Large "Bad Faith" Verdict Raises Two Intriguing Issues

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The verdict by a Los Angeles jury last week awarding a health insurance claimant over $19 million raises a pair of issues of interest to health and disability insurers.

In *Thomas Nickerson v. Stonebridge Life Insurance Company*, the plaintiff, an ex-Marine, sought payment for 109 days in the hospital after a fall. The insurance company believed expenses for only 19 of those days were medically necessary. A jury awarded Nickerson $35,000 in emotional distress damages, plus $19 million in punitive damages.

As this case undoubtedly proceeds, first in a motion directed to the trial judge, and then likely on appeal, one issue that will be addressed is the appropriate amount of punitive damages that should be permitted (assuming any punitive damages survive).

Case law in recent years has established that except in the most extraordinary circumstances, punitive damages should not exceed other compensatory damages by more than a single digit ratio. Some courts have even opined that a 4:1 ratio is the maximum amount to be awarded, and that a 2:1 or even 1:1 ratio would be more appropriate.

Here, the ratio of punitive damages to compensatory damages somewhat exceeds the above guidelines -- it pencils out to 543:1. It's true that depending on the level of reprehensibility of a defendant's conduct, and where compensatory damages are nominal, the courts may be open to approving punitive awards in excess of a the above ratios, but those circumstances do not appear to apply in this case.

The second issue raised by the *Nickerson* case is the alleged obligation by an insurer to accept or give great deference to the opinion of an insured's physician, with respect to the question of medical necessity under a health policy.

Nickerson's lawyer, William Shernoff of the Claremont, California firm of Shernoff Bidart & Echeverria LLP, has expressed the hope that this case will lead to a recognition by the courts that the medical judgment of policyholders' treating physicians should be accepted by carriers.

In fact, this case is unlikely to lead to such a result.

Appellate courts have long recognized that the issue of medical necessity should not be one that is dictated by the view of any particular expert or practitioner, but instead should turn on which party presents the most compelling evidence on the coverage question.

The notion that a policyholder's doctor has a monopoly on truth or good judgment, especially when that physician may hold a view based on a longstanding affinity for a patient, and an unquestioning acceptance of self-reported symptoms that may or may not be reliable in light of clinical or objective testing, is unlikely to find favor with the bench officers asked to decide coverage questions.