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News

Decision to Discharge Patient Appropriate and Medical Malpractice Prelitigation Screening Panel Not Equivalent to Trial

By Matthew T. Mehalic, Esq., CPCU

In *Randy N. Oliver, II et al. v. Eastern Maine Medical Center*, 2018 ME 123 (August 21, 2018), the Law Court addressed whether EMMC was negligent when it discharged an individual despite contrary instructions given by the individual's limited guardians to the hospital. The Superior Court entered judgment in favor of EMMC and the Law Court affirmed holding that EMMC was not negligent.

The case arose out of the hospitalization of an individual, Randy Oliver. Randy was found severely intoxicated at his home and was taken to EMMC by his daughter and his ex-wife. The conditions of Randy's home were unsanitary, there was no running water, and there were a number of fire hazards. Randy was admitted with diagnoses of liver-related brain damage, possible alcohol withdrawal, deterioration of functional status, and a neglected state. He also had burns on his hands. The day after his admission, a psychiatrist conducted an evaluation of Randy, at which Randy expressed that he did not understand why he was at the hospital. The evaluation concluded that Randy's alcohol addiction was potentially lethal, that he suffered from significant cognitive impairment, and that a guardian might need to be appointed. About a week later another evaluation was performed by a neuropsychologist that concluded that Randy lacked the capacity to manage simple or complex finances independently or make informed decision about his health.

Randy's son and daughter filed a petition with the Probate Court to be appointed Randy's co-guardians. After a hearing Randy's son and daughter were appointed as co-guardians. However, the appointment was limited in that the guardians were authorized to "act only as necessitated by [Randy's] actual mental and adaptive limitations or other conditions warranting this procedure." *Id.* at ¶ 9.

Over the course of Randy's two month hospitalization his condition improved and he expressed that he wanted to leave the hospital. Another neuropsychological evaluation was performed. The evaluation indicated that Randy was alert, friendly, pleasant, and very cooperative. Randy was noted as "strikingly different" from the earlier evaluation. It was concluded that Randy had the capacity to "manage simple or complex finances independently" and "make better informed decisions regarding his health." *Id.* at ¶ 10. Randy had also indicated that he planned to quit drinking.

Based on the evaluation, EMMC concluded that Randy "no longer needed acute medical care and that the hospital was possibly holding him there against his will." *Id.* at ¶ 11. Randy's son and daughter, his limited guardians, disagreed with the evaluation findings and disapproved of Randy's discharge from the hospital. EMMC offered to have another evaluation performed by another practitioner, but the guardians informed EMMC that they did not want another evaluation. EMMC ultimately discharged Randy based on the Probate Court's order providing limited guardianship to Randy's son and daughter only where Randy was unable of making decisions and Randy's request to be discharged. When Randy was discharged a plan was generated that included a referral to Randy's primary care provider, a pain clinic, community case management, and a recommendation to participate in substance abuse treatment. Randy's son and daughter were informed by EMMC of Randy's discharge on the date of discharge.

Randy's son and daughter visited Randy twice over the course of the night and when they left him the last time he was intoxicated. Randy died later that night as the result of a fire.

Randy's son and daughter, individually and as personal representatives of the estate filed a complaint in the Superior Court against EMMC based on negligence for breach of the standard of care. Judgment was entered in favor of EMMC. An appeal was filed by Randy's son and daughter.

The issues raised on appeal were whether the Superior Court erred in: (1) "concluding that the Probate Court's guardianship order did not preclude EMMC from discharging Randy, given the contrary instructions they had given in their capacity as Randy's court-appointed guardians"; (2) "concluding that Randy had regained capacity to make the decision to be discharged"; and (3) "concluding that EMMC's discharge plan was reasonable." *Id.* at ¶ 26.

With regard to the first issue, the Law Court held that the Superior Court was correct in concluding that the Probate Court guardianship order did not preclude EMMC from discharging Randy. The guardianship order was a limited guardianship order, pursuant to 18-A M.R.S. § 5-105. This section allows appointment of a guardian with fewer than all of the legal powers and duties of a guardian. In addressing healthcare decisions, per the Probate Code, the limited guardian is to make decisions in accordance with the ward's individual instructions when the ward has capacity. *See* 18-A M.R.S. § 5-312(a)(3). Furthermore, the healthcare provider, per the Uniform Healthcare Decisions Act contained within the Probate Code, is to presume capacity and when capacity is lacking if the individual regains capacity the healthcare provider is to communicate the determination to the patient and any other person authorized to make decisions on behalf of the patient. Because of the determination by the healthcare provider that Randy had regained capacity and because of the limited scope of the Probate Court guardianship order, EMMC was not precluded from discharging Randy.

In regards to the second issue, the Court concluded that EMMC met the standard of care involved in concluding that Randy regained capacity. Having the same neuropsychologist evaluate Randy upon the initial admission and almost two months later in order to compare the condition of Randy met the standard of care. Also, the other EMMC providers that had interacted with Randy during his hospitalization also concluded that he had regained capacity. The medical records supported Randy's improvement and regaining of capacity. The expert witnesses called by EMMC to testify also supported that the EMMC met the standard of care for evaluating whether Randy had regained capacity to make the decision to be discharged.

Finally, with regards to the third issue, the Court concluded that the discharge plan was safe and reasonable. Appointments were scheduled for Randy to a pain clinic and his primary care physician. Information was provided for case management services. EMMC also gave strong recommendations that Randy stop drinking, attend group meetings, and EMMC even offered substance abuse counseling. Randy's acknowledgment that he needed to stop drinking was evidence that the discharge plan was appropriate. Therefore, the discharge plan was held to be safe and reasonable and not negligent. Judgment in EMMC's favor was affirmed.

Another issue involved in the appeal, was whether the Superior Court had erred when it refused to award EMMC its expert costs incurred during the medical malpractice prelitigation screening panel process. Title 14 M.R.S. § 1502-C allows the courts within their discretion to award reasonable expert witness fees and expenses as allowed under 16 M.R.S. § 251. Section 251 provides in pertinent part, "The court in its discretion may allow at the trial of any cause, civil or criminal, in the Supreme Judicial Court, the Superior Court or the District Court, a reasonable sum for each day's attendance of any expert witness or witnesses at the trial." Due to the confinement of section 251 to "trial" in a court, the Law Court held that the prelitigation screening panel proceeding was not a "trial" that permitted the courts to award expert witness fees and expenses incurred in the panel proceeding.

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No Liability Coverage Under Homeowner's Policy for Premeditated Assault

By Matthew T. Mehalic, Esq., CPCU

In *Vermont Mutual Insurance Company v. Jonathan Ben-Ami, et al.*, 2018 ME 125 (August 21, 2018), the Law Court addressed whether the expected or intended injury exclusion applied where an individual carried through a premeditated attack on another. James Poliquin, Esq. of Norman, Hanson & DeTroy, LLC represented Vermont Mutual on this claim and successfully argued that the exclusion applied.

The case arose out of Joshua Francoeur's attack on a fellow high-school student, Jonathan Ben-Ami. The two individuals had a verbal altercation at a football game several days before the attack. Francoeur was encouraged by his friends to plan an attack on Ben-Ami. During the school day, Francoeur went to Ben-Ami's classroom. The door to the classroom was locked, but Francoeur was able to convince the teacher to open the door. Francoeur went up behind Ben-Ami who was wearing headphones and punched him repeatedly in the face resulting in injuries and a broken jaw.

Francoeur's father had a homeowner's policy with Vermont Mutual. The policy included an exclusion for expected or intended injury which provided in pertinent part that coverage was excluded for "bodily injury . . . which is expected or intended by the insured." *Id.* at ¶ 12. Ben-Ami filed a complaint against Francoeur and Vermont Mutual provided a defense under a reservation of rights based on the expected or intended injury exclusion and on other grounds not addressed by the Law Court on appeal. Eventually, Ben-Ami and Francoeur agreed to a stipulated judgment with a covenant not to execute against the personal assets of Francoeur. Ben-Ami proceeded solely against any liability coverage that was provided under the Vermont Mutual policy. Vermont Mutual filed a declaratory judgment action on the basis of the application of the exclusion, among other reasons, and Ben-Ami filed a reach-and-apply action against Vermont Mutual. The two matters were consolidated.

The Superior Court denied Vermont Mutual's motion for summary judgment and held a bench trial on the applicability of the expected or intended injury exclusion and ruled in favor of Ben-Ami. The Superior Court did not conclude that Francoeur "subjectively intended to inflict the level of damage that ultimately was inflicted upon Mr. Ben-Ami in the form of his broken jaw." *Id.* at 6. Furthermore, the Superior Court determined that, "Mr. Francoeur's testimony that he did not consider the consequences of his action or consider the likelihood that his punching of Mr. Ben-Ami would produce a serious injury [was] credible." *Id.* Vermont Mutual appealed the Superior Court's decision.

The Law Court framed the dispositive issue as "whether the evidence compelled the court to find that Francoeur either "intended or expected" bodily injury to Ben-Ami, which would trigger the exclusion." *Id.* at ¶ 14. The Court determined that the evidence did compel such a finding.

Crucial to the Courts determination were the following facts:

> Francoeur and Ben-Ami had had a hostile verbal encounter several days earlier; Francoeur then developed a plan to attack Ben-Ami; in execution of that plan, Francoeur left his classroom and proceeded to another classroom where Ben-Ami was present; Francoeur induced the teacher to unlock the door in order to allow him into the classroom; Francoeur approached Ben-Ami from behind so that Ben-Ami, who had

> headphones on, was "likely unaware" of the imminent attack; Francoeur punched Ben-Ami about the face with a closed fist "multiple times"; and, as the direct result of the assault, Ben-Ami sustained serious injuries, including a broken jaw.

Id. at ¶ 15. The Court could not rectify these facts with the Superior Court's findings that Francoeur did not consider the consequences of his action or did not subjectively intend the extent of damage he could, and did, cause. "Given the premediated nature of the assault, the ambush tactic that Francoeur used, and the location and magnitude of the resulting injuries, the evidence compelled the court to find, at the very least, that Francoeur must have subjectively foreseen as practically certain (i.e., expected) that his deliberately violent conduct would result in bodily injury to Ben-Ami." *Id.* at 17.

Despite the Court's decision in favor of Vermont Mutual, the Court refused to categorically hold that an assault, as that at issue in the matter, always fell within the expected or intended exclusion without consideration of the subjective intent or expectation of harm of the perpetrator, as was requested by Vermont Mutual.

In a concurring opinion, Justices Mead, Alexander and Jabar, three of seven Justices on the panel, agreed with the Court's entry of judgment in favor of Vermont Mutual, but wished that the Court had gone further, as requested by Vermont Mutual. "I would go further and conclude that this factual scenario – the intentional striking of an unsuspecting person in the face with a closed fist – leads to a conclusion that as a matter of law the physical injuries resulting from the attack were intended and expected." *Id.* at ¶ 25. The concurring Justices wished to do away with an examination of the subjective intent of the perpetrator under these circumstances when determining if the expected or intentional injury exclusion applied.

Medicare Set-Asides: Are You Paying Too Much?

By: Stephen Hessert

Background

Medicare came into being in 1935 as part of the original Social Security Act enacted by Congress. It was described as "a federally funded health insurance program for the elderly and the disabled." Over the years, its cost became problematic and in the late 1970s, a General Accounting Office study suggested that forty-one billion dollars of Medicare benefits were being used to subsidize other insurance programs such as workers' compensation and liability insurance. Consequently, in 1980, Congress passed the Medicare Secondary Payor Act which required beneficiaries to exhaust all other health insurance options before Medicare would pay benefits. Those other options include insurance for workers' compensation, liability, auto etc. The Act provided that Medicare would make "conditional payments" and provide benefits if the other carriers initially denied liability, but it is required that Medicare be repaid if other benefits are found to be applicable.

In the workers' compensation arena, a Medicare set-aside arrangement (MSA) is necessary to account for the future medical component of the primary payor's responsibility. MSAs are the tool used to account for the future medical expense associated with injuries, in order to avoid shifting responsibility for future medical from the primary payor to the Medicare system. This article will briefly touch on two separate issues. The first will be to describe the appeal process for dealing with contested conditional payments. The second will deal with the question of whether too

much is being set-aside in providing for Medicare's future interests.

Conditional Payments

Conditional payments are made by Medicare based upon diagnosis codes. The Centers for Medicare and Medicaid Services (CMS) will attribute certain diagnosis codes to an injury. In workers' compensation, it will depend upon the diagnosis of the injury, but will also include any payments for any diagnoses that are made voluntarily and without prejudice. These potentially unrelated codes/conditions become part of the liability for the work injury in Medicare's point of view.

Once liability for a primary payor is "demonstrated" by either an acceptance of liability or by settlement of the claim, conditional payments must be addressed. The parties should request that the case be put into the "final conditional payment process" which notifies the CMS Benefit Coordination and Recovery Center that the case is within 120 days of settlement. A request may be made for a final conditional payment amount within three business days of settlement via the Medicare Secondary Recovery portal. Once you have that amount, the question becomes whether it is an accurate description of the medical costs of the consequences of the actual injury, or whether it includes other treatment for which there should be no liability, either in a liability case or in the workers' compensation arena.

Appeal Process

The law is now clear that workers' compensation administrative bodies and state courts lack subject matter jurisdiction over Medicare Secondary Payor (MSP) reimbursement disputes that have not been fully exhausted through the mandatory Medicare appeal process. Any challenge to MSP's entitlement "arises under the Medicare Act" and the appellant, or the Medicare enrollee, must first proceed with an administrative appeal prior to any judicial review. *See, e.g., 42 U.S.C. §405(g-h) §1395w-22g5; 42 C.F.R. §422.560-422.612.* That appeals process has five steps:

1. The parties must appeal the conditional payment demand letter within thirty days.
2. The appealing party will receive an independent outside entity review (qualified independent contractor) that contracts with CMS to do this work.
3. If the result from the independent qualified contract review is unfavorable, an Administrative Law Judge hearing may be requested.
4. If the Administrative Law Judge hearing produces an adverse result, the party may appeal to a Medicare Appeal Council, if the ruling is adverse to the appellant and exceeds a threshold amount ($1,000).
5. Finally, if the ruling is still adverse, an appeal may be made for federal judicial review, to the Federal District Court in the appropriate jurisdiction. From there, an appeal can be taken to the Circuit Court of Appeals and possibly to the United States Supreme Court.

The important point is that absent a timely utilization of this appeal process, there is no possibility of attacking the issue of whether a conditional payment was, in fact, for the workers' compensation injury or automobile accident in question in any state proceeding, or whether other defenses such as the statute of limitations are available. Any factual issues will be resolved either through the initial administrative steps of the appeal process, or before the Administrative Law Judge.

Are You Paying Too Much?

Accounting for Medicare's interests for future medical expense for an injury is a well-developed process in workers' compensation. CMS has established work review thresholds of $25,000 for a current Medicare beneficiary, or $250,000 and the potential that the Medicare beneficiary is likely to become enrolled in Medicare within thirty months, for workers' compensation cases. If those thresholds are met, CMS will review a future MSA proposal and will provide an opinion that the parties can rely upon in settling their case. This conventional practice of submitting an MSA proposal to CMS for review and approval, which is entirely voluntary, predictably inflates costs and over burdens claim payors. In 2017 alone, some 26,000 claims had an average of about $93,000 each set aside as funds to reimburse Medicare for future medical treatment. Care Bridge International, a vendor that does work on MSAs recently did a study focusing on the actual spending on behalf of an injured worker for the first five years post MSA report approval. Their finding was that in the fifth year post settlement, the pace of medication spending was 64% of the forecast and 55% for all other medical care. In another study, they analyzed a huge database of eight million non-settled workers' compensation claims noting the medical spending for up to eleven years after injury.

Why the inflated numbers?

1. Medicare requires that medications be priced unrealistically high at RED BOOK average wholesale price. Most claims payors pay for drugs with pharmacy benefit managers and arrange for prices that are up to 35% lower.
2. Medicare unrealistically requires that medications be budgeted unaltered for the projected life of the worker. There is no scientific assurance that this will be the case.
3. Medicare requires that treatment the worker is receiving or has planned, as of the time of settlement, will continue but, in reality, treatment evolves as patients adapt.

MSA vendors are learning this and using it to their advantage. There are several vendors who now will produce an MSA proposal and recommend that it not be submitted to CMS regardless of whether it falls within the work-review threshold. Those vendors offer to stand behind their proposal and take over and pay if CMS rejects their analytics and if, in fact, payment exceeds the amount proposed. It is my understanding that they are developing or utilizing an insurance product for this purpose. Moreover, in some states, MSAs that are structured are being negotiated with consideration given to making the beneficiary the insurance carrier or the self-insured employer, rather than the claimant's estate. These products are new to the market, but should be considered as potential cost savings can be significant.

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WC Appellate Division Decision issued on June 14, 2018 – Average Weekly Wage

Average Weekly Wage

The employee was employed by the same employer for 52 weeks prior to a December 17, 2014 injury, but for approximately 13 of those weeks she was out of work for non-occupational reasons and received STD benefits which were substantially lower than her customary weekly earnings. The ALJ determined the average weekly wage by excluding the weeks on which the employee was out of work on medical leave and averaging the remainder. The employer appealed to the Appellate Division.

In *Thibeault v. Twin Rivers Paper Company, LLC*, Me. W.C.B. No. 18-20 (App. Div. 2018) the Division ruled that the STD benefits were not analogous to vacation pay and should not be included in the wage calculation. The Division found that during the period in which the employee had been taken out of work by her physician she received no wages, earnings, or salary. The Division found that including the weeks of STD benefits would artificially deflate the average weekly wage and would not fairly compensate the employee for the loss of earning capacity.

Accordingly, the Division found that the ALJ had properly excluded from consideration the weeks in which the employee did not work and had correctly calculated the average weekly wage.

WC Appellate Division Decision issued on May 14, 2018 – Statute of Limitations

Statute of Limitations

Ten years ago the Law Court ruled in *Wilson v. Bath Iron Works*, 2008 ME 47, 942 A.2d 1237 that the two-year statute of limitations does not begin to run until the employer files a First Report of Injury, regardless of how much time may have passed since the injury occurred. In the years following the employer community invested considerable effort to amend Section 306(1) to reverse the *Wilson* decision, as the effect of that case was to delay the commencement of the statute of limitations until such time as an employer had an obligation to file a First Report. Ultimately, the legislature amended Section 306(1) effective August 30, 2012. The Law Court has never had an opportunity to interpret the language of the amended statute, but in a recent decision the Appellate Division addressed the matter “head on” and ruled how the amended statute is to be applied.

In *Bickmore v. Johnson Outdoors*, Me. W.C.B. No. 18-18 (App. Div. 2018) the employee sustained two separate

injuries eight years apart while working for the same employer but when different insurers were on the risk. The insurer at the time of the second injury filed a Petition for Award seeking to establish the compensability of the first injury and a corresponding obligation on the part of the first insurer to contribute to benefits owed to the employee. The first insurer had paid medical expenses but was never required to file a First Report. More than six years from the date of the last payment had elapsed before the duty to file a First Report arose.

The Division tackled the complex legislative history behind the 2012 amendment to Section 306(1), and it is not necessary to recite the sequence of events in this brief article. Ultimately, the adopted amendment lacked clarity and was susceptible of different interpretations. Indeed, the Division found that it was not clear exactly what the Legislature had intended and that the Legislature had never specifically stated that it was acting to modify *Wilson.* Because the meaning of the statute was found to be ambiguous, the Division analyzed the legislative history and concluded that the Legislature had actually intended to limit the scope of *Wilson*. Specifically, the Division held as follows:

> …we conclude that the appropriate interpretation of Section 306(1) as amended is: except as otherwise provided in section 306, a claim is barred two years after the date of injury or, if within that two year period the employee's employer is obligated to file a First Report under Section 303 and fails to do so, two years from the date the employer files the First Report.

Thus, the Division held that if an employer is not required to file a First Report within the two year period immediately following the injury, the statute of limitations bars a claim after that point.

The Division then addressed whether the amended version of Section 206(1) could be applied retroactively. The Court found no express or implied legislative intent that the amendment should be given retroactive effect. However, the panel concluded that this finding was not determinative, and that retroactive application must be determined by the timing of two events. Specifically, if the date that an employer becomes obligated to file a First Report of Injury and the date that the employer actually files a First Report of Injury occur after the effective date of the 2012 amendment, the amended version of Section 306(1) will therefore apply to determine whether or not a claim is barred by the statute of limitations. Accordingly, because of the passage of time the first insurer in *Bickmore* had no obligation to file a First Report for the initial injury until long after the amendment took effect, all claims with respect to the initial injury were barred by the statute of limitations.

This is an extremely important decision and resolves a number of questions that have remained unanswered since the 2012 attempt to modify or reverse the scope of *Wilson*. Carriers and self-insureds can now determine with greater accuracy whether or not the statute of limitations on a particular claim has expired.

WC Appellate Division Decision issued on May 10, 2018 – Waiver of Issues

Waiver of Issues

The employee filed a Petition for Award resulting from a December 8, 2015 injury to her neck and left hand. She also filed a Petition for Reinstatement. She had not worked for the employer since the date of injury, and a dispute arose as to whether the employer had offered her suitable employment which had then been rejected without good and

reasonable cause. Also in dispute was the issue of whether or not the employee had properly preserved her claim for reinstatement.

In *Ornberg v. Pineland Farms Potato Company, Inc.*, Me. W.C.B. No. 18-17 (App. Div. 2018), the Petition for Award was granted and the employee was given the protection of the Act. However, the claim for incapacity benefits was denied on the grounds that the employee had rejected a bona fide offer of employment within her restrictions without good and reasonable cause. There was conflicting evidence on this issue; the employer's evidence showed that an offer had been made while the employee argued that no such offer had been extended. The ALJ, as the fact finder, accepted the testimony from the employer's witnesses, and the Appellate Division affirmed, finding that an ALJ has full authority to select between the testimony of conflicting witnesses.

On the Petition for Reinstatement, the employee evidently had made only a vague and limited reference to the issue during litigation, without actually requesting reinstatement. No mention of the issue was made in the employee's written position paper or in a post-hearing Motion for Findings of Fact. Following in the footsteps of *Henderson v. Town of Winslow*, Me. W.C.B. No. 17-46 (App. Div. 2017) and *Waters v. S.D. Warren Company*, Me. W.C.B. No. 14-26 (App. Div. 2014), the panel found that the ALJ committed no error in finding that the claim for reinstatement had been abandoned. The key conclusion is that all issues raised by the parties, whether in the nature of claims for benefits or defenses to such claims, must be explicitly raised and maintained both during litigation and in the post-litigation stage in closing memos and Motions for Findings. A party that barely mentions an issue at all and fails to back up their positions with developed argumentation will be found to have waived the issue.

Damages for Medical Expenses: Review of the Judicial Split on Admission of Medical Services Billed vs. Paid

By Jessica S. Smith, Esq.

There has been a longstanding discussion in the Maine legal community surrounding the recoverability and, therefore, the admissibility, of medical expenses billed by a provider versus those that are actually paid by the patient, her insurer, or the government. The argument stems from the fact that third-party payers such as Medicare and private insurers pay less than the expenses reflected in medical bills, either by contract or law. Plaintiffs argue to exclude evidence of the lesser amount actually paid, while defendants argue for its admission. In the right case, the difference can add up to hundreds of thousands of dollars in medical expenses that the jury gets to see and award as damages.

The Law Court has yet to decide whether the amount billed or the lesser amount paid is admissible as evidence of the reasonable value of the medical services rendered to the patient. The Superior Court has addressed the issue, but little consensus has been reached, leading to a split amongst the Justices. This article addresses the debate, the legal doctrines involved, and the various approaches taken by the Superior Court Justices.

The Debate

The courts and parties often look to the *Maine Jury Instruction Manual* for guidance on what is recoverable. Prior to 2004, the *Manual's* jury instruction stated, "The reasonable value, *not exceeding actual cost to the plaintiff*, of examination and care by doctors and other medical personnel..." *Eastman v. Eastern Maine Medical Center*, 2003

WL 26559786 (Me.Super.), 2. This jury instruction appeared to decide the question in favor of the defense, at the time, by making the amount actually paid, and not the higher amount billed, recoverable. However, in approximately 2004, the *Manual* was amended and now states, "Medical expenses includes the reasonable value of medical services...shown by the evidence to have been reasonably required and actually used in treatment..." Alexander, *Maine Jury Instructions Manual* §7-108 (2017 ed). This version of the instruction removed the limit on recovery and left open the question of how one proves and recovers the reasonable value of medical services rendered to the plaintiff. Whether reasonable value is proven best by the amount medical providers billed for their services or the reduced amount paid by the patient or third parties and accepted by the providers remains the debate.

The Collateral Source Rule

The Collateral Source Rule commonly is cited in this debate about admissible and recoverable medical expenses. As the argument goes, if medical bills were paid by someone other than the plaintiff or were a gift to the plaintiff, the Rule prohibits the admission of evidence of the payment so that the jury does not limit the award of damages. *Hoitt v. Hall,* 661 A.2d 669, 673 (Me. 1995). This is based on the reasoning that the intent of awarding damages is to make the Plaintiff whole for her injury, and any benefit to the plaintiff from a third party should not also benefit the defendant. In addition, in many instances, third-party payers of medical expenses are entitled to reimbursement from damage awards, thereby preventing a windfall double recovery by the plaintiff.

On the other hand, the argument against recovering the amount billed for medical services, when a lesser amount was accepted by the provider, is that the Collateral Source Rule is not implicated. When a provider accepts a negotiated rate or a regulated rate from a third-party payer, the plaintiff is never liable for the higher amount originally billed. The lesser amount paid is in full satisfaction of the amount due for the medical services provided. Since the plaintiff never incurs liability to pay the higher amount billed, the plaintiff does not suffer any loss related to the difference in payment and the Rule is never implicated. The Supreme Court of California best summarized this reasoning:

Having never incurred the full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule would be inapplicable... The rule does not speak to losses or liabilities the plaintiff did not incur and would not otherwise be entitled to recover. Certainly, the collateral source rule should not extend so far as to permit recovery for sums neither the plaintiff nor any collateral source will ever be obligated to pay...

Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130 (Cal.2011), reh'g denied (Nov. 2, 2011).

Since the amount paid is admissible, it can be considered by the jury as *evidence* of the reasonable value of the medical services provided to the plaintiff. The jury never knows the identity of the payer, the amount billed, or that there was a difference between the amounts billed and paid, so the rationale for the Collateral Source Rule does not apply. The jury is only aware of the amount the provider was willing to accept as payment in full for its medical services. The jury ultimately weighs that evidence and determines what the reasonable value of the medical service is and awards damages.

The Maine Health Security Act

When it comes to medical malpractice claims, the Legislature has considered the windfall a plaintiff may receive when the amount of medical expenses actually paid is not admitted in evidence and used by the jury to award damages. The Maine Health Security Act provides for an adjustment of the plaintiff's recovery if a third-party collateral source exercises its right to subrogation in order to recoup the cost of the medical expenses it has paid within thirty days of receiving notice of the plaintiff's verdict. 24 M.R.S.A. § 2906(2). If a third-party payer seeks to

recover the money it paid for medical bills on the plaintiff's behalf, then the court will not reduce the plaintiff's damage recovery. However, if the third-party payer does not seek to recover from the plaintiff's damages award, then the court will reduce the damages awarded by the amount that has been paid or that is payable by a collateral source. 24 M.R.S.A. § 2906(2).

The Act does not expressly address the admissibility of medical expenses billed or paid during trial. The statute only enables a judge to reduce damages for medical expenses awarded by a jury.

The Split in the Superior Court

There have been a handful of orders from the Superior Court Justices deciding the admissibility of medical expenses, typically in the context of motions *in limine*. There are three, sometimes conflicting, outcomes the Justices have reached: (1) to admit only the actual amount paid and accepted by the provider; (2) to admit only the amount billed by the provider; (3) and lastly, to admit both, the amount billed and the amount actually paid and accepted by the provider.

Admitting Evidence only of the Amount Paid is the Best Result

Damages awarded for the expense of medical services are "compensatory" damages. The purpose is to put the plaintiff in the position she would have been if she never were injured. *Wendward Corp. v. Group Designs, Inc.*, 428 A.2d 57, 61-62, (Me. 1981). "While the measure of damages should avoid a windfall to either party, it should compensate the Plaintiff as precisely as possible for the loss without recourse to speculation and conjecture." *Cote Corp. v. Thom's Transport Co., Inc.,* 2000 WL 762076, * 3 (D. Me) (citing *Wendward Corp. v. Group Designs, Inc.*, 428 A.2d 57, 61-62, (Me. 1981). By awarding money for an expense the plaintiff (or a third party source) never incurred or paid, it would leave the plaintiff better off than if the accident had never happened. Damages for medical services should precisely compensate the plaintiff for medical services costs.

The best evidence of the reasonable value of the medical services rendered is the amount the providers accept in final payment. The amount billed is typically an unusually inflated value because providers are looking to recoup funds lost from defaulting patients or compensate for lesser government or insurance payments. Therefore, the amount billed is not reliable evidence of the reasonable value of a provider's medical services.

Courts outside of Maine have decided that the amount paid and accepted by the provider is proper evidence of the reasonable value of the medical expenses recoverable by a plaintiff. Most notable in *Hanif v. Housing Authority of Yolo County*, reasonable value was found to be a "term of limitation, not of aggrandizement" noting that compensatory damages should compensate the plaintiff for actual injuries sustained and no more. 200 Cal.App3d 635, 641 (Cal.Ct.App. 1988).

Conclusion

When and how the Law Court will rule on this issue is unpredictable. Until then, the outcome in Superior Court will depend on which Justice is sitting on the bench.

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Rental Car Insurance: Are You Paying for Coverage You Already Have?

By Samuel G. Johnson, Esq.

Introduction:

It's not every day an attorney tells you to decline insurance coverage for a potential loss. Well brace yourselves, because that is exactly what I am going to do in this article.

Whether your car is in the shop for repairs or you are taking a long vacation far away from home, chances are you have rented a car and will do so again. Given your experience renting cars, you are familiar with the exchange that will likely take place each time you step up to the counter to rent a car. You are given the rental contract, but before you sign on the dotted line the salesperson is pushing hard for you to elect certain additional coverages for your vehicle, such as a Collision Damage Waiver. They invoke fear by explaining the expenses you could incur in the event of an accident if you decline the Collision Damage Waiver and you damage the rental vehicle. Fear not, they tell you, because for an additional cost of anywhere from $10.00 to $30.00 a day—depending on your location and the rental company—you will not have to worry about incurring these potential expenses.

So should you purchase the Collision Damage Waiver for your rented vehicle? In that moment not having previously considered the question, and given the compelling sales pitch from the agent behind the counter, you may not feel confident in your answer. On the one hand, you are a responsible driver and don't want to pay what could be upwards of $30.00 a day extra for the Collision Damage Waiver. On the other hand, accidents happen, that's why they are called accidents, right? Even an extra $30.00 a day is far less than what you would have to pay if you somehow damaged the rented vehicle. So what do you do?

Decline the Collision Damage Waiver! Chances are you already have coverage for this type of situation, and despite the compelling sales pitch from the agent behind the counter, you do not need to purchase the Collision Damage Waiver. It is important to note at the outset that the answer to this questions is not one size fits all. There are several considerations you should undertake before making your decision. This article, however, should equip you with the tools needed to confidently answer this question when the time comes.

What is a Collision Damage Waiver?

So what is a Collision Damage Waiver? Despite what you may think, it is not insurance. It sounds like you are paying for coverage on the vehicle, but a Collision Damage Waiver, or a Loss-Damage Waiver, is actually what the name implies, it is a waiver. What this means is for the additional fee the rental company waives its right to pursue you in the event there is damage to the rented vehicle or it is stolen. Sounds like a good deal right? Although such a waiver may sound like all-encompassing protection, be aware of the fine print.

Most Collision Damage Waivers contain limitations and exceptions. For example, the damage or loss will likely not be covered if the vehicle is driven by someone who was not listed as an authorized driver, the driver has consumed any alcohol—whether or not he or she is over the legal limit—or the car is driven in a careless or reckless manner. While these don't sound like limitations that would be difficult to avoid, consider the following hypotheticals:

The Single Glass of Wine Hypothetical: It's another cold winter in Maine, so you and your spouse decide that it would be nice to take a trip somewhere warm, so you book a week-long vacation in Florida. After your flight lands, you step up the counter to rent a car. After a compelling sales pitch from the agent, you decide to purchase the

Collision Damage Waiver from the rental company, sign on the dotted line, and rush out to check in to your hotel. After you get settled in you and your spouse head out for a nice dinner. At dinner you have of a glass of wine. After dinner, while leaving the parking lot, you back up into a light pole and damage the bumper and frame of your rental car. Although you are not over the legal limit, because you had a glass of wine at dinner you are likely on the hook for the damage despite purchasing the Collision Damage Waiver.

The Designated Driver Hypothetical: Consider the same hypothetical with a slight twist. Before leaving dinner you remember that you will not be covered for any damage caused to the rental vehicle because you have consumed alcohol. Even though you are not over the legal limit, you have your spouse who has not consumed any alcohol drive. While leaving the parking lot they back up into a light pole and damage the bumper and frame. Again, despite your spouse being a licensed driver, you are likely on the hook for the damage despite purchasing the Collision Damage Waiver because you did not list your spouse as an authorized driver.

Even if you determine that these situations are avoidable and you would like the Collision Damage Waiver, don't check that box just yet. You may already be covered, and that coverage would likely protect you in the two hypotheticals discussed above. To determine if you already have coverage you will want to consult your personal auto policy.

Where to look:

All motorists in Maine are required to carry, at a minimum, liability and uninsured motorist coverage. Typically, there are four potential coverages available in a personal auto policy.

- **Mandatory Liability Coverage** insures the owner of an automobile for damages he or she becomes legally liable for due to bodily injury or property damage caused by an accident of the insured vehicle.
- **Medical Payments Coverage** covers medical expenses incurred because of bodily injury that is sustained by an insured and caused by a motor vehicle accident.
- **Mandatory Uninsured Motorist Coverage** covers the insured for compensatory damages for bodily injury that the insured is legally entitled to recover from the owner or driver of an uninsured motor vehicle. In Maine, this coverage must match the motorists liability limits.
- **Physical Damage Coverage** covers damage or loss to the covered vehicle itself. Typically, there are two types of Physical Damage Coverage that an insured can elect to carry, Collision Coverage and Comprehensive Coverage. Collision Coverage covers loss stemming from the upset of the covered vehicle or its impact with another vehicle or object. Comprehensive coverage is often defined as other than collision coverage, meaning damage to the vehicle stemming from something other than upset or impact with another vehicle or object.

So are you already covered?

Chances are, depending on your personal auto policy, you are already covered for damage to the rented vehicle. In ascertaining whether you can decline a Collision Damage Waiver when renting a vehicle due to existing coverage, you will need to look to the Physical Damage Coverage section of your personal auto policy. It is important to note that this type of coverage is not required, so the first thing you need to determine is if you carry this type of coverage. If you do, great, you may be one step closer to confidently declining the Collision Damage Waiver. What should you be looking for if you do carry this coverage? Here are a few excerpts from different personal auto policies:

Example 1: The standard ISO Policy includes an endorsement with language pertaining to rented vehicles, and provides coverage for "direct and accidental loss to any "*non-owned auto* which is a private passenger auto, pick up

or van, or trailer, rented to you or any *family member* for a term of 45 continuous days or less, by any person or organization, including franchises, in the business of providing private passenger autos, pickups, vans or trailers to the public." This coverage applies to direct and accidental loss to a rented vehicle and equipment, minus the applicable deductible, caused by *collision* or *other than collision* so long as that coverage has been elected by the insured.

Regarding loss of use expenses, the endorsement provides that the insurer "will pay, without application of a deductible, for verifiable loss of use expenses that are for a continuous period of up to 30 days and for which [the insured] becomes legally responsible in the event of loss to a rented vehicle." If the loss is caused by other than theft, the coverage is limited to the period of time reasonably required to repair or replace the rented vehicle.

If you elected this coverage, and you verify that your present circumstances fall within definitions outlined in the policy, a Collision Damage Waiver is unnecessary.

Example 2: Other policy language from a major auto insurer states that if you carry Collision Coverage, the insurer "will pay for sudden, direct, and accidental loss to a *covered auto* . . . or a *non-owned auto*, and its *custom parts or equipment* resulting from a collision." The policy defines a *non-owned auto* as "an *auto* that is not owned by or furnished or available for the regular use of *you* or a *relative* while in the custody of or being operated by *you* or a *relative* with the permission of the owner of the *auto* or the person in lawful possession of the *auto*," and defines collision as "the upset of a vehicle or its impact with another vehicle or object."

If you have Comprehensive Coverage, the insurer will cover loss to a *non-owned auto* that is not caused by collision. The policy then lists the types of damage that qualify as not caused by collision. If you elected to carry Comprehensive Coverage under this policy, the insurer will also pay for loss of use damages that you are legally liable to pay if a *non-owned auto* is stolen up to a combined maximum of $900.00 not exceeding $30.00 per day.

Again, if you have elected this coverage a Collision Damage Waiver is likely duplicative of the coverage you already have, and have already paid for.

Example 3: The last example, from a national auto insurer, states that if the insured elects to carry Collision Coverage the insurer "will pay for *collision loss* to the *owned auto* or *non-owned auto* for the amount of each *loss* less the applicable deductible." The policy defines *collision loss* as "loss that is caused by upset of the covered auto or its collision with another object, including an attached vehicle." *Non-owned auto* is defined by the policy as "an automobile or *trailer* that is not owned by or furnished for the regular use of either *you* or a *relative*, other than a *temporary substitute auto*. An auto that is rented or leased for more than 30 days will be considered as furnished for regular use." If the insured elects to carry Comprehensive Coverage, the insurer will pay "for each *loss*, less the applicable deductible, that is caused by other than *collision* to the *owned auto* or *non-owned auto*." The policy then lists losses that qualify as other than collision.

This policy, too, will provide coverage for damage to a rented vehicle, less the applicable deductible, so long as the vehicle is not rented for more than 30 days and the damage falls within the definition of a collision or other than collision. No Collision Damage Waiver is needed.

Deciding whether your policy provides coverage necessarily requires determining first if you have elected to carry Physical Damage Coverage. This information will be contained in your policy's Declarations Page. Then you must determine whether the rental vehicle qualifies as a covered auto under the definitions provided by your policy. This will require cross-referencing the specific coverages with the definitions provided by your policy. Lastly, you should check if any limitations or exclusions apply to the Physical Damage Coverage.

After reviewing your personal auto policy if you are still unsure whether you are covered for damage to a rented vehicle, you can always call your insurance agency to ask about coverage for rented vehicles under your policy.

Additional Considerations:

As mentioned previously, the answer to whether you can decline a Collision Damage Waiver is not one size fits all. There are additional considerations you should make. For example, if you do not have a personal auto policy, the Collision Damage Waiver or some other form of coverage is advisable.

Depending on your policy, what appears to be a covered loss may nevertheless be excluded. For example, if you are using the rented vehicle to conduct business many policies seek to exclude coverage for the loss. Even with coverage, you will likely have to pay a deductible in the event damage is caused, that amount, depending on the length of your rental, may far exceed the price of the Collision Damage Waiver.

Another consideration is your location. Many personal auto policies do not provide coverage if you are renting a vehicle outside of the United States or Canada. Additionally, some policies provide coverage for loss of use while others may limit the amount covered or exclude it entirely. This means that a rental agency could potentially come after you for the loss of use of the vehicle while it is out of commission even though your policy covers the actual damage to it.

Conclusion:

With this information you now know where to look to determine for yourself whether you are already covered for potential damage to a rented vehicle. You have reviewed your personal auto policy or spoken with your insurance agent and can feel confident when you step up to the counter and are met with the fear-inducing sales pitch from the rental company. If you have elected to carry Physical Damage Coverage, you are likely already covered, and you can confidently decline the Collision Damage Waiver and spend your $30.00 a day on something you will enjoy, rather than coverage you already have.

Jonathan W. Brogan Admitted to the American College of Trial Lawyers

Jonathan W. Brogan, a member of the law firm of Norman, Hanson & DeTroy, LLC, has become a Fellow of the American College of Trial Lawyers, one of the premier legal associations in America.

Brogan, who concentrates his practice in litigation, was recently inducted into the College during the association's 2018 annual meeting. Fellowship in the College is extended by invitation only — and only after careful investigation — to those experienced trial lawyers who have mastered the art of advocacy and whose professional careers have been marked by the highest standards of ethical conduct, professionalism, civility and collegiality.

The College was founded in 1950 and is composed of the best of the trial bar from the United States and Canada. Lawyers must have a minimum of 15 years of trial experience before they can be considered for Fellowship. Membership is limited to no more than 1 percent of the practitioners in any state or province.

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Brogan has more than 30 years of experience representing businesses and individuals in complex civil litigation matters. He has received numerous honors for his legal work, including recognition by Martindale-Hubbell, New England Super Lawyers, Best Lawyers in America and Chambers USA. Best Lawyers named Mr. Brogan “Lawyer of the Year” for medical malpractice — defense (2017) and personal injury — defense (2015, 2018).

Active professionally, he is a member of the Maine State Bar Association, Cumberland County Bar Association and is a fellow of International Society of Barristers and Litigation Counsel of America and a member of International Association of Defense Counsel.