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Brown & James Announces the Opening of its Arkansas Office



To better serve its clients in the Arkansas area, Brown & James is pleased to announce the opening of its Little Rock, Arkansas office. Due to a significant increase in case load and client requests, Little Rock is an ideal site for meeting our clients' needs.

The Little Rock office is Brown & James' fifth office location. The office demonstrates the firm's commitment to serve its clients' needs throughout the midwest region.

Timothy J. Wolf will be the principal in charge of the Little Rock office. Tim has taken the lead in servicing the needs of the firm's clients in the Arkansas area for the past several years. We anticipate that at least three lawyers will be working at the Little Rock office in the near future.

The address for our Arkansas office is 400 West Capitol Avenue, 17th Floor, Little Rock, Arkansas. For additional information concerning the Arkansas office, contact Tim Wolf at 314-242-5350 or twolf@bjpc.com.

Medicare Liens – An Overview and Update Part II

Christine A. Vaporean



Effective July 1, 2009, all self-insured organizations and insurers that potentially pay bodily injury claims under a workers' compensation, a no-fault auto, or a liability plan must submit detailed electronic reporting to the federal government under the Medicare Secondary Payer Act. In the last issue of *The Firm Inquiry*, the Medicare lien laws and recovery rights were addressed. In this issue, the 2009 reporting requirements, which are detailed, complex, and burdensome, will be summarized.

Every insurer, third-party administrator, and lawyer engaged in adjusting, defending, and settling personal injury claims involving Medicare-qualified claimants should be familiar with these requirements. The failure to comply with these reporting requirements will expose subject parties to significant penalties.

Moreover, familiarity with these requirements is important to facilitate proper claim resolution through settlements and to

ensure that counsel for plaintiffs are aware of them. Plaintiffs' counsel must be educated that Medicare will be looking for one hundred percent reimbursement of the benefits that the government has paid in the event of a personal injury settlement. In past, many settlements escaped Medicare's notice and the government's recovery rights were lost. Not so anymore. The new 2009 reporting requirements demonstrate Medicare's commitment to recover every cent in benefits paid to Medicare-qualified claimants.

NOTICE REQUIREMENTS - MMSEA

Upon learning that Medicare has made conditional payments to a claimant, a third party must notify Medicare of the party's status as a primary payer. Medicare has no duty to notify third parties of its lien and recovery rights. As a matter of law, Medicare's lien exists so long as the third party knew or should have known of its existence.

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Missouri Decision Limits Remedies for Asserting Workers' Compensation Exclusivity Defense

Kenneth R. Goleaner



It has long been the law in Missouri that the way to challenge a lawsuit where the defendant has a defense that the exclusivity provision of Missouri's Workers'

Compensation Act (Section 287.120, R.S.Mo. 2000) applies, is to file a motion to dismiss for lack of subject-matter jurisdiction. Such a defense could be raised at any time in the proceedings, even on appeal, and the Supreme Court of Missouri has recognized for decades that such a motion is the appropriate method for raising a workers' compensation exclusivity defense. A decision by the Southern District of the Missouri Court of Appeals now maintains the Missouri Supreme Court has changed this long-held view.

In *McCracken v. Wal-Mart Stores East, LP*, 2009 WL 464860 (Mo. App. S.D.), the Missouri Court of Appeals addressed a recent decision by the Missouri Supreme Court and held that the assertion of a workers' compensation exclusivity defense as a subject-matter jurisdiction defense was no longer the proper method, whether it be asserted in a motion to dismiss or as an affirmative defense in a responsive pleading, of raising the workers' compensation exclusivity defense that is codified in Section 287.120. In *McCracken*, the defendant, Wal-Mart, did not raise the workers' compensation exclusivity defense in its responsive pleading. Rather, on the morning of trial, Wal-Mart filed a motion to dismiss, claiming the trial court lacked subject-matter jurisdiction because the plaintiff was Wal-Mart's statutory employee under the Workers' Compensation Act and, hence, Wal-Mart was protected by Section 287.120. The trial court agreed and dismissed plaintiff's lawsuit for lack of subject-matter jurisdiction.

On appeal, the Missouri Court of Appeals relied on the Missouri Supreme Court's recent decision in *J.C.W. v. Wyciskalla*, 275 S.W.3d 249 (Mo. banc 2009), which was actually issued after the trial court ruled in *McCracken*. *J.C.W.* was not a workers' compensation exclusivity case; however, the Southern District in *McCracken* held that it was bound by the Supreme Court's analysis in *J.C.W.* Specifically, the Supreme Court

held there are only two types of jurisdiction: personal jurisdiction, which is a court's power over a person and that is governed by federal constitutional law, and subject-matter jurisdiction, which is the court's authority to render a judgment in a particular case and that is governed by Article V of the Missouri Constitution. The issue in *J.C.W.* was a subject-matter jurisdiction defense based on a Missouri statute holding that a person cannot file a lawsuit to seek to change or modify custody if that person is more than \$10,000 in arrears in child support. Hence, because the defense asserted was based on a *statute* and not

on either personal jurisdiction or the subject-matter jurisdiction afforded the circuit courts under the Missouri Constitution, the Supreme Court held that defenses created by statute are not subject-matter jurisdiction defenses.

The Supreme Court then concluded that "[e]levating statutory restrictions to matters of 'jurisdictional competence' erodes the constitutional boundary established by Article V of the Missouri Constitution," which gives the circuit courts original jurisdiction over all civil and criminal cases. *Id.* at 253-54. Therefore, the Supreme Court instructed

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Brown & James Helps the Homeless Through Habitat for Humanity

Brown & James participated in Phase One of the Habitat for Humanity St. Louis City Build in May 2009. The Build took place in the JeffVanderLou Neighborhood in south St. Louis. This area has a rich history and a future full of promise due to the many redevelopment projects in the area.

The Brown & James crew – including over thirty-five lawyers, secretaries, support staff, and clients – volunteered their time on May 1 and May 2, 2009. Working side-by-side with the new homeowners, the Brown & James crew in their bright yellow tee shirts raised the home's exterior and interior walls and installed trusses, doors, and windows despite adverse weather conditions. Everyone in the Brown & James crew shared a tremendous sense of accomplishment and satisfaction in helping others through this Habitat for Humanity project.

Brown & James celebrated the home's completion on August 2, 2009. At the joyous occasion, the owners received the keys to their brand new home.

Brown & James, P.C., will again sponsor a Habitat for Humanity Build in 2010. If you would like to participate with us in the 2010 Build, contact Donna Howard, Human Resources Director, at 314-242-5223 or dhoward@bjpc.com. ■



The Brown & James Build Crew

Illinois Dramshop Act is Strict, but Limited

Daniel G. Hasenstab



Almost every state has its own version of a “Dramshop Act,” a statute that imposes liability on a restaurant or tavern owner for selling alcohol to someone who

later injures someone else. The Illinois Dramshop Act (235 ILCS 5/6-21) is unique among these enactments, differing from the dramshop laws of Missouri and other surrounding states in several important ways.

Unlike Missouri, the Illinois Dramshop Act is a “no-fault” statute. Under the Act, liability can be imposed against a business even if its employees had no reason to believe the customer was intoxicated. Indeed, liability can even be imposed against a grocery store owner for selling packaged liquor to a customer who drinks it at home. A dramshop plaintiff in Illinois needs only to prove three essential elements: (1) a gift or sale of alcohol to a party; (2) the alcohol caused, to some extent, the party’s intoxication; and (3) the plaintiff was injured as a result of the intoxication.

Also, since recovery under the Dramshop Act is based on strict liability and not on negligence, the plaintiff’s comparative fault or negligence is not a liability defense, no matter how egregious the plaintiff’s negligence may be. Thus, a plaintiff who knowingly accepts a ride from a drunken driver can still recover the plaintiff’s full damages under the Act in the event the drunk causes a wreck. Also, a dramshop defendant is prohibited from recovering contribution or indemnification from the intoxicated party or any other party who may be liable in tort for the plaintiff’s injuries.

Given the statute’s draconian strictness and the limited defenses available, it may appear that dramshop defendants in Illinois are at a significant disadvantage from their fellow purveyors of alcohol in other states. However, the Illinois law does provide a few bright spots for dramshop defendants and their insurers.

First, the Illinois Supreme Court has held the Dramshop Act is the *exclusive* remedy in Illinois for claims based on liability for the sale or gift of alcoholic beverages (except for sales or gifts to minors under age eighteen). Therefore, a plaintiff must strictly comply

with the statute to recover. A claim cannot be asserted under common-law negligence, no matter how blameworthy the dramshop defendant may be.

Second, the intoxicated person cannot recover for his own injuries under the Act, nor can the person’s family assert a claim for loss of support or loss of society for any injuries the person may suffer.

Third, any complaint under the statute must be filed within one year of the date of the injury. This includes claims by minors and incompetent persons, who normally are entitled to much longer limitation periods under Illinois law.

Finally, and perhaps most significantly, the damages for which a dramshop defendant may be liable under the statute are capped at

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Illinois Clarifies Meaning of “Separate Occurrences” in Insurance Policies

David M. Wilkins



The Illinois Supreme Court recently clarified the law concerning separate occurrences for purposes of interpreting insurance policies. Understanding

how Illinois courts interpret the occurrence provisions of an insurance policy is key to determining whether an incident triggers either the aggregate or single occurrence coverage limits. There are two competing theories courts use to determine whether a loss triggers separate occurrences under an insurance policy. Under the first theory, known as the “cause theory,” a court will determine the number of occurrences by referring to the cause of damages or injuries. This is the theory adopted by Illinois courts. Under the “effect theory,” the number of individual claims or injuries resulting from the incident will determine the number of occurrences. This theory has been explicitly rejected by Illinois courts. However, recent rulings have created exceptions or clarifications that broaden the “cause rule” in order to find the existence of multiple occurrences.

The Illinois Supreme Court, in *Nicor, Inc. v. Associated Electric & Gas Ins. Services, Ltd.*, 223 Ill.2d 407 (2006), reaffirmed that Illinois follows the “cause theory.” In so declaring, the court held that “where each asserted loss is the result of a separate and intervening human act, whether negligent or intentional, or each act increased the insured’s exposure to liability, each loss will be deemed to have arose from a separate occurrence.”

Even with the relative simplicity of the “cause theory,” courts often encounter great difficulty in cases involving acts of negligence that are spread over time and distance, sometimes over a period of many years. When a case involves a continuing act of negligence, Illinois courts take a broader view of the “cause theory” and find that each particular injury is a separate occurrence. In *Roman Catholic Diocese of Joliet v. Lee*, 292 Ill.App.3d 447 (1997), the Appellate Court of Illinois held that even a single act or omission, such as a failure to supervise employees, can still lead to multiple occurrences, if the single act or omission is spread over a long period of time.

Recently, the Illinois Supreme Court, in *Addison Ins. Co. v. Donna Fay*, 232 Ill.2d 446 (2009), clarified the application of the “cause theory” in such situations. In *Addison*, two young boys, on the way home from fishing, decided to take a shortcut across unbarricaded property. In the process, the children fell into an excavation with a quicksand-like bottom. The trapped children subsequently died. The evidence was unclear as to how close in time the two boys became trapped and died. The trial court held that the deaths stemmed from multiple occurrences. The appellate court reversed, utilizing a recent New Jersey opinion called a “time and space” test to determine whether the two occurrences were tied or separate.

Under the “time and space” test, the appellate court held that “if cause and result are simultaneous or so closely lined in time

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Metal Bat Injuries and Assumption of the Risk in Sports Injury Cases

Edward W. Zeidler, II



Bodily injuries in sports are commonplace. They arise in a variety of sports and under a multitude of circumstances. One particular class of injuries that has recently garnered much publicity

involves baseball injuries “caused” by players being struck by batted balls where the hitter used a high-performance metal or composite bat. These injuries have sparked a debate over the relative safety of metal bats when compared to more traditional wooden bats. This debate has led to bans of non-wood baseball bats in numerous baseball and softball leagues throughout the country. These injuries have also resulted in many “metal bat injury” lawsuits against coaches, players, leagues, sports associations, youth organizations, including Little League Baseball, baseball research testing centers, and sporting equipment manufacturers. *See, e.g., Baggs v. Little League Baseball, Inc.*, 840 N.Y.S.2d 529 (Sup. Ct. 2007); *Cockrell v. Hillerich & Bradsby Co.*, 611 S.E.2d 505 (S.C. 2005); and *Sanchez v. Hillerich & Bradsby Co.*, 104 Cal.App.4th 703 (2003).

Given the national attention on the wood bat versus metal bat debate, the number of children and adults participating in organized baseball and softball, and the severity of injuries that can result when a player is struck by a batted ball, those participating in organized sports and their insurers should understand the nature of these claims and the applicable defenses to them, including the assumption-of-risk doctrine.

Traditionally, the assumption-of-risk doctrine in Missouri has constituted the principal defense to personal injury claims arising from sporting events. Missouri law distinguishes between *express* and *implied* assumption of the risk. Missouri courts also recognize two types of implied assumption of the risk – *primary* implied assumption of the risk and *secondary* implied assumption of the risk. Secondary implied assumption of the risk is further classified as either *reasonable* or *unreasonable*. *Sheppard v. Midway R-1 School Dist.*, 904 S.W.2d 257 (Mo. Ct. App. 1995). Each type of assumption of risk can be concisely defined as follows:

- **Express Assumption of Risk:** This occurs when the plaintiff expressly agrees, in advance, that the defendant owes him no duty. Recovery is completely barred because no duty was owed in the first instance. Most often, express assumption of the risk is accomplished through a signed waiver.
- **Primary Implied Assumption of Risk:** This occurs when the parties have voluntarily entered into a relationship in which the plaintiff assumes well-known incidental risks. For these risks, the defendant owes no duty to protect the plaintiff. Primary implied assumption of the risk rests on the plaintiff’s consent. Unlike express assumption of the risk, the consent is *implied* from the plaintiff’s act in electing to participate in the activity.
- **Secondary Implied Assumption of Risk:** This occurs where the defendant

owes and breaches a duty of care to the plaintiff, but the plaintiff proceeds to encounter a known risk caused by that breach. If the plaintiff’s decision to encounter the known risk is *reasonable*, the plaintiff is not barred from recovery nor can the defendant seek any assessment of comparative fault to the plaintiff. If the plaintiff’s decision to encounter the known risk is *unreasonable*, the plaintiff is still entitled to recover, but the defendant is entitled to seek an allocation of comparative fault against the plaintiff.

Generally, assumption of risk in sports involves primary assumption of the risk because the plaintiff has assumed certain risks inherent in the sport. *McKichan v. St. Louis Hockey Club, L.P.*, 967 S.W.2d 209 (Mo. Ct. App. 1998) (injury sustained by professional hockey goalie when checked after play was risk inherent to sport of hockey and no

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B&J Attorneys Help Fire Investigators Sharpen their Courtroom Skills

On March 13 and 14, 2009, Brown & James attorneys John Cunningham, Denise Baker-Seal, Dan Hasenstab, and Matt Young participated as instructors in an Expert Witness Courtroom Testimony Course sponsored by the International Association of Arson Investigators (IAAI).

The purpose of the course was to provide fire investigators with a realistic courtroom experience and to assist them to become effective trial witnesses.

The course consisted of classroom training as well as a mock mini-trial in which the student investigators testified in a real courtroom about their investigation of a hypothetical house fire. Each student had the opportunity to present testimony through direct examination, and each was subjected to rigorous cross-examination during the mock trial.

John Cunningham headed the classroom portion of the training. Denise Baker-Seal served as the judge during the mock trial. Dan Hasenstab and Matt Young served as the trial attorneys. Dan and Matt met with the students individually and prepared them for their trial testimony. During the trial, Dan and Matt conducted the direct and cross-examinations of the student witnesses.

Seven students participated in the two-day course, part of which was held at the Brown & James Belleville office. The mock trial was held at the St. Clair County Courthouse in Belleville.

After the course was completed, William Buxton of the Illinois Chapter of the IAAI praised John, Denise, Dan and Matt for their work with the students, stating that our attorneys’ expertise was “very valuable” to their students.

Workers' Compensation Reform (Or Not) – Has the Exclusive Remedy Doctrine Been Weakened?

William E. Paasch



The Missouri General Assembly, in August 2005, enacted sweeping amendments to the Missouri Workers' Compensation Law. The General Assembly passed these changes to restore

balance to a system that was viewed to have tipped far too much in the employees' favor and to the great detriment of employers in Missouri.

Labor groups and the Missouri Association of Trial Attorneys quickly challenged the amended law. In fall 2005, they mounted a constitutional attack to the new law. These interests claimed the Workers' Compensation Law constitutes an "agreement" between labor, employers, and the State of Missouri. They argued the restriction in the 2005 amendments

that placed restrictions on what constitute compensable workers' compensation claims violated the rights of labor under this compact.

Labor's challenge quickly reached the Missouri Supreme Court. There, however, the case languished for three years until the Supreme Court handed down its decision in *Missouri Alliance for Retired Americans v. Missouri Dep't of Labor & Industrial Relations*, 277 S.W.3d 670 (Mo. banc 2009), in February 2009.

Although the Supreme Court did not strike down the 2005 amendments as unconstitutional, the Court granted certain declaratory relief that may ultimately undermine the "exclusive remedy" defense available to employers under the Workers' Compensation Law. Now claims – that upon first blush might be thought to give

rise to workers' compensation claims only – may expose employers to civil lawsuits.

The Supreme Court observed that where the 2005 amendments narrowed the specific definition of what constitutes a compensable injury or accident for workers' compensation, the amendments, as a concomitant, necessarily broadened the potential for civil lawsuits by injured employees against their employers based on negligence. The upshot of the Supreme Court's decision is that counsel for employees may now be more aggressive in filing parallel actions – one in civil courts against the employer for negligence and one before the Division of Workers' Compensation – for the same injury. Indeed, the Supreme Court's decision may cause claimants to forego filing workers' compensation claims and proceed only in Missouri's common-law civil courts where the claimants' potential recovery is much greater and in no way restricted by the limitations under the Workers' Compensation Law.

Ultimately, the Supreme Court's decision will require employers and their insurers to consider the significant ramifications that may flow from the denial of workers' compensation claims, including the risk of civil litigation against employers. To this end, the proper adjustment of workers' compensation claims will require employers and their insurers to carefully investigate the injury facts and weigh the consequences of a denied claim against the potential of exposing the employer to civil liability that may far outweigh the employer's liability under the Workers' Compensation Law.

The law surrounding the 2005 amendments to the Missouri Workers' Compensation law remains in an evolutionary stage. As further judicial decisions address these amendments, they will be reported in future editions of *The Firm Inquiry*. ■



Denise Baker-Seal, Dan Hastenstab, and Matt Young and the IAAI Fire Investigator Students

Illinois Court Clarifies Scope of the “Automobile Use” Exclusion in Homeowners and CGL Policies

Gregory Odom



When does “use” really mean “use”? The courts have struggled with the meaning of what appears to be a relatively simple term when applying it in the context of exclusionary provisions in liability insurance policies. Until recently what is commonly referred to as the “automobile use” exclusion has resulted in numerous conflicting decisions in Illinois.

The provision operates to bar coverage for property damage and bodily injury claims arising out of the use of an automobile. An “automobile use” exclusion often reads as follows:

Coverage L [Liability] and Coverage M [Medical Payments to Others] do not apply to:

- e. Bodily injury or property damage arising out of the ownership, maintenance, use, loading and unloading of:
 - (2) A motor vehicle owned or operated by or rented to or loaned to any insured.

See *State Farm Fire & Cas. Co. v. Perez*, 899 N.E.2d 1231, 1235-36 (App. Ct. 1st Dist. 2008).

In Illinois, the “automobile use” exclusion operates to bar coverage where the claim at issue arises from injuries sustained while an automobile was being used in a manner consistent with its customary use and a causal relationship exists between the vehicle’s use and the alleged injuries. *Mount Vernon Fire Ins. Co. v. Heaven’s Little Hands Day Care*, 343 Ill.App.3d 309, 319-20 (1st Dist. 2003); *State Farm Mut. Auto. Ins. Co. v. Pfiel*, 304 Ill.App.3d 831, 836-37 (1st Dist. 1999). Illinois courts have applied the “automobile use” exclusion and upheld an insurer’s coverage denial where the alleged injury giving rise to the claim clearly arose from the use of an automobile. For example, the exclusion has barred coverage for claims arising from the negligent operation of a school bus, the negligent and reckless operation of a dirt bike, and the negligent interference with traffic after exiting a broken down vehicle. See *Northbrook Prop. & Cas. Co. v. Transportation Joint Agreement*, 194 Ill.2d 96 (Ill. 2000); *Allstate Ins. Co. v. Pruitt*, 177 Ill.App.3d 407

(1st Dist. 1988); *Aryainejad v. Economy Fire & Cas. Co.*, 278 Ill.App.3d 1049 (3rd Dist. 1996).

While the application of the “automobile use” exclusion appears straightforward for claims directly arising from the use of an automobile, greater uncertainty surrounds claims tangentially related to the use of an automobile. In situations where an injury giving rise to the claim at issue only relates to an automobile, insurers are faced with the difficult task of determining whether the claim could be construed as arising from the “use” of an automobile. However, the First District of the Appellate Court of Illinois recently addressed this issue and emphasized the broad nature of the “automobile use” exclusion. Ultimately, that court concluded that even claims not directly arising from the use of an automobile could fall within the exclusion’s ambit. *State Farm Fire & Cas. Co. v. Perez*, 899 N.E.2d at 1241.

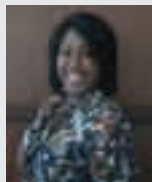
In *Perez*, the plaintiff was injured while a passenger in a vehicle operated by the insured. Perez subsequently filed suit against the insured alleging that, among other things, the insured negligently modified the seats in his vehicle and failed to warn Perez of the modifications. At the time of the accident giving rise to Perez’s suit,

State Farm provided a homeowner’s policy to the insured. The policy contained the “automobile use” exclusion previously cited in this article. Based upon that provision, State Farm filed a declaratory judgment action against the plaintiff, claiming it owed no duty to defend or indemnify the insured in the underlying lawsuit. Perez argued that State Farm owed a duty to defend and indemnify its insured because the “automobile use” exclusion did not bar coverage for her negligent modification claim. She argued that her injuries giving rise to the negligent modification claim did not derive solely from the insured’s negligent operation of his vehicle.

The First District disagreed with Perez, concluding the “automobile use” exclusion barred coverage for her negligent modification claim. In reaching its decision, the First District explained that no matter how negligent the insured was in modifying his vehicle, the modifications could not, on their own, proximately cause the injuries allegedly suffered by Perez without the actual operation of a vehicle. Stated differently, Perez could not have been injured by the insured’s negligent operation of the vehicle without the insured actually operating – *i.e.* using – the vehicle.

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Brown & James Participates in the St. Louis Internship Program



Chanel Goodson

The St. Louis legal community founded the St. Louis Internship Program following the 1992 Los Angeles riots to create summer employment for St. Louis City high school students entering their junior and senior years. Law firms participating in the program sponsor an eight-week internship that gives these high school students the opportunity to learn about the business world and the legal system and provides them with work experience, educational programs, and the professional and mentoring relationships, role models, and moral support that they need to achieve success after they graduate from high school.

Brown & James supports the lofty goals of the St. Louis Internship Program. Our firm’s intern this summer, Chanel Goodson, will graduate from Central Visual & Performing Arts High School in May 2011. Chanel has set her goal to become a lawyer or medical scientist and would like to attend college at Yale, Harvard, or Princeton. While participating in a 2009 debate tournament, Chanel received the second place award for best debater, a medal for the most speaking points, and a third place award for best debate partner. Chanel, in her private time, volunteers with the March of Dimes Program and at St. Louis Children’s Hospital. ■

Anti-Concurrent Causation Language Upheld in Claims Involving Multiple Causes of Loss

Kenneth R. Goleaner



The total extent of a loss and damage is caused by two different causes – one covered, and one not. Does the insurer owe?

Determining the existence of coverage in first-party claims necessarily involves determining the cause or causes of the insured's loss. This is complicated often times by the fact that many claims involve one or more "causes" that contributed to the resulting loss sustained by the insured. Specifically, issues often arise where one of the causes of the loss is a covered loss under a property policy, and one is not. As one state supreme court's decision recently made clear, this issue is often resolved by simply applying the plain language of the insurance policy. This decision is consistent with what appears to be Missouri law as well.

In *South Carolina Farm Mut. Ins. Co. v. Durham*, 671 S.E.2d 610 (S.C. 2009) (en banc), the South Carolina Supreme Court, as the majority of states have done, upheld "anti-concurrent causation" language in the property portion of a homeowners' policy. In *Durham*, a claim was submitted after a swimming pool floated out of its foundation following the draining of the

pool by the insureds. The trial court found that the cause of the loss was the insured's failure to remove the drain plug from the bottom of the pool before draining it, which resulted in the pool becoming dislodged from its foundation, and not from the presence of water underground. However, the Supreme Court held that the trial court applied the wrong analysis of the "cause" of the loss because "cause" in the context of an insurance policy is different from "legal causation." Instead, the Supreme Court concluded there were two causes of the loss – the insured's failure to remove the plug and the pressure of the underground water.

The South Carolina Supreme Court, in so ruling, noted the majority of jurisdictions (including Missouri) have adopted the "efficient proximate cause" doctrine. This doctrine provides that "[w]here a risk specifically insured against sets other causes in motion in an unbroken sequence between the insured risk and the ultimate loss, the insured risk is regarded the proximate cause of the entire loss, even if the last step in the chain of causation was an excepted risk." *Toumayan v. State Farm General Ins. Co.*, 970 S.W.2d 822, 825 (Mo. App. 1998). However, despite the doctrine's recognition

in South Carolina, and despite the fact that one of the causes of the loss was covered under the homeowners' policy, the South Carolina Supreme Court held there was no coverage for the loss.

The Supreme Court so held by enforcing the anti-concurrent causation provision that appeared in one of the exclusion sections in the policy. This clause provided that "[s]uch loss is excluded regardless of any other cause or event contributing concurrently or in any sequence of the loss." 671 S.E.2d at 512. Hence, the South Carolina Supreme Court held that insurers and insureds may agree to contract out of the "efficient proximate cause" doctrine and that the language set forth above is sufficient to do so. *Id.*

The *Durham* case is significant because it is the most recent confirmation by a state supreme court that anti-concurrent causation provisions in property policies, so long as they are unambiguous, are enforceable and can neutralize the "efficient proximate cause" doctrine that is the law in a majority of states. Though the Missouri Supreme Court has never specifically addressed the issue of anti-concurrent causation language in an insurance policy and its effect on the "efficient proximate cause" doctrine, courts applying Missouri law have issued essentially identical rulings as did the South Carolina Supreme Court in *Durham*. For instance, in the *Toumayan* case, the Missouri Court of Appeals held that the parties to the insurance contract successfully contracted out of the "efficient proximate cause" doctrine so as to exclude a loss caused by both earth movement (excluded cause) and a sewer backup (covered cause). 970 S.W.2d at 825-26.

When confronted with this issue, the key inquiry is the policy language itself. Traditional property policies have three categories of exclusions: those that have the anti-concurrent causation language, those that exclude loss resulting from a sole cause of loss, and those that exclude a specific cause of loss but provide for resulting loss. Hence, it is only those exclusions

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Illinois Court Clarifies Scope of the "Automobile Use" Exclusion in Homeowners and CGL Policies

Gregory Odom

Because Perez's alleged injuries derived from the negligent modification claim could only have occurred through the actual operation of the insured's vehicle, her claim fell within the policy's "automobile use" exclusion.

Overall, the *Perez* decision provides substantial guidance on the "automobile use" exclusion. For cases involving that exclusion, *Perez* clarifies that, where the injury giving rise to the claim could not have occurred absent the operation of a vehicle, the exclusion will bar coverage, even where the claim may

derive from conduct not directly related to the use of an automobile. That case also emphasizes the importance of obtaining coverage counsel for claims against a policy containing an "automobile use" exclusion. A careful analysis of the facts may reveal that, although the claim does not appear to arise from the use of an automobile on its face, the claimant's injuries could not have occurred but for the use of an automobile, thus triggering the exclusionary provision. ■

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Anti-Concurrent Causation Language Upheld in Claims Involving Multiple Causes of Loss

Kenneth R. Goleaner

that fall within the category of exclusions containing the anti-concurrent causation language that will allow an insurer to successfully exclude a loss that falls within the “efficient proximate cause” doctrine. Equally important is the requirement of plain and unambiguous policy language that contracts away the “efficient proximate cause” doctrine. As has been noted by the courts that have addressed the question, such provisions should contain language

excluding loss “caused directly or indirectly” by an excluded cause and “regardless of any other cause or event that contributes concurrently or in any sequence to the loss.” *Machecha Transport Co. v. Philadelphia Indem. Ins. Co.*, 2008 WL 851295 (E.D. Mo.). So long as such language is included in a policy, and so long as the exclusion at issue is included in the category of exclusions containing such language, courts in a majority of jurisdictions have had no

problem in concluding that an insurer and insured can contract out of the judicially-created “efficient proximate cause” doctrine.

Anti-concurrent language can be an effective tool for carriers in tailoring, however narrow or broadly, the coverage they intend to provide to their insureds based on how many of a policy’s exclusions a carrier decides to attach, or not attach, to anti-concurrent causation language. ■

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

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.

Fears v. Safeco Ins. Co. of Illinois. Butler County, Missouri. The plaintiff in this underinsured motorist claim recovered \$25,000 from the tortfeasor’s insurer. She then demanded the \$50,000 limit from her Safeco underinsured motorist policy, claiming multiple injuries, including acute onset back pain with lower extremity radiculopathy, mild annular disc bulges at L2-3, L3-4, and L4-5, chronic pain, and myofascial pain syndrome. On Safeco’s behalf, we challenged causation and argued that the plaintiff had already been compensated in excess of the value of the claim. At trial, the plaintiff asked the jury to return a \$100,000 verdict. However, the jury returned a defense verdict for Safeco. Tried by Marty Clay.

Mitzan vs Western Heritage Insurance Co. United States District Court, Eastern District of Missouri. Equitable garnishment action asserting the defendant insurer

had coverage for a \$5 million judgment in a wrongful-death, dram-shop claim against a night club, where the drunk driver consumed over fifteen alcoholic drinks. Western Heritage wrote a CGL policy on the night club that included a liquor liability exclusion. The district court granted summary judgment for the Western Heritage, holding the liquor liability exclusion was unambiguous and did not create illusory coverage. Tried by Russ Watters and Patrick Bousquet.

Wesling v. Mel Malone. St. Clair County, Illinois. The trial court dismissed Brown & James’ client as a matter of law. An eight-year-old child was killed when a car crashed through the Shiloh, Illinois elementary school. The plaintiff brought claims against the general contractor and subcontractor who built the wall involved in the collision, as well as the school district and the manufacturer of the wall system. The plaintiff claimed the wall’s construction was inadequate. Following discovery, the trial court granted the defendant’s motion to dismiss. Tried by John P. Cunningham and Denise Baker-Seal.

Kenneth Wilson v. David Fults. St. Clair County Circuit Court. The defendant rear-ended the plaintiff after the plaintiff stopped because of a deer in the road. The defendant argued the sudden stop defense and contested whether the plaintiff was injured. The plaintiff claimed \$8,000 in medical specials and \$1,400 in lost wages. An arbitration panel previously awarded \$19,000 as part of mandatory arbitration process. Following the

arbitration and before trial, the plaintiff’s demand was \$16,000; the defense having offered \$13,000. The jury found comparative negligence on the plaintiff’s part and awarded only \$2,450. Tried by John P. Cunningham.

State Auto v. Northern Harvest. United States District Court, Central District of Illinois. The court granted summary judgment for Brown & James’ client in a property damage claim arising out of a fire at a furniture facility. Our client denied the claim because the insured failed to keep its sprinkler system in proper working order, as required by the policy. The insured claimed damages in excess of \$5 million. The court granted our summary judgment motion, finding the sprinkler system was not in proper working order and, therefore, finding no coverage for the loss. Tried by John P. Cunningham and Daniel G. Hasenstab.

Paul Rinderer v. Safeco Ins. Co. of America. St. Louis City. The plaintiff, in this underinsured motorist case, recovered \$25,000 from the tortfeasor’s insurer and then sought an additional \$90,000 from his underinsured motorist insurer, claiming S1 radiculopathy and L5-S1 disc herniation. On Safeco’s behalf, we challenged medical causation and alleged pre-existing degenerative disc disease. The jury returned a defense verdict for Safeco. Tried by Marty Clay.

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Medicare Liens – An Overview and Update Part II

Christine A. Vaporean

Effective July 1, 2009, the notice requirements imposed on liability, no-fault, and workers' compensation insurers (a non-GHP primary payer) became more comprehensive and stringent under the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"). The relevant section, Section 111, requires non-GHP insurers: (1) to determine whether a claimant, including one with an unresolved claim, is entitled to Medicare benefits; and if so, (2) to submit the claimant's identity and other information necessary to allow the Secretary of Health and Human Services to make a determination regarding the coordination of benefits, "including any applicable recovery claim." Thus, all primary payers must identify individuals for whom Medicare has made a payment for which Medicare might be eligible for reimbursement and to promptly notify Medicare of its reimbursement right. An insurer's failure, as a "Responsible Reporting Entity" ("RRE"), to comply with this requirement carries a penalty of \$1,000 per day.

The Code of Federal Regulations and the Centers for Medicare and Medicaid Services ("CMS") outline the information that RREs must report to Medicare. This information includes the circumstances of their primary payment responsibility, including the type of insurance, and the time period for which coverage applies. The MMSEA regulations generally divide Medicare Secondary Payers ("MSP") into "pre-payment" and "post-payment" activities. Pre-payment activities are intended to stop Medicare from mistakenly making primary payments when it should be the secondary payer. Post-payment activities are designed to recover mistaken or conditional payments when a non-GHP insurer settles a case or pays a judgment.

MMSEA requires RREs to provide data to CMS's Coordination of Benefits Contractor (COBC). RREs must perform all required reporting electronically. They are required to register with COBC through a secure website. Once registered, RREs receive a data reporting regimen. Data collection frequency will be no more than quarterly. No-fault insurers and workers' compensation plans for non-contested claims are required to report data on an ongoing basis. Non-GHP RREs involved in contested

claims are required to submit reports on a one-time basis when a single settlement or judgment is paid. Additional information concerning these reporting requirements is available at www.cms.hhs.gov/mandatoryinsrep/.

The Mandatory Insurer Reporting Requirements outline the additional information that CMS requires of RREs. This mandatory information includes: (1) the identity of the injured party, including specific identifying information; (2) the identity of the claimant; (3) information on the primary plan, including type of insurance and other specific data; (4) the identity of the policy holder; (5) the identity of the plaintiff's attorney; (5) information about the incident giving rise to the claim; and (6) the manner of claim's resolution, including how a settlement or judgment is funded.

The new rules under MMSEA require insurers to report every payment they make to plaintiffs and provide sufficient information to allow CMS to track down and recover the monies that should have gone to satisfy the government's lien. These rules will make it virtually impossible for parties to fail to satisfy a Medicare lien in the future.

MEDICARE SET ASIDE TRUST PROVISIONS – NOT JUST FOR WORK COMP ANYMORE?

Regulations addressing the overlap between Medicare payments and workers' compensation payments mandate that lump-sum settlements in workers' compensation cases allocate a portion of the payments for future medical care. If a settlement includes a release for future medical care but no funds are specifically allocated for future care, Medicare does not make a payment until the medical expenses for the related injury equal the amount of the *entire lump-sum payment*.

On the other hand, if funds are allocated for future care, Medicare will pay for the beneficiary's health care service once the medical expenses equal the amount *allocated for future care*. Thus, in such cases, the beneficiary does not have to spend the entire settlement before Medicare resumes payments. In such cases, the funds allocated for future medical care are deposited into a Set Aside Trust subject to

CMS regulations and guidelines. In short, the Set Aside Trust arrangement satisfies Medicare's right to recover overpayment from the settlement.

No such regulations exist for no-fault or liability insurance payments even though the enabling legislation for both is the MSP Act. Because the statutory basis is the same, Medicare has taken the position that the lack of a formal set aside program for liability settlements does *not* absolve a primary payer from the obligation to ensure that Medicare remains a secondary payer. It is anticipated the new reporting requirements under MMSEA may prompt CMS to create a Set Aside Program for non-workers' compensation settlements, although MMSEA does not speak to the Set Aside Trust requirements.

Set Aside Trusts have been utilized in certain non-workers' compensation cases for some time. The current debate pertains to whether and to what extent parties to a settlement in a civil liability case must comply with the set aside provisions to preserve a beneficiary's future Medicare coverage and, at the same time, relieve their obligation to satisfy a Medicare lien. To be on the safe side, parties should always designate a portion of any settlement for future medical care in high-dollar cases and cases involving small sums, but where a specific element of future care has been identified.

In calculating the amount to set aside, only those reasonable medical expenses that are covered by Medicare should be included. Set aside funds should not be used to pay for expenses not ordinarily covered by Medicare. The Code of Federal Regulations details the method for calculating the amount apportioned for future medical payments in workers' compensation cases. This formula can be applied to non-workers' compensation cases as well.

Given the budget issues facing the federal government and the percentage of the budget devoted to Medicare payments, insurers and their counsel must anticipate that the CMS will seek to minimize its financial burdens to every extent possible. Thus, although not currently mandated by federal law, consideration should be given to the need for a set aside trust in every case involving a Medicare beneficiary claiming future medical care as an element of damages. ■

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Illinois Dramshop Act is Strict, but Limited

Daniel G. Hasenstab

set amounts. The liability limits are adjusted each year on January 20th, based on the consumer price index. The limits, as adjusted on January 20, 2009, are \$58,652.33 for claims of personal injury or property damage, and \$71,686.18 for claims of loss of society or loss of support.

At trial, the jury is not instructed on the statutory limits. Rather, the court instructs the jurors to return a verdict for the full amount of damages they believe the plaintiff is entitled to, and if the damages exceed the statutory limits, they are reduced by the court accordingly.

When one considers the types of injuries that are often inflicted by intoxicated persons, particularly drunken drivers, it is easy to see how the advantages of the statutory damage limits often outweigh the drawbacks of the statute's strict liability.

The statutory damage limits apply separately to each category of injury. The personal injuries suffered by one person and the loss of society suffered by that person's family members are considered separate injuries under the law. Thus, an injured plaintiff can recover the maximum for his or her own personal injury, and, on top of that, his or her family members may recover the statutory maximum for loss of society. Also, medical expenses are considered an element of personal injury if incurred by the injured party, but are considered damage to "property" if they are incurred by someone else, such as a spouse, who is obligated to pay the bills.

This treatment of damages under the Act can lead to bizarre results. For example, a critically injured single plaintiff with no family can never collect more than the

personal injury limit (currently \$58,652.33). However, a married plaintiff could recover up to \$58,652.33 for his own pain and suffering, while his spouse could recover up to an additional \$58,652.33 for payment of her husband's medical bills, plus an additional \$71,686.18 for loss or support or loss of society. This sum would result in a total potential recovery of \$188,990.74, more than triple the amount available to the unmarried plaintiff.

The unique nuances of the Illinois Dramshop Act can, and often do, create pitfalls for attorneys who are unfamiliar with this particular area of practice. Thus, a liability insurer faced with a suit filed under the Illinois Dramshop Act would be well-advised to seek representation from a law firm, such as Brown & James, which has substantial experience in defending Illinois dramshop claims. ■

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Metal Bat Injuries and Assumption of the Risk in Sports Injury Cases

Edward W. Zeidler, II

recovery for goalie); *Chaney ex. rel. Chaney v. Creten*, 658 S.W.2d 891 (Mo. Ct. App. 1983) (risk of falling and colliding with other skaters was inherent in skating activity and plaintiff assumed that risk); and *Thompson v. Sunset Hills Country Club*, 227 S.W.2d 523, 525 (Mo. Ct. App. 1950) (golf spectator injured by rock hidden in grass assumed risk inherent in walking golf course to observe match). Due to its exculpatory effect, the primary assumption-of-risk defense is a valuable weapon with which to combat personal injury claims arising in the context of sporting events. However, this defense is not always a viable one because it depends entirely on the court's opinion as to what risks are inherent in various sporting activities.

In *Bennett v. Hidden Valley Golf & Ski, Inc.*, 318 F.3d 868 (8th Cir. 2003) (applying Missouri law), the Eighth Circuit of the United States Court of Appeals recognized that the lower Missouri courts have spoken inconsistently on whether application of the assumption-of-risk defense is conditioned on the plaintiff's actual knowledge and appreciation of the risk as well as whether the

risk itself was inherent in the sport. In *Bennett*, a sixteen-year-old girl was injured when she fell over a "bump" while skiing down a hill at the defendant's establishment. The plaintiff argued that assumption of risk could not be submitted to the jury because she did not have actual knowledge of the "bump" that caused her fall. After examining the decisions of the Missouri Supreme Court, the Eighth Circuit observed that the Missouri Supreme Court has analyzed primary assumption of risk by focusing on whether the risk was incidental to or inherent in the plaintiff's activity, rather than on the plaintiff's subjective knowledge of the risk. Thus, a defendant owes no duty to protect an athletic participant from risks inherent in or incidental to an activity, regardless of whether that participant was actually aware of the risk.

The express assumption-of-risk defense is most commonly and effectively implemented through obtaining a proper waiver and release from an athletic participant before that participant's engagement in the activity at issue. Exculpatory clauses contained in release agreements that exonerate a party from acts of future negligence are not against

public policy in Missouri and are valid and binding on the parties as long as they are specific to the conduct involved. *Hornbeck v. All American Indoor Sports, Inc.*, 898 S.W.2d 717 (Mo. Ct. App. 1995). While these clauses are permissible, care must be taken in their drafting because they will be strictly construed against the party claiming the clause's benefit. An exculpatory clause to exonerate a party from that party's future negligence must be clear and unambiguous. *Hornbeck*, 898 S.W. 2d at 721-22 (clause releasing operator of indoor soccer arena from "any and all claims of any kind" was too general and not effective to release operator from liability based on operator's own negligence).

Assumption-of-risk defenses have traditionally represented the first layer of defense in sports injury cases. These defenses will be undoubtedly challenged and explored with renewed fervor as metal bat cases wind their way through the Missouri court system. As these cases do so, we will keep you posted on the development of the assumption-of-risk defense under Missouri law. ■

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Missouri Decision Limits Remedies for Asserting Workers' Compensation Exclusivity Defense

Kenneth R. Goleaner

its lower courts that they “should confine their discussions of circuit court jurisdiction to constitutionally recognized doctrines of personal and subject-matter jurisdiction” since “there is no third category of jurisdiction called ‘jurisdictional competence.’” *Id.* at 254.

In applying the Supreme Court’s analysis, the Southern District in *McCracken* held the trial court erred because Wal-Mart’s subject-matter jurisdiction motion was not premised on any constitutional challenge, but on Section 287.120. 2009 WL 464860 at *1-2. Despite acknowledging that the plaintiff may still be unable to recover a judgment against Wal-Mart due to Section 287.120, the court held that Section 287.120 could not deprive the trial court of its constitutionally-granted, subject-matter jurisdiction.

Assuming the rule in *McCracken* is not reversed by the Missouri Supreme Court, the significant practical effects of the *McCracken* decision should be noted. The obvious effect is

that the exclusive remedy defense is no longer a subject-matter jurisdiction defense and will now likely have to be asserted as a motion to dismiss for “failure to state a claim upon which relief can be granted.” While this change may seem to be a benign one, the change is quite significant in several ways. First, as the Southern District in the *McCracken* case noted, the burden of proof is much higher on a motion to dismiss for failure to state a claim than it is in a motion claiming lack of subject-matter jurisdiction. For instance, where subject-matter jurisdiction has been challenged, courts are generally not confined to the allegations in the plaintiff’s petition. In contrast, a court in considering a motion to dismiss for failure to state a claim must accept as true all facts alleged by the plaintiff. Hence, it is almost certain that fewer cases where workers’ compensation exclusivity is an issue will be dismissed by way of a motion to dismiss, which means that some of the cases

that would have likely been disposed of for lack of subject-matter jurisdiction will now likely stick around until at least the summary judgment stage of the litigation.

Another significant difference is that the workers’ compensation defense can no longer be raised for the first time at any time in the litigation and can now be waived if not pleaded as an affirmative defense. Because it cannot be asserted as a subject-matter jurisdiction defense, the defense based on workers’ compensation exclusivity must now be raised as an affirmative defense in a defendant’s responsive pleading. As noted above, however, it still can be raised through a motion to dismiss for failure to state a claim, but it is likely that fewer of these motions will now be granted because a prudent plaintiff’s attorney should be able to artfully plead a petition with allegations sufficient to withstand a motion to dismiss. For instance, in a case against a fellow employee where the petition contains allegations referencing the “something more” referred to in the Workers’ Compensation Act as one of the exceptions to the exclusivity provision, it now appears somewhat unlikely that such a case will be dismissed for failure to state a claim.

While the true effects of this major change in Missouri law remain to be seen – how trial courts will deal with workers’ compensation exclusivity cases and the heightened burden of proof that a defendant now bears is unknown – it is almost certain that fewer of these cases will now be dismissed at the motion to dismiss stage and that such cases will now be more expensive to successfully defend.

For the future, we may know whether the Missouri Court of Appeals correctly interpreted the Missouri Supreme Court’s precedent in limiting the mechanism for asserting the exclusive remedy defense. On May 5, 2009, the Missouri Supreme Court granted transfer in the *McCracken* case. The Supreme Court will now have the last word on this question. As soon as the Supreme Court hands down its decision, we will report in *The Firm Inquiry* the decision’s impact on the exclusive remedy defense. ■

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Illinois Clarifies Meaning of “Separate Occurrences” in Insurance Policies

David M. Wilkins

and space as to be considered by the average person as one event, then the injuries will be deemed to be the result of a single occurrence.” The Illinois Supreme Court, in *Addison*, held the “time and space” test was an appropriate tool for a court to use when interpreting whether a single or multiple occurrences occurred. While this was the correct approach, the Court observed that the evidence produced by both the insurer and the claimants was insufficient to establish how closely in time the two boys became trapped and died. As a result, the Illinois Supreme Court reversed the appellate court, and reinstated the trial court’s ruling.

In actions addressing whether an injury or loss triggers a single or separate occurrences, courts hold that the insurer must produce evidence that the time and space of the two losses or injuries were closely linked together, enough to trigger a single occurrence instead of multiple ones.

The lesson from *Addison* is that, while Illinois courts have adopted the “cause theory,” recent rulings show a trend to limit the theory, which often produces the same results as if the courts adopted the “effect theory.” It is often up to the insurance carrier and defense counsel to develop the facts of the case in a way to clearly indicate that the injuries stemmed from a single act of negligence to prevent a court from finding multiple occurrences. ■

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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UPDATE: Statutory Presumption Governing the Recovery of Medical Expenses in Personal Injury Cases Declared Unconstitutional

We addressed, in the last issue of *The Firm Inquiry*, the impact of Section 490.115.5, R.S.Mo. Cum. Supp. 2005, on the recovery of medical expenses in personal injury cases. The Missouri General Assembly enacted Section 490.115.5 to resolve the anomaly created by the advent of managed care and the payment of medical insurance reimbursements at rates less than the sums actually charged by health care providers.

The disparity between medical bills and the sums paid for medical services often gave rise to “windfall” recoveries in Missouri personal injury cases. In many cases, the damages awarded bear no relation to the sum actually paid by the claimants or their insurers for the medical treatment received. Health care insurers typically reimburse physicians at highly discounted rates, often at rates as low as thirty to fifty percent of the amounts charged.

The Missouri General Assembly’s remedy to prevent “windfall” recoveries, as codified under Section 490.115.5, created a rebuttable presumption that the sum necessary to satisfy the financial obligations owed by plaintiffs to their medical providers represents the

reasonable value of the medical treatment received. In other words, evidence of the amount of the plaintiff’s *paid* medical bills establishes a presumption of reasonableness that the plaintiff may rebut with other evidence.

Since the statute’s enactment, the application of this presumption in personal injury cases has been hotly disputed by the plaintiffs’ bar. Recently, the battle over Section 490.115.5 reached a new stage. A St. Louis County trial judge, in granting a plaintiff’s motion for a new trial, declared Section 490.115.5 to be unconstitutional.

The Honorable Stephen Goldman found the statute’s procedure for determining the reasonable value of medical care vague and a violation of the due process clauses of the United States and Missouri constitutions. Judge Goldman rendered his ruling in a personal injury lawsuit arising out of a motor vehicle accident.

The plaintiff claimed, as his damages, reasonable medical expenses of \$86,027.93. However, during pre-trial proceedings, Judge Goldman sustained the defendant’s motion *in limine*, finding under the statutory presumption

that the reasonable value of the plaintiff’s medical bills, based on the sum actually paid, was \$51,544.90.

Following a jury verdict for the plaintiff for a sum of only \$25,772.45, Judge Goldman reversed himself and awarded the plaintiff a new trial. In so ruling, Judge Goldman declared Section 490.115.5 unconstitutional. In support, he noted the plaintiff had argued in his motion for new trial that his treating neurosurgeon had rebutted the presumption that the amount paid, \$51,544.90, was the reasonable value of his medical care.

Judge Goldman’s decision will likely pave the way for the final battle over Section 490.115.5 and the statutory presumption governing the recovery of medical expenses. We anticipate the defendant will appeal Judge Goldman’s ruling. The ensuing appeal should give the Missouri Supreme Court the opportunity to decide this contested question once and for all. As further developments occur in the battle over Section 490.115.5, we will report them in *The Firm Inquiry*. ■