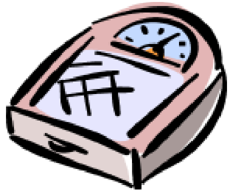
JS&H | REPORTER

A PUBLICATION OF JONES, SKELTON & HOCHULI, P.L.C. | SPRING 2009



Arizona High Courts Weigh in on Expert Witnesses in Medical Malpractice Cases

By Kathleen S. Elder

The Arizona Supreme Court has finally spoken: A.R.S. §12-2604, governing proof of the standard of care in medical malpractice cases, does not violate the separation of powers doctrine. The Arizona Court of Appeals has also recently provided additional guidelines for admissibility of expert testimony and the scope of an expert's testimony in medical malpractice cases. These two opinions will have a significant impact on medical malpractice cases and will provide guidance regarding proper foundation for expert opinions in Arizona cases generally.

Qualifications for Standard of Care Experts -- *Seisinger v. Siebel*.

In enacting A.R.S.§12-2604, the Arizona Legislature set forth minimum qualification standards for testifying standard of care experts in medical malpractice cases. The statute requires that a standard of care expert: (1) match the defendant's board-certification and field of practice (i.e. general practitioner or specialty); and (2)

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The Assault and/or Battery Exclusion: Winning Summary Judgment Despite Reasonable Expectations Challenges

By Ryann S. Embury

Many general liability insurance policies sold to bars and restaurants include a specific assault and/or battery exclusion to coverage. This exclusion is commonly used in insurance contracts to preclude coverage for damages arising from assaults and/or batteries that occur in establishments where alcohol and criminal activity sometimes mix. The public policy behind such an exclusion is aimed at preventing an insured from indemnifying a person for his or her misconduct.

When claims are submitted as a result of an assault or battery occurring in a bar or restaurant, insurance companies routinely deny coverage based upon this exclusion. A denial of coverage based upon an assault and/or battery exclusion often spurs costly litigation and involves heavily-papered challenges to the validity and construction of the exclusion itself. This is due, at least in part, to the variety of types of assault and/or battery

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Insurers Required to Report Settlements to Medicare Starting July 1, 2009

By Christina Kelly Geremia

Beginning July 1, 2009, every insurer (including no-fault and self-insured policies) will be required to report first and third party personal injury settlements and workers' compensation settlements to Medicare whenever Medicare paid medical expenses on behalf of its beneficiary that are part of the settlement proceeds. This change is part of an Amendment to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, signed into law by former President Bush. *See* 42 U.S.C. §1395y(b)(7) & (8). This Amendment marks a significant change in the way Medicare liens are handled by effectively shifting the burden to the insurer to put Medicare on notice of settlements so that they can pursue their statutory right of reimbursement.

A Medicare right of reimbursement,[1] sometimes referred to as a "superlien" because of its supremacy over all other liens and/or rights of reimbursement, is governed by the Medicare Secondary Payer statute, set forth in Section 1862(b) of the Social Security Act.[2] Section 1862(b)(2)(B)(ii) provides that when a Medicare beneficiary is injured as the result of the negligence of another, the medical expenses should be paid by the "primary plan" or the liability insurance policy; Medicare is considered a "secondary plan." To facilitate the coordination of treatment and benefits, however, Medicare often pays the medical expenses up front as a "conditional payment" and then seeks recovery from the "primary plan."[3] This is, in essence, how the Medicare "lien" or right of reimbursement is created. Pursuant to 28 USC §2415(a), Medicare has six years to pursue its subrogation rights.

Currently, the personal injury claimant/plaintiff's attorney takes responsibility for contacting Medicare to determine if it will be seeking reimbursement, and if so, to request a conditional payment letter. Then, after the settlement is finalized, the claimant's attorney negotiates and compromises the lien. If the Medicare lien is not compromised or paid, Medicare can pursue a direct right of action against its beneficiary, her attorney, and the insurer and its attorney.[4] Beginning July 1, 2009, in order to assist Medicare in identifying and pursuing its lien rights, the insurer must report its personal injury settlements *directly* to Medicare. Failure to do so may result in $1,000 per day fines and double damages. *See* 42 USC §1395y(b)(7) and (8).

In light of the Amendment to the statute, how do insurers report settlements? Based upon information from

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[1] *See U.S. v. Geier*, 816 F.Supp. 1332, 1334 (W.D.Wis. 1993).

[2] Section 1862 [42 USC 1395y] (2) Medicare secondary payer.-

(A) In general.-Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that-

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In the subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. 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.

[3] Section 1862 [42 USC 1395y] (2)(B) Conditional payment.-

(i) Authority to make conditional payment.-The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

[4] Section 1862 [42 USC 1395y] (2)(B) Conditional payment.-

(iii) Action by united states.-In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.

Arizona Court of Appeals Reduces Punitive Damages Award

By A. Blake DeLong

In *Hudgins v. Southwest Airlines, Co.*, --- P.3d ----, 2009 WL 73251 (App. 2009), two Virginia-based bail enforcement agents (Plaintiffs) flew Southwest Airlines from Baltimore to Phoenix for the purpose of apprehending a fugitive in Arizona. Before their flight, Plaintiffs worked with the airline to obtain instructions about to how to lawfully transport handguns on the aircraft. Plaintiffs complied with the airline's instructions, including the completion of airline forms. Airline employees advised Plaintiffs to take their guns on board even after Plaintiffs asked to check the guns because they did not yet have their fugitive in custody on the outbound flight to Phoenix. After the aircraft departed, a series of events associated with the flight crew's attempts to understand Plaintiffs' forms culminated in Plaintiffs' arrest upon arrival in Phoenix for carrying concealed dangerous weapons on an aircraft. Following a weekend in custody, federal prosecutors dismissed the charges after determining that although Plaintiffs violated federal law by flying with their guns, they made good-faith efforts to comply with instructions given to them by airline representatives.

Plaintiffs sued Southwest Airlines for negligence and sought punitive damages. The jury entered a verdict for Plaintiffs and awarded each of them $500,000 in compensatory damages and $4 million in punitive damages. Southwest appealed the verdict and argued, in part, that the punitive damages award was unconstitutionally excessive.

In determining the constitutionality of the punitive damages award, the Arizona Court of Appeals (Division One) analyzed the airline's misconduct in light of the following three guideposts outlined in the U.S. Supreme Court's ruling in *BMW of North America, Inc. v. Gore*, 517 U.S. 559 (1996): (1) the degree of reprehensibility of the misconduct; (2) the ratio between compensatory and punitive damages; and (3) how the award compared with other available penalties. The Court focused largely on the appropriateness of the ratio between the jury's compensatory and punitive damages awards, and based its decision primarily on the portion of *Gore* establishing that a 4:1 punitive to compensatory damages ratio approaches constitutional impropriety. It added that where compensatory damages are substantial, even smaller ratios may approach unconstitutionality.

The Court held that Southwest's misconduct fell within the low to middle range of the scale of potentially reprehensible acts and ruled that the 8:1 ratio of punitive to compensatory damages was unreasonable. It observed that the airline's conduct did not cause Plaintiffs to sustain physical or economic injury, that the compensatory damages award was substantial, and that the compensatory damages award "likely contained a penal element that the jury duplicated in the punitive damages award." The Court reversed the jury's punitive damages verdict and reduced the punitive damages award to $500,000 for each Plaintiff, or a1:1 punitive to compensatory damages ratio.

Given that the determination of the appropriateness of a punitive damages award is fact-intensive and specific

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Announcements

JS&H is pleased to announce that **Timothy J. Bojanowski** and **Kathleen Elder** have been elected into the partnership.

Christina Kelly Geremia will receive the Attorney of the Month Award (June 2008) at the Volunteer Lawyers Program's "For Love of Justice" luncheon ceremony on May 4, 2009.

A. Melvin McDonald was reappointed to serve as a member of the Arizona Racing Commission by Governor Jan Brewer.

Jennifer Holsman has been named to the 2009 Phoenix Business Journal Forty Under 40 list that honors young leaders in metro Phoenix.

Steven D. Leach has been named Sales Commissioner for the Fiesta Bowl Committee.

Changes to the Family and Medical Leave Act: What Every Employer Needs to Know

By Barry H. Uhrman

On November 17, 2008, the Department of Labor published a new set of Family and Medical Leave Act (FMLA) regulations, the first signficiant changes since the current regulations were issued in 1995. These regulations took effect on January 16, 2009, and they implement new forms of military FMLA leave and many other significant changes. As a result, employers must be aware of these changes and adjust their policies and employee handbooks accordingly.

The Basics of the Family and Medical Leave Act

The FMLA requires employers with 50 or more employees within a 75-mile radius to provide eligible employees up to 12 weeks of unpaid leave in a 12-month period. An employee is eligible for leave under the FMLA if he or she has been employed for at least 12 months and has worked 1,250 hours for the employer within the previous 12 months.

Before the amendments, an eligible employee was entitled to FMLA leave upon the occurrence of one or more of the following events: (1) for the birth of a child and care for the newborn; (2) for the placement of a child for adoption or foster care; (3) to care for the employee's spouse, child, or parent with a "serious health condition;" or (4) because of a "serious health condition" that makes the employee unable to perform the functions of his/her job.

A "serious health condition" is one that involves inpatient care in a hospital, hospice, or residential medical facility and includes any period of incapacity. It also includes continuing treatment by a health care provider, which may involve:

- Any period of incapacity that involves absence from work, school, or other daily activities for more than three calendar days and any subsequent treatment period of incapacity relating to the same condition.
- Pregnancy or prenatal care.
- Chronic or long-term health conditions requiring periodic visits for treatment over an extended period of time.
- A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease, severe stroke, or terminal stages of a disease).
- Any period of absence to receive multiple treatments (including any period of recovery) by a health care provider either for restorative surgery after an accident or other injury, or for a condition that is so serious that it would likely result in incapacity for three or more calendar days in the absence of medical intervention or treatment (e.g., cancer, severe arthritis, or kidney disease).

Revisions to the FMLA Regulations

1. *"Serious Health Condition"*

The final regulations from the Department of Labor retained the above six definitions of "serious health condition," but modified the tests of "incapacity and treatment." For continuing treatment involving two or more doctor visits, those visits now must occur within 30 days of the start of the incapacity. In addition, the first visit with a health care provider must occur within seven days of the start of the incapacity.

A second way to satisfy the definition of a "serious health condition" under the regulations involves more than three consecutive, full calendar days of incapacity plus a regimen of continuing treatment. The first visit to the health care provider must take place within seven days of the first day of incapacity.

Finally, chronic serious health conditions require periodic visits of at least twice a year for treatment of the incapacity.

2. *"Light Duty"*

Under the final regulations, time spent performing "light duty" work does not count against an employee's FMLA leave entitlement. The employee's right to restoration is held in abeyance during the period of time the employee performs light duty or until the end of the applicable 12-month FMLA leave year. If an employee is voluntarily performing a light duty assignment, the employee is not on FMLA leave.

3. *"Waiver of Rights"*

The regulations codify the Department of Labor's longstanding position that employees may voluntarily settle or release their FMLA claims without approval from the Department or the courts. Prospective waivers of FMLA rights, however, continue to be prohibited under the final rule.

4. *"Substitution of Paid Leave"*

Although FMLA leave is unpaid, the statute provides that employees may take (or employers may require employees to take) any accrued paid vacation, personal, family or medical or sick leave, concurrently with any FMLA leave. This is called the "substitution of paid leave." Under the final regulations, all forms of paid leave offered by an employer will be treated the same, regardless of the type of leave substituted (including generic "paid time off").

Employers may require compliance with the procedural requirements of paid leave benefits when substituting paid leave for unpaid FMLA leave. An employee electing to use any type of paid leave concurrently with FMLA leave must follow the employer's policies that apply to other employees for the use of such leave. The employee may use unpaid FMLA leave if he or she does not meet the employer's conditions for taking paid leave.

5. *"Notice Requirements"*

The regulations place more demanding notice requirements on employers. Employers are required to provide employees with a general notice about the FMLA (through a poster, and either an employee handbook or upon hire); an eligibility notice; a rights and responsibilities notice; and a designation notice. An employer now has five business days to provide these notices (instead of two).

Absent unusual circumstances, employees who require FMLA leave must comply with the employer's usual and customary call-in procedures for reporting an absence.

6. *"Perfect Attendance Awards"*

Employers may deny a "perfect attendance" award or a bonus for perfect attendance to an employee whose imperfect attendance is due to FMLA leave, so long as the employer treats employees taking non-FMLA leave in an identical way.

7. *"Medical Certification"*

Under the new regulations, an employer's representative who contacts a health care provider must be a health care provider, a human resource professional, a leave administrator, or a management official. The employee's direct supervisor is prohibited from being the representative who contacts the employee's health care provider. Employers may not ask health care providers for additional information beyond that required by the certification form.

If a certification is incomplete or insufficient, the regulations provide that the employer give the employee written notice of the additional information needed and allow the employee seven days to cure the deficiency.

8. *"Fitness for Duty Certification"*

The regulations make two changes to the fitness-for-duty certification process. First, an employer may require that the certification specifically address the employee's ability to perform the essential functions of the employee's job. Second, where reasonable job safety concerns exist, an employer may require a fitness-for-duty certification before an employee may return to work when the employee takes intermittent leave.

9. *"Military Caregiver Leave"*

Employees may take up to 26 weeks of leave during a single 12-month period to care for a covered servicemember with a serious illness or injury incurred in the line of duty, while on active duty.

10. *"Qualifying Exigency Leave"*

The second new military leave entitlement indentifies eight circumstances that constitute a "qualifying exigency" for which an eligible employee is entitled to FMLA leave while that employee's parent, spouse, son, or daughter is on active duty or called to active duty status. These "qualifying exigencies" are: (1) short-notice deployment (seven days or less); (2) military events; (3) childcare and school activities; (4) financial and legal arrangements; (5) non-medical counseling for self, servicemember, or servicemember's child; (6) rest and recuperation leaves; (7) post-deployment activities; and (8) additional activities not encompassed in the other categories, but agreed to by the employer and employee.

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Mediator v. Arbitrator - Two Birds of a Very Different Feather

By Jennifer Erickson

In the plethora of Alternative Dispute Resolution (ADR) options, mediation and arbitration are the two most commonly used. These can take many forms in and of themselves - they can be binding or non-binding, have high/lows or no caps, be court ordered or privately agreed upon. Regardless of the means and method, one would be wise to give careful consideration to the person chosen to head up the proceeding.

The first step in choosing someone to act as mediator or arbitrator is understanding the difference between the two types of proceedings, and with it, the role of the mediator or arbitrator.

In a mediation, the parties are brought together to hash out their differences. The parties provide the mediator with briefs setting forth the highlights of their cases and what they believe the evidence will be at trial. The objective of the mediator is to sort through the differences between the parties and find a meeting of the minds. Generally, the process is not binding, but the parties need to come to the table with reasonable settlement authority and a desire to resolve the case that day.

In contrast, an arbitration is essentially a mini-trial. The parties usually provide the arbitrator with a statement of their cases and a notebook of exhibits prior to the arbitration hearing. The parties will put on witnesses and evidence for the arbitrator who acts as judge and jury for the day. The arbitrator will rule on evidentiary issues, consider credibility of witnesses, and decide the factual issues in dispute. After the arbitration, the arbitrator's job will be to render a decision on both liability and damages. The arbitrator's decision is often binding.

In either case, your mediator or arbitrator needs to be an experienced attorney who can understand the issues in your case and have the knowledge base from which to evaluate a case like yours. The two jobs, however, are very different. The mediator's job is bring the parties together, whereas the arbitrator's job is to render a decision.

Your mediator, then, needs to be an expert at finding compromise and most importantly, an expert negotiator. You can expect that your mediator will tell you what is wrong with your case. But, you will want your mediator to do the same with the other side. A good mediator will negotiate your case for you and explain to the other side why they need to come to a more reasonable settlement position. It is therefore critical that your mediator be well respected in the legal community and have the ability to communicate, not just with lawyers but also with the parties. Often times a retired judge can make a good mediator because he or she has seen many verdicts and can give both sides a sense of what to expect if the case goes to trial.

In contrast, your arbitrator needs to be an expert at sorting through evidence and making a decision. Your arbitrator's job is not to find a compromise between the parties, but rather to make a ruling based on the evidence presented in arbitration. A good arbitrator knows the rules of evidence and will put in the time to review and consider all the documents and exhibits brought into evidence. A good arbitrator will also not be afraid to make a tough decision that one of the parties may not like. You are hiring that arbitrator because you trust in that person to make a decision based on the evidence.

So, how do you go about picking the right mediator or arbitrator for your case? Start by considering what you want that person to do for you. Ask the other side who they would like to use. This is particularly important when selecting a mediator. Remember, you want the mediator to explain to the other side why your case is better than theirs. Discuss potential choices with your attorney and don't forget to solicit feedback from others in your office.

Finally, keep in mind that you are usually going to pay your mediator or arbitrator for his or her time. Hourly rates can differ greatly as will the mediator's or arbitrator's speed at getting the job done. It is common for the parties to split the costs of the mediator or arbitrator but even then, the process can be expensive. It is therefore a good idea to know the cost of your mediator or arbitrator ahead of time so that you can properly budget for your case.

If you have any questions about finding a good mediator or arbitrator for your particular case, feel free to contact the author of this article, Jennifer Erickson, at 602-263-1740, or call any other attorney at Jones, Skelton & Hochuli. ◆

Appellate Highlights

Flagstaff Affordable Housing Ltd. Partnership v. Design Alliance, Inc.
AZ Court of Appeals
The economic loss doctrine does not apply to a claim for professional negligence against a design professional.

Seisinger v. Seibel
AZ Supreme Court
The Arizona statute requiring standard of care experts in medical malpractice cases to be practicing or teaching physicians does not violate the separation of powers by conflicting with a rule of evidence, because the statute is substantive, rather than procedural, in nature.

Monterey Homes v. Federated Mutual Insurance Co.
AZ Court of Appeals
An insurer defending under a reservation of rights can lose its right to subrogation if the insured enters into a settlement agreement releasing such rights, so long as the settlement is reasonable and the insurer receives proper notice.

Scottsdale Ins. Co. v. Cendejas
AZ Court of Appeals
A court may stike a non-party at fault notice if it does not contain facts explaining why the non-party is liable. Additionally, an award of reasonable expert witness fees pursuant to a Rule 68 sanction may include fees for non-testifying expert witnesses incurred after the offer of judgment is made.

City of Phoenix v. Fields (Perez)
AZ Supreme Court
An assertion of lack of compliance with Arizona's Notice of Claim statute is an affirmative defense that can be waived by the governmental entity if it conducts substantial litigation that would not have been necessary had the entity promptly raised the defense.

Backus v. Arizona
AZ Supreme Court
Under Arizona's Notice of Claim statute, a claimant must provide the facts he or she subjectively believes are necessary to support the "amount claimed." If the government entity feels those facts are not sufficient to evaluate the claim, it may ask for additional information.

Hudgins v. Southwest Airlines
AZ Court of Appeals
An 8:1 punitive/compensatory damages ratio was unconstitutionally excessive and reduced to a 1:1 ratio where the defendant's misconduct fell on the low to middle range of the reprehensibility scale and the substantial compensatory damages award likely contained a "penal element."

Let's Talk About the Issues: Will Arizona Courts Apply Issue Preclusion to all Criminal Plea Bargains?

By Jay R. Adleman

In the criminal justice system, the concept of "plea bargaining" dominates the daily lives of most prosecutors and defense attorneys. Contrary to what we see on television shows such as *Law and Order* or *The Practice*, most criminal matters are resolved with a negotiated plea agreement rather than a jury trial. This is especially true in Maricopa County and most other large urban counties throughout the United States. During the past decade, guilty pleas accounted for approximately 95% of convictions in the nation's largest counties. *See* Bureau of Justice Statistics, U.S. Department of Justice (2005).

What happens when the criminal conduct results in a subsequent civil dispute? In the Summer 2007 JS&H Reporter, we discussed an Arizona statute that is frequently applicable. Specifically, A.R.S. § 13-807 states:

> A defendant convicted in a criminal proceeding is precluded from subsequently denying in any civil proceeding brought by the victim ... against the criminal defendant the essential allegations of the criminal offense of which he was adjudged guilty, including judgments of guilt resulting from no contest pleas.

This statute applies equally to all criminal convictions, *regardless* of whether they arise out of a plea agreement or a jury verdict. The rationale behind the statute is simple. Our elected officials want to protect crime victims and prevent criminal defendants from denying the basic elements surrounding their criminal convictions. Despite that fact, the Arizona Court of Appeals has repeatedly noted that defendants remain entitled in subsequent proceedings to assert affirmative defenses such as contributory negligence and comparative fault. In other words, the jury retains the ability to determine the relative fault of all parties in the civil litigation. *See Williams v. Baugh*, 214 Ariz. 471, 475, 154 P.3d 373, 377 (App. 2007).

The million-dollar question is this: What is the legal effect of a criminal plea agreement in cases where the related civil litigation is not initiated by the crime victim? The Arizona appellate courts recently had the opportunity to address this issue in *Picaso v. Tucson Unified School District*, 214 Ariz. 462, 154 P.3d 364 (App. 2007), *vacated by* 217 Ariz. 178, 171 P.3d 1219 (2007).

In *Picaso*, a school bus struck and killed a fourteen-month-old boy in front of his own house. Prosecutors charged the boy's mother for her failure to properly supervise her son, and she subsequently pled guilty to one count of misdemeanor child abuse. The mother and father later brought a wrongful death claim against the school district. Pursuant to the school district's motion, the trial court applied A.R.S. § 13-807, thereby precluding the parents from offering any explanations for the mother's guilty plea. The jury found in favor of the school district and an appeal followed.

The Arizona Court of Appeals first determined that A.R.S. § 13-807 was entirely inapplicable under these facts because the litigation was not initiated by a victim against a criminal defendant. At that point, the Court turned to the question of issue preclusion. Specifically, the Court discussed whether the mother's guilty plea constituted "actual litigation," which would establish issue preclusion in favor of the school district. This was an issue of first impression among Arizona's appellate courts.

In its discussion, the Arizona Court of Appeals noted that there was a long-established split of authority in other jurisdictions throughout the country. Many courts have readily determined that a criminal defendant's voluntary plea of guilty - along with a court-sanctioned factual basis for the plea - is sufficient to demonstrate the "actual litigation" necessary to create a preclusive effect. Other courts, however, have insisted that anything short of a jury verdict cannot constitute "actual litigation." Ultimately, the Arizona Court of Appeals agreed with the latter approach, holding that a plea agreement cannot establish a preclusive effect in any subsequent civil litigation involving a criminal defendant. Accordingly, the Court awarded the parents a new trial against the school district.

When we last addressed the *Picaso* decision in the Summer 2007 JS&H Reporter, the case was still pending review by the Arizona Supreme Court. The Supreme

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exclusions, the language of the particular exclusion and arguments favoring coverage.

Two common challenges to the assault and/or battery exclusion routinely made by claimants are: (1) ambiguity and (2) the reasonable expectations doctrine. Both challenges are usually unsuccessful.

A recent case (and costly example) involving both challenges demonstrates the need for continued review by counsel and insurers of the particular provisions in liability insurance policies sold to bars, restaurants and other establishments where damages often result from an assault and/or battery occurring within or on the establishment's premises. This is particularly true where the owner of an insured establishment purportedly believes (and testifies) that the policy failed to conform to the coverage the insured believed he or she had purchased. Obtaining summary judgment under these circumstances is especially difficult in light of the inherent factual issues concerning the insured's expectations. Consequently, the reasonable expectations of the insured may permit an avenue for finding coverage, despite the existence of an otherwise valid exclusion.

Under the reasonable expectations doctrine, a court will not enforce standardized insurance policy language in certain, limited situations. *See Cullen v. Koty-Leavitt Ins. Agency, Inc.*, 216 Ariz. 509, 518, ¶ 25, 168 P.3d 917, 926 (2007). In the seminal case involving the reasonable expectations doctrine, *Gordinier v. Aetna Cas. & Sur. Co*, the Arizona Supreme Court outlined four situations where the court will not enforce an insurance policy's language based on the objective, reasonable expectations of an insured. 154 Ariz. 266, 272-73, 742 P.2d 277, 283-84 (1987). Those situations are:

> (1) Where the terms of an insurance policy, although not ambiguous to the court, cannot be understood by the reasonably intelligent consumer . . . the court will interpret them in light of the objective, reasonable expectations of the average insured;
>
> (2) Where the insured did not receive full and adequate notice of the term in question, and the provision is either unusual or unexpected, or one that emasculates apparent coverage;
>
> (3) Where some activity which can be reasonably attributed to the insurer would create an objective impression of coverage in the mind of a reasonable insured; and,
>
> (4) Where some activity reasonably attributable to the insurer has induced a particular insured reasonably to believe that he has coverage, although such coverage is expressly and unambiguously denied by the policy. *Id.*

After extensive briefing and oral argument by the parties in a recent Arizona case involving a reasonable expectations challenge to an assault and/or battery exclusion, an Arizona trial court ruled in favor of an insurance company and granted summary judgment, despite the claimant's attempt to create a genuine factual dispute regarding the insured's expectation of coverage. As noted above, this type of a challenge will often preclude summary judgment due to the factual issues inherent in the "reasonable expectations" analysis. Indeed, in the subject case, the insured bar owner's belief that her bar was fully protected against patrons involved in a barroom fight would normally preclude summary judgment.

The case involved a violent barroom fight and an insured bar owner, who had owned a bar for many years and had purchased the same insurance policy year after year. The insured bar owner testified that it was her longtime understanding and expectation that coverage would apply to harm resulting from bar fights between patrons. Although the insured bar owner admitted to never fully reading the policy, let alone the exclusion, her deposition testimony revealed her belief that a bar should be protected from fights occurring within or on its premises. Notably, this testimony came only after coverage was denied and after the bar owner had previously admitted to having no expectations, one way or another, from the policy language.

Despite the *apparent* factual dispute, the trial court agreed with the insurance company that the insured bar owner could not have had any reasonable, objective expectation of coverage where it did not involve any of the above four situations discussed in *Gordinier*. In particular, the trial court noted that the insured bar owner never read her rights under the policy, including the exclusion, despite having purchased the policy nearly 12 years earlier and renewing it annually. The court also noted that although the insured bar owner testified that she believed she was covered, she admittedly had never

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be actively practicing in the year before the incident in question. To meet the "active practice" requirement, an expert must have devoted a majority of his or her professional time to active clinical practice or teaching of the same specialty.

Although A.R.S. §12-2604 went into effect in June 2005, the statute has been subject to ongoing constitutional challenges. The most successful challenge to date contended that the statute is unconstitutional because it violates the separation of powers doctrine. The Arizona Constitution requires the three branches of government (legislative, executive, and judicial) to be separate and distinct. Each branch is allotted certain powers to exercise and is prohibited from exercising the powers exclusively allocated to the other two branches of government. Challengers to §12-2604 argued that the statute violated the separation of powers because it directly conflicts with the expert witness requirements under the Arizona Rules of Evidence, and therefore constituted a wrongful encroachment by the legislature on the rule-making power of the judicial branch.

In *Seisinger v. Siebel*, 203 P.3d 483, 551 Ariz. Adv. Rep. 38 (2009), the plaintiff sued Dr. Siebel, an anesthesiologist, for negligently administering a spinal epidural. The defendant objected to plaintiff's standard of care expert as he had not performed or taught anesthesia in the 3 years prior to the incident as required by A.R.S. §12-2604. The plaintiff acknowledged the expert did not meet the statute's qualifications, however, she argued that the statute was unconstitutional because it conflicted with Rule 702 of the Arizona Rules of Evidence. The trial court rejected the plaintiff's constitutional challenge and ultimately dismissed the case when the plaintiff failed to identify a new expert.

The Arizona Court of Appeals reversed the trial court's ruling, holding that the statute unconstitutionally infringed on the judiciary's rule-making powers. This ruling was based on its view that A.R.S. §12-2604 was in direct conflict and could not be harmonized with Rule 702. Under Rule 702, a witness may be qualified to testify based on "knowledge, skill, experience, training or education," and does not require the additional requirements under A.R.S. §12-2604 of board-certification, particular specialty, and active temporal practice. As noted by the Court of Appeals, the statutory qualification requirements are more stringent, as an expert could conceivably qualify under Rule 702 yet be precluded from testifying under A.R.S.§12-2604.

The defendant appealed to the Arizona Supreme Court. While the Supreme Court agreed that A.R.S.§12-

Speaking Engagements

Les Tuskai and **William Caravetta** will present "Problems With Insuring Teens on Their Own Auto Policies," at the Independant Insurance Agents and Brokers of Arizona's (IIABA) 75th Annual Convention on August 27, 2009. **Les** and **Bill** also presented "Family Purpose Doctrine and Other Auto Issues" to the IIABA on March 26, 2009.

Eileen GilBride will present "Updates in the Notice of Claim Area," at the Twelfth Annual Public Practice Legal Seminar on May 7, 2009 in Prescott, AZ.

Michael Hensley presented "2009 Changes to the Family Medical Leave Act," at The Mahoney Group's Benefits Litigation Seminar on April 10, 2009.

Edward Hochuli and **Donald L. Myles, Jr.** presented "Negotiation Strategies in Mediation," at the Council on Litigation Management's (CLM) Annual Conference on March 12, 2009. **Don** also presented "Advanced Strategies and Techniques in Mediation," at the Federation of Defense & Corporate Counsel's (FDCC) Winter Meeting on February 26, 2009.

Barry H. Uhrman presented "Working with Injured and Ill Employees: The ADA Amendments and Reasonable Accommodation," at the Arizona Work Disability Prevention Association's seminar on March 11, 2009.

Steven Leach and **Gordon Lewis** presented "Avoiding Workplace Harassment Claims," to McCandless of Arizona on February 7, 2009. **Gordon** was also a moderator at the Information Exchange Network presented by the Black Board of Directors Project on February 19, 2009.

2604 and Rule 702 are in conflict, it went beyond this first step of analysis. The Supreme Court noted that where a conflict exists, a court must then determine if the statutory provision is substantive or procedural in nature. If it is *substantive*, the legislature has authority to speak on the subject unless prohibited by the Constitution; the separation of powers doctrine never comes into play. In contrast, if the statute is deemed *procedural*, it becomes the judiciary's domain and the legislation would be held unconstitutional. Unfortunately, this determination is not always black and white and leads to frequent challenges to the separation of powers doctrine.

Substantive law is that which creates and defines rights. Examples of substantive rights include burdens of proof, common law privileges, and modification of a common law cause of action, such as the creation of a cause of action for wrongful death under Arizona's Wrongful Death Act. In contrast, procedural law encompasses the method of enforcing a right or obtaining relief for an invasion of a right. Examples of procedural law include filing and service of notice requirements. Traditionally, procedural rulemaking power is thought to be a power of the judicial branch, but it is generally accepted that the legislature can draft statutes that supplement rather than conflict with a procedural rule. In the event of an irreconcilable conflict between a procedural rule and a statute, however, the rule will always control.

Obviously, the plaintiff in *Seisinger* argued that A.R.S. §12-2604 is procedural in nature, as it precludes certain expert testimony from being offered in a case. Generally speaking, rules of evidence are thought to be primarily procedural, though they often also have substantive aspects. Thus, the Court looked to "the true function" of A.R.S.§12-2604 in analyzing its purpose. When analyzing a statute, courts must begin with the presumption that a statute is constitutional and resolve all uncertainties in favor of constitutionality. Where permitted, courts will try to resolve a conflicting statute as substantive to uphold its constitutionality.

In deciding *Seisinger*, the Supreme Court noted that the legislature is not precluded from modifying or abolishing a cause of action, nor is it restricted from increasing a plaintiff's burden of proof. The Court cited a long-standing common law history of requiring that the standard of care be established by expert medical testimony in malpractice cases even before the Arizona Rules of Evidence were adopted in 1977. Based on this fact, the Arizona Supreme Court reasoned that the expert testimony requirement in medical malpractice cases is a *substantive* component of a common law tort action, reflecting a policy decision by the courts that a plaintiff's burden of proof can only be met through evidence presented by another physician. The elements of a medical malpractice action were later codified in A.R.S. §12-563.

In support of its conclusion that A.R.S. §12-2604 was a permissive modification of a substantive right to bring an action against a healthcare provider, the Arizona Supreme Court went on to cite legislative intent to address the serious public policy issue of rising medical malpractice insurance rates and the reluctance of qualified physicians to practice in Arizona without safeguards against frivolous lawsuits. Legislative history of the statute reveals its intent to address these concerns by increasing a plaintiff's burden of production in medical malpractice actions by ensuring that testifying experts are knowledgeable about the applicable standard of care. In that regard, A.R.S. §12-2604 and Rule 702 are consistent rather than conflicting.

Even though Dr. Siebel was successful in fending off a constitutional challenge to the statute, he ultimately will not get the benefit of the statute on remand to the trial court. At the time the *Seisinger* lawsuit was filed, the statute had not yet gone into effect. Generally, a statute is not applied retroactively unless specifically provided for in the statute. Courts have made exceptions to this rule if the statute is only procedural in nature. Because the Supreme Court ruled that A.R.S. §12-2604 had "substantive components," the statute will not apply to cases filed before June 2005. The trial court may still ultimately rule, however, that the plaintiff's expert in Seisinger does not qualify under Rule 702.

So what does the *Seisinger* case mean for all those files on your desk? It means that A.R.S. §12-2604 has survived the constitutional challenge as to separation of powers only. The Supreme Court did not address whether the statute violates any other constitutional provision, leaving the statute potentially subject to other constitutional challenges in the future. For those cases filed after June 2005, the files should be reviewed to determine if the retained standard of care experts meet the additional qualifications concerning specialty, board-certification, and active practice within one year of the

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incident. If not, it may be possible to approach opposing counsel to request a stipulation that he or she would not try to disqualify the expert under A.R.S. §12-2604 given that the statute was in a state of flux at the time of retention. Also keep in mind that the statute does not apply to causation experts.

Scope and Admissibility of Expert Testimony -- *Pipher v. Loo*.

A second case recently decided by the Arizona Court of Appeals, *Pipher v. Loo*, --- P.3d ----, 2009 WL 596653 (App. 2009), provides further guidelines for admissibility of expert testimony and the scope of an expert's testimony in both medical malpractice and other cases.

In *Pipher*, the plaintiff brought a medical malpractice action against his dentist, alleging he sustained nerve damage as a result of negligent administration of the anesthetic. During trial, the plaintiff presented testimony from his causation expert that the defendant caused the plaintiff's injury by not immediately withdrawing the anesthetic needle upon eliciting an "electric shock" at the site of the injection. Defendant presented contrary testimony from his expert as to the cause of injury. Both the plaintiff and the defendant objected to the elicited testimony from the causation experts. The trial court overruled the plaintiff's objections but upheld the defendant's objections, essentially leaving the plaintiff with no causation testimony. Plaintiff filed an appeal after the jury entered a defense verdict.

Defendant's expert had testified that his opinions regarding the cause of the plaintiff's nerve injury were based upon his own laboratory research regarding the cause of lingual nerve damage, clinical experience with patients with similar injuries, and interviews of other patients with this injury and their dentists. Plaintiff argued that the expert's opinions were based upon inadmissible hearsay. The trial court denied the objection, permitting the expert to testify. This ruling was upheld by the Court of Appeals under Rule 703, Arizona Rules of Evidence, which permits an expert to testify as to traditionally inadmissible facts and data in support of his or her opinions when the data is the type of information reasonably relied upon by experts in that field. Such "reasonable reliance" by others in the field overcomes the inherent untrustworthiness of hearsay statements. The Court of Appeals was further persuaded by the fact that the interviews were not the sole basis of the expert's opinions; he also had clinical experience and performed his own research on the topic.

The plaintiff also challenged the trial court's ruling excluding three portions of the plaintiff's expert testimony relating to causation. The Court of Appeals first held that the trial court properly excluded testimony from plaintiff's causation expert relating to the expert's personal practices. It agreed this was duplicative standard of care testimony in violation of the presumptive "one expert" rule. The Court next addressed the admissibility of the plaintiff's expert testimony that had the defendant dentist properly administered the injection slowly as required by the standard of care, the needle could have been backed out without causing significant damage to the lingual nerve even if contact was made with the nerve. The defendant had objected to the testimony as erroneous standard of care testimony, speculative and lacking foundation. Because the trial record did not provide a basis for upholding the defendant's objections, the Court of Appeals considered all of the objections. It determined that the testimony was improperly precluded as duplicative standard of care testimony, as the reference to the standard of care violation was merely a predicate for the expert's opinion that the dentist's actions caused the plaintiff's injury. Furthermore, the expert's clinical training and experience, along with the defendant's own description of the injection procedure, provided adequate foundation for him to testify as to the cause of injury. The Court noted that contrary to defendant's objection, the lack of published scientific data goes to the credibility of the expert's opinions rather than to admissibility. It concluded that preclusion of the expert's causation testimony had the effect of unfairly prejudicing the plaintiff, as he was unable to meet his burden of proof. The Court of Appeals therefore vacated the judgment in favor of the defendant and remanded the case for a new trial.

One of the important holdings in *Pipher* is that a party may elicit limited standard of care testimony from a causation expert when done as a predicate for the opinion that the defendant caused injury to the plaintiff, as opposed to stacking standard of care experts. This is particularly helpful when defendants do not use the same expert to testify as to standard of care and causation. *Pipher* is also instructive as to proper foundation for an expert's opinions in Arizona, and these guidelines extend far beyond the medical malpractice arena. ◆

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the CMS website (www.cms.hhs.gov), the intent is to have all insurers report electronically. When a claim is presented that involves Medicare payments, the insurer should open an MSP (Medicare Secondary Payor) claim with the COBC (Coordination of Benefits Contractor). CMS (Centers for Medicare & Medicaid Services) is responsible for the oversight of Medicare and has been charged with implementing the new reporting requirements. CMS is going to begin the registration of insurers, or RREs (Responsible Reporting Entities) in May 2009 through the internet. More information about the registration process can be found at www.cms.hhs.gov/MandatoryInsRep. Once an insurer is registered as an RRE, it can then report electronically. An attorney representing a Medicare beneficiary can also open a claim with the COBC by phone or in writing.

Attorneys handling personal injury and workers' compensation cases will need to do the following in order to assist their insurance carrier clients in complying with the reporting requirements:

1. Identify as early on in the litigation as possible whether the case involves Medicare. This can be done through a letter to opposing counsel or in the form of a non-uniform interrogatory.

2. Obtain the Medicare beneficiary's Social Security Number and his or her Health Insurance Claim Number (HICN). This information must be included in the reporting process.

3. Modify your Settlement Releases, and if applicable, your settlement check transmittal letters to reflect that the case involves Medicare and that the claimant/plaintiff acknowledges that pursuant to 42 USC §1395y(b)(7) & (8), the settlement will be reported to Medicare.

4. Obtain confirmation of the Medicare reporting from the insurer and include it as part of your documentary file prior to closing.

Finally, it is important to keep in mind that the new reporting requirements will not affect a beneficiary's ability to dispute Medicare's claim for reimbursement and/or set aside. A beneficiary will still be able to pursue an administrative appeal (42 USC §1395ff), compromise (42 C.F.R. §405.376), or waiver (42 USC §1395gg). ◆

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Court later accepted review, intending to decide this "interesting issue" regarding the preclusive effect of guilty pleas. *Picaso v. Tucson Unified School Dist.*, 217 Ariz. 178, 181, 171 P.3d 1219, 1222 (2007). In the first part of its opinion, the Supreme Court seemed to indicate it disagreed with the Arizona Court of Appeals, noting that many jurisdictions have persuasively decided that the judicial "safeguards" surrounding a guilty plea - reliable enough to deny a criminal defendant's personal freedom - are sufficient to establish a preclusive effect as to the elements of the offense.

Upon further review of the trial record, however, the Supreme Court determined that it was unnecessary to decide this issue within the confines of the Picaso litigation. The Court ultimately reinstated the original defense verdict in favor of the school district and reasoned that the relative fault of the parents was irrelevant in light of that verdict. In the end, deciding the "interesting issue" of the preclusive effect of plea agreements would be left for another day.

For now, one thing remains certain. Plea agreements continue to serve a vital role within the landscape of the criminal justice system. The United State Supreme Court has noted that these agreements are both "essential" and "highly desirable" for victims and criminal defendants alike. *See Santobello v. New York*, 404 U.S. 257, 261 (1971). Given this reality, we can only hope that the Arizona Supreme Court will decide the preclusive effect of plea agreements in the near future. ◆

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to each case, the decision to drastically reduce the jury's award appears to signal an effort by the Arizona Court of Appeals to reign in the potential for "runaway" punitive damage verdicts. Arizona defendants appealing excessive punitive damages awards should also find encouraging the Court's suggestion that large compensatory damages awards may in some circumstances encompass "a penal element." This portion of the Court's decision allows litigants to take the position that even a 4:1 ratio may not be justified when a jury issues an artificially inflated compensatory damages award. ◆

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Employers may obtain copy of the final regulations from the Department of Labor's website: http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=21763.

Practical Advice and To Do List for Employers

Employers must understand their legal obligations and requirements with respect to the new regulations. Employee handbooks and other written policies must be updated to include the new military leave provisions and comply with the new regulations. New notice and medical certification forms must be prepared to comply with the Department of Labor's regulations.

Employers should adopt policies requiring use of paid leave concurrent with FMLA leave and consider changing rules regarding the use of paid leave to take advantage of the new flexibility.

Most importantly, employers must ensure that all human resources personnel, as well as supervisors and managers, have been trained regarding the new regulations and that an adequate tracking system for FMLA leave exists. ◆

Jones, Skelton and Hochuli's Employment Law Practice Group will continue to keep you apprised of all future developments concerning the Family and Medical Leave Act. Please feel free to contact Barry H. Uhrman [(602) 263-7328, buhrman@jshfirm.com] with any questions you may have regarding this important development in employment law.

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asked her broker whether coverage for an assault and/or battery existed. The trial court ultimately granted the insurance company's summary judgment motion, despite challenges of ambiguity and reasonable expectations.

In sum, the reasonable expectations defense to an assault and/or battery exclusion is often no more than an attempt to create a factual dispute to avoid summary judgment and find coverage. Careful analysis of the insured's understanding of the exclusion, the history of the insured's policy, and the insured's testimony is therefore crucial when seeking summary judgment. ◆

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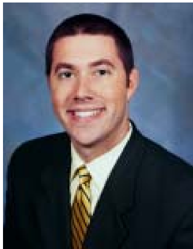

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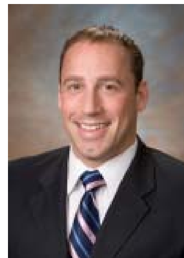

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