2009 Annual Convention

Insurance and Negligence Law Update

Insurance Law Committee/Negligence Law Committee

3.0 General CLE Hours

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Insurance and Negligence Claims

Session # 603

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Patrick W. Allen and Rhys J. Richards

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**Chapter 3**

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Robert W. Kerpsack

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Supreme Court Highlights 2008-2009

Patrick W. Allen
Rhys J. Richards
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CIVIL PROCEDURE


1. Syllabus: when a plaintiff asserts multiple claims against one defendant, and some of those claims have been ruled upon but not converted into a final order per Civ. R. 54(B), the plaintiff may not create a final order by voluntarily dismissing pursuant to Civ. R. 41(A) the remaining claims against one defendant.

2. Opinion by Pfeifer; Moyer, O'Conner, O'Donnell, Lanzinger, and Cupp concur; Stratton dissents.

3. The Court noted that Civ. R. 41(A)(1)(a), as amended following the Court's decision in *Denham v. New Carlisle* (1999), 86 Ohio St. 3d 594, 716 N.E.2d 184, now states that plaintiff “may dismiss all claims asserted by the plaintiff against a defendant.” The Court concluded that Civ. R. 41(A)(1) no longer allows for the dismissal of a portion of the claims against a particular defendant and stated the proper course of action for a plaintiff to dismiss fewer than all claims against a single defendant is to file an amended complaint. *Citing Borchers v. Winzeler Excavating* (Apr. 10, 1992), 2d Dist. No. 13297, 1992 WL 82681; *Savage v. Cody-Ziegler, Inc.*, 4th Dist. No. 06CA5, 2006-Ohio-2760, 2006 WL 1514273, ¶ 33; *Kildow v. Home Town Improvements*, 5th

* The following cases represent some of the important highlights of decision issues by the Ohio Supreme Court in 2008. Decisions of the Sixth Circuit, federal district courts, or state courts of appeals have not been included. The cases are grouped in terms of areas of law they address. These summaries are intentionally broad in scope and are meant to provide information on significant issues to those attorneys whose practice involves insurance and tort law. For more detailed information and to obtain PDF versions of these cases, please visit the Supreme Court Web site at http://www.sconet.state.oh.us/default_highres.asp. I would be remiss if I did not thank our law clerks, Matthew Loesch and Edward Delp, for their assistance, and also our members Bob O'Conner and Rhys J. Richards.

4. The Court found that defendants could be potentially prejudiced if a plaintiff were allowed to partially dismiss fewer than all claims against a party because doing so would allow plaintiff to create a final and appealable order as to one issue under Civ. R. 41(A) while still saving the dismissed claim to be refiled later. The Court reasoned that allowing plaintiff to dismiss fewer than all claims against one defendant could create an increased burden on said defendant, who would be forced to go through the appeals process and may still be subjected to the dismissed claim upon refiling.

5. In her dissent, Justice Lundberg Stratton argued that the majority’s approach to Civ. R. 41(A) does not prevent piecemeal litigation and that the rule permits a party to dismiss fewer than all claims against another party. In the alternative, she suggested that a Civ. R.41(A) notice of dismissal of fewer than all claims against one party be treated as a Civ. R. 15(A) motion for leave to amend the complaint to dismiss the claim or claims. Justice Lundberg Stratton argued that a plaintiff is left in a conundrum wherein he or she must decide to dismiss with prejudice all other unresolved claims in order to appeal an adverse judgment on one or more claims, or, in the alternative, proceed on the remaining unresolved claims, which may be weaker or peripheral and a waste of judicial time. Citing Eiland v. Coldwell Banker Hunter Realty (1997), 122 Ohio App. 3d 446, 451-452, 702 N.E.2d 116 (dismissing a claim or party creates a final, appealable order as to the remaining claim or claims decided on the merits).


1. Syllabus: (1) The amended complaint did not relate back to date of original complaint; and (2) the savings statute did not apply to extend the period of time for plaintiffs to obtain service on defendants.

2. Opinion by Cupp; Moyer, Stratton, O’Conner, O’Donnell, and Lanzinger concur; Pfeifer dissents.

3. An injured worker, who was accidentally exposed to chemicals in 2002, sued his employer on May 28, 2004, naming five John Doe defendants. On May 6, 2005, the injured worked filed an amended complaint naming his employer, the shipping company, and a container company, but no John Doe defendants. The injured worker obtained service on the shipping and container companies by certified mail.
4. The trial court sustained the shipping and container companies’ motions to dismiss, ruling that the amended complaint did not relate back. The court of appeals reversed, concluding that the saving statute of Ohio Rev. Code § 2305.19(A) allowed the injured worker one year from the filing of the amended complaint to comply with the Civil Rules and obtain service on the shipping and container companies.

5. The Supreme Court affirmed the dismissal, finding that, although the injured worker complied with Civil Rule 3(A), he did not comply with Civil Rule 15(D). Pursuant to Civil Rule 15(D), a plaintiff may file a complaint and amend it when the name of an unknown party is discovered. The Court noted when a plaintiff files an amended complaint and the applicable statutory time limit has expired, the determination of whether service has been effected on the formerly fictitious and now identified plaintiff requires Civil Rule 15(D) to be read in conjunction with Civil Rule 15(C) and 3(A). Civil Rule 15(D) specifically requires that the summons contain the words “name unknown” and that the summons be personally served upon the formerly fictitious and now identified defendant. The injured worker’s service upon the shipping and container companies by certified mail was insufficient. Because the injured worker failed to meet the specific requirements of Civil Rule 15(D), the Court held that the saving statute was inapplicable so as to allow the amended complaint to relate back to the date of the original complaint.


1. Syllabus: when a plaintiff insurance company brings a claim against an electric company alleging that the company was negligent in failing to respond to a customer’s call, resulting in property damage, the claim underlying the subrogation claim arises from a common-law tort and was properly tried in the court of common pleas.

2. Opinion by Pfeifer; Moyer, Stratton, O’Connor, O’Donnell, and Lanzinger concur; Cupp concurs in judgment only.

3. Allstate paid $161,792.47 in property damage due to a fire, then filed a subrogation claim against Cleveland Electric Illuminating Co. (CEI), alleging that CEI was negligent in failing to respond to emergency calls detailing a tree limb falling on electric lines. CEI appealed a jury verdict finding them 100% liable, alleging that the trial court did not have jurisdiction to hear the case. The court of appeals reversed and remanded, instructing the trial court to dismiss the action based on lack of jurisdiction pursuant to Civ. R. 12(B)(1).
4. The Public Utility Commission of Ohio (PUCO) has exclusive jurisdiction over most matters concerning public utilities. This jurisdiction does not, however, diminish “the basic jurisdiction of the court of common pleas...in other areas of possible claims against utilities, including pure tort and contract claims.” Citing State ex rel. Ohio Edison Co. v. Shaker, 68 Ohio St. 3d 209 (1994). Moreover, PUCO is not a court and has no power to judicially ascertain and determine legal rights and liabilities. State ex rel. Dayton Power & Light Co. v. Riley, 53 Ohio St. 2d 168 (1978).

5. Allstate’s complaint alleged negligence, a common law tort. In cases involving public utilities, however, jurisdiction is not based solely upon the pleadings. To determine jurisdiction, the Court adopted the following test from Pacific Indemnity Insurance Co. v. Illuminating Co., Cuyahoga App. No. 82074, 2003-Ohio-3954:

“First, is PUCO’s administrative expertise required to resolve the issue in dispute? Second, does the act complained of constitute a practice normally authorized by the utility? If the answer to either question is in the negative, the claim is not within PUCO’s exclusive jurisdiction.”

6. The Court applied the test to the case before them, finding that the ultimate question in the case was whether the delay between CEI’s receipt of emergency calls and arrival at the residence was reasonable. That issue was particularly appropriate for resolution by a jury. The expertise of PUCO was not necessary for resolution of the case. Accordingly, PUCO did not have exclusive jurisdiction over the case, and the decision of the court of appeals was reversed.

CONSUMER SALES PRACTICES ACT/ TELEPHONE CONSUMERS ACT


A. Syllabus: the Court held (1) to establish a “knowing” violation under the federal Telephone Consumer Protection Act, for an award of treble damages, a plaintiff is required only to prove that the defendant knew that it acted or failed to act and that such conduct violated the TCPA, not that defendant knew the conduct itself constituted a violation of law; (2) to establish a “willful” violation of the TCPA, for an award of treble damages, a plaintiff must prove that the defendant consciously and deliberately committed or omitted an act that violated the TCPA, irrespective of any intent to violate the law; and (3) to establish a “knowing” violation of the Ohio Consumer Sales Practice Act, for an award of attorney’s fees, a plaintiff need prove only that the defendant acted in a manner that violated the Act and need not prove that the defendant knew that the conduct violated the law.
B. Opinion by Lanzinger; Moyer, Pfeifer, Stratton, O’Conner, O’Donnell, and Cupp concur.

C. On December 9, 2003, Phillip Charvat received a pre-recorded phone call advertising dental services from Thomas Ryan DDS on his home telephone. The call was made using automated dialing equipment. After the call, the plaintiff sent a letter to the defendant demanding a copy of the office “do not call” policy, which the plaintiff never received. The Ryan office did not respond. On January 24, 2004, Phillip Charvat filed a complaint setting forth multiple violations of the TCPA and CSPA and asked for statutory damages allowed by state and federal law, the treble damages allowed by the TCPA, the attorney fees allowed by the CSPA, and a permanent injunction. Ryan’s office admitted a single violation of the TCPA but argued that it complied in good faith with the law by downloading and honoring the federal do-not-call list per the instructions of the Ohio Attorney General’s office prior to his telemarketing campaign. Charvat had not elected to put his name on the list, but registration is not a prerequisite for a consumer to maintain an action for violations of the TCPA. The trial court awarded damages for a single violation of the CSPA but granted Summary Judgment as to the remaining TCPA and CSPA claims, declining to award treble damages under the TCPA or attorney fees under the CSPA. The court of appeals affirmed, finding two violations under the TCPA for delivering the message and failing to send the “do not call” policy and granting statutory damages but not treble damages or attorney fees. Further, the court of appeals held that the trial court did not abuse its discretion in finding that the violation was not willful and remanded the case to the trial court to examine “knowing” and “willful” for such violations. The Supreme Court accepted a Motion for Certification that a conflict existed between the Tenth District and Sixth District as to the definition of “knowingly” under the TCPA.

D. The Supreme Court affirmed in part and reversed in part. The Court affirmed the denial of attorney fees under the CSPA and reversed and remanded to the trial court the issue of awarding treble damages under the TCPA. The Court examined Reichenbach v. Financial Freedom Centers, Inc., 2004-Ohio-6164, 2004 WL 2634624, at ¶ 37 (defining “knowingly” as merely requiring proof of knowledge of the facts that constitute the offense), Charvat v. Colorado Prime, Inc. (Sept. 18, 1998), 10th Dist. No. 97APG09-1277, 1998 WL 634922, at *4 (defining “knowingly” as affirmative knowledge of a violation of law when making the phone call) and federal criminal cases. The Supreme Court held that a plaintiff need only prove that the defendant knew the underlying facts of the conduct that violated TCPA and/or CSPA, not that the defendant knew the conduct violated a law.

DAMAGES FOR CARE PROVIDED BY SPOUSE

Hutchings v. Childress, 119 Ohio St. 3d 486, 2008-Ohio-4568, 895 N.E.2d 520.

Supreme Court Highlights 2008-2009 • 1.5
A. The Fifth District Court of Appeals certified the question of whether spouses can recover the income lost due to one spouse caring for another or whether they may only recover the cost to hire outside home health care.

B. Holding: part of an injured spouse’s damages against a defendant can include the fair market value of home health care provided by an uninjured spouse, with damages being measured not by lost income of supporting spouse but by market value services he or she renders.

C. Opinion by Pfeifer; Moyer, O’Donnell, Lanzinger, and Cupp concur; Stratton concurs in part and dissents in part; O’Conner dissents and would dismiss the cause as having been improvidently accepted.

D. On January 9, 1999, Nancy Hutchings was injured in an automobile collision caused by an employee of Central Ohio Paintball, Inc. She suffered a traumatic brain injury. Nancy filed a claim for her injuries and her husband filed one for loss of consortium. Nancy’s husband, John, a financial planner, functioned as a caregiver for Nancy after her accident, including staying at home caring for his wife the first six weeks after the accident and continuing to attend therapy and medical appointments with her. In addition, John took over all of Nancy’s household activities and took time off work to care for his wife. Nancy and John claimed that John’s business suffered because of the time John spent away from his duties caring for his wife. At trial, they presented evidence, including the testimony of an economist and evidence of John’s lost wages, as to the economic loss the family suffered because of the time John spent caring for his spouse. The trial court refused to instruct the jury that it could award either plaintiff damages for John’s loss of income during the time he spent caring for Nancy. The jury returned a verdict in favor of the Hutchingses for $255,000 on Nancy’s claims and $20,000 on John’s claims for loss of consortium. The Hutchingses appealed, arguing that the trial court erred in refusing to instruct the jury that it could award damages for John’s lost income due to caring for his wife at home. The Fifth District affirmed and granted the Hutchingses’ Motion to Certify a Conflict with the Second District Court of Appeals in Depouw v. Bichette, 162 Ohio App. 3d 336, 2005-Ohio-3695, 833 N.E.2d 744 (holding that an injured spouse could recover the income her spouse lost when he missed work to care for her).

E. The Supreme Court noted that Ohio courts addressed the issue of recovery of damages for the care provided by a family member, but only Depouw allowed the spouse to recover the income her spouse lost when he missed work to care for her (examining Griffen v. Cincinnati Realty Co. (1913), 15 Ohio N.P. (N.S.) 123, 27 Ohio Dec. 585, 1913 WL 1009 (granting a motion to strike a claim for lost wages brought by an uninjured spouse)). The Court reasoned that most Ohio courts allow recovery for the value of the nursing services provided (citing Howard
v. McKitrick (July 2, 1987), Franklin App. No. 87AP-148, 1987 WL 13837 (holding an adult plaintiff could recover damages for the nursing care provided by her mother). The Court stated that Depouw was based on the duty of financial support that spouses owe to one another. Supra, 162 Ohio App. 3d, 2005-Ohio-3695, 833 N.E.2d 744, at ¶ 15. In analyzing Ohio Rev. Code § 3103.03(A), on which Depouw relied, the Court differentiated between the statute’s requirement of spouses to support each other and any requirement that a spouse work full-time, earn a certain income, or forego his or her employment to care for an ailing spouse. The Court reasoned that the statute did not create a duty to provide a certain level of income, thus, it could not require tortfeasors to pay damages for an uninjured spouse’s lost income. In addition, the Court also considered the collateral source rule preventing the tortfeasor from reaping the benefits of the uninjured spouse’s provision of care. Under the auspices of consistency and practicality, the Court decided that the appropriate measure of damages for an uninjured spouse’s provision of care to an injured spouse was the economic value of the care provided, not the value of lost wages incurred by the uninjured spouse.

F. In her partial concurrence and dissent, Justice Lundberg Stratton agreed that an injured spouse’s damages can include the fair market value of health care provided by the uninjured person, but wished to remand the case to permit Nancy to present evidence of the economic value of the care her spouse provided. She noted that the Court had not previously addressed the issue of the proper damages for a spouse’s services and argued that disallowing the Hutchingses from presenting evidence of the fair market value of John’s services would deprive them of compensation and allow the tortfeasor to unjustifiably escape liability.

IMMUNITY/ POLITICAL SUBDIVISIONS


A. Syllabus: township was immune from liability because the ice on the roadway was not an “obstruction” under the tort liability statute.

B. Opinion by O’Conner; Stratton, O’Donnell, Lanzinger, and Cupp concur; Moyer and Pfeifer dissent.

C. On January 24, 2004, the Miami Township Fire Department conducted a day-long training exercise involving various crews and engines from the fire department responding to real fires deliberately set by fire officials in a former dwelling on the burn site. The site was accessed by a driveway from a gently rolling, rural road, which had several curves and many yellow caution signs recommending the speed at which the curves should be taken. The water used during the exercises ran from
the burn site onto said road. On the night of the exercises, a deputy fire chief ordered fire department crews to visit the site periodically throughout the evening to ensure the fire was out and to apply road salt to the roadway as needed. At 6:00 p.m., one such crew spread a five-gallon bucket of salt where water had run from the burn site onto the roadway. At 7:30 p.m., another crew returned checking the roadway for water and ice, but none was found and no salt was used. At approximately 10:00 p.m., a 16-year-old, who had previously negotiated a turn in the northbound lane, at approximately 50 mph 10 minutes earlier that was recommended to be taken at 30 mph, attempted to repeat the same feat at 60 mph. The teenager lost control of his vehicle, went across the roadway, traveled up a berm, and vaulted into the air before striking a tree near a culvert. He died instantly, but his passenger survived. The estate of the driver brought action against the township and fire department alleging liability for the driver’s death because the driver lost control of his vehicle when it hit ice that formed on the roadway due to the negligence of the aforementioned defendants.

D. The trial court concluded that the general blanket immunity provided for in Ohio Rev. Code § 2744.02(A)(1) applied to the township and that no exception to that immunity existed; namely, the trial court reasoned that the ice on the roadway was not an “obstruction” as the term is used in Ohio Rev. Code § 2744.02(B)(3). The court of appeals reversed, holding that the term “obstruction” should be construed broadly to include any object with the potential to interfere with the safe passage of motorists on public roads.

E. The Supreme Court reversed and reinstated the holding of the trial court granting Summary Judgment in favor of the township and fire department. The Supreme Court summarized the three-tiered analysis of the immunity of political subdivisions as set forth in Chapter 2744. The Court stated that the case turned upon the second prong, whether an exception to the general rule of immunity from personal injury and/or wrongful death claims for political subdivisions performing a governmental or proprietary function applied. The Court noted Ohio Rev. Code § 2744.02(B)(3), which provides an exception to political subdivision immunity caused by a township’s “negligent failure to keep public roads in repair and otherwise negligent failure to remove obstructions from public roads.” The Court analyzed the definition of “obstruction” in Webster's New World Dictionary, citing the concepts of hindering and impeding included therein and utilized by the court of appeals in its decision. The Supreme Court, however, found that the General Assembly purposely replaced the language “free from nuisance” as it appeared in the former version of the statute with the language “other negligent failure to remove obstructions.” The Court found that the legislature deliberately changed that language to further limit political subdivisions’ liability for injuries and deaths on their roadways.
F. In his dissent, Chief Justice Moyer with Justice Pfeifer concurring, stated his belief that ice can qualify as an obstruction as defined in the statute. Justice Moyer noted that the Court is duty-bound to follow the plain meaning of the statutes as written, thus, “obstruction” defined as impeding and hindering progress made a political subdivision liable for its negligent failure to remove ice from the roadway. Chief Justice Moyer argued that the Court’s broad reading of the prior statutory language “free from nuisance” meant that political subdivisions could be liable for the presence of objects outside the actual roadway that altered travel thereon. See, e.g., Manufacturer’s Nat’l Bank of Detroit v. Erie Cty. Rd. Comm. (1992), 63 Ohio St. 3d 318, 587 N.E.2d 819, ¶ 1 of the syl. (“a permanent obstruction to visibility” along a roadway could be a nuisance within the statutory meaning). Chief Justice Moyer stated that the more reasonable interpretation of the legislature’s “obstruction” language was to limit a political subdivision’s liability to conditions on the roadway that either block or impede safe travel.

LEGAL MALPRACTICE


1. Clients sued former attorneys who had represented them in matters involving development and operating of a landfill business. A settlement was reached in the underlying matter between the former clients and other parties. The clients sued the attorneys, claiming a coerced settlement and that a better result would have been achieved at trial. The jury found in favor of the former clients and awarded damages. The attorneys moved for JNOV or new trial, which the trial court denied. The Eighth District affirmed. The Supreme Court considered only the issues of proximate cause and damages.

2. Syllabus: to make a claim for legal malpractice:

a plaintiff must show (1) that the attorney owed a duty or obligation to the plaintiff, (2) that there was a breach of that duty or obligation and that the attorney failed to conform to the standard required by law, and (3) that there is a causal connection between the conduct complained of and the resulting damage or loss.

Vahila v. Hall (1997), 77 Ohio St. 3d 421, 674 N.E.2d 1164. Plaintiff must establish by preponderance of the evidence that defendant’s actions were the proximate cause of plaintiff’s losses. Strother v. Hutchinson (1981), 67 Ohio St. 2d 282, 423 N.E.2d 467.
3. The majority opinion was joined by five justices (with only Pfeifer dissenting).

4. The Court stated:

when a plaintiff premises a legal-malpractice claim on the theory that he would have received a better outcome if his attorney had tried the underlying matter to conclusion rather than settled it, the plaintiff must establish that he would have prevailed in the underlying matter and that the outcome would have been better than the outcome provided by the settlement.

It reasoned that the case implicated the “case-within-a-case” doctrine, which says that the plaintiff needs to establish that he or she would have been successful in the underlying cause of action. The Court was careful to distinguish this from other types of legal malpractice cases by repeating this action was premised on the idea that a better outcome would have been gotten if the case were taken to trial instead of settled. The Court rejected the idea that a plaintiff only need to provide “some evidence” of the merits of his or her claim, but instead endorsed the higher causation standard of preponderance of the evidence. The Court also had to consider whether the trial court erred in denying appellant’s Motion for Judgment notwithstanding the verdict. The Court concluded the trial court’s ruling was incorrect, as the appellees failed to establish that they actually would have won their case and that losses would not have been offset by the claims against them. The court of appeals was reversed.

B. *Paterek v. Petersen & Ibold*, 118 Ohio St. 3d 503, 2008-Ohio-2790, 890 N.E.2d 316.

1. Syllabus: to make a claim for legal malpractice:

    a plaintiff must show (1) that the attorney owed a duty or obligation to the plaintiff, (2) that there was a breach of that duty or obligation and that the attorney failed to conform to the standard required by law, and (3) that there is a causal connection between the conduct complained of and the resulting damage or loss.

*Vahila v. Hall*, 77 Ohio St. 3d 421, 674 N.E.2d 1164 (Ohio 1997). “In determining collectability of an unrealized judgment, the factfinder should consider the amount of the plaintiff’s UIM policy.” *Sparks v. Craft*, 75 F.3d 257 (C.A.6, 1996).
2. The majority opinion was joined by five justices (with O'Connor and Cupp concurring in part and dissenting in part).

3. Paterek was negligently injured in an auto accident. Tortfeasor had no assets but did have $100,000 liability policy. Paterek had UIM coverage of $250,000. Suit was filed but dismissed against tortfeasor without prejudice. It was refiled, but after one year from the dismissal.

4. In this case, the allegations were in regards to the appellants’ negligence in representing appellee and her now-deceased husband in a negligence action resulting from a car accident. Malpractice was stipulated. The issue was whether the attorneys could be liable only for the amount collectible from the tortfeasor and that insurer or for $250,000. At trial, the jury awarded Paterek $382,000 and his non-injured wife $100,000. By JNOV, the trial court reduced it to $100,000 without addressing UIM. The 11th District reversed and reinstated the verdict.

The Supreme Court was careful to point out that the issue was not what Paterek suffered on account of the original tortfeasor's driving, but what his wife suffered on account of appellants’ bad lawyering. In determining this amount, the lower courts only considered the amount of the original tortfeasor’s $100,000 automobile insurance policy in determining damages, but the majority held that the Patereks’ UIM coverage of $250,000 (which increased the overall damages by $150,000) should have been included in the calculation of damages as well. The Court noted that the sole dispute is in regards to appellants’ negligence. The Supreme Court limited inquiry to how much the clients could have received. The Court reasoned, “collectibility is logically and inextricably linked to the legal-malpractice plaintiff’s damages, for which the plaintiff bears the burden of proof.” In other words, to show what was lost, the plaintiff must show what would have been gained. The Court held that UIM coverage is evidence of collectability in an attorney malpractice case and that the trial court and appellate court erred by limiting recovery to $100,000 when the parties stipulated the UIM was $250,000.

MEDICAL RECORDS—CONFIDENTIALITY


A. Syllabus: when the confidentiality of medical records is waived for the purposes of litigation, the waiver is limited to that case.
B. The decision was a 5-2 decision in which the court limited disclosure of privileged medical information in litigation to the specific case.

Hageman was engaged in a divorce proceeding with his ex-wife and filed a counterclaim for custody. The wife’s attorney obtained medical records from the husband’s psychiatrist because his mental condition was an issue in the custody matter. She, in turn, gave a copy to the prosecutor at a civil-protection-order hearing. He was acquitted. The medical records were never used in evidence. He sued his wife, her attorney, the doctor, the doctor’s employer, and the hospital where the employer was located.

The trial court granted Summary Judgment to all defendants. The court of appeals affirmed Summary Judgment except as to the wife’s attorney and reversed as to her. She appealed to the Supreme Court.

The Supreme Court agreed that the custody matter put his medical history at issue and implied the medical records were properly disclosed to the ex-wife’s attorney. However, the court noted that Hageman did not authorize his doctor to disclose the records and that they were disclosed to the prosecutor in Hageman’s criminal case arising out of alleged assault on his wife only a few days after the disclosure to the attorney. Hageman, therefore, had no meaningful opportunity to object to their production. The court believed the public policy in regards to medical records now requires their utmost confidentiality and stated, “[w]aiver of medical confidentiality for litigation purposes is limited to the specific case for which the records are sought and...an attorney who violates this limited waiver by disclosing the records to a third party unconnected to the litigation may be held liable for these actions.” The issue of whether Hageman should have taken steps to keep the records private was not brought up until Supreme Court oral argument by wife’s attorney.

STATUTE OF LIMITATIONS


A. Syllabus: Ohio’s two-year statute of limitations for bodily injury and injury to personal property, Ohio Rev. Code § 2305.10, rather than the Ohio Rev. Code § 2305.09(D) four-year statute, is Ohio’s general statute of limitations for all § 1983 claims filed in state court. Since appellant’s filing fell outside that two-year statute of limitations, it was time-barred.

B. A mother filed § 1983 claims against a children’s services agency employee who filed alleged false child-abuse charges and refused to return custody of her child to her after resolution of criminal charges. The trial court granted Summary Judgment based upon her filing more than two years after filing of the charges against her and the award of custody to child’s father.
C. The trial court dismissed based upon the two-year statute of limitations.

The court of appeals reversed based upon the four-year statute for § 1983 claims. The Supreme Court reversed the appellate court.

D. The decision was 5-2 and engaged in an extensive analysis of § 1983 claims, and how they can be applied in state courts. The most important issue in the court’s mind was deciding which statute of limitations applied to this federal cause of action. The Court concluded that Ohio Rev. Code § 2305.10 applied instead of Ohio Rev. Code § 2305.09(D) because it viewed Ohio Rev. Code § 2305.10 as being more generally applicable and Ohio Rev. Code § 2305.09(D) as being too narrow to apply to this federal cause of action. Because the cognizable events, the filing of the child abuse complaint and the award of permanent custody, occurred more than two years before appellant’s filing, it was held to be time-barred.

The Supreme Court reviewed numerous courts of appeal decisions and federal cases and determined that claims for personal injury in § 305.10 include claims for humiliation and loss of reputation.

UNINSURED AND UNDERINSURED MOTORIST COVERAGE


1. Syllabus: The issue in this case is whether the versions of Ohio Rev. Code §§ 3937.18 and 3937.31 in effect on September 12, 2002, permitted modification of an automobile insurance policy’s uninsured and underinsured motorist (UM) coverage at the beginning of the policy-renewal period within the two-year statutory guarantee period. Because the two-year period began after the effective date of 2000 (Sub. S.B. No. 267, 148 Ohio Laws, Part V, 11,380) and after the effective date of 2001 (Am. Sub. S.B. No. 97, 149 Ohio Laws, Part I, 779), the Court held that modification of UM coverage was a change permitted by law.

2. Opinion by Cupp; Moyer, Stratton, O’Connor, O’Donnell, and Lazinger concur; Pfeifer dissents.

3. The Court noted that UM coverage laws were amended by S.B. 267, which expressly permitted insurers to change policies at the beginning of any policy-renewal period within a two-year guarantee period; then further amended by S.B. 97, which eliminated “any requirement of a written offer, selection, or rejection form” and was also intended to “eliminate the possibility of uninsured motorist coverage being implied as a
4. Plaintiff in the case was the executor of his deceased wife’s estate, who were named insureds on an insurance policy with liability limits of $300,000/$500,000 and UM coverage limits of $50,000/$100,000. Plaintiff settled claims against the tortfeasor under the tortfeasor’s limits, which was $100,000. Plaintiff made a claim for $200,000 against Allstate under his UM coverage on the theory that by operation of law, the amount of UM coverage was equivalent to his policy’s liability limits of $300,000, subject to an offset of the $100,000 already recovered. The trial court awarded Summary Judgment to Allstate, which was affirmed by the appellate court.

5. The UM statute applicable to the plaintiff’s policy reflected the changes enacted by S.B. 267. At the renewal of the six-month policy period immediately prior to the six-month policy period during which the accident occurred, Allstate included an “Important Notice” indicating the method of selecting UM coverage had changed, which specifically stated, “[t]he coverage limits you have chosen for UM Insurance and Bodily Injury are less than your limits for Bodily Injury under Automobile Liability Insurance.” Plaintiff neither objected to this change nor acted to modify the UM limits of his policy. Therefore, the UM coverage limits in effect on the date of the accident were $50,000 per person and $100,000 per occurrence. The court of appeals’s judgment was affirmed.

6. In his dissent, Justice Pfeifer argued that a unilateral reduction in UM coverage constituted a cancellation of the policy within the two-year guarantee period, which is forbidden by Ohio Rev. Code § 3937.31(A); and that notice given by Allstate in this case was deficient. Therefore, he argued that the law in effect at the beginning of the two-year guarantee period was in effect at the time of the accident. The plaintiff’s UM coverage limits matched those of their liability coverage.

B. Angel v. Reed, 119 Ohio St. 3d 73, 2008-Ohio-3193, 891 N.E.2d 1179 (UM/UIM and statute of limitations).

1. Plaintiff/appellee was injured in an accident while a passenger in tortfeasor’s vehicle. Plaintiff brought action against her automobile insurer for uninsured motorist (UM) benefits and against tortfeasor.

3. In June 2001, appellee was a passenger in a motor vehicle accident caused by the negligence of the driver whose insurance policy had been cancelled three months prior to the accident. At the time of the accident, appellee had UM insurance with appellant Allstate. The policy stated that “any legal action against Allstate must be brought within two years of the date of the accident. No one may sue us under this coverage unless there is full compliance with all the policy terms and conditions.”

4. Appellee filed suit against the tortfeasor in May 2003, later dismissing the suit without prejudice. In May 2004, appellee discovered that tortfeasor’s insurance policy had been cancelled prior to the accident. In July 2004, appellee notified appellant that she was making a claim for UM benefits. In 2005, appellee re-filed her suit against the tortfeasor, including appellant as an additional defendant. The trial court granted appellant’s Motion for Summary Judgment, noting that appellee had the benefit of two full years in which to bring her UM claim and had failed to do so. The majority of the court of appeals held that the two-year limitation period was unenforceable and that it was “essentially impossible” for appellee to discover Reed’s uninsured status within the two-year period, concluding that a cause of action for UM benefits accrues when the injured party knows, or has reason to know, that the tortfeasor was uninsured.

5. The Supreme Court reversed, first determining that the two-year limitation period was a “reasonable and appropriate” period of time in which an insured who has suffered bodily injury to commence an action under the UM provisions of an insurance policy. The Court went on to hold that appellee could have determined the tortfeasor’s uninsured status by simply calling Nationwide, his former insurer. There was no reason why it should have taken appellee three years to realize the tortfeasor was uninsured. The Court distinguished the facts from Kraly v. Vannewkirk, (1994), 69 Ohio St. 3d 627, where it held that the right of action for UM benefits accrues on the date that an insured received notice of his or her insurance company’s insolvency. Unlike Kraly, this case presented a standard UM claim in which the tortfeasor was uninsured at the time of the accident.

C. Rogers v. Dayton, 118 Ohio St. 3d 299, 2008-Ohio-2336, 888 N.E.2d 1081 (UM/UIM and political subdivisions).

1. Syllabus: a political subdivision is self-insured for purposes of former Ohio Rev. Code § 3937.18(K)(3) if it qualifies as a self-insurer under Ohio Rev. Code Chapter 4509, although it is not required to obtain a certificate of self-insurance.
2. Opinion by Stratton; Pfeifer, O'Connor, and O'Donnell concur; Moyer, Lanzinger, and Cupp dissent.

3. A city of Dayton employee operating a vehicle owned by the city struck another vehicle being driven by the plaintiff. Plaintiff filed suit against the driver, the city of Dayton, and his personal insurer for UM purposes. The trial court awarded Summary Judgment to the driver on the basis of immunity under Ohio Rev. Code § 2744.03 and acknowledged that Dayton was liable for the negligence of its employee, also finding that Dayton was uninsured under Ohio Rev. Code § 4509.72. The court of appeals affirmed, concluding that Dayton was not self-insured under Ohio Rev. Code § Chapter 4509 because it did not have a certificate of self-insurance from the registrar of motor vehicles.

4. Dayton did not purchase insurance policies for its vehicles; instead it established a self-insurance program to directly pay damages in civil actions, consistent with Ohio Rev. Code § 2744.08. Ohio Rev. Code § 3937.18 provides that an “uninsured motorist” does not include the owner or operator of a vehicle that is self-insured within the meaning of the financial responsibility law of the state in which it is registered. In Safe Auto Insurance v. Corson, 155 Ohio App. 3d 736 (2004), the First District held that the city of Cincinnati was self-insured in the practical sense where it had not purchased liability insurance but instead paid claims directly from city funds.

5. Dayton did not have a certificate of self insurance because it was not required to have one. Therefore, it argued that its vehicle was uninsured for purposes of Ohio Rev. Code § 3937.18. Dayton also contended that requiring a private insurance company to pay is consistent with public policy to shift the financial burden for torts committed by political subdivisions from taxpayers to insurance companies. Galanos v. Cleveland, 70 Ohio St. 3d 220, 638 N.E.2d 530 (1994).

6. The Court found that because Dayton had complied with the financial responsibility law that applies to political subdivisions by creating a self-insurance program for tort liability as authorized under former Ohio Rev. Code § 2744.08, Dayton was self-insured within the meaning of the financial responsibility law of the state, and its vehicle was not uninsured for purposes of Ohio Rev. Code § 3937.18(K)(3).

7. The dissent argued that the majority incorrectly defined “operator” as including “political subdivision,” and that it improperly relied on Ohio Rev. Code § 2744.08 to hold that Dayton was self-insured within the meaning of the financial responsibility law of the state. Barring language in the Ohio Rev.
Code that states that a political subdivision may qualify as a self-insurer by obtaining a certificate of self-insurance issued by the registrar of motor vehicles, the dissent could not rely on Ohio Rev. Code § 2744.08(A) to hold that Dayton was self-insured within the meaning of the financial responsibility laws of the state. Section 2744.08(A) does not require a political subdivision to affirmatively demonstrate financial responsibility, but merely permits it to self-insure.

WORKERS’ COMPENSATION, SUBROGATION, AND PRODUCTS LIABILITY


A. Syllabus: Ohio Rev. Code §§ 4123.93 and 4123.931 do not violate the Takings Clause, the Due Process and Remedies Clause, or the Equal Protection Clause and are, therefore, facially constitutional. Ohio Rev. Code § 2305.10(C) and former § 2305.10(F) do not violate the open-courts provision, the Takings Clause, the Due Process and Remedies Clauses, the Equal Protection Clause, or the one-subject rule and are, therefore, facially constitutional. To the extent that former Ohio Rev. Code § 2305.10(F) affects an accrued substantive right by providing an unreasonably short period of time in which to file suit for certain plaintiffs whose injuries occurred before the amendments to Ohio Rev. Code § 2305.10 enacted by 2004 S.B. No. 80 became effective, and whose causes of action, therefore, accrued for purposes of Ohio Rev. Code § 2305.10(C), former Ohio Rev. Code § 2305.10(F) is unconstitutionally retroactive under § 28, Article II of the Ohio Constitution.

B. Opinion by O'Connor; Moyer, Stratton, and Cupp concur; O'Donnell concurs in the answers to the certified questions only; Lanzinger concurs in the answers to the certified questions and concurs in the opinion in part; Pfeifer concurs in part and dissents in part.

C. Groch was injured on March 3, 2005, in the course of and scope of his employment with General Motors when a trim press manufactured by Kard Corporation and Racine Federated came down on his arm. Groch filed an intentional tort action against GM and a product liability action against Kard and Racine. Kard and Racine asserted that they were immune from liability based on the statute of repose for product liability claims. Groch raised numerous constitutional challenges to the statute of repose. The case came to the Ohio Supreme Court in nine certified questions from the Northern District of Ohio. Five of the questions involved constitutional challenges to the statute of repose for product liability claims, three involved constitutional challenges to workers’ compensation subrogation provisions, and one was a challenge to S.B. 80.
D. In regard to the constitutionality of the statute of repose, Groch’s arguments largely were based on past decisions of the Court finding other statutes of repose unconstitutional. Much of the Court’s analysis focused on its previous decisions in Sedar v. Knowlton Construction Co., 49 Ohio St. 3d 193 (1990), and Brennaman v. R.M.I. Co., 70 Ohio St. 3d 460 (1994). The Sedar Court upheld the constitutionality of a former statute of repose applicable to construction contractors and others involved with improvements to real property. Four years later, this same statute was held unconstitutional in Brennaman.

E. With respect to the open courts/right to remedy challenge, the Court first criticized its previous decision in Brennaman and rejected the argument that all statutes of repose are unconstitutional under Brennaman. As a result, the statute at issue warranted a “fresh review” of its individual merits. The Court adopted the rationale of Sedar that recognized that foreclosing claims against certain defendants does not mean that a right to remedy is extinguished. The Court recognized that although Ohio Rev. Code § 2305.10(C) may prevent suits against product manufacturers, in many situations an injured party will be able to seek recovery against other parties, such as those who control and maintain the product. The Court held that the statute of repose, on its face, does not violate the Ohio Constitution’s open courts and right to remedy provisions.

F. In connection with the due process and equal protection challenges, the Court applied a rational basis test because neither a fundamental right nor suspect class is involved. The Court said that the legislative findings and statements of intent, set forth in § 3(C) of S.B. 80, “adequately demonstrate that the statutes bear a real and substantial relation to the public health, safety, morals, or general welfare of the public and are not unreasonable or arbitrary.” The Court concluded that the statute of repose, on its face, does not violate the principles of due process or equal protection.

G. The Court rejected the argument that Ohio Rev. Code § 2305.10 deprives a person of property under the takings clause as follows, “[t]he statute of repose at issue in this case involves a cause of action that never accrues and thus is prevented from vesting once the ten-year repose period has passed. Because there is no property right, there can be no taking.”

H. Lastly, the Court addressed the petitioner’s argument that the statute is unconstitutionally retroactive as applied to him. The Court noted that the statute applies to all actions brought on or after its effective date (April 7, 2005) and that the petitioner’s injury occurred on March 3, 2005. The Court applied the two-part test used to determine whether a statute is unconstitutionally retroactive. Van Fossen v. Babcock & Wilcox Co. (1988), 36 Ohio St. 3d 100. The Court first found that the General Assembly expressed its clear intent to apply the
statute of repose retrospectively and went on to determine whether the statute is substantive or remedial. The Court stated that “whether a statute is remedial depends upon its operation and not upon a label placed upon it by the General Assembly.” Here, the statute operated as a very short statute of limitations that cut off the petitioner’s right to bring suit 34 days after he was injured on a cause of action that had accrued. Based on other provisions of Ohio Rev. Code § 2305.10, the Court concluded that a reasonable period of time to commence suit would have been within two years of the date the cause of action accrued (as two years is generally the statute of limitations applicable to bodily injury claims). The Court held that, as applied to the petitioner, the statute of repose was unconstitutionally retroactive.

I. The questions certified to the Ohio Supreme Court concerning the Subrogation Statutes were whether they violated the takings clause, the due process and remedies clauses, or the equal protection clause of the Ohio Constitution. The Court responded in each instance that the statutes were facially constitutional.

J. In *Holeton v. Crouse Cartage Co.*, 92 Ohio St. 3d 115 (2001), the Court determined that there was an unconstitutional taking of an injured worker’s property or denial of remedy by due course of law in that the former subrogation statutes allowed for reimbursement to the statutory subrogee from proceeds that did not constitute a double recovery. In addition, the Court determined that the subrogee could receive proceeds that would exceed what the injured worker might expect to receive.

K. The Court also found that in *Holeton* an injured worker who settled his claim was in a different position than one who received a verdict based upon interrogatories to the jury. In other words, the full amount of the settlement could be applied to subrogation, whereas interrogatories to the jury in a trial could distinguish between amounts claimed under subrogation versus amounts in the verdict that applied to pain and suffering. The new statutes developed a formula that the Court found to be constitutional and, therefore, did not violate the takings clause nor the due process and remedies clauses. Plus, an injured worker has the option of establishing a trust to avoid the consequences of overestimating future benefit values. Under the former statute, the statutory subrogee could retain any overpayment, whereas the current trust option ensures the return to the claimant of all funds remaining after the final reimbursement of the subrogee. The petitioners argued that the subrogee still may take a portion of the non-duplicative damages so that the current statutes remain unconstitutional. In order to refute that assertion, the Court used examples to demonstrate that the subrogee does not recoup any portion of the claimant’s attorneys fees, costs, expenses, or punitive damages, as the formula referred to above excludes those amounts from the amount recovered by the claimant.
The Court went on to demonstrate that the procedure described above is facially constitutional and does not constitute an impermissible taking or violation of due process inasmuch as the claimant and subrogee share in the pro rata division of the net amount received. The compromise between the claimant and the subrogee constitutes a sharing of the burden equally between the two. In determining that the equal protection section of the Ohio Constitution is not violated, the Court reviewed the statutes under the “rational-basis” test. In Holeton, the Court found that the former subrogation statute violated the equal protection clause by distinguishing between claimants who received a verdict after trial and those who settled. The Court stated that “such disparate treatment of claimants who settle their tort claims is irrational and arbitrary….” That disparity was remedied by the legislature when it developed in the new statutes a formula to determine the division of the net amount recovered. Moreover, the claimant and the employer or the Bureau of Workers’ Compensation, as a subrogee, can enter into an agreement to divide the amount available on a fair and reasonable basis. In addition, there could be a conference with the Bureau of Workers’ Compensation administration to mediate the division of an award or settlement. Finally, the parties could submit the issue to an alternate dispute resolution process. In the new statute, the formula for dividing the net amount recovered, applies to both claimants who settle their claims and those who recover after trial. Therefore, the Court determined that the rational-basis test was met.

In regards to the constitutionality of S.B. 80, the Court held that although it did contain a number of provisions, the core of the bill, concerning amendments to Ohio’s tort law, was sufficiently unified to comply with the one-subject rule.

In his concurring opinion, Lanzinger wrote separately to question the continued vitality of Westfield Insurance Co. v. Galatis, 100 Ohio St. 3d 216 (2003), which set forth a three-part test to determine when previous decisions should be overruled: (1) when the decision was wrongly decided at that time or changes in circumstances no longer justify continued adherence to the decision; (2) the decision defies practical workability; and (3) abandoning the precedent would not create an undue hardship for those who have relied upon it. Lanzinger stated that due to strict adherence to this test, Galatis jurisprudence had itself become unworkable. He believed that the Court should move away from the rigid rules of Galatis and be forthright about overruling cases when that is the Court’s true intent and is the practical effect of a decision.

In his opinion concurring in part and dissenting in part, Pfeifer, dissented from the majority’s holding that Ohio Rev. Code § 2305.10 was facially constitutional. He concurred with the majority’s holding that Ohio Rev. Code § 2305.10 was unconstitutional as applied to the
appellant and that Ohio Rev. Code §§ 4123.93 and 4123.931 were facially constitutional. Pfeifer argued that Ohio Rev. Code § 2305.10(C), establishing a 10-year limit on product liability claims, takes from one class of potential plaintiffs a fundamental right, the right to a remedy. Pfeifer illustrated his point with cases where the product in question did not fail for multiple decades, which in Ohio would leave the victims with no opportunity for recovery. Although the General Assembly had carved out exceptions for certain products, that list cannot account for all products that may possibly fail more than 10 years from now.
Elephants in the Room: MSAs, Settlements, and the New Medicare Reporting Rules

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Act Two
Reporting Obligations for Settling Insurers where Medicare is a Secondary Payer:
The Medicare, Medicaid and SCHIP Extension Act of 2007

By Matthew L. Garretson & Sylvius H. von Saucken

Abstract: A new Medicare law could make it more difficult for plaintiffs and defendants to settle single event and mass tort personal injury claims after July 1, 2009. Now more than ever, practitioners must embrace new procedures on the front end of cases in order to minimize disruption on the back end.

On December 29, 2007, President Bush signed into law the “Medicare, Medicaid and SCHIP Extension Act of 2007” (MMSEA) adding yet more teeth to the Medicare Secondary Payer (MSP) Statute. Section 111 of the MMSEA will require the providers of liability insurance (including self-insurance), no fault insurance and workers’ compensation insurance (hereinafter “insurers”) to determine the Medicare-entitlement of all plaintiffs and report certain information about those claims to the Secretary of Health and Human Services. With the objective of assisting the Secretary with coordinating benefits and uncovering potential reimbursement claims, this recent legislation reinforces that the federal government is intent on ensuring Medicare always is treated as the payer of last resort. The penalty for non-compliance has teeth indeed - $1,000 per day for each day the insurer is out of compliance. This penalty is in addition to the often-feared, rarely-levied “Double Damages Plus Interest” that defendants can be fined if Medicare’s reimbursement claim is ignored in any settlement. The new rules will apply to settlements on or after July 1, 2009.

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1 Matt Garretson, B.A., Yale University; J.D., Northern Kentucky University’s Salmon P. Chase College of Law (Chase College of Law), founded The Garretson Law Firm (Cincinnati, Ohio), which provides government benefit verification and preservation services. Matt is also the founder, President and CEO of the Garretson Firm Resolution Group, Inc. (GFRG), which assists litigating attorneys with a variety of Medicare, Medicaid and Private Health Insurance / EKISA issues, including resolving reimbursement claims and liens in single-event and mass tort cases. GFRG also provides mass tort/class action settlement allocation and claims administration services, including probate and bankruptcy coordination. Matt is the author of Negotiating and Settling Tort Cases (AAJ / Thompson West Publishing) and is a frequent lecturer at national and state bar association and industry association meetings. Sylvius von Saucken B.A., Miami University, J.D. Northern Kentucky University’s Chase College of Law is a partner of The Garretson Law Firm and serves as GFRG’s Chief Compliance Officer, where he leads the firm’s internal protocol development and training initiatives, as well as providing compliance support to the firm’s lien resolution, bankruptcy & probate coordination, and MMSEA notice agent services, as well providing oversight to the firm’s Medicare Set Aside custodial company, Affiance Partners, LLC.

2 Public Law No: 110-173.

3 MMSEA amended Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) by adding at the end these new requirements as paragraph 8.

4 Section 111 of the MMSEA also addresses new amendments to the Medicare Secondary Payer statute regarding reporting requirements for Group Health Plans. This article, however, only addresses the amendments related to providers of liability insurance (including self-insurance), no fault insurance and workers’ compensation insurance.

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Many things would need to go terribly wrong before a Medicare reimbursement claim gets to the point of a Defendant being liable for double damages plus interest. For instance, Medicare’s final demand for reimbursement...
The Centers for Medicare & Medicaid Services (CMS) is responsible for collecting various data elements from applicable reporting entities to implement the mandatory MSP reporting requirements of Section 111 of the MMSEA. This information will assist CMS in its “post-payment” debt recovery activities arising from medical expenses paid by Medicare on a conditional basis. Because Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers’ compensation, the MSP rules are intended to identify those situations in which Medicare does not have primary responsibility for paying for the medical expenses of a Medicare beneficiary.

MMSEA represents the next turbulent adjustment in the long continuum of change since President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act in December 2003 ("MMA"). The MMA further defined Medicare’s recovery rights, clarified its enforcement powers, and erased all doubt regarding a plaintiff’s lawyer’s affirmative duty to verify and resolve conditional Medicare payments made from the date of injury through the date of settlement. Whereas the teeth added to the MSP framework by MMA in 2003 were targeted from the plaintiff after a settlement must be paid 60 days from the date the final demand was issued by the Medicare Secondary Payer ("MSP") department of The Centers for Medicaid and Medicare Services ("CMS"). The MSP department allows 180 days for payment. After these 180 days transpire, the department will send an “intent to refer” letter (i.e., refer to Treasury for collection) and provide an additional 60 days to respond. So, in effect, settling parties are allowed 240 days to address the final demand. (Certain exclusions apply to a referral involving a case pending on appeal). When a case ultimately is referred to Treasury, their first step is to send a letter to the beneficiary seeking collection of the debt. If unsuccessful, the second step is to seek the remedy available through the Tax Refund Offset Program ("TARP") whereby Treasury seeks satisfaction of the lien by being “constructively paid” through offsetting the plaintiff’s government checks (benefits) and/or refunds (tax). The government will pursue this exhaustive solution to secure reimbursement from the beneficiary. Plaintiff counsel and the defendant/Carrier typically is not a target for reimbursement until the second step of Treasury recovery is fully explored. But see United States of America v. Henry L. Sosnowski, D.J. Weis, and Home Mutual Insurance Company, Defendants (822 F.Supp. 570, 41 Soc.Sec.Rep.Serv. 312, [Feb. 5, 1993]). When payment was received, Sosnowski and his attorney neglected to reimburse Medicare from the settlement, as required under federal law (42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 411.24). The federal government therefore commenced an action against both Sosnowski and his attorney, jointly and severally, for recovery of the amount due. Consistent with the MSP provisions, the court ruled that the government did have a cause of action for recovery against not only the Medicare recipient, but also his attorney for the entire reimbursement.


The Centers for Medicare and Medicaid Services ("CMS") has a right to seek recovery “against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly” if those third-party funds—rather than Medicare—should have covered injury-related medical expenses. The right of reimbursement exists regardless of whether the settlement acknowledges liability and how the settlement agreement stipulates disbursement should be made. This includes situations in which the settlement does not expressly include damages for medical expenses. The plaintiff attorney and defendant can be held responsible for twice the amount owed to the agency. See 42 U.S.C. §1395y(b)(2)(B)(iii) (2000 & Supp. 2004). Until the 2003 amendments, there was little statutory support for this position, but 42 U.S.C. §1395y(b)(2)(B)(ii) now provides recovery from an entity that receives payment from a primary insurer.

As a result, no matter how a particular settlement agreement is worded and no matter whether the tortfeasor is covered by a commercial insurance insurer or a self-insured insurer, or is just paying the claim out of its general assets, any payments Medicare makes are considered conditional.
at the plaintiff community, those added by MMSEA are directed at insurers. In this regard, the ongoing transformation of Medicare reimbursement policy and practice creates continual challenges for lawyers and their clients in personal injury and workers' compensation cases. Simply put, the days of either treating Medicare as the proverbial sleeping dog or punting the issue until the end of the case are long gone.

**Who Will Have To Report?**

Business entities responsible for complying with the reporting requirements of Section 111 (MMSEA) are referred to by CMS as “Responsible Reporting Entities” (RREs). For liability and worker’s compensation settlements, the applicable plans, including the fiduciary or administrator of such law, plans or arrangements, and/or the insurers will have to comply with specific reporting requirements. For purposes of MMSEA compliance, this group of reporting entities is considered non-Group Health Plans, or non-GHPs.

To better understand these reporting concepts it is helpful to be able to distinguish who reports for non-GHP purposes and who does not. Under the MSP, the term "Group Health Plans" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. For example, any employer-sponsored plan which provides health insurance coverage, such as Blue Cross/Blue Shield, or a self-insured plan such as Wal-Mart Associate’s Health & Welfare Plan, would have a reporting obligation that started January 1, 2009. Non-GHPs, then, are everyone else who has an obligation or assumes the responsibility for medical payments for Medicare entitled beneficiaries.

The applicable statutory language and the definitions provided by the MMSEA’s Paperwork Reduction Act Supporting Statement clarify which business entities need to report. In the context of non-Group Health Plans, fiduciaries and plan administrators (but not third party administrators) for the following entities have a mandatory reporting obligation when a claimant (plaintiff) is a Medicare entitled beneficiary.

**Insurer.**

A liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the

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9 One could argue, however, that the indirect target of MMSEA is the plaintiff community since MMSEA would be superfluous if the federal government felt its interests were being protected by plaintiffs' bar after MMA.


13 Id. The Supporting Statement For the MSP Mandatory Insurer Reporting Requirements of Section 111 of the MMSEA defines claimant (plaintiff) as including: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in “1)” or “2)).
Section 111 reporting requirements regardless of whether it uses another entity for claims processing.

No-Fault Insurance.
Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. However, for Section 111 reporting purposes, the controlling definition of no-fault insurance is insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage."

Liability Self-Insurance.
For Section 111 reporting purposes, an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession.

Workers' compensation law or applicable plans.
A workers' compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness. An "applicable plan" in the workers' compensation context is the Federal agency, the State agency, or self-insured employer or the employer's insurer.

Can Agents Report on behalf of RREs?
Yes, but agents may not register with CMS during the initial data file set up process. RREs must register themselves, but may at that time designate agents for subsequent file submissions. CMS recognizes that business entities use third party administrators and other agents to handle the large volume of claims and administration processes. Agents are not, however, RREs for purposes of Section 111 of the MMSEA. RREs may contract with agents to handle reporting, but the RRE will still be required to register with CMS, and to register its agent(s) with CMS for data file submission.

14 42 U.S.C. §411.50(b).
15 42 U.S.C. §411.50 also provides that liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. However, MMSEA would not require reporting in property damage settlements only.
What triggers a reporting obligation for non-GHPs?

Reporting for non-GHPs is event-specific (as opposed to ongoing coverage provided by GHPs). The triggering events are the dates when a business entity accepts responsibility for medical payments or when an entity settles or concludes a dispute such that there is an award or judgment. Notice to CMS of a pending settlement, judgment or award does not constitute compliance with respect to reporting obligations.

RREs are to report to CMS only with respect to Medicare beneficiaries (including a deceased individual who was a Medicare beneficiary at the time of settlement, award, judgment or other payment). If a reported individual is not a Medicare beneficiary or CMS is unable to validate a particular Social Security Number (SSN) or Health Care Identification Number (HICN) based on the submitted information, CMS will reject the record for that individual. This does not mean, however, that the reported individual is not a Medicare beneficiary, but rather that the RRE needs to further investigate the identification numbers for the next quarterly submission. Equally important is an RRE’s monitoring responsibilities. If, for example, an individual was not a Medicare beneficiary at the time an RRE assumed responsibility for ongoing medical payments, the RRE must continue to monitor the status of that individual and report when that individual does become so entitled (to Medicare coverage), unless the responsibility for ongoing medicals ends before the individual qualifies for Medicare.

Understanding triggering events is simplified when taken in context of the MSP. The sole purpose of Section 111 of the MMSEA is to ensure that settling parties fully comply with the MSP requirement – That is, conditional payments must be verified and resolved in all liability, workers compensation and no-fault settlements. In this regard, if plaintiffs’ attorneys are already verifying and resolving Medicare’s reimbursement claim in all their settlements, these new reporting rules should result in business as usual for plaintiffs and their attorneys. And, according to the Supporting Statement of the MMSEA,\(^\text{16}\) for most non-GHPs, gathering the data required may not create a huge burden for those entities that have traditionally coordinated proper claim payments with Medicare to ensure proper order of payment. Non-GHP entities not currently reporting to CMS, on the other hand, will need to adopt the CMS reporting methodology being developed for them by CMS.

The history of the Medicare Secondary Payer (“MSP”) statute provides further insight into the true meaning of Section 111 of the MMSEA. On Dec. 5, 1980, the MSP statutes as we know them today were modified to take into account Medicare’s conditional payment recovery rights. It was not until twenty-three years later, under Section 301 of the Medicare Modernization Act, when additional enforcement provisions were added to the MSP statute, focusing compliance on plaintiffs’ attorneys and their Medicare-entitled clients. Now, Congress has closed the loop with Section 111 of the MMSEA by placing a reporting obligation on self-insured defendants and/or insurance carriers. CMS’ February 3, 2009 MMSEA guidance emphasizes the fact that Section 111 did not change or remove any existing MSP rules, but adds to existing MSP requirements. As a result, for plaintiffs and their attorneys, the obligation is still to “verify and resolve” Medicare’s conditional payments, but for defendants, the sole obligation (through MMSEA) is to verify Medicare entitlement and inform CMS.

\(^{16}\) See fn. 12.
What are the reporting rules?

For all triggering events occurring on or after July 1, 2009, Responsible Reporting Entities (insurers, etc.) must engage in a two-step process:

Step 1: Determine whether a plaintiff (including an individual whose claim is unresolved) is entitled to Medicare benefits.

Step 2: If the plaintiff is determined to be entitled, electronically submit data about the plaintiff, the injury, and other, more specific information concerning the settlement to the Secretary of Health and Human Services through a website that is in the process of being established by CMS.

While seemingly straightforward, when the MMSEA first became law practitioners needed clarification regarding the intended scope of the words entitled and information. Since then, practitioners have been given guidance in the form of multiple “town hall” teleconferences with CMS representatives to ensure this process is understood and compliance is effective as of the beginning dates.

Through these open forums, and interim record layouts (leading to the completion of a CMS Reporting Manual for all non-GHPs), the following points can be gleaned:

- RREs must report where there has been a settlement, judgment, award, or other payment (when a case has not settled, but an initial payment for medical expenses has been made based on an RRE accepting such responsibility).
- One-time payments for settlements, judgments or awards are reportable.
- If an RRE has accepted an ongoing responsibility for medical payments (ORM) (e.g. workers' compensation settlements), two events must be reported: (1) an initial record to reflect the acceptance of such responsibility; and (2) a second (and final) report reflecting the termination of that responsibility. An example of such reporting would be the case where an insurer starts making medical payments based on an injury (initial date of payment obligation), and then stops when the case settles and that obligation ends (date of settlement).
- RREs must report settlements, judgments, awards or other payments regardless of an admission or denial of, or determination of liability.
- The RRE, for reporting purposes, only needs to report the total obligation, and does not have to allocate damages between indemnity and medical payments.17
- To date, there is no de minimus exception for reporting requirements.
- There is no reporting requirement for "property damage only" claims.
- There is, however, a reporting requirement for settlements, awards or judgments or other payments in which medicals are claimed and / or released, regardless of allocation by the parties or a determination of "no medicals" by a court. This does not affect an RRE's reporting obligation, although it may impact whether or not CMS has a recovery claim with respect to that settlement, judgment, award or other payment.
- There is no age threshold for reporting purposes.

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17 This is an important point when defusing the misinformation claiming that MMSEA now requires a liability Medicare Set Aside. Whereas in the context of considering Medicare's interests for future costs of care in settlements, allocation is a key tool to determining the propriety of a set aside, allocation plays no role in reporting for MMSEA compliance purposes.

2.6 • Insurance and Negligence Law Update
If there is no settlement, judgment, award or other payment and the file is ready to be
closed, there is no reporting obligation.

However, if a file is closed due to a “return to work,” but a payment responsibility is
subject to reopening or otherwise subject to an additional payment request, the RRE
must add this plaintiff to the reporting list.

For liability insurance cases (including self-insurance), each new payment obligation
must be reported as a separate settlement, judgment, award or other payment. But,
where such payment is made through structured settlement, or annuity purchase, there
is only a single report required with respect to the total amount of the obligation.

CMS is considering appropriate modifications to reporting rules for mass tort or Multi-
District Litigations.

General Reporting Requirements
CMS is developing a process in which a website will be created to receive all data submissions
electronically. Each RRE will be assigned a separate identification number. Files will be
submitted on a quarterly basis, within an assigned seven day submission period during each
quarter.

Input Claim Files will contain forty-five data points, organized by injured party, plaintiff (if
different from injured party), primary plan (requiring a separate report for each plan and / or
insurance type), policy holder, injured party / plaintiff attorney / representative, incident and
resolution. Further data point details are available at www.garretsonfilm.com.

A reporting timeline
Because CMS is still completing its Coordinator of Benefits Secure Website, RREs will have to
adhere to a specific timeline. While the original statutory interpretation of Section 111 of the
MMSEA suggested to settling parties that reporting would have to occur starting on July 1,
2009, the practical application of this new Medicare law clarifies that registration must be
complete by July 1, 2009. As a result, RREs will have the following timeline (for non-GHP
matters):

- **Current Systems Dev. Period:** 01/01/09 – 05/01/09
- **RRE Registration:** 05/01/09 – 06/30/09
- **Testing Period:** 07/01/09 – 09/30/09
- **Submission of Prod. Files:** 10/01/09 – 12/31/09
- **Completion date of implementation:** 01/01/10
- **Special Extension Date (see below):** 06/30/10

File Submission Steps & Timing Issues
Once insurers and other RREs identify a reporting obligation, steps need to be taken to both
register, and implement a claims procedure in which the additional information is gathered for
reporting purposes. The key element in any claims procedure will be determining whether an
injured party is a Medicare beneficiary. RREs will have to submit (to CMS) either the SSN or
the HICN for the injured party on all Input Claim File detail records. RREs will have to report on
all claims whether the injured party is/was a Medicare beneficiary, that are resolved or partially
resolved through a settlement, judgment, award or other payment on or after July 1, 2009,
regardless of the assigned date for a particular RREs first submission. Any ongoing responsible
medical payment that is completed before July 1, 2009 will not require reporting. But any such
payment that starts before July 1, 2009 and continues past that date will be required to be listed on the RRE’s first submission starting in October, 2009. Because information about prior triggering events may not be readily available, CMS is providing RREs with a special extension through June 30, 2010 to go back to determine the Medicare status of individuals for whom there is a pre-existing ongoing medical payment responsibility which continues past the July 1, 2009 trigger date.

The Need for SSNs and HICNs in the Section 111 Reporting Process.
At the same time, CMS recognizes the critical importance of RREs being able to obtain Social Security Numbers (SSN) and / or Health Care Identification Numbers (HICN). This is because the SSN is the basis for the HICN, and the Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet its administrative responsibilities to pay for health care and to operate the Medicare program. The HICN is also used by CMS to ensure the Medicare program makes payment in the proper order and / or take the proper recovery actions. Without this cornerstone, CMS would not be able to systematically link the reported data to a particular beneficiary.

Any topic of providing SSNs cannot be reviewed without referring to the Federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created regulations which strictly regulate data transfer issues such as when an SSN is to be used for personal health information, how that information is to be managed and used, who can collect it, and how it can be shared. Understandably, in light of today’s “information age” and legitimate concerns surrounding identity theft, plaintiffs may be hesitant about providing their SSNs to insurers and other RREs. However, the collection of SSNs and similar protected health identification information for the purposes of coordinating benefits with CMS is a required, legitimate and necessary use of the SSN under Federal law.¹⁰

Despite the legitimate function of an RRE collecting this protected health information, Section 111 does not provide “implied consent” allowing RREs to request Medicare entitlement information. And, Section 111 of the MMSEA does not require a plaintiff to authorize an RRE to obtain entitlement information from the Social Security Administration. Finally, CMS has clarified in its many town hall teleconferences and in its guidance on MMSEA reporting that RREs remain responsible for creating procedures to determine a plaintiff’s Medicare status.

To attempt to address this seeming dichotomy, CMS is developing a QUERY ACCESS System to be added to its Section 111 MMSEA website for RREs. This system would be usable by RREs to determine Medicare entitlement status provided the RREs have some identifying health information such as an SSN or a HICN. To date, CMS has advised it anticipates the system to provide “yes/no” answers to questions, but would not provide any dates of Social Security entitlement via application or otherwise, and would not be considered a “safe harbor” such that the RREs would not have to develop their own verification procedures.

¹⁰See fn 12, 13 and The Supporting Statement For the MSP Mandatory Insurer Reporting Requirements of Section 111 of the MMSEA, which notes that while collecting SSNs is a legitimate Federal function, MSP and HIPAA laws also preempt any state statutes which might otherwise attempt to limit this information.
How will Medicare use this information?

As MMSEA implementation begins, a moment should be spent contemplating how Medicare will utilize this plaintiff/settlement information. The statutory language of Section 111 of the MMSEA provides that the Secretary (of Health & Human Services) shall specify the information that insurers must submit that will enable the Secretary to make "an appropriate determination concerning coordination of benefits, including any applicable recovery claim."19

The phrases “coordination of benefits” and “applicable recovery claim” address two separate, but inter-related issues. The former refers to MSP’s two activities: “pre-” and “post-payment.” Pre-payment activities are generally designed to stop mistaken payments from occurring when Medicare should be secondary. Post-payment activities are designed to recover mistaken or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers’ compensation case which has resulted in a settlement, judgment, award or other payment. The latter phrase speaks solely to who should have paid those expenses.

More specifically, in the personal injury and workers’ compensation context, coordination of benefits is Medicare-speak for ensuring that if there is another source of coverage that is available for someone’s injury-related care, he or she should use it. If no other source of coverage is available (and the person is eligible for Medicare), Medicare will begin paying for injury-related care. Further, in the same context, recovery claim refers to situations where some other source of funding is later found that should have been paying all along. In that instance, Medicare gets reimbursed for past injury-related expenses.

MMSEA Does Not Equal Liability MSAs.

The point of this article is to spark dialogue and provide a MMSEA roadmap for those impacted entities, not anxiety. In recent years, the timeframe that is subject to Medicare’s interest in personal injury matters has been the subject of tremendous scholarly as well as practical debate. Specifically, the focus of the debate is whether Medicare’s interest is only related to the past (i.e., for injury-related care from the date of injury through the date of settlement) or, whether Medicare has an interest in settlement proceeds related to the future cost of care. In previous articles,20 our firm explored the issue of whether Medicare requires parties who settle liability claims to calculate a “set aside” amount that the injured client must spend on injury-related care before Medicare picks up the tab again. The roots of the set aside obligation are similar to the coordination of benefits concept, which, in effect stands for the proposition that if another source of coverage (i.e., settlement dollars earmarked as payment for medicals) exists for a plaintiff, he or she should use it first.

In the workers’ compensation arena, this question has been squarely, yet controversially, answered. If a workers’ compensation carrier is settling its future obligation to pay for injury-related care, the settlement must properly recognize the shift of this future burden to Medicare by allocating a portion of the settlement proceeds to cover those costs of care.21 Medicare does not pay for care -- before or after a settlement -- until the beneficiary has exhausted his or her

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20 “Making Sense of Medicare Set Asides,” Trial, May 2006. See also “The Only Constant is Change” available in the library at www.garretsonfirm.com, which contains further analysis regarding set aside issues in the liability settlement context.
remedies under workers' compensation. This includes spending the portion of any settlement earmarked for future medical expenses.

For liability settlements, this set aside question has never been addressed to the satisfaction of most personal injury practitioners. Certainly, the fundamental statutory principle requiring settling parties to protect Medicare's interests in workers' compensation settlements already exists and appears to apply to liability settlements as well. Yet, while perhaps no new laws or regulations need be promulgated before Medicare could extend the reach of set asides to the liability context, obstacles currently exist which have made it, in our opinion, very difficult to fairly, efficiently and uniformly apply the set aside requirement to liability settlements.

Specifically, unlike workers' compensation, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. Currently, CMS' "set aside" calculation methodologies are geared toward the full-value, "no fault" nature of workers' compensation statutes. The types of damages in workers' compensation cases, such as "indemnity" and "medical" payments, are readily delineated, but in personal injury settlements, an array of damages can be categorized as "general" and "special." Absent a court finding on the merits of the case, presently there is not an efficient mechanism to determine what the intention of the parties was in making payment to the plaintiff (i.e., allocation between medical and non-medical damages).

"MSA" has become a buzzword in the settlement community due to various memoranda from the Centers for Medicare and Medicaid Services ("CMS"). As a part of the "Patel memorandum" issued in 2001, CMS expressed its preference for practitioners to use MSAs as the suggested means for considering Medicare's interest in workers' compensation settlements. Subsequent memoranda further elaborated on the proper application of MSAs in workers' compensation settlements. However, CMS has yet to address the use of MSAs in liability settlements in a similar manner. This lack of guidance has created uncertainty among practitioners involved in liability settlements.

When MMSEA was announced, some opined that Medicare would now begin requiring liability settlements to include MSAs starting July 1, 2009 and / or that such guidance is expected shortly from CMS. Such an interpretation of MMSEA misses the mark. CMS has not offered any formal guidance on the issue of liability MSAs and we believe such guidance will not be coming in the near future. Moreover, CMS has repeated in its last five "town hall"

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24 The MSP provisions say Medicare is always secondary to workers' comp and other insurance, including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan." 42 U.S.C. §1395y(b)(1), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006). Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' comp settlements does. Social Security Act §1862, as amended, 42 U.S.C. §§1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006).
25 The only statement this author envisages Medicare making on the issue will be designed to clarify any misinformation about whether or not MMSEA is intended to lead to formal protocols/procedures for addressing the liability set aside issue. For more information about the factors involved in conducting a good-faith, case-by-case analysis of whether steps must be taken to protect Medicare's future interest in liability settlements see page 15 of
teleconferences that MMSEA’s settlement-reporting requirements are not intended to replace or change CMS’s recovery practices, including MSA guidance. CMS’ February 3, 2009 MMSEA guidance emphasizes the fact that Section 111 did not change or remove any existing MSP rules, but adds to existing MSP requirements. Quite simply, the MMSEA is not designed to be a “Trojan horse” for liability MSAs.26

A rationale interpretation of Section 111 of MMSEA is that the new requirement for defendants to report information about resolved or unresolved claims is a sign that CMS is not yet content with the entire regulatory framework utilized to enforce its secondary payer status. It is a work in progress so to speak.

Changing Habits

From the start of every new case, plaintiff’s counsel is familiar with worrying about possible liens on the claim. These concerns, however, are in large part relatively new for defendants and insurers. Accordingly, insurers will need to institute internal procedures for compliance with the MMSEA. Such procedures will follow, of course, the 45 data points provided by CMS. While dialogue continues to take place and will lead to clarity, below are some initial practice considerations for insurers:

- **Consent to Release Information** - Since insurers will need to determine the Medicare eligibility status of every plaintiff, regardless of whether the claim has been resolved, they may need to require each plaintiff to sign a Social Security Form SSA-3288 (Consent to Release Information). This form can be submitted to the Social Security office closest to the plaintiff’s residence with a request for complete benefit eligibility information. Ideally, this should be done at the time the claim is opened and again at the time the claim is resolved through judgment, settlement or award. A plaintiff who is not eligible for Medicare at the time the claim is initiated may have become eligible by the time the claim is finally resolved. Be sure consent to release information includes the plaintiff’s counsel so he/she is included on any resulting correspondence.

- **Data Collection and Storage** - Further, insurers must take the required steps to ensure they are set up to collect, manage and transmit (in a HIPAA-compliant manner) such data as the plaintiff’s SSN or Medicare HICN and the additional required data points. In other contexts, like resolving Medicare reimbursement claims after settlement or seeking the approval of Medicare set asides, the data transmitted includes a copy of the judgment or settlement; medical records, applicable ICD-9 codes, life care plans or cost projections; life expectancy information; the insurer’s payment history on the claim and


26 When CMS announced the “review and approval” protocols for Workers Compensation MSA, it did so with a series of memoranda. See for instance, Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers’ Compensation: Commutation of Future Benefits" (July 23, 2001), available at [www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.rtf](http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.rtf) (last visited Mar. 4, 2006). At this point, there is no objective evidence that such policy memoranda could be coming soon for set asides in liability settlements.
any other documentation that Medicare deems helpful in determining whether its interests were reasonably considered.

One also may question whether the new requirements ultimately will lead to a change in the process by which claims are paid by defendants. In recent years, many in the plaintiff bar have seen insurers place both the plaintiff's name and Medicare on a settlement check, leaving the attorney and plaintiff with the obligation of getting Medicare to endorse the check. The assumption by the carrier is that this process, while a terrific burden on the plaintiff and his or her attorney, ensures that any obligation to Medicare is addressed since the check cannot be cashed by the plaintiff unless Medicare first signs off. Those insurers who like to wear a "belt with suspenders" are going even farther and agreeing on settlement in principle, but requiring some written verification by Medicare (provided by plaintiff or his/her attorney) demonstrating that no reimbursement obligation exists, or that it has been satisfied. Is it too far of a stretch to now envision an end-game wherein Medicare will expect (and/or the insurer will want to make) payment directly to Medicare from the insurer and not to the trust account of the attorney?

Indeed, on this point Medicare's intent is clear – Medicare wants its interest satisfied in any settlement prior to distribution to the plaintiff or attorney. Medicare states that no disbursement of settlement should be made until Medicare's interest is satisfied in full. The authors believe that the cautionary steps of requiring Medicare's name on the check and/or asking for proof that Medicare's interests have been satisfied can be avoided if the plaintiffs' firms have in place a formalized process to identify, verify and resolve Medicare claims early in their firms case management procedures. Doing so would allow those firms to demonstrate to RREs that they reported the case timely to the COBC; and to provide the RREs with a) the data that was already reported to the COBC (to ensure it comports with the RREs' data reporting); as well as b) the most current conditional payment summary (such that the only remaining step is to get the final demand issued by presenting MSPRC with the settlement details). Integrating an RREs procedures with those of plaintiffs' counsel will only serve to protect the RREs from the penalties associated with Section 111 reporting, and if connected properly, can result in greater efficiencies and protection throughout the settlement process, without resorting to adding Medicare to a settlement check, which does not satisfy those reporting obligations in the first place.

**Issues for Plaintiffs' Counsel**

Medicare's role in settlements is undeniably evolving. As most plaintiff attorneys already understand, formal procedures must be implemented in their practice, and they cannot wait to receive a notice of a potential claim from CMS before taking action. The agency is not required

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27 If the insurer makes the check out to more than one party including Medicare, Medicare's policy is as follows: All parties must endorse the check. The check is then sent to Medicare for deposit. Medicare will issue a separate check for the award amount less Medicare's claim amount to the attorney after a five-day waiting period. Alternatively, if Medicare is sent separate a check for Medicare's claim amount, Medicare will deposit the check made out to Medicare and endorse the multi-party check. The multi-party check will be immediately returned to the attorney.

30.4.1 Medicare Secondary Payer Manual, "Existence of Overpayment", stating that settlement proceeds should not be disbursed until Medicare's claim has been satisfied.
to give notice, so lawyers must proactively identify, verify, and satisfy Medicare’s interests before distributing any settlement proceeds. For those practitioners who have not yet created solid internal protocols, this new law will place greater importance on making sure that an appropriate Medicare verification and resolution strategy is fully integrated into their practice. The tenets to such a successful strategy would include protocols for getting started early, enhanced client intake information, client education modules, and, for complex cases, perhaps changes in retainer agreements that allow the attorney to seek outside assistance to handle lien verification and resolution.

For those practitioners representing insurers (and other RREs), the plaintiff’s obligations to “verify and satisfy” would be complemented by this new obligation to verify, provided the plaintiffs have representation. In the case of the unrepresented plaintiffs, the necessity to verify and satisfy becomes more readily apparent, in which case, insurers should implement a protocol in which assistance is sought to ensure proper compliance with the MSP rules, including satisfaction of conditional payments. Simply put, given the impact of Section 111 of the MMSEA, a RRE’s mandatory duty to verify Medicare entitlement through reporting on the CMS website may not be enough to properly address Medicare’s interests where conditional payments have been made. In that case, outsourcing to a qualified lien resolution firm may be an insurer’s best response.

Neutral Assistance for the Parties

This notion of seeking outside assistance with lien resolution is a relatively new development, yet it is not without good purpose. Plaintiffs’ attorneys are keenly aware that they struggle to keep up with the changing regulations, protocols and contractors associated with the liens competing for a “share” of the client’s recovery. Many believe their clients’ interests are best served if the attorney’s time and efforts are spent on addressing damages and liability. With MMSEA, defense attorneys now share these same concerns.

This authors’ firm, The Garretson Firm Resolution Group, has a practice area exclusively focused on evaluating and resolving healthcare liens and reimbursement claims with federal (Medicare), state (Medicaid) and private health insurance (ERISA) providers in single event and mass tort settlements. In this respect, while the attorney focuses on litigation (his or her expertise), our firm’s attorneys, billing/coding specialists and experienced lien resolution analysts focus on ensuring reimbursement claims and liens are handled in a compliant manner; affirmative duties are properly executed; defendants receive the benefit of the bargain and injured individuals receive the maximum benefit from their settlement.

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28 Medicare’s right to reimbursement is superior to almost all other claims, including those of the injured individual. 42 C.F.R. §411.26, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006). See also footnote 5 for discussion of United States of America v. Henry L. Sosnowski.


30 Certainly seeking the assistance of experienced and knowledgeable resources is the accepted practice in personal injury matters when the client’s case requires attention related to probate, bankruptcy, the calculation of Medicare Set Aside accounts and disability planning (e.g., special needs trusts).
Conclusion

As discussed above, this new legislation puts new reporting burdens on insurers which are designed to close the MSP reporting loop to ensure that plaintiff and their counsel alike have satisfied their obligations to verify and satisfy Medicare’s (conditional payment reimbursement claim) interests. At the same time, the new reporting requirements have sharp teeth, with a $1,000 per day penalty for non-compliance. And, the MMSEA also allocates $35 million towards assisting CMS in its compliance activities.

Undeniably, lien resolution is no longer an administrative function that can be addressed by the plaintiff’s attorney on the back end. Nor is it any longer a subject that defendants address simply by requiring only an indemnification clause. Rather, it has evolved over the last several years into one of the most demanding condition precedent in any settlement agreement, often requiring counsel to affirmatively notify the governmental healthcare agencies (i.e., Medicare and Medicaid) of plaintiffs who are settling their cases, and then proactively satisfying those agencies’ interests prior to disbursement of settlement proceeds to those plaintiffs.

In light of MMSEA, plaintiffs, defendants and insurers must communicate and cooperate to make sure MMSEA does not add yet another level of disruption to the already complex and time-consuming settlement process. With all settlement-related Medicare issues, a proactive rather than reactive approach will yield a better result. Integrating your claims procedures to verify entitlement with plaintiffs’ attorneys (if any) existing procedures to verify and resolve those subrogation issues will protect you from the potentially harsh realities of today’s MSP program. It is equally important to not fall into the hysterical trap of believing that MMSEA does more than add a reporting requirement to insurers and other RREs. The statutory history and recent CMS guidance does not bear out the missives being promulgated by the MSA industry and others. Instead, if you focus on implementing the reporting procedures that have been provided by CMS, you can get back to settling your cases with confidence that Medicare’s interests have been properly addressed and penalties will not accrue. Given the time needed to gather the required information, you need to start earlier in the settlement process. That is the true meaning of MMSEA. Simply put, if you know you are going to have to deal with it in the end, why not start addressing it in the beginning?

To learn how the Garretson Firm Resolution Group is taking proactive measures to implement MMSEA requirements into its lien resolution practice for settling parties, please contact the authors at (513) 794-0400.
Elephants in the Room: MSAs, Settlements & The New Medicare Reporting Rules

Sylvius von Saucken
The Garretson Firm Res. Group

Presented to the Ohio State Bar Association
May 14, 2009; Renaissance Cleveland Hotel
Insurance and Negligence Law Update

One More Thing To Worry About...

MEDICARE's EVOLUTION
✓ MSP changes (12/5/80)
✓ MMA 301 (12/7/03)
✓ Medicare (1/1/96)
  > Changes in MSP/MRC
  > Medicare Part D
✓ Medicare in 2008-09
  > MMA 2008 (1/2/08)
  > Effective July 1, 2009

The Big Shift
✓ All this change is causing...
✓ Shift away from "indemnification" clauses...
✓ To affirmative obligation as condition of settlement
✓ Requires starting much earlier
✓ Formal verification of entitlement
✓ New rules for defendants / Insurers as of 1/2009 and 7/2009
When Rules Change, So Must the Gameplan

Old Post-Settlement Continuum

Agreement On Settlement Amount  Medicare / Medicaid Preservation (Trusts / Set Aides)  Disbursement

Lien Reimbursement  Structured Settlement Paperwork

New Settlement Continuum

Agreement On Settlement Amount  Medicare / Medicaid Preservation (Trusts / Set Aides)

Lien Resolution  Structured Settlement Paperwork  Disbursement

Medicare & Single Event Cases

✓ §301 - Medicare Prescription Drug Improvement & Modernization Act
✓ Authorizes reimbursement in all settlements
✓ Eliminated the debate
✓ Regardless of "wordsmithing"
✓ First right of recovery (before Medicaid or ERISA)
Types of Medicare

- Part A (federal)
- Part B (federal)
- Part C (or Medicare "Advantage" plans)
- Part D (or Prescription Drug Coverage)
- Medigap Policy or Medicare Supplemental Insurance

Do All These Plans Have “Liens”?

- Part A and B
  - Federal MSP Tort Recovery Division
- Part C, D and Supplements
  - Private, independent providers / plan specific

Consequences For Not Considering...

- Client dissatisfaction
  - Potential loss of coverage
  - Future benefits may be offset until claim satisfied
- Further strain on firm resources
- Attorneys/parties – Direct liability
Why Does It Take So Long
✓ Private contractors
✓ Medical providers have up to 25 months to bill Medicare
✓ Need to review to ensure...
   ➢ Expenses occurred between date of injury and date of settlement
   ➢ Related

A Big Statement
✓ If you know you are going to have to deal with it in the end, why not start addressing it in the beginning?
✓ Completion in 30 to 45 days from settlement?
   ➢ Is it possible?
   ➢ 100 days start to finish if done right

Medicare Resolution Process
FIRST - VERIFICATION - your duty to find out if there might be a Medicare lien in any way - your obligation to give notice!
Resolution Process
✓ Coordination of Benefits Office
   ➢ (800) 999-1118
   ➢ Always call...never fax
✓ Assign Lead Contractor
✓ Request Injury Related Care
Conditional Payment Summary
What to Provide COB

- Client Profile Information
  - Name, Address, DOB, SSN, Medicare #
- Injury Detail – BE SPECIFIC
  - Date of Injury
  - Injury Description
    - Rifle Shot Approach vs. Shot Gun
      - Serves as filter for preexisting
      - Prevents needing to use medical records to get removed
    - Provide Detail (windows and codes)
    - Liable party info (if available), or form MVA include insurer info with policy/claim #
    - Names, address, info re other coverage

Resolution Process (Cont.)

- Final Demand
- Re-determination or reconsideration requests of Final Demand
- Appeals are time sensitive (120 days from date of demand)
- Consider Waiver (does not have deadline)
  - After final demand has been issued
  - Waivers can't be reviewed until the "overpayment" has been created

Preservation of Settlement

- Compromise
  - Out of Pocket
  - Request for Fals Reduction
- Waiver
  - Fair & Equitable
  - Harmful
- Compelling Story
  - Use of Net Proceeds – what is the client going to use the extra $ for?
- Rule of thumb – Never more than 1/3.
What Can Settling Parties Do To Assist?
- Make sure they provide you with all the info
  - Name, DOB, SSN, Medicare #, type of plan
- Make sure client does not duplicate efforts by contacting Medicare directly
- Sign up and access Explanation of Benefits (EOB) through www.MyMedicare.gov
- Keep accurate journal of all medical treatment related to injury
  - Include name of provider, date and service type
  - Monitor treatment history to make sure accurately reported on the EOB.

What Changes Are Coming?

✓ Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")
On or after July 1, 2009, insurers must engage in a two-step process:

> Step 1: Determine whether a claimant (including an individual whose claim is unresolved) is entitled to Medicare benefits.
> Step 2: If the claimant is determined to be entitled, submit certain information about the claimant to the Secretary of Health and Human Services in a form and manner (including frequency) specified by the Secretary (CMS website portal).

How will Medicare use this information?

> Two separate and distinct time frames...
> "Coordination of benefits" – Who should be paying for medical care presently and/or in the future
> "Applicable recovery claim" – who should have been paying in the past

How will the MMSEA change future settlement programs?

> Prospectively, CMS will request 45 data points from defendants in the following areas:
  - Injured Party data (name, contact info, DOI, SSN, HICN)
  - Claimant data (if different than Injured Party)
  - Primary Plan data (type, name, contact info, policy #, claim #, limits)
  - Policy Holder data (name, self-insured)
  - Injured Party/Claimant Attorney data (name, contact info)
  - Incident data (DOI, nature, cause, versec)
  - Resolution data (settlement amount, claim resolution, funding)
MMSEA

✓ Five CMS Town Hall Conferences (Highlights)
  From Oct. 2009 thru Feb. 2010, 6 conferences with CMS clarified the
  new reporting obligations:
  > BRE - Reporting Entity has obligation.
  > Triggering Event - Date RRE obligated to pay (per settlement,
    judgment, award), if no payment yet.
  > Deadline - 7/1/09 remains a key date. Carriers and self-insured
    plans to report gross settlements if accounting prospectively. But
    reporting will not start until 10/1/09.
  > Exempt with MMSEA - No. Interim CP verification does not relieve
    RRE of exp. obligation, but registering by RRE and reporting on a quarterly
    basis will satisfy Sec. 111 of MMSEA.
  > Info - name, DOB, M/F, SSN (follow Paperwork Red. Act).

How will the MMSEA change what defendants demand in future Settlement Programs?

✓ Prospectively, CMS will request 45 data points from defendants in the following areas:
  * Injured Party data (name, contact info, DOB, SSN, HICN)
  * Claimant data (if different than Injured Party)
  * Primary Plan data (type, name, contact info, policy 
    #, claim #, limits)
  * Policy Holder data (name, self insured)
  * Injured Party/Claimant Attorney data (name, contact 
    info)
  * Incident data (DOE, nature, cause, venue)
  * Resolution data (settlement amount, claim resolution, 
    funding)

Additional Points from Conferences

✓ MMSEA - Obligation ofhic. carriers and self insureds same as that of WC carriers, despite lack of any formal process.
✓ Ct determined allocation - A non-judicial allocation 
  resulting in $0 liability may not preclude CMS recovery of 
  conditional payments.
✓ Electronic reporting only. Registration process starts May 
  1, 2009 for non-GHP entities. CMS will work on a manual
✓ CMS website - Look to for further information as the 
  registration website gets completed:
    www.cms.hhs.gov/MandatoryInsReg.
✓ CBT Training for Sec. 111 Reporting - Call 866-458-6740 
  to register!
Changing Habits

- Changing habits for defendants / insurers
- Consent to release information
- Data collection and storage
- Will it lead to change in process by which claims are paid by defendants?

Issues for Plaintiff's Counsel

- Change, Change, Change
  - Internal protocols for verification and resolution
  - Tenets – starting early, enhanced client intake, education modules, resolution strategy/assistance.
- Collaborate!
- Advise counsel up front of your procedure to integrate with RRE-COBC reporting process.

Other Issues

- CMS: is working to ensure education and compliance (since Oct. 2008)
- CMS's QUERY ACCESS System
  - Tool for determining Medicare Entitlement Status
- Time Line for Compliance
  - Jan. 1 – May 1, 2009 (registration set up)
  - May 1 – June 30, 2009 (RRE registration)
  - July 1, 2009 (starting date for events subject to reporting)
  - October 1, 2009 (first quarterly reports due)
Not a Trojan Horse
✓ MMSEA does not = MSAs!
  ➢ Don't succumb to paranoia:
    ➢ MMSEA = reporting requirement (defense)
    ➢ MSA = permanent burden shift for future cost of care analysis (ailment)
  ➢ CMS has repeatedly in its last 5 town hall teleconferences that Section 111's reporting rules are not intended to replace or change CMS' recovery practices, including MSA guidance.

What About Future Payments? (Do I need one of those set asides?)

Setting aside an amount to be spent down after the settlement on injury-related care before using Medicare

WHAT Exactly is a Medicare Set-Aside
✓ Money set aside after a settlement to satisfy the Medicare Secondary Payer (MSP) statute requirements
✓ Covers future medical expenses related to the injury for which Medicare would ordinarily pay.
✓ Acts like a deductible that client pays before getting benefits from Medicare again...
More on MSAs

✓ When a part of a settlement is allocated to future medical expenses, if settling the case creates a shift of that payment obligation to Medicare, you must consider Medicare's interests.

  ➢ Manages Future Costs of Care
  ➢ Not a statutory requirement, but suggested as part of CMS memos (in complying with MSP).
  ➢ Focus: permanent burden shift - who will pay for the treatment after the settlement

Future Costs of Care (Medicare covered)

✓ Authority already exists to require "set-asides" in all settlements (work comp and liability)

✓ Under the MSP provisions, Medicare is always secondary to worker's compensation and other insurance such as no-fault and liability insurance.

✓ Under Section 1862(b)(1) of the Social Security Act payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan).

WHEN Is a Medicare Set Aside Required

Work Comp - Yes, if meets criteria....

✓ Already on Medicare
  ➢ > $26,000 CMS will review; or,
  ➢ Under $26,000 – they don’t want to see it… but still may be required if part of settlement is for future medicals

✓ Not already on Medicare - Reasonable Expectation, 30 months eligibility, > $250,000

Liability - Yes, if FCCs + PBS, then analyze/allocate damages to determine MSA obligation.
What To Do?
- Regional office discrepancies (i.e. Atlanta, S.F.) re review/approval for Liability Medicare Set-Asides.
- BLACKBOARD DAMAGES (analyze)
- Substantial compliance + good faith
- Recognize and develop a formalized process for Medicare Set-Asides (documenting file).

Analysis
- What was plead & released
- Who has been paying for injury-related care?
- Will there be future injury-related care (treatment, management, drugs)?
  - if not, get a treating physician letter
  - Don't be spooked by large life care plan
- Is claimant on Medicare?
- Will Medicare now be absorbing the burden?
- Documentation of types of damages being released...

Documenting the File...
- The parties should heavily document their files and incorporate language into the settlement documents explaining how they have "considered Medicare's interests."
- Examples include:
  - Complete analysis and allocation by qualified "MSA" professional;
  - Letters from treating physicians supporting that no future injury-related care is necessary or supporting small costs only
MSA Reform – Any Legislative Relief?

- MSP Reform Bill (H.B. 2549) – dormant, but ...
- Would amend 42 USC §1395y(b) – to create a statutory rule for MSAs (none exists today)
- Would create exemptions from MSA statutory requirements.

Completing an MSA Evaluation Requires...

- Completed assignment sheet
- Social Security Release
- CMS Release
- Last 2-3 years of payments (Med & Ind)
- Last 2.5 years of medical reporting
- Part D consideration
- Rated Age (when applicable)
  - May Lower Set – Aside Amount
  - CMS approves
  - Helps settle cases (carrier/life company)

Final Tips –
What More Can I Do Now?
What Else Can I Do Now?

- Improve Your Case Intake
  - Screening and questionnaires
  - Simply "yes"/"no" is no longer sufficient
  - Need entitlement dates
  - Detail regarding plan elections A, B, C, D
  - Sample questionnaire available in our website library:
    - www.garretsonfirm.com/library.php
  - Article: "Does Your Retainer Agreement Still Cut It?"

What Else Can I Do Now?

✓ Provide educational materials to unrepresented clients
  ➤ See video series on Garretson Firm website
  ➤ The point is to better educate clients to manage their expectations and...
  ➤ Let them know what they can do to help speed up the process

YMSEA ACTION STEPS

✓ Discuss reporting requirements with agent or internally to develop compliance model.
✓ Ensure systems follow CMS guidelines – COBC submissions:
  ✓ Via HTTPS (via SFTP) need to use ASCII format.
  ✓ Transmitted directly to COBC mainframe can use Direct Connect (AT&T Global Network System (AGNS)).
✓ REGISTER BETWEEN 5/1/09 and 6/30/09
✓ START TESTING 7/1/09
✓ FIRST BATCH SUBMITTED STARTING 10/1/09

2.30 • Insurance and Negligence Law Update
Consider Partnering

- The shift away from defendants relying upon "indemnification clauses" in Master Settlement Agreements to requiring "proof of resolution" prior to reimbursement to clients.
- Statistics—How many clients does this issue impact?
- Today, there are dozens of companies focused on providing specialized services to facilitate recovery for the government and private plans. Collectively they employ over 15,000 people.
- Recent study suggests that 55% of the average personal injury law firm's cash flow is tied up in liens that impact 15% of the firm's overall case inventory.
- Increasingly, the laws are saying it is the attorney's obligation.
- The MMSEA reporting requirements for defendants will complicate things further.

What the ABA Says

- Protect confidential information.
- Ensure that the service providers are competent and suitably trained.
- Conduct reference checks and background info for service providers.
- Perhaps interview the primary professionals on a project team.
- Obtain the client's informed consent.
- Referring attorney must "oversee".
- The client gets a net benefit out of the arrangement (if passing fee to client).
- The fees are reasonable (if passing the fee to the client).

Conclusion

If you know you are going to have to deal with it in the end, why not start addressing it in the beginning?
Thank You

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Emerging Issues in Ohio UM/UIM Law

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Emerging Issues in Ohio UM/UIM Law*

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INTRODUCTION

A. Recent Ohio appellate court decisions illustrate how the landscape of uninsured/underinsured motorist (UM/UIM) law has changed dramatically by the General Assembly’s 2001 abolishment of mandatory offering/rejection of UM/UIM coverage.

B. This chapter summarizes recent trends in Ohio UM/UIM law that have emerged during the past year or so.

ABOLISHMENT OF STATUTORY LIMITATIONS ON UM/UIM COVERAGE EXCLUSIONS

A. In Snyder v. American Family Insurance Co., 114 Ohio St. 3d 239, 2007-Ohio-4004, the Ohio Supreme Court was presented with two issues: (1) whether the 2001 amendments to Ohio’s UM statute, Ohio Rev. Code § 3937.18, contained in Am. Sub. S.B. No. 97 (S.B. 97), effective October 31, 2001, permit a motor vehicle insurance policy to exclude UM benefits when the tortfeasor is statutorily immune from liability; and (2) whether an insurance policy that restricts coverage to amounts that the insured is “legally entitled to recover” from the uninsured tortfeasor unambiguously provides that coverage will be denied when the uninsured tortfeasor is protected by statutory immunity.

1. The Snyder Supreme Court held that the current version of Ohio Rev. Code § 3937.18 does not prohibit enforcement of a motor vehicle insurance policy that excludes UM benefits when the tortfeasor is statutorily immune from liability.

* Current through March 13, 2009.
2. The *Snyder* Supreme Court also held that policy language restricting UM coverage to those amounts the insured is “legally entitled to recover” from the tortfeasor owner or operator of an uninsured motor vehicle unambiguously denies coverage for injuries caused by uninsured motorists who are immune from liability under Ohio Rev. Code Chapter 2744 or Ohio Rev. Code § 4123.741.

3. Among the significant changes in the 2001 S.B. 97 amendments to Ohio Rev. Code § 3937.18 were the removal of insurers’ mandatory offering of UM/UIM coverage and the authorization of the parties to agree to coverage exclusions not listed in the UM statute.

   a. Ohio Rev. Code § 3937.18(A) now provides that an insurer “may, but is not required to,” include UM coverage or UIM coverage, or both, in a motor vehicle policy.

      i. S.B. 97 eliminated the requirement in former Ohio Rev. Code § 3937.18(A) that insureds must be “legally entitled to recover” from the tortfeasor.

      ii. S.B. 97 also eliminated the provision in former Ohio Rev. Code § 3937.18(A) that coverage is not precluded when the tortfeasor is statutorily immune from liability under Ohio Rev. Code Chapter 2744.

   b. Ohio Rev. Code § 3937.18(B) now lists several specific circumstances in which an owner or operator of a motor vehicle is considered an “uninsured motorist,” including when the owner or operator has immunity under Chapter 2744 of the Ohio Rev. Code.

   Ohio Rev. Code § 3937.18(B) also now expressly *excludes* the owner or operator of a motor vehicle that is “self-insured” from the definition of an “uninsured motorist.”

   c. Ohio Rev. Code § 3937.18(I) now provides that:

      [a]ny policy of insurance that includes uninsured motorist coverage, underinsured motorist coverage, or both uninsured and underinsured motorist coverages *may include* terms and conditions that preclude coverage for bodily injury or death suffered by an insured under specified circumstances, including but not limited to any of the following circumstances....

     (Emphasis added.)
4. The *Snyder* Supreme Court noted at ¶ 15 that eliminating the mandatory coverage offering and simultaneously permitting the parties to agree to coverage exclusions not listed in the statute provides insurers with considerable flexibility in devising specific restrictions on any offered UM coverage.

5. The *Snyder* Supreme Court noted at ¶ 24 that the current wording of Ohio Rev. Code § 3937.18 neither requires nor prohibits inclusion of the “legally entitled to recover” provision at issue.

6. The *Snyder* Supreme Court also noted at ¶ 26 that Ohio Rev. Code § 3937.18(I) now expressly permits the parties to agree to other specified conditions or exclusions of UM coverage that are not expressly enumerated in the UM statute.

7. In determining the plain ordinary meaning of the phrase “legally entitled to recover,” the *Snyder* Supreme Court found instructive its prior decision in *State Farm Mutual Automobile Insurance Co. v. Webb* (1990), 54 Ohio St. 3d at 64, 562 N.E.2d 132, in which an insured was found not to be “legally entitled to recover” from a fellow-employee with tort immunity under Ohio Rev. Code § 4123.741.

8. In upholding the validity of the “legally entitled to recover” UM coverage exclusion in *Snyder*, the Ohio Supreme Court noted that its ruling does not prevent insurers from responding to consumer demand by offering UM coverage without precluding recovery because of a tortfeasor’s immunity. See *Snyder*, at ¶ 34.

B. Intra-family exclusions are enforceable under the current UM statute.

1. Sub. S.B. No. 267 (S.B. 267), effective September 21, 2000, repealed Ohio Rev. Code § 3937.18(K)(2), which expressly excluded “[a] motor vehicle owned by, furnished to, or available for the regular use of a named insured, a spouse, or a resident relative of a named insured” from the statutory definition of an uninsured or underinsured motor vehicle. (Commonly referred to as an “intra-family exclusion” or sometimes as an “other-owned-auto exclusion.”)

2. However, S.B. No. 97, effective October 31, 2001, amended the Ohio UM statute to eliminate the mandatory offering of UM coverage and to permit insurers and insureds to agree to coverage exclusions not expressly listed in the UM statute.

3. In upholding the validity of an intra-family exclusion in a 2003 policy, the Huron County Court of Appeals (Sixth District) in *Wertz v. Wertz*, 2007-Ohio-4605, at ¶ 21, stated that “we believe that the Supreme Court of Ohio would find the intra-family exclusion enforceable under the current UM coverage statute.”

C. Narrow definitions of an “uninsured motor vehicle” are enforceable under the current UM statute.

In *Calhoun v. Harner*, Allen App. No. 1-06-97, 2008-Ohio-1141, the Third District Court of Appeals upheld the following UM coverage limitation: “uninsured motor vehicle does not include any vehicle or equipment...that is a covered automobile for which [liability] coverage is provided under...this policy.”

*Accord: O’Connor-Junke v. Estate of Junke*, Cuyahoga App. No. 91255 (8th Dist.), 2008-Ohio-5874 (“an uninsured motor vehicle does not include a motor vehicle which is insured under the Automobile Liability Insurance of this policy”).

D. Narrow definitions of an “insured” and “insured auto” are enforceable under the current UM statute.

1. In *Crabtree v. 21st Century Ins. Co.*, 176 Ohio App. 3d 507, 2008-Ohio-3335, the Ross County Court of Appeals (4th District) upheld the following UM coverage limitations: A “person insured” is “a relative while occupying an insured auto” (defined as “an auto described in the declarations”).

2. *See also Wohl v. Swinney*, 118 Ohio St. 3d 277, 2008-Ohio-2334 (upholding the UM coverage definition of an “insured” as “[a]ny other person occupying your covered auto who is not a named insured or insured family member for uninsured motorist’s coverage under another policy”).

   a. “When the Motorists policy in this case is viewed as a whole, it becomes clear that the intention of the parties was to narrowly define “insured” for UM coverage.” *Wohl*, at ¶ 14.

   b. “We therefore reverse the decision of the court of appeals and hold that the phrase “for uninsured motorists coverage under another policy” is unambiguous and applies to “a named insured” as well as “an insured family member.” *Wohl*, at ¶ 24.
E. Narrow contractual limitations periods for presenting UM/UIM claims are enforceable under the current UM statute.

1. In *Stuck v. Coulter*, Darke App. No. 1707, 2008-Ohio-485, the Second District Court of Appeals upheld a two-year contractual limitations period (from the date of the motor vehicle collision) for filing suit on an UM claim.
   
a. The *Stuck* court of appeals held the following provision to be enforceable and non-ambiguous: “Any lawsuit seeking recovery under Part IV, Uninsured/Underinsured Motorists Coverage, must be filed within two (2) years from the date of the auto accident.” *Stuck*, at ¶¶ 56-57.

b. The *Stuck* court of appeals further upheld the policy provision that all insureds are subject to the same obligations that the named insured has, which include the obligation to file a lawsuit for recovery of UM/UIM benefits within two years from the date of the auto accident. *Stuck*, at ¶ 57.

2. In *Lynch v. Hawkins*, 175 Ohio App. 3d 695, 2008-Ohio-1300, the Huron County Court of Appeals (Sixth District) upheld a three-year contractual limitations period (from the date of the motor vehicle collision) for filing suit on a UIM claim.
   
a. The *Lynch* court of appeals noted at ¶¶ 59-61 that no unique facts or circumstances were presented in the case that would make unreasonable the application of the 3-year limitation period commencing on the date of the accident rather than on the date of exhaustion of liability coverages.

i. In *Kraly v. Vannewkirk* (1994), 69 Ohio St. 3d 627, 635 N.E.2d 323, the Ohio Supreme Court invalidated a two-year limitations on period public policy grounds in a UIM case in which the liability insurer became insolvent approximately three months before the expiration of the two-year limitations period.

ii. The *Lynch* court of appeals noted at ¶¶ 49-54, however, that *Kraly* has been interpreted by a number of Ohio appellate courts to require a fact specific analysis of the equity of enforcing a limitations period that commences before the contractual obligation of the insurer to provide UIM coverage (i.e., exhaustion of liability coverage). *See Ross v. Farmers Ins. Group of Cos.* (1998), 82 Ohio St. 3d 281, 287 (“Kraly unarguably involved a
unique factual situation, and this court accordingly fashioned a remedy based upon concepts of fairness and public policy.

Montgomery v. State Auto. Mut. Ins. Co., Pike App. No. 99CA639 (4th Dist.), 2000-Ohio-2010; and State Auto. Mut. Ins. Co. v. Lewis, Cuyahoga App. Nos. 81121 and 81209 (8th Dist.), 2003-Ohio-291, ¶ 17 (“Although various cases have found such a provision limiting the time for bringing an action to be unenforceable, the holdings in those cases are fact-specific and not a broad holding that such limitations are unenforceable per se.”).

b. The Lynch court of appeals also noted at ¶¶ 53-58 that Ohio Rev. Code § 3937.18(H), which became effective on October 31, 2001, specifically authorizes a three-year contractual limitations period in UM and UIM insurance policies commencing from the date of the accident unless underinsured status is predicated on the insolvency of the liability insurer.

3. It should be noted, however, that Ohio Rev. Code § 3937.18(H) expressly provides as follows:

(H) Any policy of insurance that includes uninsured motorist coverage, underinsured motorist coverage, or both uninsured and underinsured motorist coverages may include terms and conditions requiring that, so long as the insured has not prejudiced the insurer’s subrogation rights, each claim or suit for uninsured motorist coverage, underinsured motorist coverage, or both uninsured and underinsured motorist coverages be made or brought within three years after the date of the accident causing the bodily injury, sickness, disease, or death, or within one year after the liability insurer for the owner or operator of the motor vehicle liable to the insured has become the subject of insolvency proceedings in any state, whichever is later. (Emphasis added.)

Caveat: citing Snyder v. Am. Family Ins. Co., ¶¶ 24-26, it can certainly be argued persuasively that Ohio Rev. Code § 3937.18(H) authorizes any contractual UM/UIM limitation period “agreed to” by the contracting parties, including periods that are more or less than the three-year limitation period referenced in Ohio Rev. Code § 3937.18(H).

4. Practice Pointer: Always join potential UM/UIM carriers and plead potential UM/UIM claims in actions against the tortfeasor. Even if it is later determined that the tortfeasor is fully insured and/or the available bodily injury liability coverage is equal to or exceeds the UIM coverage limits, then the UM/UIM claims can always be dismissed. However, arguments
relating to whether the insured complied with policy conditions or limitations (i.e., prompt notice, timely suit against the insurer, consent to settle, etc.) will be squelched and/or managed proactively.

THE STATUS OF UM/UIM COVERAGE BY OPERATION OF LAW IN OHIO

A. S.B. No. 97, effective October 31, 2001, amended the Ohio UM statute to eliminate the mandatory express offering/rejection of UM/UIM coverage.

1. No Ohio automobile insurance policies issued after October 31, 2001, are going to provide UM/UIM coverage by operation of the Ohio UM statute.

2. Insurers are still required, however, to give insureds notice of policy changes in order to effectuate new coverage exclusions, conditions, and/or limitations that are added to existing policies.

   a. In *Smith v. Speakman*, Franklin App. No. 08AP-211, 2008-Ohio-6610, the 10th District Court of Appeals held that Summary Judgment in favor of the insurer is precluded when there is a material issue of fact as to whether the insured received notice of the addition of a policy endorsement excluding UM/UIM coverage during the operation of a vehicle that is available for the insured’s “regular use.”

   Citing *J.R. Roberts & Son v. National Insurance Co. of Cincinnati* (1914), 2 Ohio App. 463 (“changes in coverage made by an insurer are invalid and unenforceable absent notice by the insurer to the insured”), and *Kasakaitas v. Floering* (Mar. 20, 1992), Lucas App. No. L-91-209 (6th Dist.), unreported, the *Smith* court of appeals found that the affidavit of insurer’s underwriting team manager, which identified a policy with a “regular use” exclusion to be the one “in effect” at the time of the accident, coupled with the insured’s affidavit denying ever having received such “new” policy booklet, is insufficient to grant summary judgment in favor of the insurer.

   b. *Caveat:* under the current S.B. 97 version of the Ohio UM statute, which provides insurers with considerable flexibility in restricting UM/UIM coverage, insureds who receive notice of policy changes are probably “agreeing” to such changes by paying their premium without objection.
B. Some pre-S.B. No. 97 policies (issued prior to October 31, 2001) may still provide UM/UIM coverage by operation of law.

1. In considering a pre-S.B. No. 97, the Ohio Supreme Court held in *Hollon v. Clary*, 104 Ohio St. 3d 526, 204-Ohio-6772, that once a signed, written rejection of UM/UIM coverage is produced, the elements of the offer of UM/UIM coverage may be demonstrated by extrinsic evidence.

   a. The *Holland* Supreme Court also advised at ¶ 13 that appellate courts should avoid elevating form over substance and to heed the expressed intent of the parties.


2. It was also held in *Peters v. Tipton*, supra, that a rejection of UM/UIM coverage under former Ohio Rev. Code § 3937.18(C) can validly be made after the policy period commences so long as the rejection occurs before the accident date that is the basis for the asserted UM/UIM claim. (Noting at ¶ 25 that the latest Supreme Court case reviewing the requirements for a valid offer and rejection, *Hollon v. Clary*, does not mention any need for the rejection to be provided prior to the policy period but rather merely cites the language of Ohio Rev. Code § 3937.18(C), “shall be effective on the day signed [and] shall create a presumption of an offer....”).

C. The two-year coverage “guaranty” period of Ohio Rev. Code § 2927.31(A) no longer delays an insurer’s ability to restrict UM/UIM coverage.

1. In *Advent v. Allstate Insurance Co.*, 118 Ohio St. 3d 248, 2008-Ohio-2333, the Ohio Supreme Court considered the certified conflict question of whether the S.B. No. 97 amendments to Ohio Rev. Code § 3937.18 may be incorporated
into an insurance policy during a two-year guarantee period that commenced subsequent to the S.B. No. 267 amendments to Ohio Rev. Code § 3937.18 and Ohio Rev. Code § 3937.31, but prior to the S.B. No. 97 amendments.

a. Pursuant to Ohio Rev. Code § 3937.31(A), all Ohio automobile insurance policies must be “issued for a period of not less than two years or guaranteed renewable for successive policy periods totaling not less than two years.”

b. Recognizing that the laws pertaining to the provisions contained in automobile insurance policies change frequently, the Ohio Supreme Court has previously interpreted Ohio Rev. Code § 3937.31 to mean that insurers are permitted to incorporate statutory changes into an insurance policy only when a two-year guarantee period begins. *Wolfe v. Wolfe* (2000), 88 Ohio St. 3d 246, 250-251, 725 N.E.2d 261.

i. After *Wolfe*, however, the General Assembly enacted S.B. 267, effective September 21, 2000, which expressly permitted insurers to change policies at the beginning of any policy-renewal period *within* a two-year guarantee period. See Ohio Rev. Code § 3937.31(E) (“Nothing in this section prohibits an insurer from incorporating into a policy any changes that are permitted or required by this section or other sections of the Ohio Rev. Code at the beginning of any policy period within the two-year period set forth in division (A) of this section.”).

ii. In *Shay v. Shay*, 113 Ohio St. 3d 172, 2007-Ohio-1384, the Ohio Supreme Court explored the ramifications of S.B. 267 on *Wolfe*, as applicable to Ohio Rev. Code § 3937.31, concluding that the provisions of S.B. 267 were “permissive”; therefore, insurers were not required to amend policy terms to incorporate recent legislative changes at a policy-renewal period within the two-year guarantee period.

c. After S.B. 267, the UM coverage laws were further amended by S.B. 97, which rewrote Ohio Rev. Code § 3937.18 with the express intention of superseding the holdings of “cases previously superseded by...S.B. 267.” See §§ 3(D) and (E) of S.B. 97.
d. The Advent Supreme Court held at ¶ 11 that the cumulative effect of the S.B. 267 and S.B. 97 amendments to Ohio Rev. Code § 3937.18 is that insurers may incorporate any changes “permitted or required” by the Ohio Rev. Code at the beginning of any policy-renewal period on or after October 31, 2001 (the effective date of S.B. 97) within the policy’s two-year guarantee period that began on or after September 21, 2000 (the effective date of S.B. 267).

The Advent Supreme Court further held at ¶ 11 that the modification of the UM coverage terms of an automobile insurance policy is a change “permitted or required” by the Ohio Rev. Code, after October 31, 2001 (the effective date of S.B. 97), at the beginning of any policy renewal period within the two-year guarantee period that began after September 21, 2000 (the effective date of S.B. 267).

2. Insurers apparently now have the option of incorporating changes into an automobile liability policy at the time of a six-month renewal or at the beginning of a new two-year guarantee period. See Smith v. Speakman, Franklin App. No. 08AP-211(10th Dist.), 2008-Ohio-6610, ¶ 25, interpreting the interplay between Ohio Rev. Code § 3937.18(A) and (E).

REVISITING THE “AMOUNT AVAILABLE FOR PAYMENT” IN UIM CLAIMS

A. In Webb v. McCarty, 114 Ohio St. 3d 292, 2007-Ohio-4162, the Ohio Supreme Court held that the “amount available for payment” in Ohio Rev. Code § 3937.19(A)(2) means the amounts actually accessible to and recovered by an underinsured motorist claimant from all bodily injury liability bonds and insurance policies. (Upholding and following Littrell v. Wigglesworth (2001), 91 Ohio St. 3d 425, 746 N.E.2d 1077, and Clark v. Scarpelli (2001), 91 Ohio St. 3d 271, 744 N.E.2d 719.)

1. In Webb, the tortfeasor’s bodily injury liability coverage limits were identical to the claimant’s limits of UIM coverage; nonetheless, the Supreme Court again rejected the argument that a “limits-to-limits” comparison controls, particularly in situations involving multiple claimants.

a. In a case involving multiple claimants, the Webb Supreme Court confirmed at ¶ 4 that in determining the “amount available for payment” under a UM/UIM policy, the amount of UIM coverage is to be compared to the amount paid under an automobile liability policy, not to the coverage limits of the automobile liability policy. (Citing Littrell, at 428-435.)
b. In Littrell, the Ohio Supreme Court stated that “a person injured by an underinsured motorist should never be afforded greater coverage than that which would be available had the tortfeasor been uninsured.” Littrell, at 430, citing Clark, at 276.

Similarly, the 10th District Court of Appeals in Brown v. Nationwide Mutual Fire Insurance Co., 174 Ohio App. 3d 694, 706-707, 2008-Ohio-174, ¶ 30, cited Webb and Littrell in holding that where UIM claimants’ recovery, either individually or collectively, would exceed the amount they would have recovered had their injuries been caused by an uninsured motorist, no UIM coverage is available, as a matter of law.


B. Note: although pre-S.B. 97 policies were considered in Webb, Brown, Estate of Jackson, and Long, the identical “amount available for payment” language is contained in the current S.B. 97 version of Ohio Rev. Code § 3937.18.

“BECAUSE OF” BODILY INJURY IS THE SAME AS “FOR” BODILY INJURY

In Lager v. Miller-Gonzalez, 120 Ohio St. 3d 47, 2008-Ohio-4838, the Ohio Supreme Court considered language in an insurance policy that provided UM/UIM coverage to insureds “because of bodily injury suffered,” but also contained another-owned-auto exclusion that denied coverage “for bodily injury or derivative claims.”

A. In Lager, the policyholders’ daughter died from injuries sustained in an automobile accident that occurred while she was a passenger in a vehicle that she owned.

1. The UM endorsement in the Lagers’ policy stated:

   We will pay compensatory damages, including derivative claims, that you or a relative are legally entitled to recover from the owner or driver of an uninsured motor vehicle under the tort law of the state where the motor vehicle accident occurred, because of bodily injury suffered by you or a relative and resulting from the motor vehicle accident. Damages must result from a motor vehicle accident arising out of the: 1. ownership; 2. maintenance; or 3. use; of the uninsured motor vehicle.
2. The Lagers’ policy also contained the following exclusion: “coverage does not apply to anyone for bodily injury or derivative claims:...3. While any insured operates or occupies a motor vehicle: a) owned by; b) furnished to; or c) available for the regular use of; you or a relative, but not insured for Auto Liability coverage under this policy.”

B. In reversing the judgments of the trial court and the court of appeals, the Lager Supreme Court found at ¶ 26 that there is nothing ambiguous, uncertain, or unclear about the meaning of the above other-owned-auto exclusion, even when applied to a UM claim arising from a wrongful death.

1. The Lager Supreme Court found at ¶ 29 that the mere potential for ambiguity in a clause in a contract is not sufficient to establish that the provision is susceptible of more than one reasonable interpretation.

2. The Lager Supreme Court also found at ¶ 30 that the Lagers’ argument that their injuries are “because of” Sara’s bodily injury, not “for” Sara’s bodily injuries, is only a semantic distinction. Though their wrongful-death claim arose “because of” Sara’s bodily injury, i.e., her death, any coverage “for” her bodily injury was extinguished because her bodily injury arose when she was in a motor vehicle that was not an insured vehicle under the Lagers’ policy.

3. The Lager Supreme Court also found at ¶ 31 that to permit coverage in circumstances like those presented here would improperly allow “a person who owns more than one motor vehicle [to] choose not to insure one vehicle and bear no financial risk for the decision because he will be deemed to have in effect purchased liability coverage for the vehicle he decided not to insure if he is struck by another uninsured motorist.” Citing Martin v. Midwestern Group Ins. Co., 70 Ohio St. 3d at 485, 639 N.E.2d 438 (Moyer, C.J., dissenting).

C. Justice Pfeifer offered the following spirited dissenting opinion in Lager at ¶ 34:

“For” and “because of” are not synonymous; for example, people do not read legal opinions or insurance contracts “because of” hours, but they can read them “for” hours. And yet this court sees only the “mere potential for ambiguity” between “for” and “because of.” I readily admit that “for” and “because of” can mean the same thing, as in “void for vagueness” and “void because of vagueness.” But “for” and “because of” do not always mean the same thing, and there is no way to know whether they do in this insurance contract.
CONCLUSION

A. Many policy exclusions, conditions, and limitations that had been unenforceable throughout the 1990s were resurrected when Ohio Rev. Code § 3937.18 was amended by the enactment of S.B. 97 in 2001.

1. While Ohio’s UM case law and statutory law were in a constant state of “evolution” throughout the 1990s, some UM/UIM policy forms continued to include UM/UIM coverage conditions, exclusions, and limitations that were unenforceable or void in Ohio.

2. The S.B. 97 amendments to Ohio Rev. Code § 3937.18 authorized UM/UIM coverage conditions, exclusions, and limitations beyond those enumerated in the UM statute.

3. Since the enactment of S.B. 97, Ohio UM/UIM law has been governed largely by the “intent of the contracting parties,” not Ohio Rev. Code § 3937.18.

B. The Ohio Supreme Court’s decision in Snyder v. American Family Insurance Co. ushered in a new era of UM/UIM law in which Ohio’s UM statute is trumped by “negotiated” UM/UIM coverage conditions, exclusions, and limitations.
Insurance and Negligence Law
Update from a Health Care Provider’s Perspective—Hot Issues

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INSURANCE AND NEGLIGENCE LAW UPDATE
FROM A HEALTH CARE PROVIDER’S PERSPECTIVE

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HOT ISSUES

Hospital Care Assurance Program (“HCAP”) – R.C. §§ 5112.01 et seq.

Robinson v. Bates, 112 Ohio St. 3d 17 (Ohio 2006)


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