

**LIEN ON ME, OR WHOSE LIEN IS IT ANYWAY?**

The basic scenario is one we have all seen on numerous occasions: a personal injury plaintiff receives medical treatment from a hospital through the plaintiff’s own insurance plan or perhaps through Medicaid. As soon as the provider learns there is a potential third party tortfeasor who may be responsible to the plaintiff for the plaintiff’s damages, the hospital or benefits provider immediately serves both the plaintiff and the third party tortfeasor (or his insurer) with a Notice of Lien under the Hospital Lien Act (Civil Code § 3045.1 et. seq.). When the case is ultimately resolved, the insured defendant and his carrier dutifully issue their draft made payable to the plaintiff, the plaintiff’s attorney and the healthcare provider in order to extinguish the healthcare provider’s lien and any potential further liability for hospital costs.

Also a part of this common scenario is the fact that the personal injury plaintiff’s insurance plan more often than not pays the hospital a pre-agreed contract price for services which is usually lower than the actual amount charged by the hospital. In the case of Medicaid, participating hospitals agree in advance that they will accept the amount determined by Medicaid, or the hospital will not be allowed to participate in the Medicaid program. So what happens to that balance between the lesser amount paid and the full amount charged? Has the hospital not been fully paid, and is it entitled to recover the balance from the insured patient (plaintiff)? Has the lien not been fully extinguished, and is the hospital entitled to pursue the balance as against the defendant or defendant’s insurance carrier? Even if the plaintiff is only entitled to recover the amount of charges that were actually paid by the plaintiff’s healthcare provider, may the hospital still recover the full amount of its charges from the plaintiff’s ultimate recovery in this case?

There now appears to be a split of authority on the subject.

In 1988, the Third Appellate District held that a personal injury plaintiff is only entitled to recover the amount actually paid for healthcare services provided to that plaintiff, even if the amount paid was less than the total amount charged. This was the *Hanif v. Housing*

*Authority of Yolo County* decision. That court held that while the source of the payment was inadmissible evidence, the amount that actually had been paid was the only amount that was admissible and could be considered by the jury as having been incurred. The basis of this ruling was that the law only permits a personal injury plaintiff to recover the value of medical services actually rendered or the value of services for which the plaintiff would become liable for in the future. In the *Hanif* case, since there was no evidence that the plaintiff could be become liable for the difference between the amount paid and the amount charged, and since there was evidence that the balance had ultimately been written off by the provider, principles of compensatory damages precluded the plaintiff from recovering the higher amount of the two figures. Even with this limitation, it was still necessary for the plaintiff to prove that the charges were “reasonable” and had been necessarily incurred before the plaintiff was allowed to recover them.

With Medicaid benefits, the issue is much simpler. Federal law preempts the field and prohibits a healthcare provider from “balance billing” someone for the difference between Medicaid benefits received, and the actual amount charged for hospital services. *Olszewski v. Scrippshealth* precluded the practice of balance billing where a hospital had placed a lien on a patient’s recovery from a third party

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in order to recoup the actual value of its services rendered. Since participants in the Medicaid program specifically agree with the federal government to waive claims for any charges over and above the benefits received from Medicaid, federal law preempted the field and the hospital was not allowed to try and recoup the balance left over from the settlement of a Medicaid recipient third party lawsuit.

So what happens to the hospital claims for the balance due after payments from a source that does not cover the charges in full? In March 2002, the Fourth Appellate District addressed the issue in *McMeans v. Scrippshealth*. When a hospital routinely placed liens on its patient's settlement to try and recover the full amount of its services, several patients sued the hospital, claiming unfair business practices. It was noted that the lien referenced in the Hospital Lien Act was a lien on the patient's recovery and was an obligation directed at the third party tortfeasor and not the patient. It was noted that since the patient had insurance and the insurance paid the full amount due under its contract with the hospital, then the hospital in theory was fully compensated and had no further rights against the patient's third party recovery. Also, any further claim against the recovery of the patient was necessarily taking away further funds from a patient's judgment or settlement which would then be attributable to lost wages and pain and suffering. The *McMeans* court held that this was impermissible since the hospital liens rights do not extend beyond the amount it agreed to receive from the patient as payment in full for the services rendered. The *McMeans* court relied heavily on the decision in *Nishihama v. City and County of San Francisco*, holding that if the patient's charges have been paid in full pursuant to an insurance contract with the hospital, then the hospital has no amount, reasonable or otherwise, it may seek from a third party tortfeasor.

The conflict arises as a result of the April 2000 decision of *Swanson v. St. John's Regional Medical Center*. This case has very similar facts to the *McMeans* case, where a patient had filed suit against his hospital when the latter placed a lien against his recovery in a third party lawsuit. The *Swanson* court held that the Hospital Lien Act specifically authorizes the very business practice of "balance billing," and further held that the hospital was entitled to reimbursement of the entirety of its lien regardless of what may have been paid by the patient's insurance company. Quite interestingly, the *Swanson* case never cited the *McMeans* case to discuss or distinguish it. Instead, the *Swanson* case relied heavily on the *Nishihama* case cited above. The *Swanson* case also relied heavily on the theory that the hospital's lien is not something that is being claimed against the patient itself, but

rather the third party tortfeasor. Since the Hospital Lien Act provided safe harbor for "balance billing," a hospital may claim a lien for the full amount of its charges as against the personal injury plaintiff's recovery from the third party tortfeasors.

The implications of these cases are not as drastic for defense counsel, defendants and insurance carriers **so long as** the defense is diligent about having the hospital's name added as a payee on every settlement check. Better yet, if the hospital has filed a lien or a complaint-in-intervention with the court, negotiate a settlement directly with the hospital and obtain a release. Since, as noted above, the lien obligation is directed at the third party tortfeasor, simply putting an "all liens are included" disclaimer in your settlement agreement with the plaintiff probably is not sufficient to completely release the defendant or his insurance carrier.

However, there is now the potential for the jury to award the plaintiff the lower amount of specials under *Hanif*, and yet the defendant is still responsible for paying the full lien under *Swanson*.

- Thomas E. Martin

## LEGAL TRIVIA: A "TORT" MEANS A "TWIST"

Law students new to the word "tort" commonly make puns referencing the pastry. Both words come from the Latin *tortus* or *torquere*, meaning to twist, from which also comes our words "torque," "torsion" and "torture." The pastry is often twisted, and the same root becomes a "torta" and "tortellini" in Spanish and Italian. The original sense of a legal tort was a physical injury and probably called to mind either the twisting of a body part or the wrongful turning or twisting of one's legal rights. For redress of a tort, one would also turn to an "attorney" - "*ad torner*," one who attorns for another.

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## WE'VE MOVED

Wesierski & Zurek LLP is pleased to announce the relocation of our downtown Los Angeles office. Please note the new address. Our phone and fax numbers remain the same.

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## **CARRIER HAS NO STANDING TO APPEAL COLLUSIVE THIRD PARTY SUIT IN WHICH IT WAS NOT A PARTY; CARRIER MUST FILE A COVERAGE ACTION TO AVOID LIABILITY ON THE JUDGMENT**

When do insurance companies have standing to appeal a judgment in a case in which they were not a named party, but where they suspect collusion? According to the recent case of *Tomassi v. Scarff, et al.*, an insurance company that is not a named party cannot appeal on the basis of being an “aggrieved party” even though it will be ordinarily bound by the judgment. Instead, if the carrier suspects that the judgment resulted from collusion, it must file a declaratory relief action and disprove coverage. It has no standing to get involved in the third party suit directly after judgment.

In *Tomassi*, plaintiffs were the surviving wife and sons of Dino Tomassi, the owner of Great America Towing, Inc., who brought suit for wrongful death and negligent infliction of emotional distress against the administrator for the estate of Christopher Moreno, Joseph Scarff, and Reliance Insurance Company (“Reliance”). Moreno co-owned Campbell Towing Company, which was insured by Reliance. Tomassi and Moreno were such fierce competitors in the tow truck business that one of their arguments culminated in the shooting death of Tomassi by Moreno. After the shooting, Moreno went to visit his wife at work and shot himself to death. A possible explanation for Moreno’s actions was his troubled marriage. He had earlier threatened to commit suicide if his wife left him.

Campbell Towing attempted to tender the suit to Reliance for defense, however, Reliance continued to reject the repeated requests for a defense on the grounds that the basis of the lawsuit fell outside the coverage of the liability policy. Nevertheless, counsel for Campbell Towing kept Reliance informed of developments in the action. During the litigation, Campbell Towing entered into an agreement with plaintiffs which limited damages but guaranteed a recovery of at least \$275,000. With the possibility of a million-dollar judgment and with the resulting probability of Campbell Towing’s bankruptcy, defendants waived a jury trial and proceeded to a one-day bench trial. The court found Campbell Towing negligent in exercising reasonable care to control the conduct of Moreno and in failing to warn Tomassi of Moreno’s threats. More specifically, the court found that corporate officers, directors and managerial employees at Campbell Towing knew of at least four prior instances of business disputes between Campbell Towing and Great America Towing. The court further found that a “special relationship” existed between Moreno and Campbell Towing based on his employment and between

Tomassi and Campbell Towing based on their business dealings. In its reasoning, the Court relied on *Tarasoff v. Regents of University of California* (1976) 17 Cal.3d 425 (a case that held that psychiatrists have a special duty to warn others of threats made by their clients) and held that Campbell Towing should have recognized a danger to Tomassi and taken reasonable steps to protect him. The court awarded plaintiffs over 4 million dollars.

The day after the court issued its decision, Campbell Towing filed a complaint against Reliance seeking declaratory relief regarding the issue of coverage and damages, breach of contract and breach of the implied covenant of good faith and fair dealing. Two days later, Reliance moved for an order to vacate the judgment obtained by the Tomassi family against Campbell Towing. Reliance based its motion on the fact that they felt the court’s legal conclusions were not supported by the facts, that Campbell Towing did not have a duty to control Moreno or to warn Tomassi because no special relationship existed. The Tomassi family and Campbell Towing opposed the motion on the grounds that Reliance was not an aggrieved party within the meaning of *Code of Civil Procedure* section 663, which allows “the party aggrieved” to set aside a judgment if there is an incorrect legal basis for the decision not supported by facts. An aggrieved party is one whose rights or interests are injuriously affected by the judgment. An appellant’s interest must be “immediate, pecuniary, and substantial and not nominal or a remote consequence of the judgment.” *Tomassi, supra*.

Reliance argued it had standing, i.e., that it was an “aggrieved party” with “an immediate...and substantial” responsibility for the judgment such that it would be bound under principles of *res judicata* if the judgment were allowed to stand. The judgment was the first step in having Reliance “foot the bill caused by Moreno’s murderous rampage.” Reliance argued that an insurer which has received notice of an action against its insured but refuses to defend will be bound by the resulting judgment on all issues material to liability, in the absence of fraud or collusion.

The trial court disagreed with Reliance’s position and denied its motion to vacate. The trial court, later affirmed by the appellate court, noted that Reliance was not necessarily bound by the finding that Campbell Towing was liable. In

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the pending declaratory relief action brought by Campbell Towing, Reliance would have ample opportunity to assert that no coverage existed, and the possibility that the judgment was a product of collusion between the plaintiffs and Campbell Towing. In actuality, the effect of the judgment on Reliance was only indirect and contingent on the outcome of the coverage action. Reliance's appeal was denied due to a lack of standing under the provisions of Section 663.

- Kimberly G. Shlesinger

### **THE EVER-EXPANDING WAISTBAND OF COVERAGE FOR ADDITIONAL INSUREDS**

Once again, the elastic boundaries of insurance coverage have been stretched by the California courts. A recent decision by the Court of Appeals expanded the scope of an additional insured endorsement on a CGL policy. An insurer is now bound to defend and indemnify an additional insured for injuries to an employee of the insured injured while performing work arising out of the terms of the contract.

In *Fireman's Fund Insurance Companies (FFIC) v. Atlantic Richfield Company (ARCO)* (2001) 94 Cal. App. 4th 842, there was a lawsuit over a coverage dispute brought by FFIC to recover money paid to settle and defend ARCO in an underlying personal injury claim. The trial court granted ARCO's motion for summary judgment, and FFIC appealed. The Court of Appeals affirmed the trial court's decision, holding the endorsement covers an additional insured because the facts in this case constituted "liability arising out of the work" of the named insured.

The underlying facts were not disputed. Sylvis Riddle, an employee of Crider Construction (Crider), brought a premises liability action against ARCO. Crider was hired by ARCO to perform maintenance at an ARCO plant. Crider carried a CGL policy with FFIC, and ARCO was named as an additional insured by a separate endorsement. At the direction of a Crider foreman, Riddle carried a pump motor weighing 40 pounds onto a wooden step that collapsed, causing serious injuries to Riddle's back. The step was owned and maintained by ARCO.

Riddle brought suit to recover damages for his injuries against ARCO alleging general negligent maintenance of its premises. ARCO tendered the defense and indemnity to FFIC, who accepted the tender under reservation of rights. FFIC then settled the injury claim with Riddle for \$400,000

and reserved its right to seek reimbursement from ARCO, resulting in this action.

The issue of coverage came down to whether ARCO's legal obligation to pay the \$400,000 settlement to Riddle arose out of Crider's work for ARCO. FFIC argued the proper interpretation of liability should not focus on whether the injury arose out of Crider's work, but rather whether ARCO's liability for Riddle's injuries arose out of Crider's work. FFIC also argued there must be more than the standard "but for" causation, and, in this case, there was no causal connection at all between Crider's work and ARCO's liability. The sole cause of Riddle's injury was ARCO's own negligence in maintaining its property.

The Appellate Court agreed with FFIC that the policy language required more than "but for" causation. However, the language "arising out of" is interpreted broadly and therefore only a minimal causal connection is required. The court held the facts were sufficient to meet that minimum because (1) Riddle was injured at the Crider worksite, and (2) he was performing a work-related task at the time of his injury. Therefore, ARCO was covered for Riddle's injuries under the additional insured endorsement.

The Appellate Court also rejected FFIC's argument that the intent of the parties was to cover only vicarious liability of an additional insured, not general liability. The court felt the intent of the parties should be interpreted through the policy language because no extrinsic evidence of intent was provided. Furthermore, if FFIC's intent was different, then FFIC should have used specific language to exclude additional liability.

The court also held that finding coverage for ARCO did not violate public policy because there is no public policy favoring a narrow interpretation of insurance policy language. The opposite is true, as the freedom to write the terms of the contract lies in the hands of the insurer.

The court is sending a message to insurers that it will continue to expand coverage and rule in favor of the insureds in cases where policy language is not specific. Once again, insurers will have to loosen their belts another notch.

- Lisa Renaud

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