ORAL ARGUMENT — 1/8/98
96-0249
PROVIDENT AMERICAN INSURANCE CO. V. CASTANEDA

LAWYER: Of the 14 points that this court granted, I believe that the bad faith points are the thorniest issues.

ABBOTT: Would you tell me as precisely as you can, the objection...did you try this case?

LAWYER: I did not.

ABBOTT: The objection that was made by whoever tried this case on behalf of your client, to question them _____?

LAWYER: I can't give a precise answer because it goes for several pages as I recall. But there were objections intermingled that there was no evidence to support...

ABBOTT: What about the form of the question?

LAWYER: In terms of how many answer blanks there were?

ABBOTT: As I understand it, there is only one answer blank for question No. 1.

LAWYER: That's correct.

ABBOTT: To the form of the question?

LAWYER: There was no specific objection in terms of form as to how many answer blanks there ought to be.

OWEN: Did you object that improper theories were being submitted in that issue?

LAWYER: I believe there was an objection also the theories that were being submitted are not legally proper. I remember counsel cited lines in *Dominguez* and said because of those cases these are not legally proper questions.

Before I turn to the bad faith issues, I wanted to mention 2 brief things about the damage questions. First, I believe that the damage questions are the least thorny of the issues in this case; and 2) the damage questions give you the opportunity to write about subjects you have not written about before. You have written extensively about mental anguish damages, about lost profits

and other forms of tort damages, but you have not written about loss of credit, which is one of the measures submitted in this case.

As to the bad faith issues, I decided I could try to go one of two ways: I could try to explain why this case demonstrates an unrecognized flaw in the entire concept of the tort of bad faith, that argument would require the court to revisit *Giles* and *Nicolau*, or I could try to explain within the confines of *Giles* and *Nicolau* why this record conclusively shows that the problem American had is that its liability was never reasonably clear.

On the premise that this court is not likely to revisit *Giles* and *Nicolau* so soon, I have decided to make the second argument that Provident American's liability was never reasonably clear.

Now we know that Denise Castaneda was born with "Hereditary Spherocytosis." The question is whether that illness ever manifested from the time of her birth up through July 17, 1991, which is the last day of the 30 day waiting period. During that 30 day waiting period, the family got a call from Denise's uncle, that he had this illness. He described what it was, the symptoms, told them that surgery was the only cure.

ABBOTT: Is there any evidence that she knew before that magic cut-off date?

LAWYER: The jury could have believed that she was not aware of the diagnosis until after the waiting period expired.

ABBOTT: Was there any evidence according a conclusion or any evidence indicating that she knew that she had it before the cut-off date?

LAWYER: Yes, because of the evidence that she had a yellow complexion all of her life, the evidence that jaundice is a symptom of this condition, that it's a hereditary condition usually _____ on the mother's side of the family, and this was her mother's brother who had had it. So when you have all of those complex of symptoms together, yes, there's evidence from when she could have deduced she had that condition.

ABBOTT: But had she deduced, or had she suspected that she had the illness?

LAWYER: What her state of mind is, I don't know.

ABBOTT: There's no evidence on that at trial?

LAWYER: Not that I can think of. Based on this phone call, the Castaneda's knew their children were at risk for this disease, they knew the nature of the disease, and they knew surgery was the only cure. They decided that of their three children, only two of them were at risk, so they took

those two children to the doctor. This is powerful evidence that the family had seen the manifestations of the illness before the waiting period expired. Why else would they choose Denise as one of the children to go to the doctor? And if they thought that she might have it, why is it unreasonable for *Provident American* to conclude that it had manifested before the end of the waiting period?

Now the family's suspicions were confirmed. On July 18, the day after the waiting period expired, Dr. Gutierrez suspected that Denise's brother had this illness. Two days later, Dr. Canales confirmed that both Denise and her brother has this illness. So the obvious question is, if they were confirmed 3 days after the waiting period expired, how could this disease not have manifested before the waiting period expired?

SPECTOR: Just going to a doctor, you're reading that that's a realization by the insured of a manifestation of the disease?

LAWYER: I don't think that the policy requires a realization. It requires a manifestation. It requires evident symptoms of some type even if you don't know the significance of those symptoms.

SPECTOR: So if they had not gone to the doctor, there would have been no manifestation?

LAWYER: No, there was manifestation because the symptoms were evident before the waiting period expired even though she didn't know for sure whether she had the disease. It does not require a diagnosis in order for manifestation to occur.

The medical records contain strong evidence that the disease did manifest before July 18. The record shows she was jaundice when the doctor saw her, that her bilirubin was at level 3, which meant that she had to have yellowness in the white part of her eye, which is a manifestation of the disease. The Provident American doctor said: that that probably occurred over a period of time.

PHILLIPS: Is it your position that if Provident did not owe this claim, that it cannot be libel for bad faith?

LAWYER: Yes, it is.

PHILLIPS: What about our language in *Stoker,* and other places saying: that the insurance company's conduct can be such that you can commit this tort independent of whether it actually turns out to have liability in the _____?

LAWYER: The conduct of the investigation does not wipe-out the fact that there was a reasonable basis for this insurance company to believe this claim wasn't covered. Also, this court

has defined bad faith in such a way that investigative deficiencies don't play into the definition. The definition is that they are to pay when liability is reasonably clear that focuses on the failure to pay as the essence of the tort. So the tort is litigating a claim you shouldn't be litigating, and the investigative aspect of it goes to whether you knew or should have known that you didn't have a reasonable basis to deny the claim.

OWEN: You're not contesting that the claim should not have been denied are you, and you're not here saying that Provident American validly denied the claim? There's no contention in this case that the policy, in fact did not cover this, is there? You now concede there's is coverage?

LAWYER: No, we do not concede there is coverage.

OWEN: You had jury findings against you on your affirmative defenses on your theory?

LAWYER: Those were submitted as defensive issues. And this court has held on two cases, I cite in the brief, that a negative finding on a defensive issues is not the same as a positive finding. Coverage is the insured's burden. The insured has to prove positive that there was coverage. The question was also submitted in terms of did it manifest before July 17? That doesn't take into account that actually the waiting period goes through July 17. So we don't know what the jury thought about that particular day. All we knew is what they thought before July 17, but not as of July 17. The policy says: If the symptoms manifest on or after July 18, that you are free and clear of the 30 day waiting period.

To finish addressing the question about the investigation, I believe that the court should not make the investigative deficiencies an independent basis for liability. I think that's taking the law down an unproductive detour. That makes the investigation an end, in and of itself. And then you get the parties fighting over who did what to who at what point in time. It invites a proliferation of lawsuits because every claim file can be criticized. And it almost creates a presumption of liability because every claim file can be criticized.

BAKER: Are you advocating then that the investigative process should not be a factor in a review of the evidence to determine bad faith?

LAWYER: I believe it goes to whether the insurance company knew or should have known that it didn't have the reasonable basis, or that liability was reasonably clear.

BAKER: And how can they do that if you're going to exclude investigation as a factor?

LAWYER: I'm saying the jury can look at that as a factor in deciding whether...they don't look at it just to whether or not there's a reasonable basis. The reasonable basis is either there or it isn't regardless of what kind of investigation was conducted. If the jury decides there wasn't any

reasonable basis, then they look at whether the insurance company knew or should have known, that's the point at which the investigative portion comes in.

SPECTOR: Going back to the manifestation again. I heard you to say that from birth, she had been jaundiced, from birth she apparently had some symptoms that would point to this disease, so why are you choosing the 17th or whatever day as when it manifested itself?

LAWYER: I'm not choosing that. I am just pointing out that there is a flaw in the question as submitted, that it didn't cover that particular day, and that day is still within the waiting period.

SPECTOR: But your citing as to evidence that shows that it probably manifested itself when she was born?

LAWYER: Not when she was born, but at various points in her life. For example, the medical record said that when she was age 12, she was treated for possible hepatitis and funny colored skin.

SPECTOR: So the 30 days is really irrelevant? It had manifested itself before she was ever covered under the policy?

LAWYER: The 30 day waiting period is not just that 30 day window if it manifested anytime before that 30 day waiting period expired.

SPECTOR: So what is your position? When did it manifest?

LAWYER: Sometime before that waiting period expired. I don't k now when. One example would be: when she was age 12 and diagnosed with possible hepatis and a funny colored skin.

The difference we've got here from the *Giles* and the *Nicolau* cases are this: We've got an insurance company relying on medical records, relying on factual information in medical records. In *Giles,* the insurance company's reliance on those records was completely impeached, because all of that evidence was proven to be nonfactual, it was wrong. At most there's two bits of information in the medical records that were proven to be wrong in this case, the rest is factual information in her medical records. It's not information that Provident American made up. So really what we've got here is a fight over what conclusion can they reasonably draw from that factual information. It was reasonable based on their review of the medical text and the descriptions of this disease and its process and its symptomatology, and based on their consultation with a medical doctor, it was reasonable for the insurance company to draw the conclusion that those facts in her medical records demonstrated that her disease manifested before the waiting period expired.

The difference from the *Nicolau* case is that there was a fight there, not only over what the facts were, that is what was going on underneath this house, but also what reasonable conclusions can be drawn from those facts?

ABBOTT: On the damage issue, under the *Bidum(?)* case, why would it not be that she would be entitled to at least $14,400, assuming that there was coverage in the bad faith claim?

LAWYER: Because the jury charge imported the policy measure of damages into the charge. The charge asked the jury to find lost benefits, the amount of benefits due under the policy. So that imported the policy measure into the case rather than relying on the DTPA general rule that whatever damages she can prove.

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RESPONDENT

LAWYER: This court does not need to reach any of the petitioner's arguments regarding good faith and fair dealing, *Watson v. Vail*, or broad form submission, because all those arguments relate to question No. 1. And there's an independent basis for supporting the judgment, and that's the jury's answer to question No. 3.

Question No. 3 is a broad form submission of a laundry list. 17.46(b)(5), (b)(7) & (b)(12), and supported by the evidence. There is nothing in the laundry list that pertains to good faith and fair dealing, the presence or absence of a reasonable basis, or when the liability becomes reasonably clear.

For almost 20 years this court has held that if a submission tracks the language of the laundry list, that's permissible submission, and if the evidence supports the affirmative answer to that question, then the verdict should be upheld.

What I would like to do is talk a little about the evidence that supports the jury's affirmative answer to Question No. 3, because I think that also to the extent it matters demonstrates that there is some evidence of a reasonable basis, some evidence of liability was reasonably clear, whether you look at it in the context of reliance, whether the insurer's reliance was reasonable on the information before it, whether you look at it in the context of *Dominguez,* whether we cast doubt upon the insurer's information, whether you look at in the *Nicolau* and *Giles* test of pretext or sham, or Justice Hecht's concurrence of arbitrariness.

SPECTOR: What you're really saying is this is not a bad faith case as we were faced in *Nicolau* and *Giles*, is that correct?

LAWYER: No, I don't think it is. I don't think the court has to write or consider any bad faith law. The initial denial was on the 6-month gallbladder provision. The carrier knew as of

12/12/91 that was an erroneous denial, which in and of itself is not actionable, at least under common law. For 7 months thereafter, until mid July, they refused to pay physicians' bills and told doctors: "We're not going to pay your bill based on a 6-month gallbladder exclusion," that their claims manager had decided was inapplicable. That's a knowing misrepresentation.

They also made misrepresentations regarding the 30-day manifestation clause, which goes to show that there is some evidence that this was not a reasonable basis for denying coverage.

The claim's manager's testimony, and her testimony was done in court, she testified: she had no idea when this condition manifested. Your questions are good questions about when it manifested because their claim's manager said: I have no idea. I denied the claim, but I have no idea when it manifested.

GONZALEZ: The position was within 30-days of the personal policy?

LAWYER: Yes, within 30-days of the effective date. But she said she had no idea when it manifested within the 30 days, or whenever, she just knew that it was something that needed to be denied and that's her testimony.

Both the claim's manager and the director of operations recognized this as a complex medical condition. But they both testified that they denied it without consulting the in-house medical director.

The President said: Well, I talked to the in-house medical director, and denied the claim. The only real evidence in the record that he talked to the in-house director was he talked to the expert, who wasn't in-house a month before trial. At the time of the denial, there's no real evidence that he had talked to the in-house medical director. He said he did, but the director of operations said: Every time you talk to the in-house medical director, there should be a notation in the file. There was no notation here.

The jury was also entitled to believe that the president had misrepresented the reasons for denying the claim to the Texas Dept. of Insurance. He wrote a letter to the TDI after 6 or 8 months in not communicating with the insured, saying basically a two-fold letter: We denied this claim based upon the symptoms; and we denied this claim based upon a preexisting condition. He goes to trial and he says: Well, it was never denied on preexisting condition. And Provident American's own expert said: Well you can't deny a claim based upon the symptoms alone, you have to relate it to a disease.

He also insisted at trial, that the 6-month gallbladder provision warranted the denial of the claim. Everybody else with Provident American said that was a wrong reason for denying the claim. So whether you couch it at bad faith, or misrepresentation laundry list case, you

have ample evidence showing that a carrier who's jumping from exclusion to exclusion to exclusion and back again, and couldn't even agree at trial the reason for denying the claim. That fits perfectly again if we need into the pretext sham type of a claim denial, that was recognized in *Giles* and *Nicolau*.

Turning to your question Justice Abbott on the preservation point, the CA held that 17.46a is not a viable cause of action in a first-party case as made actionable through the insurance code. We think that holding is wrong. We think it is a viable cause of action. But they did not preserve that complaint. There is no objection to question No. 1 on the grounds that it contains a legally flawed theory, a defective theory a noncognizable cause of action in 17.46a.

The references to the inclusion of the reasonable basis concept in the charge, what the trial attorney said was: We think that *Lyons* and *Dominguez* applies to every cause of action, and there should be an instruction about reasonable basis in the charge on every theory of liability. That objection is just plainly wrong unless we're going to rewrite the DTPA laundry list.

PHILLIPS: Even assuming you're right, how can you uphold the judgment of the CA on the quality of proof that resulted?

LAWYER: Turning to the policy benefits first. I think there was legally sufficient evidence of the policy benefits...the bills were introduced. It's apparent but it's hazy from the record if the policy measure of damages applies, they are introduced via affidavit under the Civil Practice & Remedy Code, so live testimony was not necessary. There are references in the record to affidavits. That's the reason in the TC there is no objection to the admissibility of those bills nor is there no objection to the charge on failing to include a limiting instruction saying: Jury if you're going to award lost policy benefits, you can only award it in accordance with that policy language.

BAKER: Wasn't that what the instruction said to the jury on the damage issue?

LAWYER: It said, under the policy.

BAKER: No. Didn't it say under the policy benefit?

LAWYER: It has the phrase "under the policy." One of our alternative positions is that their complaint about our damage evidence not satisfying the policy measure was waived, and that they have the obligation to request a limiting instruction. Because I think it's unrealistic to require the jury to look at a health policy and calculate the damages. I think that's up to the trial counsel to include the entire measure of damages in the charge.

BAKER: You alluded to the affidavit that was the sponsoring way for the medical bills. Did that affidavit say that those bills were reasonable, usable and customary?

LAWYER: Unfortunately, I don't think the affidavit is in the record. That's why I said the record is hazy. It's apparent from the way it's introduced that they were introduced by affidavit.

BAKER: Is there any evidence in the record that meets the policy benefit definitions, or whether those medical bills were reasonable, usual or customary?

LAWYER: Assuming it was our burden to produce that evidence.

BAKER: Well, you're the plaintiff aren't you?

LAWYER: Yes. I think that at least part of the policy language is a little ambiguous. You could almost look at the way it's phrased: the benefits are coverable unless they exceed the usual and customary. And I think you could take the position that it's up to the insurer to prove that the benefits are not usual and customary. I don't think we need to do that.

BAKER: How do you transfer the burden to the carrier to do your job?

LAWYER: Basically in the sense that it's an exception to coverage rather than part of coverage. I can see this is not a strong point.

HECHT: But if you had the burden, there's no evidence?

LAWYER: Absent the references in the record of the affidavit indicating it was proved up and under the Civil Practice & Remedies Code.

BAKER: The second part of the damage question has to do with the loss of credit. Is there any evidence in the record by anybody that mentions dollar figures on the loss of the credit aspect of your client's case?

LAWYER: No, there is not.

BAKER: So the assertion by the CA is correct then, that she was denied credit cards, and that's it?

LAWYER: That's not the only evidence bearing on lost credit though.

BAKER: What else is there in the record?

LAWYER: The evidence is she was sent bills, she's libel for her own debts, she couldn't pay the bills, she applied for credit cards after Dec. 1991, she was turned down for those credit cards. The only outstanding bills that she had were the unpaid medical expenses.

BAKER: But loss of credit doesn't necessarily equate to the first part of what you said. Don't you have to prove that you asked somebody for specific credit and was denied, or in the alternative, that you had an ability to borrow or use a credit card before this event happened and you could no longer do it?

LAWYER: I think it's reasonable and _____ from the evidence that if the only credit problem she could possibly have involves $14,000 of unpaid medical bills, that her inability to get a credit card is attributable to that $14,000 outstanding debt.

OWEN: What if her income wouldn't support the application?

LAWYER: If that were in evidence...

OWEN: Her income's in evidence.

LAWYER: It is in evidence.

OWEN: Wasn't it $400 a month?

LAWYER: It's $400 a month. That was something the jury had the right to either agree with defense counsel or argue about it and say: Hey, it wasn't not on account of unpaid medical bills, it was denied on account of her income, she had a student visa. That was something for the jury to decide.

BAKER: The last part of my inquiry is of the way that the issue was submitted, the assumption is that the loss of credit damages is approximately $36,000, is that right, do you agree with that? If you're saying the $14,000 is a proper measure of damages for the loss of benefits, then the rest of the $50,000 is $36,000?

LAWYER: Yes.

BAKER: What evidence is there that would permit the jury to pick $36,000 if that's what they did?

LAWYER: Loss of credit is an intangible damage.

BAKER: Then do you have any case that says you can prove loss of credit without ever telling anybody how much you thought you lost? No evidence of what you could do in the past, what you did lose?

LAWYER: I have not cited any case for this court.

BAKER: Are there any out there?

LAWYER: I don't know. I can look. That brings up a point, if there's a problem with the policy benefit submission, and the policy of benefits evidence, the CA held correctly that so long as there's one item, one element of damages in a multi-element broad form submission that supports a verdict, then the entire verdict must be upheld. So if this court believes there is legally sufficient evidence of $36,000 in lost credit, _____ be no reason why there could not be $50,000 in lost credit assuming there's any problem with the lost benefits.

One of the Justices asked a question about the applicability of *Stoker*. *Stoker* is an important case, because *Stoker* says there could be no bad faith liability essentially for an insured who promptly denies a claim, then turns out not to be covered. Here, unlike *Stoker*, we don't have a prompt denial. As the CA held, the finding that the carrier did not promptly communicate with its insured, was supported by the evidence. And essentially all the Provident American witnesses agreed that they violated their obligation to communicate promptly and effectively with their insured.

OWEN: Is there any finding by the TC that the claim was in fact covered?

LAWYER: There is not a finding. I think as a matter of common sense, if not as law, it has to be covered. The only two theories of noncoverage advanced by Provident American at trial, and again witnesses for Provident American went back and forth on whether these were just theories or not, with a 30-day manifestation and the 6-month gallbladder exclusion, the jury found against Provident American on both those policy provisions. The reason that's important is not because of what opposing counsel was talking about what a no answer establishes, it's because under article 21.15 of the insurance code, the carrier now has the burden of proof of policy exclusions. So if the only theories of noncoverage were found adversely to the carrier, this is a matter of logic, again if not law, the claim was covered.

Talk a little more about manifestation. Provident American approach to manifestation demonstrated actually proved their liability under the laundry list and the insurance code _____ is incredibly a one-sided construction of manifestation. They took the position that manifestation basically meant symptoms. Whenever there was a symptom, you had manifestation. It didn't matter when they happened. To this day, I really cannot understand what their position on when it manifested.

OWEN: How many days after the policy was issued was she actually diagnosed?

LAWYER: She was diagnosed on July 20.

OWEN: So 33 days after the policy...

LAWYER: Yes. And turning back to your question Justice Abbott. She didn't know that she had the disease until July 20. She had had yellow skin, like her dad, who does not have "HS", and she had occasional indigestion. But she didn't know there was anything wrong. She didn't know she had the disease until July 20.

This is a complex medical condition. She had no way of knowing it, and that's why it is so egregious that the claims manager and the director of operations denied the claim without talking to the announced medical staff.

Manifestation is not defined in the policy. At trial, the Provident American witnesses said: Well, the policy might be ambiguous, but we're not going to construe the ambiguity in favor of the insured, and the insured can't rely on a common sense dictionary definition of manifestation. And they also said: well if the insured wants to know what manifestation means, what the insured needs to do is they need to call us on the phone and ask what manifestation meant.

When this condition manifested depends on the definition of manifest. And if there is any ambiguity by what manifest means, it should be _____ insured.

I think it's important for this court to realize that Provident American has not attacked the sufficiency of the evidence to support the knowing finding. This is a good size judgment. But all the court needs to do is review the liability findings in order to uphold the judgment in its entirety and the damage findings of course. We think the CA reached the right result and it should be affirmed.

ABBOTT: Were the medical bills eventually paid?

LAWYER: No.

ABBOTT: So they are still today unpaid?

LAWYER: They are not paid through trial.

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REBUTTAL

LAWYER: Mr. Patton argues that this is really a misrepresentation case. And I don't have time to get into all the ins and outs of that. But I will comment that assuming there was a misrepresentation that's supported by the record, that cannot be the cause of any damages here. He's saying misrepresentations occurred after Dec. 12. There's a dispute whether or not that Dec. 12 letter was a denial letter, but regardless the misrepresentations they are talking about occurred after that. How can that be the cause of any damage particularly the damages the jury found: the loss of benefits and the loss of credit. Those damages were caused if at all by the mere denial of the claim.

If they had handled this claim perfectly, and then denied it, it would have caused her to lose the benefits and any credit loss that might have flowed from that. So the misrepresentations didn't do anything.

Mr. Patton also mentioned that this was a pretextural sham investigation and it falls in *Giles* and *Nicolau*. As I've tried to explain earlier, it doesn't fall in *Giles,* because we've got unimpeached medical evidence from her own medical records. It doesn't fall within *Nicolau,* because there's no evidence in the record whereby they challenged the reasonableness of the insurance company's conclusion that they drew from those unimpeached medical records. There is no evidence challenging what the medical tests say about this disease or what the medical doctor said about this disease. There's no challenge for example, that people with this disease will be jaundiced. There's no challenge that most of them will develop gallstones, that that will cause epigastric pain in the upper part of the abdomen, that her epigastric pain was likely caused by those gallstones. She said: I thought it was mild indigestion. But she has no basis to know what was really causing it. She's a lay person. The doctor said it was probably the gallstones.

GONZALEZ: The argument was made that this claim was going to be denied from the get go, they requested additional records from the young lady, there was no follow-up, there's a statement in the CA that there was an admission by one of the officers of the company that what they did was improper. And the last argument that was made that the medical in-house person was never consulted up until shortly before trial, would you comment on that type of evidence that to me speaks to a decision very similar to the movie "RainMaker", that the insurance company was going to deny the claim and it was looking for reasons to deny the claim?

LAWYER: That doesn't remove the facts that the undisputed evidence shows a reasonable conclusion could be drawn that there was prior manifestation. No matter the worst you might think of an insurance company, this doesn't take away from the fact there was a reasonable conclusion to be drawn. So, if an insurance company wants not to investigate a claim and take the risk, then that's the gamble they take. If there's a reasonable basis then they get lucky, if there's not they are going to get punished for not having that reasonable basis.

ABBOTT: What's your position concerning the extent to which the medical bills were proved up through the civil practice & remedies code?

LAWYER: My recollection of the record is they were simply marked and introduced into evidence. The record doesn't say whether the affidavits were attached. But there are no affidavits attached to them in the exhibit files. So my conclusion is, that there was no affidavit used to prove reasonableness. They were simply marked and introduced _____ the evidence.

ENOCH: If the charge to the jury says: What is due as a benefit under the policy? And the policy said: What is due does not exceed usual and customary. And then the jury has an answer, and there is no evidence of what's reasonable and customary, but this would be going to the policy

as long as it doesn't exceed reasonable and customary. What about the argument that the insurance company was the one that had the burden to demonstrate that these records to not be covered exceeded the usual and customary?

LAWYER: Usual and customary is part of the coverage of the policy. It's not an exclusion. Coverage is provided, on page 4 of the policy: Covered expenses are the charges for medical services to the extent that such charges do not exceed usual and customary charges.

ENOCH: If they submitted a bill, the insurance company would say: We'll pay $5 of it, but we're not going to pay $6 of it because $6 exceeds that amount. So the insurance company would cover whatever got submitted accept those portions that exceeded the usual and customary?

LAWYER: That's correct.

ENOCH: And I tender medical bills into the record, the company would say: These bills are not covered, they are not admissible on the issue of what was due, because they are not covered, so we object to them coming into evidence. But that didn't occur in this case.

LAWYER: Not when the insured submits $14,000 worth of bills. It's the insured's burden to prove how much of that $14,000 falls within the policy coverage.

ENOCH: Accept under the policy the person submitting it doesn't have to prove they are usual and customary. Under that policy simply if the insurance company determines that what they submitted exceeds, they just don't cover the excess portions?

LAWYER: I still believe the insured has to prove how much it doesn't exceed the usual and customary.

ABBOTT: Where in the record can I find the medical bills were introduced into evidence? Was it at the beginning of the trial? Do you have a transcript cite?

LAWYER: I'm looking at the index, the bills are listed as Plaintiff's exs. 29-34, and shown as being offered and admitted on pages 657 and 658. I did have some problem correlating these page numbers when I was going through the record. I don't know that the court reporter was completely accurate with her page numbers.