal property were damaged by a fire that started next door in the defendant's mobile home, and the plaintiffs filed a negligence action against the defendant. Shortly before the fire, the defendant moved out of the home and retained the services of a real estate agent to sell the home. The defendant had returned to the home approximately ten days before the fire to retrieve items out of the garage. On the day of the fire, the defendant was visiting out of state.

The evidence at trial showed the fire's origin was the defendant's home, but a fire investigation expert was unable to determine where the fire originated within the home. Due to the extent of the fire damage, the expert was unable to determine the cause or to rule out potential causes, including arson, electrical malfunction, or act of nature.

Following a trial, the trial court noted there was no known cause for the fire. The trial court also noted that the defendant had not been to the property in over ten days and her last visit involved only the garage area. Thus, the trial court found the defendant was negligent for failing to properly monitor the home and to periodically check the home, and that her negligence was the fire's direct and proximate cause.

On the defendant's behalf, Brown & James, P.C. appealed the trial court's judgment, asserting the plaintiff failed to make a submissible case of negligence. There was no

Australian Court Allows Service on Defendant via Facebook

Carolyn Geoghegan



An Australian Supreme Court recently ruled that service of a default judgment could be made on a defendant via a Facebook account. The defendants had defaulted on a loan to refinance the mortgage on their home. The court entered a judgment for the plaintiff, a lending company, after the couple failed to appear in court to defend the action.

The plaintiff's lawyers made multiple unsuccessful attempts to contact the defendants, including hiring a private investigator to serve the default judgment on the couple, and advertised it in a local newspaper. The plaintiff's lawyers were able to locate the defendants on Facebook based on their email addresses. They then

convinced the court that the Facebook profiles found were, in fact, those of the defendants based on the defendants' dates of birth, email addresses, and friends' lists that identified each other.

The court ruled that the plaintiff's lawyers could communicate the information privately on the defendants' Facebook profile pages and that such posting would constitute service of legally binding documents on the defendants. In granting plaintiff permission, the court required evidence that all alternatives had been exhausted and that it could reasonably be assumed that the Facebook accounts were set up and maintained by the defendants. The court decided that Facebook was a valid way to serve the defendants and was a means of communication that

was reasonably likely to bring the proceedings to the defendants' attention.

Unfortunately for plaintiff, by the time the court documents were approved for transmission (and after much media attention regarding the ruling), the defendants had privacy restrictions placed on their Facebook pages.

Australian courts are regarded as some of the most technologically advanced in the world and, in recent years, have allowed service by email and text message if a person could not be physically found. But, this appears to be a first for Facebook. In fact, last summer an Australian court denied a plaintiff's request for service on a defendant via Facebook, noting that because anyone can create an identity on Facebook that could mimic the true person's identity, whether a Facebook page was in fact created and maintained by the defendant was too uncertain.

The Australian Supreme Court's decision could be the beginning of a universal trend toward service of court documents by less traditional means. Currently, Missouri courts require service on an individual by personal delivery or by leaving the papers at the person's house or usual place of abode. MO.R.CIV.P. 54.13. In some cases, service by mail or publication is permitted. MO.R.CIV.P. 54.12.

While email has evolved into a generally accepted written form of communication and as a valid way to file and serve certain documents during litigation, service via text messaging or through a social networking website raises significant due process concerns. Certainly, a plaintiff will be required to overcome significant obstacles and present overwhelming evidence that service by such means is reliable and reasonably calculated, under all the circumstances, to notify defendants of the pendency of an action and afford them an opportunity to respond.

In a public statement, Facebook praised the court's ruling as "validating" Facebook as a reliable and secure medium of communication; however, the ruling will likely give most non-users another reason not to participate in a social networking site – to avoid legal process. ■

evidence of the fire's cause or of any specific act of negligence on the defendant's part that was or could have been the fire's proximate cause. The Eastern District of the Missouri Court of Appeals agreed and reversed the trial court's judgment.

In so holding, the Eastern District set forth the conditions upon which a property owner may be liable for fire spread to a neighboring property. To establish a submissible case of negligence, a plaintiff must prove by substantial evidence that (1) there was negligence, and (2) such negligence caused the fire. *Sparks v. Platte-Clay Elec. Co-op., Inc.*, 861 S.W.2d 604, 606 (Mo. App. W.D. 1993). The showing of circumstances must be such that would indicate to reasonable minds the fire's cause and source, not leaving it to mere conjecture or speculation, and must be sufficiently strong and complete to reasonably eliminate the probability of any other source or cause. *Bridgeforth v. Proffitt*, 490 S.W.2d 416, 422-23 (Mo. App. 1973) (holding plaintiffs made a submissible case of negligence where there was evidence that defendants had set a trash fire that spread to adjacent property).

A property owner may be held liable for the spread of fire caused by the premises being maintained in a negligent condition, which is in such a manner as to create an unreasonable risk of harm to others. *Custom Craft Tile, Inc. v. Engineered Lubricants Co.*, 664 S.W.2d 556, 558 (Mo. App. E.D. 1983) (finding there was sufficient evidence to submit a negligence case to the jury where an expert testified the fire would not have spread from the wooden pallet stored next to the building that contained highly combustible materials resulting in the spread of the fire to adjacent property had they been stacked fifteen feet away from the building). The property owner is not liable for the spread of a fire accidentally started by the act of a stranger or by some other cause over which the owner has no control, unless the owner is guilty of some negligence for the condition of its premises which proximately caused the fire or caused the fire to spread to the adjoining landowner. Unless there is at least circumstantial evidence to show some act on the landowner's part caused a condition to exist that had something to do with the fire there is no liability. *Id.* At 559. ■

Missouri's Partial Loss Statute Limited to Fire Losses

David P. Bub



In one of the most important first-party insurance decisions in Missouri in years, the Eighth Circuit of the United States Court of Appeals recently upheld a jury verdict for the insurance company in the hotly disputed first-party insurance case of *Bluewood, Inc. v. Cincinnati Ins. Co.*, 560 F.3d 798 (8th Cir. 2009). In doing so, the Court held that Missouri's Partial Loss statute Section 379.150, R.S.Mo. 2000, clearly and unambiguously applies only to losses caused by fire. The *Bluewood* court is the first appellate court in the 100 plus year history of this statute to explicitly hold that this statute applies to fire claims *only*.

The *Bluewood* case involved an intensely disputed claim over the extent of damages suffered by an insured at a commercial property. The insured, Bluewood, Inc., is a large real estate conglomerate owning numerous apartment complexes across the Midwest. In January 2004, it sustained a significant water damage loss due to frozen pipes in one of its apartment buildings. There were significant legal issues pertaining to Bluewood's notice to Cincinnati Insurance Company as to whether Bluewood gave the insurer proper and timely notice of the claim. Bluewood's claimed damages were approximately \$540,000.

At the end of its adjustment and investigation, Cincinnati paid Bluewood approximately \$94,000, representing what Cincinnati believed to be the covered portion of Bluewood's damages. Shortly after Cincinnati's payment, Bluewood filed suit in state court and the case was removed to the United States District Court for the Eastern District of Missouri. At trial, Bluewood argued that Section 379.150 (commonly known as Missouri's "Partial Loss Statute") applied to the water damage loss and attempted to introduce evidence of what the insured believed to be loss of fair market value of the property caused by the water damage.

Missouri's Partial Loss Statute specifically states that whenever a partial loss exists to property covered by insurance, the insurer shall pay the insured "a sum of money equal to the damage done to the property," which Missouri law equates to the loss of fair market value. The statute goes on to say that the sum paid should put the insured property in "as good as condition before the fire."

It has long been argued that this statute, which was first enacted in the late 1800s, only applies to fire damage claims because the statute specifically uses the word "fire." Alternatively, arguments have been made that the word "fire" in the statute is irrelevant in that at the time the statute was enacted only insurance for fire damage was available. Thus, it has often been argued that the statute applies to all property damage claims and not just fire claims. In the 100 plus year history of the statute, this issue has never been explicitly addressed by a Missouri appellate court.

At the trial in *Bluewood*, the insured attempted to introduce a commercial property appraiser as an expert witness to testify to the loss of fair market value to the property caused by the water damage. Bluewood's expert opined that the loss in fair market value was in excess of \$700,000. In response, Cincinnati argued the Partial Loss Statute did not apply; the fair market value analysis was not relevant; therefore, the real estate expert should not be allowed to testify. Cincinnati argued the policy's language on covered damages (based upon replacement costs minus adequate depreciation) was the only relevant evidence for the jury's determination of covered damages.

The district court agreed with Cincinnati and refused to allow Bluewood's expert to testify at trial. After a five-day trial, the jury unanimously found for Cincinnati and awarded

Bluewood no damages. Bluewood then appealed the jury verdict, arguing the district court erred in not allowing Bluewood's real estate expert to testify.

In a unanimous decision, the Eighth Circuit affirmed, holding the real estate expert's testimony was irrelevant and should not have gone before the jury. In doing so, the *Bluewood* court held that it believed a proper reading of Missouri law required a finding that the Partial Loss Statute only applies to fire claims. The *Bluewood* court specifically held "the most natural reading of section 379.150 holds that the limiting phrase 'as before the fire' identifies the one and only type of 'partial destruction or damage to property covered by insurance' that triggers the insured's right to choose between a cash settlement and a course of repairs."

In doing so, the *Bluewood* court answered, for the first time in over 100 years, a very critical question in Missouri governing the applicability of Missouri's Partial Loss Statute. The insurance industry in Missouri can now finally feel comfortable in taking the position that this statute clearly applies to fire claims only. This decision is an extremely important one and has received much attention by the insurance industry in both Missouri and across the country.

This case was tried by David Bub. Patrick Bousquet assisted in the appeal before the Eighth Circuit. ■

(continued from page 1)

The Impact of a Foreclosure on the Mortgagee's Right to Recover Under a "Standard" Mortgage Clause

Robert Brady

policy was extinguished when it purchased the property at the trustee's sale for the full amount of the indebtedness.

These cases illustrate the importance of ascertaining whether the insured property has gone into foreclosure and been sold at a trustee's sale. When presented with a claim from a named mortgagee, the carrier should immediately request a complete copy of the loan file, including a payment history and all correspondence between the mortgagee and insured. The carrier should also review any information on file with the county recorder's office and the county assessor's office to check whether the property has been subject to foreclosure.

In short, it is critical that claims personnel have a good understanding of the effect a foreclosure can have on the mortgagee's right of recovery under a property policy. A heightened awareness of this issue on an industry-wide basis should effectively curtail the commonly held view that the mortgagee "always gets paid." ■

(continued from page 2)

Medicare Liens – An Overview and Update Part 1

Christine A. Vaporean

ENFORCEMENT PROVISIONS

The United States is authorized to bring an action to recover conditional payments directly “against any or all entities that are or were required or responsible” for the primary payment. The United States may collect double damages from any such entity and recover “from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.” The United States also has a subrogation right to the extent of the conditional payment amount on an individual’s behalf and against a primary payer. Thus, not only does the United States have a lien, the United States may enforce the lien against insurers (including self-insureds) and anyone receiving payment under an insurance policy. Parties subject to lien enforcement claims include health care providers, plaintiffs, plaintiffs’ counsel, insured defendants, and even defense counsel to the extent counsel are compensated from insurance proceeds. The right of subrogation allows Medicare to assert its lien whether the beneficiary asserts a claim or not.

Federal regulations establish the recovery procedures for conditional payments. The

regulations require a beneficiary to cooperate in recovery actions. In the case of liability insurance settlements and disputed claims under workers’ compensation or no-fault insurance, if Medicare is not reimbursed within sixty days of the beneficiary’s receipt of payment, the primary payer must reimburse Medicare *even though it has already reimbursed the beneficiary or other party*. This regulation applies if payment is made to an entity other than Medicare when the primary payer knew or should have known that Medicare has made a conditional payment.

Interest accrues until reimbursement is made if Medicare is not reimbursed by the primary payer within sixty days of notice of responsibility. Interest is applied for full thirty-day periods. The interest rate is determined by statutory formula. The reimbursement amount is determined by whether Medicare must initiate an action to recover payments. If no action is required, the amount due is the lesser of: (a) the amount of the Medicare payment; or (b) “the full primary payment amount the primary payer would have been required to pay had it paid for the care directly.” If a recovery action must be brought, Medicare

may recover *twice* the payment amount. In practice, Medicare must reduce its recovery to account for the costs of procuring a judgment or settlement.

Federal regulations set the manner for calculating the recovery amount. Generally, the costs of procuring a judgment or settlement are apportioned between Medicare and the claimant based on the ratio of the lien to the total award or settlement.

Medicare liens of less than \$100,000 may be settled by a CMS regional office. When settling a claim greater than \$100,000, the factors considered by the Department of Justice include: the debtor’s inability to pay; the government’s inability to collect payment promptly; the cost of collection versus the full amount of the debt; and the existence of doubt over the government’s ability to prove its case. A CMS regional office must be notified of a plaintiff-beneficiary’s intent to settle a claim.

In Part II of this article, notice requirements under the Medicare, Medicaid, and SCHIP Extension Act of 2007 as well as Medicare Set Aside Trust provisions will be addressed. ■

Statutory Presumption May Limit the Recovery of Medical Expenses in Personal Injury Cases

Elizabeth S. Silker



Missouri’s wide-ranging tort reforms passed in 2005 have impacted many facets of tort law. One significant reform may impact the value of personal injury claims by limiting the sums that plaintiffs may recover for their medical expenses. Although the 2005 reforms retain the collateral source rule, the new law modifies the rule to allow the actual amount of paid medical expenses to be introduced into evidence while excluding evidence of the sums charged by health care providers but not actually paid by plaintiffs and their insurers. Under the new law, defendants may be able to limit the value of plaintiffs’ medical bills to the sum actually paid rather than the full cost

of the care billed by health care providers to plaintiffs before any negotiated health insurance discounts.

The recovery of medical expenses in Missouri by plaintiffs in personal injury actions as a result of another’s negligence has long required proof of the necessity and reasonableness of the medical expenses incurred. Plaintiffs could sustain this burden by offering expert opinion testimony – usually from their treating physicians – on the medical necessity and reasonableness of the charges at issue.

Missouri courts also allowed plaintiffs to prove the reasonableness of their medical bills by presenting testimony that their bills had been paid. *Wise v. Towse*, 366 S.W.2d 506, 508 (Mo. App. 1963). The courts

considered a plaintiff’s actual payment of the charges at issue as substantial evidence that the medical bills were reasonable. *Hughes v. Palermo*, 911 S.W.2d 673, 675 (Mo. App. 1995). The courts so held based on the presumption that if the charges were unreasonable the plaintiff would not have paid them. *Williams v. Jacobs*, 972 S.W.2d 334, 342 (Mo. App. 1998).

In recent years, the application of the presumption based on payment has become a heated issue in personal injury cases. The advent of managed care and the payment of insurance reimbursements at rates less than the sums actually charged by health care providers led to the anomaly of plaintiffs seeking “windfall” recoveries based on medical expenses that they had never paid.

(continued on page 10)

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Missouri Bad Faith Law – The Elements are Watered Down

Jackie M. Kinder

by the Missouri Court of Appeals. One recent decision handed down by Missouri appellate court held that in certain situations, depending on the facts, satisfaction of all of the elements set forth by the Dyer court is unnecessary to make a submissible bad faith claim.

In *Shobe v. Kelly*, 2009 WL 230230 (Mo. App. W.D. February 3, 2009), an Allstate insured, Shobe, was in an accident while test driving a vehicle that she was going to purchase from L.C. Harris. The Lotts, who were apparently injured as a result of the accident, sued Shobe. Shobe tendered the claim to Allstate and its adjuster, Ms. Kelly, informed Shobe that the accident was not covered. Kelly apparently made this decision without any legal support and without considering Shobe's financial interests. The Lotts offered to settle the case for Shobe's policy limits of \$50,000, but Allstate responded, stating it had no coverage and would not settle the case. Allstate further refused to defend Shobe. Judgment was entered against Shobe for

\$138,339.20. In the subsequent equitable garnishment action, the court found coverage under the Allstate policy and Allstate paid its limits along with interest. Shobe then sued Allstate for bad faith, seeking damages for the outstanding portion of the judgment and accumulating interest.

In the bad faith case, Allstate argued there was no evidence to support element number one from *Dyer*, namely, that it controlled the settlement negotiations and thus Shobe could not show bad faith as a matter of law. The court held that where an insurer wrongly denies coverage, does not provide a defense under a reservation of rights, and completely refuses to engage in settlement negotiations, the insured need not show that the insurer controlled the settlement negotiations to make a submissible case of bad faith. The court reasoned that an insurer should not be able to avoid liability by completely ignoring the situation and, thus, eliminate the evidence supporting the control element.

Allstate also argued the insured never formally demanded that it settle the case within the policy limits; therefore, there was no evidence to support the third *Dyer* element. Again, the court in *Shobe* held that if an insurer is aware of a settlement demand, it should not be rewarded and, thus, be allowed to avoid liability because the insured did not send a letter to the insurer demanding the insurer accept the settlement demand, when such formal request would obviously be futile where the insurer has knowledge of the settlement demand and has refused to engage in settlement negotiations. Therefore, the court held no formal demand was necessary to make a submissible case for bad faith.

Thus, following the *Shobe* decision, depending on the facts, it may only be necessary to show that the insurer refused to settle the case and in doing so, acted in bad faith, to make a submissible case for the tort of bad faith. ■

BROWN & JAMES^{PC.} LAW FIRM Case Results

Annita Williams v. Ken Chiu. St. Louis City, Missouri. The plaintiff was stopped at a stop light when she was rear ended by the defendant. The plaintiff claimed she suffered soft tissue injuries to her neck, back, hip, knee, and ankle, as well as two bulging discs in her lumbar spine as a result of the impact. Her medical bills totaled \$35,000 and she requested the jury to award her \$200,000 at trial. The defendant argued it was a low impact accident and that the plaintiff was seeking recovery for pre-existing conditions unrelated to the accident. After a three-day jury trial, the jury returned a verdict for the defendant. Tried by Timothy J. Wolf.

Cedar Hill Hardware and Const. Supply, Inc. v. Insurance Corp. of Hannover. United States Court of Appeal, Eighth Circuit. In defense of the insured's action to recover fire-related damages in excess of \$1.7 million, the insurer advanced material misrepresentations by the insured as a defense to coverage and argued that it

was entitled to restitution for the sums that the insurer advanced to the insured during the fire's investigation and for those sums paid to the insured's mortgage holder. The Eighth Circuit affirmed the jury's verdict for the insurer, concluding the insured had made an intentional and material misrepresentation to the insurer regarding its interest in the property as well as the district court's restitution award to the insurer. Appeal handled by Robert W. Cockerham and Cory Kraushaar.

American Family Ins., Co. v. Safeco Ins. Co. of Ill. St. Charles County, Missouri. Plaintiff American Family brought a declaratory judgment seeking a declaration that its boat policy did not apply to the accident. In the underlying matter, the plaintiff was sitting on the bed of a pickup truck that was backing up to get a boat that had been docked. The plaintiff fell off and allegedly sustained a serious head injury. Safeco, represented by Brown & James, which issued the plaintiff's uninsured motorist policy, took the position that the boat policy applied; therefore, the driver of the pickup truck was insured. The court, finding for Safeco, concluded that, at the time of the accident, the driver qualified

as an insured under the American Family boat policy. Tried by Rebecca Schubert.

Trtanj/State Farm v. City of Granite City, Illinois. Madison County, Illinois. This case resulted in a plaintiffs' subrogation verdict for Brown & James' client on a property damage claim involving sewage back up into a residential basement. The plaintiffs claimed Granite City was negligent in responding to an electrical outage and in maintaining the sewer system. The last offer before trial was \$20,000. The jury found for the Trtanjes and State Farm, and awarded \$261,928.10 in damages, the full amount of damages requested by the plaintiffs. Tried by John P. Cunningham and Daniel G. Hasenstab.

Carl Huff v. J & M House Builders, Inc. Jefferson County, Missouri. The trial court granted summary judgment based upon the acceptance doctrine. The plaintiff, an employee of a drywall subcontractor, fell through a hole left in the floor of a home under construction. The defendant was the framing contractor that created the hole and allegedly failed to install safety railing. The owner and general contractor had accepted and paid for the work

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Workers' Compensation Exclusion Limits UM Benefits to Statutory Minimum in Missouri

Megan K. Dana

to be provided to, or on behalf of, such insured as a result of the same accident, or

b) required by any compensation law to be provided to, or on behalf of, such insured as a result of the same accident.

This exclusion does not apply to the amounts of coverage mandated by any uninsured motorist insurance law or financial responsibility law applicable to the accident, but does apply to coverages which are not mandated by such laws.

Following the list of exclusions is a section with another "savings clause" identical to the first, entitled "EFFECT OF UNINSURED MOTORIST INSURANCE LAWS OR FINANCIAL RESPONSIBILITY LAWS." The court first interpreted whether the exclusion itself was valid before having to interpret the savings clauses.

In reading the entire UM section of the Shelter policy, the insured is afforded at least the statutory minimum in all instances. *Rice*, at *4. By stating in the exclusion that it does not apply to the MVFRL, Shelter avoids the conflict with Missouri public policy altogether. According to the court: "Because we have determined that section 379.203 mandates only \$25,000 of UM coverage per person, per accident, there is no statute that requires more than this amount. Therefore, as in the case of underinsured motorist coverage, the rights of the parties are governed by contract law." *Id* at *8.

The *Rice* decision is significant because the Shelter policy appears to be the first UM/compensation exclusion written to withstand the public policy requirements contained in Section 379.203. Previously, insurers had unsuccessfully attempted to enforce UM exclusions on several occasions because they did not afford claimants the

statutory mandated minimum of \$25,000 per person, per occurrence in uninsured motorist coverage. *Cano v. Travelers Ins. Co.*, 656 S.W.2d 266 (Mo. banc 1983); *Douthet v. State Farm Mut. Auto. Ins. Co.*, 546 S.W.2d 156 (Mo. banc 1977).

While this exclusion may only be used in limited circumstances, it is strong in effect. The Shelter provision in *Rice* is as close to a pure exclusion as possible while still complying with the MVFRL. Insurers should keep the *Rice* decision in mind when redeveloping policy language to create effective UM exclusions as they relate to duplicate payments or benefits. The insurer's policy should adopt the language that has been upheld by the Missouri Court of Appeals in attempting to limit exposure in UM matters when workers compensation benefits have been paid to the injured insured. This decision creates a road map for developing an effective exclusion in this area. ■

of the framing contractor and released it from the job. The plaintiff fell through the hole weeks later. The trial court held the acceptance doctrine barred the plaintiff's action against the framing contractor and entered judgment for defendant. Tried by Russ Watters.

Good Hope Missionary Baptist Church v. St. Louis Alarm Monitoring Co., Inc. St. Louis City. In this fire property damage subrogation case, the jury returned a verdict for \$1,360,000, arising out of the negligence of a fire alarm monitoring company, under a spread theory based on the defendant's failure to properly monitor the alarm system. Tried by Robert W. Cockerham and Richard I. Woolf.

Dickerson v. Mitchell. St. Clair County, Illinois. The plaintiff, in this dental malpractice case, claimed she developed endocarditis following the extraction of eight teeth by our defendant, claiming she had valvular heart disease and, under the American Heart Association Guidelines, the defendant dentist was required to give her antibiotic prophylaxis before performing the extractions. The defendant dentist denied that the plaintiff had told him of her heart condition. At trial, the plaintiff sought \$6.9 million in damages. After a three-week

trial, the jury returned a verdict for the defendant dentist. Tried by Ken Burke.

Parker v. Lawler. St. Clair County, Illinois. The defendant rear-ended the plaintiffs' vehicle. The plaintiff husband testified the impact was so hard, that if he had not been wearing his seatbelt he would have been thrown through the windshield. The plaintiff wife also testified that the impact was "very hard." The defendant claimed the impact was a mere tap that occurred at a speed of less than 5 m.p.h. Photographs of both vehicles were admitted into evidence. The plaintiff wife claimed soft tissue injuries, with medical specials of \$8,000. The defendant admitted fault, but denied the plaintiffs were injured as a result of the accident. The jury returned a defense verdict after deliberating for 35 minutes. Tried by Matthew P. Young.

Ash v. Krone Construction Inc. Franklin County Circuit Court. Defendant Brian Ransom was building his own home and acting as the project's general contractor. He hired Defendant Krone Construction to do the framing work and the plaintiff's employer, Terry Schatz, to do the concrete work. The plaintiff, an employee of the

concrete company, was injured when the stairs leading to the basement of the home collapsed, suffering ankle fractures in the fall. The stairs were allegedly attached with the wrong size staples, causing them to come loose with the plaintiff on them. The plaintiff sued Ransom as the landowner, Krone Construction, the company that framed the stairs, and his employer Terry Schatz, who did not have workers' compensation insurance. The plaintiff alleged that Ransom, the landowner and general contractor, was negligent for failing to ensure that the stairs were properly constructed and for failing to warn him of the dangerous condition. The trial court granted summary judgment for Ransom based on the independent contractor defense, holding that a landowner hiring an independent contractor not under its control or direction cannot be liable to that contractor's employee while the employee is doing work pursuant to the contract. Since the landowner had hired an independent contractor to do the work and had relinquished control there could be no negligence on the landowner's part as a matter of law. Tried by Jackie Kinder.

(continued from page 7)

Statutory Presumption May Limit the Recovery of Medical Expenses in Personal Injury Cases

Elizabeth S. Silker

In these cases, the evidence would establish that the plaintiffs' medical insurance had paid an amount less than the charges billed by the plaintiffs' health care providers.

The difference between the sums charged by health care providers and paid by insurance can be significant. Health care insurers reimburse physicians at highly discounted rates. These rates may represent discounts of as much as thirty to fifty percent off the amount billed by physicians to their patients.

Despite this discrepancy, plaintiffs have argued that the amount charged, but not paid, should control for purposes of their special damage claims. Their counsel explain that when an insurance company pays a lower amount than the doctor billed, the lesser amount is simply a reflection of a contract between an insurer and a medical provider and should not change the value of the provider's services on the "open market." In opposition, defendants have argued that the reduction in payment reflects the insurer's determination that the charges at issue were higher than what would be considered reasonable and customary in the area.

The Missouri General Assembly – in an attempt to resolve disputes over the recovery of medical expenses and to ensure that plaintiffs are made whole without receiving windfalls – created, as part of the 2005 Missouri Tort Reform Act, a rebuttable presumption that the sum necessary to satisfy the financial obligations owed by plaintiffs to their health care providers represents the value of medical treatment rendered. Section 490.715.5(2), R.S.Mo. Cum. Supp. 2005. The General Assembly further provided that the court, on the motion of any party, may determine the value of medical treatment rendered in a hearing outside the presence of the jury based upon "additional" evidence, including the medical bills incurred by the party, the amount actually paid for the treatment, and the actual or estimated amount of unpaid medical bills that the party is obligated to pay any entity in the event of a recovery. Section 490.715.5(2)(a) to (c).

The impact of the statutory presumption created by Section 490.715.5 on the value of personal injury claims is uncertain. No Missouri appellate court has yet addressed the question. However, as a practical matter, if a plaintiff presents expert testimony concerning the value of medical care received that exceeds the presumed amount, the presumption is effectively rebutted. Conversely, a defendant may rebut the presumption by presenting expert testimony calling into question the reasonable value of the medical services rendered.

Brown & James has monitored how Missouri's courts have applied the presumption on a county-by-county basis. Many trial judges have admitted evidence of only the amount paid, plus the amount the plaintiff may be obligated to pay, but has not yet paid. Other judges, including some in St. Louis County and St. Louis City, have permitted plaintiffs to rebut the

presumption by offering testimony from their treating doctors that their bills were fair and represent the reasonable value of the services provided, although the bills were not paid in full by the plaintiffs' insurers. Still other judges have ignored the statutory presumption altogether and have permitted plaintiffs to admit evidence of the amount charged as proof of the bills' reasonableness.

How a particular trial court applies Section 490.715.5 and the rebuttable presumption may impact the value of a personal injury claim. The discrepancy between the amount charged and the amount paid may be significant in serious injury cases. Should you have any questions about the presumption's application by a particular Missouri court, please contact Brown & James. We maintain a database of the available court rulings, by venue, on this important issue. ■

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Right to Medical Records – Not Always Automatic

A. J. Bronsky

medical records. Additionally, the court held that, as Lisa Allison was no longer a party to the suit, she could not be compelled to execute a medical authorization, and that her husband, Jeremy, had no legal right to execute a medical authorization for her records. Citing the Missouri Supreme Court decision in *State ex rel. Wilfong v. Schaeperkoetter*, 933 S.W.2d 407 (Mo. banc 1996), the court reinforced the tenet that only the court can order discovery of a non-party's medical records and the only proper procedure for the production of non-party medical records is through a subpoena duces tecum, and not a medical authorization.

It is clear from the plaintiffs' procedural machinations that the defendants were on the right track in seeking Lisa Allison's pregnancy medical records. Unfortunately the defendants went about it in the wrong way. To obtain medical records of a non-party or a party who has not expressly placed his or her physical condition at issue, the defense must show by competent medical evidence why the requested records are material and germane to the case. With an expert medical report or deposition outlining the relevancy and need for the records, the defense should be able to convince the trial court that the records are relevant and material. Once armed with the information relative to the non-party's health care providers, the defense should also seek the non-party's medical records by serving a subpoena duces tecum on the relevant health care provider. By proceeding in this fashion, the defense will save time and expense in obtaining what may be critical exculpatory evidence. ■

Case Results (continued)

Bunger v. Federated Mut. Ins. Co. United States District Court, Western District of Missouri. The jury returned a unanimous defendant's verdict on a claimed \$400,000 breach of contract and fiduciary duty case against the insurer and its agent. Tried by Robert W. Cockerham and Christopher J. Seibold.

Nix v. Slater. Marion County, Illinois. The plaintiff, wife and administrator of the decedent's estate, filed a medical malpractice complaint against the defendant emergency room physician. The decedent collapsed at home and was brought to the emergency room by paramedics. As the ambulance arrived at the hospital, the patient became unresponsive and cardio-pulmonary resuscitation was started. The emergency room physician had difficulties intubating the decedent, but the intubation was completed in a timely manner. The decedent had a significant medical history, which the defendant claimed caused or contributed to the cause of his death, including diabetes, chronic obstructive pulmonary disease, cardiac problems, including bypass surgeries and congestive heart failure, among others. The plaintiff's attorney asked the jury to award \$1.5 million to the family for the wrongful

death. After a six-day trial, the jury returned a defense verdict after less than three hours of deliberations. Tried by Beth Kamp Veath. *Adrian Barlow v. ADSO, Inc.* St. Louis Circuit Court. The plaintiff filed suit claiming that an employee of defendant's service station assaulted and battered him, which resulted in a knee injury requiring surgery. The plaintiff's pretrial demand was \$250,000. After a three-day trial, the jury returned a verdict for the defendant. Tried by Irene J. Marusic.

Thomas v. Reddy. Williamson County, Illinois. The plaintiff, in this medical malpractice case, alleged the defendant pulmonologist had erroneously removed his right lung after having been diagnosed with a large mass that was highly suspicious for lung cancer. The defendant performed a bronchoscopy, which was non-diagnostic, and then referred the plaintiff to a surgeon who removed the entire right lung without performing a frozen section of the mass tissue. Post-surgery examination of the mass disclosed that the mass was a fungal infection that could have been treated with medication. The plaintiff alleged the pulmonologist negligently performed the bronchoscopy and failed to perform other tests

before referring plaintiff to the surgeon. The plaintiff sought \$1.75 million at trial. The jury returned a verdict for the pulmonologist. Tried by Ken Burke.

Wells v. Farmers Alliance Cos. United States District Court, Eastern District of Missouri. The jury returned a unanimous defendant's verdict in a claimed \$1.4 million breach of insurance contract case for property damage. The jury found against the insured on fifteen different counts, including fraud, misrepresentation, concealment, false statements, and breach of policy conditions. Tried by Robert W. Cockerham and Jaimie L. Thompson.

Beckon, Inc. v. AMCO Ins. Co. United States District Court, Eastern District of Missouri. Plaintiff sued for breach of insurance contract and vexatious refusal to pay, claiming over \$2 million in property damages and business interruption. The district court entered summary judgment for the insurer based on lack of insurable interest, and also entered judgment against the insured and for the insurer for \$532,000. Tried by Robert W. Cockerham and Jaimie L. Thompson.

Firm Inquiry Announcements

Brown & James has been honored as the "Dominant Defense Trial Firm" for 2008 by *Missouri Lawyers Weekly*. Brown & James far outdistanced every other firm in the number of jury defense verdicts for the year. **Russ Watters, David Bub, Brad Hansmann, and Robert Cockerham** were singled out by *Missouri Lawyers Weekly* as those Missouri lawyers with the greatest number of defense verdicts during that year as reported in *Missouri Lawyers Weekly's* Top Verdicts and Settlements Issue on January 26, 2009.

John McMullin will be the lead speaker at a construction law seminar sponsored by the National Business Institute on June 24, 2009, "Construction Defect Litigation: From A to Z." His topic will be "Discovery -- The Key Elements That Can Make or Break a Construction Defect Case."

Russell Watters has been inducted into the "Multi Million Dollar Advocates Forum." This organization honors and is

limited to those attorneys nationwide who have obtained multiple jury verdicts for their clients in excess of \$2 million.

Robert W. Cockerham spoke at the annual Property Loss Research Bureau 2009 Claims Conference and Insurance Services Expo in Seattle, Washington, on Examinations Under Oath with Gene Roberts, Assistant Vice President, Director, Claims Operation, of State Auto Insurance Companies.

David Bub, on January 29, 2009, spoke at the Annual Conference of the Missouri Association of Mutual Insurance Companies on "The Role of Your Attorney in the Claims Process from Start to Finish."

David Bub spoke at the National March 2009 PLRB/LIRB conference in Seattle on the topic "Trial of the Complex Soft Tissue Injury Case."

Robert W. Cockerham spoke at the Sixth Annual National Property Subrogation Strategies ExecuSummit in Uncasville, Connecticut. His presentation addressed essential information and practical solutions for resolving subrogation roadblocks, including

proper large loss handling, waivers of subrogation, exculpatory clauses, and spoliation of evidence.

At the recent National Business Institute seminar on "What Civil Court Judges Want You To Know," **David Bub** acted as the moderator and a speaker on April 23, 2009.

Russ Watters presented a seminar to the Claims Managers of Missouri Annual meeting on "Bad Faith and the Consent Judgment 537 Statute" in May 2009.

At the upcoming Missouri State Bar Annual Meeting in September 2009, **Russ Watters** will speak on the "Admissibility of Medical Bill Evidence in Missouri."

His presentation will address the new rules passed as part of the Missouri Tort Reform Act.

All written materials used at these presentations are available upon request. Please email or phone the presenter and the written materials will be promptly sent to you.

If anyone receiving The Firm Inquiry would prefer to receive it by e-mail, simply e-mail Donna Howard at dhoward@bjpc.com and Brown & James will arrange for it to be sent electronically to you.

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Case Law Update

Jennine D. Adamek Moore



Defamation verdict for actual and punitive damages affirmed and trial court did not abuse its discretion in denying the insurer's motion for remittitur. Insured's

damages were supported by competent and substantial evidence that insured's reputation was damaged by statements in the denial letter when he later attempted to obtain insurance. *Johnson v. Allstate Indemnity Co.*, 278 S.W.3d 228 (Mo. App. E.D. 2009).

When an insured is entitled to workers' compensation, the policy can limit uninsured motorist coverage as long as policy pays the statutory minimum for uninsured motorist coverage. *Rice v. Shelter Mut'l Ins. Co.*, 2009 WL 585903 (Mo. App. W.D.).

Where plaintiff independent contractor alleged injury from a defective condition on the defendant's property and negligence arising from failure to meet a contractual duty, and not a duty to keep premises safe, the defendant's status as a landowner is irrelevant to theory of liability and premises liability defenses were inapplicable. *Cossey v. Air Systems Intern'l, Inc.*, 273 S.W.3d 588 (Mo. App. E.D. 2009).

While the term "business pursuits" was not defined in the policy, "business" was defined and the court reasoned that using the definition and common understanding of the terms, the policy barred coverage for business activities engaged in either on or off the insured premises. Therefore, the policy was upheld as clear and unambiguous. The supervisor's act of placing a weld on a water tank that later exploded at employer's place of business was a "business pursuit" and coverage was barred under the farmowners' policy. *Burns v. Smith*, 2009 WL 368608 (Mo. App. S.D.).

An uninsured motorist insurer has an absolute right to intervene in an underlying action against an uninsured driver and the right to file a motion to set aside a default judgment in such an action. But, a motion to set aside a default judgment will not be granted unless good cause to do so is established. Reckless conduct, such as deliberately choosing to risk allowing a default judgment to be taken, does not satisfy the good cause requirement; therefore, the trial court's denial of a motion to set aside default judgment was upheld. In addition, the court reiterated that an insurer's honest error in judgment about the law is neither reasonable nor made in good faith when the issue has been

definitely settled. *Nervig v. Workman*, 2009 WL 281300 (Mo. App. S.D.).

Insurer under a liability policy has a fiduciary duty to its insured to evaluate and negotiate third-party claims in good faith. When an insurer breaches this duty and refuses to settle within policy limits, the insurer may be liable for resulting losses to the insured. The absence of a policy limits settlement demand from the insured and the insurer's lack of control over a lawsuit is no defense when the insurer knew of the claim and decided not to defend under a reservation of rights. The court reiterated that the insurer is liable for the damages proximately caused by its bad faith and punitive damages are justified when there is evidence supporting the inference the insurer acted with reckless indifference to the insured's interests. *Shobe v. Kelly*, 2009 WL 230230 (Mo. App. W.D.).

Stacking of underinsured motorist coverage was required due to ambiguity between "other insurance" and "limits of liability" sections. The "limits of liability" provision was unambiguous and entitled the insurer to a set-off for amounts paid on the tortfeasor's behalf. *Ritchie v. Allied Property & Cas. Ins. Co.*, 2009 WL 596657 (Mo. App. S.D.). ■