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LITIGATION QUARTERLY - MARCH 2009

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ANNUAL CLAIMS MANAGEMENT SEMINAR

GUIDE TO CLAIMS HANDLING AND BREAKTHROUGH STRATEGIES

SAVE THE DATE

MARCH 26-27, 2009 ORLANDO, FLORIDA

MARCH 27, 2009
CSK - LIABILITY DEFENSE PROGRAM SCHEDULE

8:00 a.m. – 8:30 a.m.	**REGISTRATION (Continental Breakfast 8:00 a.m. – 9:00 a.m.)**	
8:30 a.m. – 9:00 a.m.	**WELCOME**	
9:00 a.m. – 9:50 a.m.	**KEY NOTE SPEAKER: TO BE DETERMINED**	
BREAKOUT GROUP 1 10:00 a.m. – 10:50 a.m. (Choose One)	**The Tripartite Relationship** - Learn the importance of the relationship of the insurance carrier and the insured, the rights and duties and responsibilities of their attorney	Barry Postman, Esq. Jonathan Vine, Esq.
	Coverage – Learn about the newest developments, case law and theories. Focuses on new cases and their potential impact on claim handling and defense strategies	Aram Megerian, Esq. Robert Swift, Esq.
	Medicare Secondary Payer Compliance and Medicare Set Asides – Learn the up to the minute recap of compliance obligations of liability, no fault and self insurers as they relate to Medicare rules and regulations	Scott Cole, Esq. Alejandro Perez, Esq.
	Settlement Proposals with Multiple Parties/Built-In Proposal for Settlement in Nonbinding Arbitration The scenarios and issues faced when there is more than one defendant involved. The second part of the presentation will focus on Florida's nonbinding arbitration statute and the built-in proposal for settlement therein	James Sparkman, Esq. Paula Phillips, Esq.
10:50 a.m. – 11:00 a.m.	**MORNING BREAK**	
BREAKOUT GROUP 2 11:00 a.m. – 12:00 p.m. (Choose One)	**How to Avoid Bad Faith in the Medical Malpractice Arena** – Learn all you need to know about managing the bad faith exposure you might face after the excess verdict	Joe Kissane, Esq. Gene Kissane, Esq.
	Construction Defects - So many hurricanes, so little room for defects. Learn how to successfully defend your construction defect case and how a little knowledge goes a long way	Henry Marinello, Esq. Ashley Sybesma, Esq.
	Products Liability – How to effectively defend your product case and come out winning in the end with this informative session	Armando Rubio, Esq. Dan Kissane, Esq.
	Computation of and Defense Against Punitive Damages - This presentation focuses on the method of computation of punitive damages at trial and strategy for defense against the same at trial including jury instructions. The second part addresses the current caselaw on the issue of whether the insurer can be held liable for a punitive award against the insured in a bad faith context and discusses the insurer and defense counsel's duty of defense against punitive damages	Richard P. Cole, Esq. James Sparkman, Esq.
12:00 p.m. – 1:15 p.m.	**COMPLIMENTARY LUNCH BUFFET**	
BREAKOUT GROUP 3 1:15 p.m. – 2:15 p.m. (Choose One)	**Effective Mediation strategies** – Learn how to approach the mediation table, efficiently and effectively and how to mediate your case to obtain the best result possible	Barry Postman, Esq. Jonathan Vine, Esq.
	Medical Malpractice – This is an informative session covering the nondelegable duties of hospitals, apparent agency, surgical centers and other theories of vicarious liability	Aram Megerian, Esq. Michael Brand, Esq.
	Nursing Home Litigation – This session includes discussion on topics such as recent long term care case law developments, risk management, in-house anti-litigation preventative measures, arbitration agreements and successful strategies for defending assisted living and skilled nursing facility cases	John Coleman, Esq. Gene Kissane, Esq.
	Cost Effective Pre-Trial Strategy/Discovery in Soft Tissue Litigation – Cutting costs are key to the success of your business. Learn the methods that will effectively reduce your pre-trial costs in your soft tissue cases	Gregory S. Stark, Esq. Robert Swift, Esq.
2:15 p.m. – 2:25 p.m.	**AFTERNOON BREAK**	
2:25 p.m. – 4:30 p.m. PANEL DISCUSSION	**OPEN PANEL DISCUSSION**: Aram Megerian, Esq., Gene Kissane, Esq., Richard Cole, Esq., Barry Postman, Esq., Joe Kissane, Esq.	
4:30 p.m. – 6:00 p.m.	**COMPLIMENTARY COCKTAIL RECEPTION**	

MARCH 27, 2009
WORKERS' COMPENSATION DEFENSE PROGRAM SCHEDULE

8:00 a.m. – 8:30 a.m.	**REGISTRATION (Complimentary Continental Breakfast 8:00 a.m. – 9:00 a.m.)**	
8:30 a.m. – 9:00 a.m.	**WELCOME**	
9:00 a.m. – 9:50 a.m.	**Fraud and Misrepresentation: Detection and Deterrence –** How to determine if the Claimant has committed fraud or misrepresented the facts in order to secure benefits and how to defend against such a claim, plus tips for deterring fraud and misrepresentation claims	Kip O. Lassner, Esq. Guest Speaker: Steve Cassell, R Sight Investigations
9:50 a.m. – 10:00 a.m.	**MORNING BREAK**	
10:00 a.m. – 10:50 a.m.	**Case Law Update –** Get up to the minute updates on the latest trends in workers' compensation law	Beth T. Koller, Esq. Monett Brewer, Esq.
11:00 a.m. – 11:50 a.m.	**Medical Causation –** Is Claimant's diagnosis related to Claimant's injury? An orthopedic physician from Atlantis Orthopedics will answer questions regarding medical conditions and whether they could be related to the work injury	Guest Speaker: Jeffrey Penner, M.D.
12:00 p.m. – 1:15 p.m.	**COMPLIMENTARY LUNCH BUFFET**	
1:15 p.m. – 2:15 p.m.	**Adjuster Ethics –** This session discusses the various ethical considerations and constraints for various classes of insurance adjusters	Kip O. Lassner, Esq. Beth T. Koller, Esq.
2:15 p.m. – 2:25 p.m.	**AFTERNOON BREAK**	
2:25 p.m. – 4:30 p.m.	**OPEN PANEL DISCUSSION**: Jami Gursky, Esq.; Aram Megerian, Esq., Gene Kissane, Esq., Richard Cole, Esq., Barry Postman, Esq., Joe Kissane, Esq.	
4:30 p.m. – 6:00 p.m.	**COMPLIMENTARY COCKTAIL RECEPTION**	

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Which session will you be attending?

___ **LIABILITY SESSION** *(please list your selection below)*

Breakout Group 1: _____

Breakout Group 2: _____

Breakout Group 3: _____

___ **WORKERS' COMPENSATION SESSION**

Please indicate if you want us to submit your CEU credits:
YES____ NO ____

Please indicate if you are attending the **Thursday Night Cocktail Reception and Dinner**:
YES____ NO ____

Please indicate if you are attending the **Friday Afternoon Cocktail Reception**:
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Did you attend our 2008 Annual Claims Management Seminar?
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Have you had the opportunity to work with our firm since last year?
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Do you plan on working with our firm in the future?
YES____ NO ____

_____
Signature

- Fax: Complete this form and fax entire panel to: Shelly Cartaya, (305) 373-2294
- Mail: Detach or photocopy this form and mail to: Shelly Cartaya, Seminar Coordinator, Cole Scott & Kissane, 9150 South Dadeland Blvd, Suite 1400, P.O. Box 569015, Miami, Florida 33156
- Phone: To register or for further information, please contact Shelly Cartaya at (305) 350-5329 or Gene Kissane at (305) 350-5345
- Email: To register or for general questions, please contact Shelly Cartaya at shelly.cartaya@csklegal.com or Gene Kissane at gene.kissane@csklegal.com
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THE IMPACT OF THE MARKETABLE TITLE RECORD ACT ON HOMEOWNERS' AND COMMUNITY ASSOCIATIONS' DECLARATIONS OF COVENANTS, CONDITIONS AND RESTRICTIONS

By Keith E. Gitman

Pursuant to Florida law, the Marketable Title Record Act ("MRTA") was created via the enactment of Chapter 712, Florida Statutes. Specifically, Florida Statute Section 712.02 states:

> "Any person having the legal capacity to own land in this state, who, alone or together with her or his predecessors in title, has been vested with any estate in land of record for 30 years or more, shall have a marketable record title to such estate in said land, which shall be free and clear of all claims except the matters set forth as exceptions to marketability in s. 712.03."

The purpose of MRTA is to extinguish claims to property which are at least 30 years old and which predate the root of title of the property in question.[1] MRTA contains the scheme to accomplish the objective of stabilizing property law by clearing old defects from land titles, limiting the period of record search, and clearly defining marketability by extinguishing old interests of record not specifically claimed or reserved.[2] In short, MRTA was established in order to assist in the simplification and facilitation of land transactions by letting interested parties rely on record title.[3]

The impact of MRTA is of vital importance to Homeowners and Community Associations, as it administers and provides the stipulations by which the Association and its members are governed and regulated while seeking to maintain and enforce their Declaration of Covenants, Conditions and Restrictions. The Declaration of Covenants, Conditions and Restrictions provides the legal mechanism by which the Association's rules and regulations can be enforced,[4] as the failure to properly secure their enforceability would be damaging to the Association's oversight of its members. If an Association's Declaration of Covenants, Conditions and Restrictions is permitted to expire, residents will no longer be compelled to act in accordance with the Declaration, and organizational and financial ruin could potentially ensue.

In order to address the evident concerns relating to the expiration of an Association's Declaration of Covenants, Conditions and Restrictions, the Florida Legislature enacted Florida Statute Section 712.05, which aimed to provide a means for parcel owners to preserve any established covenant or restriction. Due to the fact that the original version of Florida Statute Section 712.05 did not permit an Association to independently act in the preservation of its Declaration of Covenants, Conditions and Restrictions, several amendments to the statute were passed in order to expand an Association's authority to do so.

One of the more recent amendments to Section 712.05, implemented in

2003, states:

> [a]ny person claiming an interest in land or a homeowners' association desiring to preserve any covenant or restriction may preserve and protect the same from extinguishment by the operation of this act by filing for record... a notice, in writing.

Section 712.05(c) specifically outlines the requirements for such notice as it pertains to Homeowners' Associations. As such, a notice filed by a Homeowners' Association must be "approved by at least two-thirds of the members of the board of directors...at a meeting for which a notice" was provided at least seven (7) days prior to the meeting.

At the time of the 2003 amendment, this incarnation of Section 712.05 provided the clearest route for an Association to preserve its Declaration of Covenants, Conditions and Restrictions by removing sole preservation authority from individual parcel owners and providing the Association's Board of Directors such capability under a specified voting formula. Although the 2003 amendment allowed the Association's Board of Directors to participate in the preservation of yet-expired Declaration of Covenants, Conditions and Restrictions, another unresolved set of circumstances remained: How would the Association proceed in the revival of already-expired Declarations?

Subsequently, Florida Statute Section 720.403 was enacted to address such a situation. Specifically, Section 720.403 created a clearly delineated process by which expired Declarations of Covenants, Conditions and Restrictions could be revived. Pursuant to Section 720.403(2):

> "[i]n order to preserve a residential community and the associated infrastructure and common areas for the purposes described in this section, the parcel owners in a community that was previously subject to a declaration of covenants that has ceased to govern one or more parcels in the community may revive the declaration and the homeowners' association for the community upon approval by the parcel owners to be governed thereby as provided in this act, and upon approval of the declaration and the other governing documents for the association by the Department of Community Affairs in a manner consistent with this act."

In conjunction with the revival process described herein, Florida Statute Section 720.404 outlines the specific requirements by which eligibility for such revival is permitted. These requirements set forth strict guidelines as to the substance of the Declaration of Covenants, Conditions and Restrictions, as well as the particular parcels that may seek revival. More specifically, Florida Statute Section 720.405 establishes that "[t]he proposal to revive a declaration… shall be initiated by an organizing committee consisting of not less than three parcel owners located in the community…" Pursuant to Florida Statute Section 720.406(1), "[n]o later than 60 days after the date the proposed revived declaration and other governing documents are approved by the affected parcel owners, the organizing committee or its designee must submit the… materials to the Department of Community Affairs" for their review and determination.

Although Florida Statutes, Chapter 720 displays much progress in the protection against the extinguishment and lapse of an Association's Declaration of Covenants, Conditions and Restrictions, further advancements are still necessary. As was the case with the evolution of Florida Statute Section 712.205, the scope of Section 720.403 and the revival of Declarations must be expanded to provide for an Association's Board of Directors direct involvement in the revival process.

It is essential for Homeowners' or Community Associations to be able to maintain the enforceability of its Declaration of Covenants, Conditions and Restrictions, or to have the ability to revive a Declaration that may have unintentionally expired. The Declaration permits an Association to impose fees, file liens, collect assessments, and implement other financial standards, which contribute to the economic security and well-being of the Association. If a Declaration is permitted to expire and the parcel owners hold the authority to revive the Declaration, the Association may be subject to parcel owners who do not want to live under such constraints and limitations.

As such, additional safeguards should be implemented in order to allow the Association further means to protect its established Declaration of Covenants, Conditions and Restrictions, especially in these times of economic uncertainty. It is understood that such overtures are currently being made in the Florida Legislature, but the situation remains unsettled. It is apparent that Homeowners and Community Associations must presently take it upon themselves to properly oversee the status of their Declaration of Covenants, Conditions, and Restrictions.

(Endnotes)

1 *Berger v. Riverwind Parking, LLP,* App., 842 So. 2d 918 (Fla. 5th DCA 2003).

2 *H & F Land, Inc. v. Panama City-Bay County Airport and Industrial District,* 736 So. 2d 1167 (Fla. 1999).

3 *Sawyer v. Modrall,* 286 So.2d 610 (Fla. 4th DCA 1973), cert. denied, 297 So. 2d 562 (Fla. 1974).

4 *Hunt Ridge at Tall Pines, Inc. v. Hall,* 766 So.2d 399 (Fla. 2d DCA 2000).

TRUTH IN LENDING ACT RESCISSION – A BORROWER'S BULWARK TO FORECLOSURE

By Jeremy Dubyak

In these uncertain economic times, reports of skyrocketing home foreclosures have become a Greek chorus on the evening news. The statistics are indeed staggering. There were nearly 2,330,483 foreclosure filings nationwide in 2008, an 81% increase from 2007, and a 225% increase from 2006.[1] More than 385,000 foreclosures were filed in Florida in 2008; almost a 500% increase from 2006.[2] The predictions for the future are grim with foreclosure rates forecast to increase for 2009.[3]

Borrowers faced with the prospect of losing their homes are increasingly taking a proactive approach by filing countersuits, or in some instances beating the lenders to the punch and initiating litigation seeking to rescind their mortgages under the provisions of the Truth In Lending Act[4] ("TILA"). "Regulation Z," the regulatory scheme implementing TILA, is not of a recent vintage. However, with the rising rates of foreclosures and the desperation many borrowers find themselves facing, the frequency of TILA rescission suits is on the upswing. As a result, lenders and their counsel must look to innovative means of resolving the issues presented by such defensive action with an eye to cost efficiency so as to obtain the best outcome in an imperfect economic climate.

I. Rescission as a Shield

TILA was enacted by Congress in 1968 with the intention that "economic stabilization would be enhanced" and "competition among various financial institutions" would be strengthened by the "informed use of credit."[5] TILA establishes requirements for lenders to make meaningful disclosures so that the borrowers "will be able to compare more readily the various credit terms."[6] TILA was originally intended to act as a vehicle to increase the information available to prospective borrowers.

In home mortgage transactions TILA requires lenders to clearly disclose the material credit terms including, *inter alia*: (1) an itemization of the amount financed, (2) the finance charge, (3) the annualized rate of the financing, (4) the payment schedule, (5) the total of payments, and (6) the Notice of Right to Cancel the loan transaction.[7] It is upon these disclosure requirements that many borrowers base their suits. Whether it is an assertion that the disclosed terms did not match the quote, the payment amount was over or understated, the disclosures were not provided, or that the disclosures were not adequately clear, clever borrowers are seeking the consumer protection measures of TILA. Borrowers are taking

advantage of TILA and the liberal pleading standards applied in state courts as a means to stave off, and sometimes completely obfuscate, a simple foreclosure.

Generally, a borrower's right to rescind a loan transaction under TILA applies to a mortgage taken on the borrower's principal dwelling.[8] Qualifying transactions provide a three-day absolute right to seek rescission.[9] This rescission right, however, can be extended up to three years if no disclosures are made, if the disclosures are not fully made, and in some instances, if the disclosures are improperly made.[10] Thus, a borrower's right to rescind under TILA will not completely expire until three years from the date of consummation of the home mortgage loan.

A. Procedural Aspects of TILA Rescission

Rescission under TILA arises generally in three ways: (1) delivery of a Notice of Right to Cancel within the three-day period following consummation, (2) written notice to the lender, or (3) by the commencement of legal action.

Invocation of a borrower's right to rescind under TILA is not an automatic "annulment that is definitively accomplished by unilateral pronouncement, but rather a remedy that restores status *quo ante*."[11] Indeed, the mere delivery of a Notice of Right to Cancel does little more than place the parties on notice that the right is being exercised.[12] Delivering the Notice alone does not void the security interest; only upon rescission does the security become void.[13]

In order to rescind, the borrower must notify the lender, at the lender's designated place of business, of the rescission by "mail, telegram or other means of written communication."[14] Upon receipt of the Notice, the lender has 20 days to return to the borrower any "money or property given as earnest money, down payment, or otherwise" and to take action consistent with termination of any security interest created by the transaction.[15] Only after the lender has performed its duties is the borrower required to "tender the property [or money] to the creditor."[16]

TILA's framework, providing for cancellation of a security interest by the lender before the borrower must tender the loan amount, essentially flips the traditional procedures for rescission. Ordinarily a security interest would not be lifted from a property until after the loan is paid in full, or until the loaned funds were tendered. Under TILA rescission claims, the security interest must be removed before the borrower is required to deliver the funds lent pursuant to the note. This places the lender in the precarious position of having to trust a borrower delinquent on payment obligations to fully repay a loan after the lender has canceled its security interest. Thus, a lender faces risking a loss of an often significant amount of money without any security interest in the real property.

B. The Alternative Procedures

While TILA grants a statutory right of rescission, rescission is still an equitable remedy, subject to equitable considerations.[17] Because rescission is an equitable remedy, courts can use their equitable powers to impose conditions upon a TILA rescission.[18] The Eleventh Circuit has held that courts have the inherent power to modify the procedures under TILA, up to and including conditioning the lender's cancellation of the security interest upon the consumer's tender of money.[19] Thus, while TILA reverses the traditional process of rescission, the alternative procedures can provide a limited restoration of the traditional rescission process. This permits a lender to maintain some security until the borrower can demonstrate an ability to tender the loan amount.

II. Working Beyond the Shield

Given the rather draconian protections afforded to borrowers who may have only the thinnest of legal bases to seek rescission, lenders must devise cost-efficient means to resolve TILA issues when they arise.

A. Calling the Bluff

Many times borrowers invoking rescission under TILA are doing so to put off what they may perceive as the inevitable loss of their home. Delay is often seen as a victory because the longer the borrowers are permitted to stay in the property, for which no monthly payments are being made, the more money they are able save in the interim.

One method of combating this tactic is to approach the borrower when notice is given. Prepare the necessary release documents and get commitments from the vendors necessary to refund any loan closing charges. Invite the borrower to pick up the lien release and refund check(s) at a local branch, counsel's office, or request a meeting at the borrower's home. When the borrower balks because they are unable to fund the tender, the jig is up, and the claim can be summarily resolved. This method will often permit the lender to conduct some "discovery" of the borrower's ability to complete rescission without suffering the typical delays in procedural discovery and without having to risk canceling the security without knowledge of the borrower's ability to tender.

B. Utilizing The Alternative Procedures

When seeking entitlement to the alternative procedures under TILA, the lender should be prepared to demonstrate

that without the use of the alternative procedures, the parties will not likely be restored to their pre-loan positions.[20] This can be a cost-intensive adventure because the lender must necessarily adduce proof, through discovery, of the borrower's inability to tender upon cancellation of the security.

However, with a relatively few well-placed requests for document production and admissions, the factual predicate can usually be established. Also, if the bluff is called early and appropriately documented, the groundwork for the alternative procedures will have already been partially laid. The alternative procedure can be an effective remedy, and is one that should be addressed early and strenuously, especially when the monetary amount at risk is high.

C. The Work-Out Option

If a borrower is determined to keep his/her dwelling, or stay in it as long as possible, the borrower may also recognize an obligation to repay, even if the borrower has no present ability. In tough times or when disaster strikes, borrowers can find themselves saddled with obligations that they simply cannot meet. In many instances, these situations are temporary.

If the borrower's situation is likely to improve and they will again have an ability to pay, approaching the borrower with a workout proposal, depending on investor requirements, can also be a cost-efficient means of reducing exposure to foreclosure fees and costs. This approach also has an added benefit if a workout is accomplished. This approach can also permit the lender to "cure" any alleged defalcation under TILA by permitting redisclosure, a cure of improper disclosures, or supplementing disclosures as necessary in the course of the workout. Thus, both a cure and a salvation of the mortgage loan investment can be accomplished.

D. The Head-On Challenge

As with parties to all types of litigation, some borrowers can be advised, but not convinced. With these borrowers, a straight-ahead defense is generally the only means to reach a favorable end. Unfortunately, a straight-forward challenge is often the most expensive and results in diminishing returns. When a borrower is in default and facing foreclosure, the likelihood that a paper deficiency judgment will be collectible is slim.

Any head-on challenge should not overlook the benefits of calling the bluff, the alternative procedures, or the work out. However, an early evaluation of the strengths and weaknesses of the defense to the TILA suit, should be paramount. Similarly, the early case work should be devoted to disposing the TILA suit, so as to narrow the issues for the court to resolve and eliminate any potential that the TILA issues may cloud the underlying right to foreclose the lien.

Each TILA rescission suit will deserve a unique strategy. When a lender is already stuck in a losing commercial relationship, minimizing costs to achieve the result is the highest concern. With an eye to effective, efficient strategies, lenders can navigate the rough seas made rougher by borrowers seeking to rescind defaulting loans.

(Endnotes)

1 Realty Trac 2008 U.S. Foreclosure Market Report: www.realtytrac.com.

2 *Id*.

3 Flood of foreclosures: It's worse than you think; CNNMoney.com; January 23, 2009.

4 15 U.S.C. § 1601 *et seq*.

5 15 U.S.C. § 1601(a).

6 *Id*.

7 12 CFR § 226.17 through 226.23.

8 12 CFR § 226.23(a)(1).

9 15 U.S.C. § 1635.

10 15 U.S.C. § 1635(f).

11 *Quenzer v. Advanta*, 288 B.R. 884 (USDC Kan. 2003).

12 *Yamamoto v. Bank of New York*, 329 F.3d 1167 (9th Cir. 2003).

13 *In re Ramirez*, 329 B.R. 727 (D. Kan. 2005).

14 12 CFR § 226.23(a)(2).

15 *Id*.

16 *Id*.

17 12 CFR § 226.23(a)(2).

18 *Williams v. Homestake Mortgage Co.*, 968 F.2d 1137 (1992).

19 *Id*. at 1142

20 *See Id*.

WHEN CAN A FRANCHISOR BE LIABLE FOR THE ACTIONS OF A FRANCHISEE

By Craig F. Novick

By its very definition, a franchisee is an independent business separate from its franchisor.[1] However, even though a franchisee is an independent business, its franchisor can still be liable for the franchisee's actions in situations where the franchisee is found to be the agent of the franchisor.[2] "The party alleging the agency relationship bears the burden of proving it."[3] Whether that party is successful in establishing the agency relationship will be a question of fact, unless the party's allegations, if taken as true, fail to meet even the minimum requirements necessary to prove that an agency relationship existed.[4]

There are two types of agency relationships: (1) actual agency; and (2) apparent agency.[5] To prove the existence of an actual agency relationship, a party must prove three elements: "(1) acknowledgement by the principal that the agent will act for him or her, (2) the agent's acceptance of the undertaking, and (3) control by the principal over the actions of the agent."[6] In establishing whether the franchisor has control over the franchisee, the question is whether the franchisor has *the right* to control the actions of the franchisee.[7]

In analyzing whether an actual agency relationship exists, the analysis should begin with a review of the franchise agreement.[8] However, because it is not unusual for a franchise agreement to use conclusory terms in an attempt to establish that the franchisee is independent of the franchisor, one must consider the entire agreement when analyzing whether an agency relationship exists between the franchisor and the franchisee.[9] For example, in *Parker v. Domino's Pizza, Inc.*, the Fourth District Court of Appeal ("Fourth District") reversed the trial court's ruling that as a matter of law the franchisee, J & B Enterprises, was an independent contractor, and not an agent of Domino's Pizza, Inc.[10] Even though the franchise agreement labeled J & B Enterprises as an independent contractor, the Fourth District looked at the entire franchise agreement and the operations manual for Domino's Pizza, Inc. and concluded that it was error to determine that as a matter of law Domino's Pizza, Inc. did not have the right to control J & B Enterprises.[11] Ultimately, there is no bright-line rule for determining whether an actual agency relationship exists between the franchisor and the franchisee.[12] Rather, the specific facts of the relationship between the franchisor and the franchisee will determine whether an actual agency relationship exists.[13]

To prove the existence of an apparent agency relationship, a party must also prove three elements: "(1) a representation by the purported principal; (2) a reliance on that representation by a third party; and (3) a change in position by the third party in reliance on the representation."[14] The theory behind the doctrine of apparent agency is that "[t]he principal is estopped [from denying] the authority of the agent, because he has permitted the appearance of authority in the agent and thereby justified the third party in relying on that appearance of authority as though it were actually conferred upon the agent."[15]

In analyzing whether an apparent agency relationship exists, one must first look to the actions of the purported principal.[16] There must be some "genuine factual representation" by the purported principal that it is exercising control over the purported agent.[17] For example, in *Mobil Oil Corporation v. Bransford*, the Supreme Court of Florida ruled that the use of Mobil symbols and products throughout a gas station, along with Mobil providing support services, was insufficient to establish the required level of control to establish an agency relationship.[18] The Court reasoned that "[i]n today's world, it is well understood that the mere use of franchise logos and related advertisements does not necessarily indicate that the franchisor has actual or apparent control over any substantial aspect of the franchisee's business or employment decisions. Nor does the provision of routine contractual support services refute this conclusion."[19]

On the other hand, in *Orlando Executive Park, Inc. v. P.D.R.*, the Supreme Court of Florida ruled that a hotel's use of "signs, national advertising, uniformity of building design and color schemes" was enough to establish that The Howard Johnsons Company had the required level of control over the hotel to create an agency relationship between the owner of the hotel and The Howard Johnsons Company.[20] The Court reasoned that "[t]here was sufficient evidence for the jury to reasonably conclude that [The Howard Johnsons Company] represented to the traveling public that it could expect a particular level of service at a Howard Johnson Motor Lodge."[21]

In addition to proving the required representation by the purported principal, in order for a party to successfully prove the existence of an apparent agency relationship, that party must show that it actually relied on the purported principal's representation in making his or her decision to use the services of the franchisee.[22] For example, in *Orlando Executive Park, Inc. v. P.D.R.*, the Court found that there was enough evidence presented that the patron of a hotel selected that hotel because of the belief that she was dealing with The Howard Johnsons Company.[23] Without evidence of this reliance, a party cannot be successful in establishing an apparent agency relationship.[24]

In conclusion, when analyzing whether a franchisor can be liable for the actions of a franchisee, one must look beyond the franchising agreement to the specific facts of the case to determine whether an actual or apparent agency relationship exists between the franchisor and the franchisee. If such an agency relationship is found to exist, a franchisor could be liable for the actions of a franchisee.

(Endnotes)

1 Fla. Stat. § 817.416; see also *Font v. Stanley Steemer International, Inc.*, 849 So. 2d 1214, 1216 (Fla. 5th DCA 2003).

2 *Mobil Oil Corporation v. Bransford*, 648 So. 2d 119, 120 (Fla. 1995).

3 *Font*, 849 So. 2d at 1216 (citation omitted).

4 *Parker v. Domino's Pizza*, 629 So. 2d 1026, 1027 (Fla. 4th DCA 1993); *Mobil Oil Corporation*, 648 So. 2d at 121; see *also Caranna v. City of Clearwater*, 466 So. 2d 259, 264 (Fla. 2d DCA 1985).

5 *See Mobil Oil Corporation*, 648 So. 2d at 120-21; and *Font*, 849 So. 2d at 1215-16.

6 *Font*, 849 So. 2d at 1216 (citations omitted).

7 *Parker*, 629 So. 2d at 1027.

8 *See Font*, 849 So. 2d at 1217; *see also Parker*, 629 So. 2d at 1028.

9 *Font*, 849 So. 2d at 1218-19.

10 *Parker*, 629 So. 2d at 1029.

11 *Id.* at 1027-29.

12 *Font*, 849 So. 2d at 1219.

13 *Id.*; *Sapp v. City of Tallahassee*, 348 So. 2d 363, 367 (Fla. 1st DCA 1977) (citation omitted).

14 *Mobil Oil Corporation*, 648 So. 2d at 121 (citations omitted).

15 *Orlando Executive Park, Inc. v. P.D.R.*, 402 So. 2d 442, 449 (Fla. 5th DCA 1981) (citation omitted).

16 *See Mobil Oil Corporation*, 648 So. 2d at 121.

17 *Mobil Oil Corporation*, 648 So. 2d at 120-21; *see also Orlando Executive Park, Inc.*, 402 So. 2d at 449-51.

18 *Mobil Oil Corporation*, 648 So. 2d at 120-21.

19 *Id.* at 120.

20 *Orlando Executive Park, Inc.*, 402 So. 2d at 450.

21 *Id.* at 450 (citations omitted).

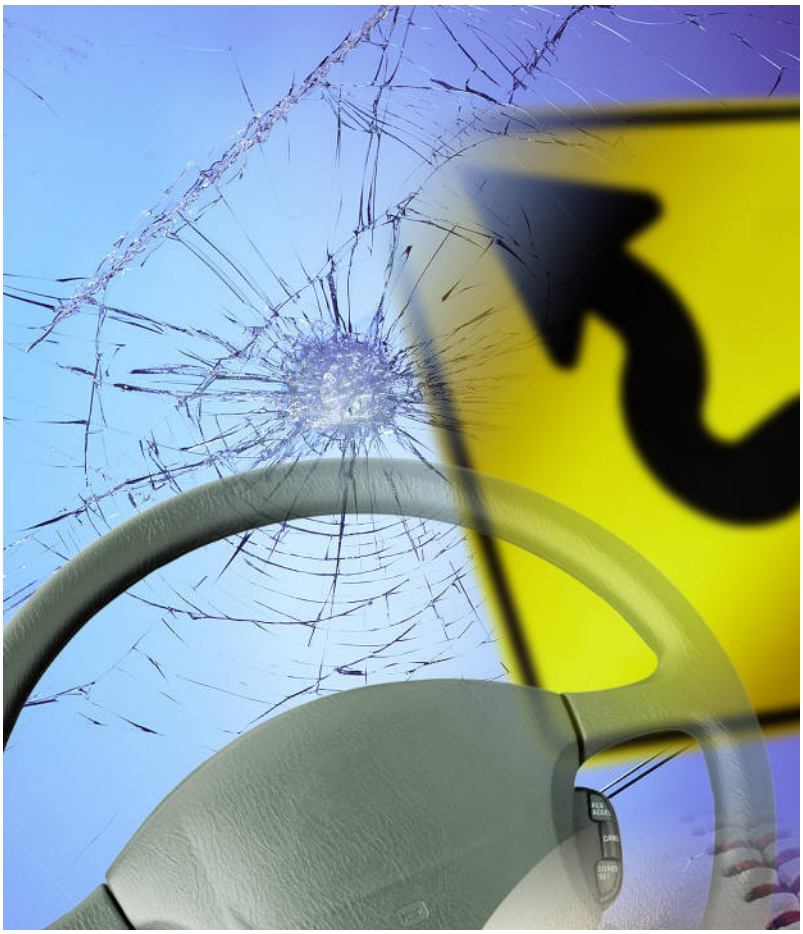
22 *See Orlando Executive Park, Inc.*, 402 So. 2d at 451; s*ee also Caranna*, 466 So. 2d at 264.

23 *See Orlando Executive Park, Inc.*, 402 So. 2d at 451.

24 *See Caranna*, 466 So. 2d at 264).

BAD FAITH CONSIDERATIONS WITH PUNITIVE DAMAGES CASES

By James T. Sparkman



Most claims representatives are aware of the concept of punitive damages and that they are not to be routinely permitted in personal injury cases in addition to the customary recovery of non-economic and economic damages, *i.e,* compensatory damages. Punitive damages are permitted to punish the person who engages in willful and wanton conduct. Fortunately, punitive damages are rare.

Florida courts have long held that there is no insurance coverage for punitive damages.[1] In the case of *Nicholson v. American Fire and Casualty*, the court rejected the argument that the policy language obliging the insurance carrier to pay "all sums which the insured shall legally become obligated to pay as damages because of bodily injury, sickness or disease" included an award for punitive damages.[2] The court's decision was based on public policy.[3] The court noted that it would be improper "to shift the burden [of punitive damages] to an insurance company."[4] The court also noted that the injured plaintiff would be made whole for his injuries by the award for compensatory damages.[5]

Although there is no duty to pay for an award of punitive damages, the insurance company does have a duty to the insured to defend against the same once they are properly pled in the complaint.[6] In the case of *American Hardware Ins. Co.*, the insured was sued for malicious prosecution.[7] Punitive damages were sought in addition to compensatory damages.[8] The insurance company agreed to defend against the claim for malicious prosecution, but informed the insured that it would not provide a defense as to the punitive damage claim.[9] The insured subsequently retained personal counsel to defend against the punitive damage claim.[10] The insured then sued the insurance company to recover the attorney's fees that it was required to expend in defense of the punitive damage issue.[11] The trial court granted the insured's motion for summary judgment and the appellate court affirmed.[12] The court stated:

> Where the complaint against the insured contains allegations which are partially within and partially without the scope of the insured's coverage, then the insured must defend even those portions of the complaint which are outside the coverage.[13]

What is the claims representative's duty toward the insured in evaluating claims where the value of the case is less than the policy limits, but the plaintiff's attorney rejects a generous settlement offer due to the specter of a punitive damage award? Can the insured file a bad faith case against the insurance company if the verdict for compensatory damages falls within the

policy limits, but there is an award for punitive damages?

A 1970 opinion from the United States Court of Appeals for the Fifth Circuit, *Ging v. American Liberty Ins. Co.,* suggests that the answer is "yes."[14] *Ging* was a wrongful death case arising from an automobile accident that occurred in Florida in 1962.[15] The insured was uncooperative and did not attend the trial.[16] The jury awarded $14,695.00 for compensatory damages and punitive damages in the amount of $25,000.00.[17] The trial court later reduced the compensatory award to $11,195.00. The insurance company paid that amount.[18]

Subsequently, the insured assigned all of his rights against the insurance company to Ging who then filed a bad faith lawsuit against American Liberty.[19] The trial court granted the insurance company's motion for summary judgment.[20] However, the appellate court reversed and remanded the case back to the lower court for a jury trial on the bad faith issues.[21] The appellate court was less concerned over the public policy issue regarding a punitive damages recovery from an insurance company than it was on the duty to defend the insured as vigorously on the matters that were not covered under the policy (punitive damages) as it did for the matters that were covered under the policy. In its analysis the court stated:

> Once having undertaken the defense of a non-covered claim, the insurance company is under an obligation to act in good faith toward its insured to the entire extent of its undertaking.[22]

The appellate court found that there was sufficient evidence to submit the case to a jury on the issue of bad faith conduct of the insurance company through the insurance adjusters and defense counsel.[23] The appellate court noted that the insured, who clearly failed to cooperate, was never informed that there was a strong probability that punitive damages would be awarded by the jury, that there had been settlement offers, including offers to settle for the policy limits, that the insured could contribute to the settlement damage claim, that the insured needed to attend the trial to offer counter evidence to the punitive damages concerning his poor financial condition, that no continuance was moved for when it was realized that the insured would not attend the trial in Florida, and finally that the insured was not informed as to the outcome of the trial until five and a half months after the same, which was thirteen days before the time to file a notice of appeal.[24]

In conclusion, the appellate court held that a duty existed to apprise the insured of settlement opportunities within a reasonable time after they were made, a duty to warn the insured of the pros and cons of the litigation even if the "cons" were not covered under the policy, a duty to timely advise the insured of the outcome of the litigation, a duty to advise the insured of actions by the insured to mitigate his own damages, and most importantly to conduct settlement negotiations in good faith including "where those interests might be divergent from the interests of the insurance company."[25]

As noted at the outset, *Ging* is a 1970 opinion, and there have been no additional significant subsequent opinions on its holding. This is due, in part, upon the fact that punitive damages claims are encountered on an infrequent basis. It could also be due, in part, to good claims handling procedures by claims examiners, as well as vigorous defense tactics by defense attorneys when punitive damages are litigated.

The *Ging* decision was based on a federal appellate court's interpretation of Florida law. No Florida state court has dealt with the concept advanced in *Ging*. However, courts in New York, California, and Colorado have held that the insurer is not liable for punitive damages to its insured when the insured may have acted in bad faith and exposed the insured to a judgment for punitive damages.

Soto v. State Farm,was a New York case that held the same.[26] *Soto* involved a wrongful death case arising from an automobile accident in which the defendant driver was legally blind, not wearing eyeglasses, and intoxicated. The insurance company was given an opportunity to settle the double-death case for the policy limits of $100,000.00. The insurer declined the settlement and defended on the basis of lack of permission and consent to use the vehicle by the driver who was the girlfriend of the insured. The jury awarded $420,000.00 in compensatory damages and $450,000.00 in punitive damages. The insurance company paid the excess verdict for compensatory damages, but declined to pay the punitive damage award. The insureds assigned their rights to proceed against the insurance company to the plaintiff. The plaintiff then sued the insurance company in an attempt to recover payment for the punitive damage award against its insureds. The insurance company filed a motion to dismiss, which was granted at the trial court level and affirmed by the appellate court. The basis for the appellate court's affirmance was that the public policy of the state prevented reimbursement by an insurance company for punitive conduct.

A similar result was reached in the case of *PPG Industries v. Transamerica Ins. Co.* where a California court used similar public policy reasons to deny the insured's recovery against its insurance company for the punitive damage award

rendered against it.[27] However, three out of seven appellate court justices dissented. Similarly, in the case of *Lira v. Shelter Ins. Co.*, the Colorado Supreme Court reached the same conclusion as *PPG* and *Soto* for basically the same reasons.[28] However, as in *PPG*, three out of the seven justices dissented.

What is the significance to the claims examiner faced with a punitive damage case when comparing the holding in *Ging* with the holding in *Lira*, *PPG*, and *Soto*? In practice, *PPG*, *Soto*, and *Lira* would have the same "persuasive" effect on a Florida state court judge as would *Ging*; *i.e,* all cases are from foreign jurisdictions and not binding on a Florida state court judge. Each would serve as persuasive authority to the trial judge and could be adopted or ignored. Given Florida's long-standing public policy argument as discussed above in *Nicholson v. American Fire and Casualty* (the burden of punitive damages on the wrongdoer should not be shifted to the wrongdoer's insurance company) one would expect a Florida judge to be more persuaded by the *Lira* trilogy than the holding in *Ging*. Notwithstanding, the holding of *Ging* might be enough persuasive authority to a Florida judge to deny a motion for summary judgment brought by an insurance company and to allow the matter proceed to a jury trial.

Although punitive damage cases are not commonplace in Florida, the prudent claims examiner should have a working knowledge of Florida Statute Section 768.72, which will not permit a plaintiff to bring a count for punitive damages in the initial complaint. This knowledge would be helpful in pre-suit negotiations where punitive damages are threatened by the plaintiff.

The claims examiner should have a working understanding of the limitation on punitive damages, especially paragraph (a) of Section 768.73. This will permit the claims adjuster to adequately place the insured on notice of its potential exposure to punitive damages as discussed in *Ging*. Furthermore, the claims examiner should be aware that a motion for statutory remittitur is available should a punitive damage award be entered against the insured.

The claims examiner should be aware that even though there is no requirement that the insurance company reimburse any insured for punitive damages rendered against it at the current time in the state of Florida, there is a duty to defend the same once the punitive damage claim is alleged in an amended complaint. The examiner should be aware that pursuant to the holding in *Ging*, the defense of the punitive damages should be as vigorous as the defense of the compensatory damages, including the hiring of an economic expert for the insured relative to the bad faith issue, if appropriate.

The claims examiner should also be aware of the other dictates elucidated in *Ging*. The insured should obviously be notified of the addition of punitive damages in the lawsuit and the fact that there is no insurance coverage available to pay for punitive damages. The insured should be given an assessment of the potential that punitive damages could be awarded against him by a jury. The examiner should be hypervigilant in notifying the insured of any and all settlement offers at all times, but especially when punitive damages are permitted. The insured should be advised that he or she is permitted to contribute his or her own funds to the settlement of punitive damage claim. The insured should be advised by a defense counsel that his or her participation in the punitive damage lawsuit is essential to establish his or her lack of net worth so that a jury would have a basis to adjust its award to one that would not bankrupt him. The insured should be immediately notified of the outcome of the jury trial when it pertains to punitive damages or otherwise. Finally, the claims examiner should conduct settlement negotiations in good faith and be open to paying settlement funds on the higher end of the settlement evaluation when punitive damages are present.

(Endnotes)

1 *Nicholson v. American Fire and Casualty*, 177 So. 2d 52 (Fla. 2d DCA 1965).
2 *Id.*
3 *Id.*
4 *Id*. at 54.
5 *Id.*
6 *American Hardware Ins. Co. v. Miami Leasing and Rentals*, 362 So. 2d 28 (Fla. 3d DCA 1978).
7 *Id.*
8 *Id.*
9 *Id.*
10 *Id.*
11 *Id.*
12 *Id.*
13 *Id.*
14 *Ging v. American Liberty Ins. Co.,* 423 F.2d 115 (5th Cir. 1970).
15 *Id.*
16 *Id.*
17 *Id.*
18 *Id.*
19 *Id.*
20 *Id.*
21 *Id.*
22 *Id.*
23 *Id.*
24 *Id.*
25 *Id.*
26 *Soto v. State Farm*, 635 N.E. 2d 1222 (N.Y. 1994).
27 *PPG Industries v. Transamerica Ins. Co*., 975 P. 2d 652 (Cal. 1999).
28 *Lira v. Shelter Ins. Co.*, 913 P. 2d 514 (Colo. 1996).

PROPOSED FLORIDA NEW SLIP AND FALL STATUTE

By John S. Penton, Jr.

In 2009, HB 495 was proposed in the legislature of the State of Florida that would repeal the current slip and fall statute, Section 768.0710, Florida Statutes.

The language of the proposed statute reads as follows:

> 768.0755 Premises liability for transitory foreign substances in a business establishment. - - If a person slips and falls on a transitory foreign substance in a business establishment, the injured person must prove that the business establishment had actual or constructive knowledge of the dangerous condition and should have taken action to remedy it. Constructive knowledge may be proven by circumstantial evidence showing that:
> (1) The dangerous condition existed for such a length of time that, in the exercise of ordinary care, the business establishment should have known of the condition; or
> (2) The condition occurred with regularity and was therefore foreseeable.
> Section 2. Section 768.0710, Florida Statutes, is repealed.
> Section 3. This act shall take effect July 1, 2009.

The proposed statute shifts the burden of proof in claims of negligence involving transitory foreign objects or substances from the duty to maintain premises of Section 768.0710, Florida Statutes, to the allegedly injured plaintiff, who, pursuant to Section 768.0710, Florida Statutes, must prove that the business establishment had actual or constructive knowledge of the condition and should have taken action to remedy it. The change will make slip and fall actions more difficult to prosecute.

MEDICARE COMPLIANCE UPDATE – The COUNTDOWN TO JULY 1, 2009

By Alejandro Perez

Effective **July 1, 2009**, the Medicare Secondary Payer Act (the "MSPA")'s new and *mandatory* reporting requirements will take effect. As this deadline approaches, the Center for Medicare & Medicaid Services ("CMS") has released volumes of information to assist all workers' compensation carriers, liability insurers, no-fault insurers and self-insurers ("primary payers") meet their reporting obligations. In December 2008, we released an article entitled "Medicare Compliance Alert – What Liability Insurers, No-Fault Insurers, Self Insurers And Workers' Compensation Carriers Need To Know About The Medicare Secondary Payer Statute's Reporting Requirements," which is contained in our December Litigation Quarterly and available online at <http://www.csklegal.com/articles/december%202008.pdf> ("Medicare Complaint Alert"). This article is an update to the Medicare Compliance Alert and will (1) briefly review the MSPA's reporting requirements, (2) analyze the timeline CMS has announced for establishing the MSPA reporting program, (3) discuss the new Query Search Function introduced to help primary payers identify whether claimants are entitled to Medicare, (4) address the upcoming computer-based training modules, (5) highlight CMS' Town Hall Meeting Teleconferences, and (6) highlight some of the noteworthy details in CMS' Revised Interim Record Layout, issued on December 5, 2008.

Prior to addressing these six points, please note that this article does not address the reporting obligations of group health plans ("GHP"), but rather, focuses on the reporting obligations belonging to what CMS refers to as non-GHP entities, which are workers' compensation carriers, liability insurers, no-fault insurers and self-insurers. In all instances throughout this article where the term "primary payer" is used, this author is referring to non-GHP entities. GHPs are also subject to the MSPA's new reporting requirements, effective January 1, 2009, but are subject to a different set of instructions from CMS.

Second, for the sake of clarification, please note that in the December Litigation Quarterly Medicare Compliance Alert, we wrote that the "key question is not whether the claimant is actually receiving Medicare benefits, but merely if he or she is eligible for Medicare." Since then, CMS has clarified that it is only interested in receiving reports concerning current Medicare beneficiaries and announced that it intends to establish a Query Search Function for use by primary payers in order to determine Medicare entitlement. Nevertheless, it remains important for primary payers to have at least a generalized understanding of the categories of persons that comprise the population of Medicare beneficiaries for purposes of implementing protocols to identify these individuals in addition to simply utilizing the Query Search Function, discussed below in Part III of this

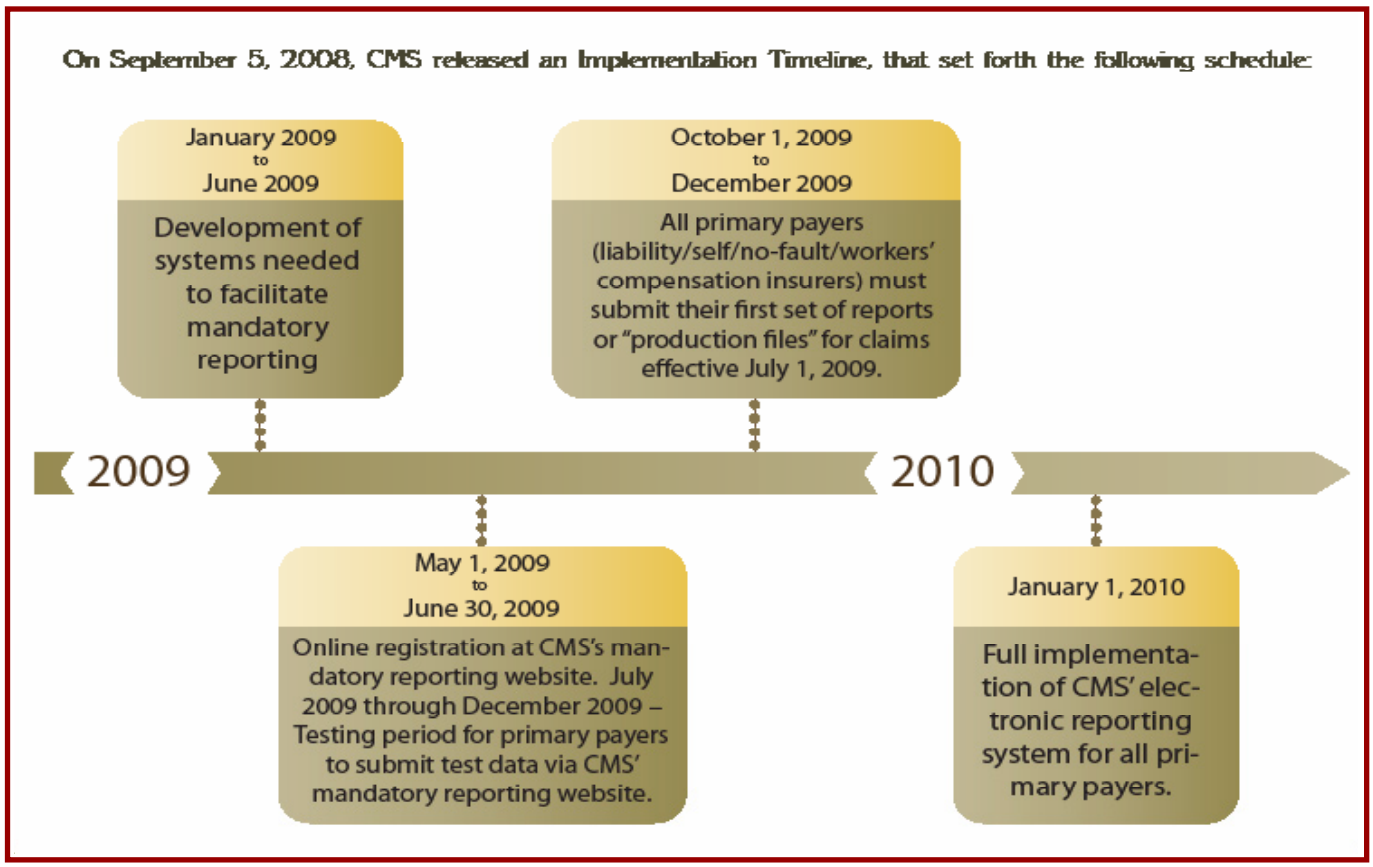
article.

I. Review of the MSPA's reporting requirements

Pursuant to the MSPA, Medicare's obligation to pay for the medical expenses of a Medicare beneficiary is secondary to any obligations assumed, whether by settlement, judgment, or otherwise, by a primary payer.[1] Accordingly, Medicare can recover "conditional payments"[2] made on behalf of Medicare beneficiaries and is entitled to assert what is, effectively, a lien[3] on settlements, judgments and awards. Amendments to the MSPA, coupled with administrative pronouncements by CMS, have culminated in what is now an increasingly detailed set of reporting obligations by primary payers. For a detailed review of the MSPA's requirements, please review the Medicare Compliance Alert. All primary payers are obligated to comply with the MSPA.[4] A failure to do so will result in fines of $1,000.00 a day, per claim.[5]

II. The Timeline

To date, CMS has remained on schedule. Thus, primary payers should now be in the process of implementing revised or entirely new procedures and collecting data in order to ensure compliance with these deadlines.



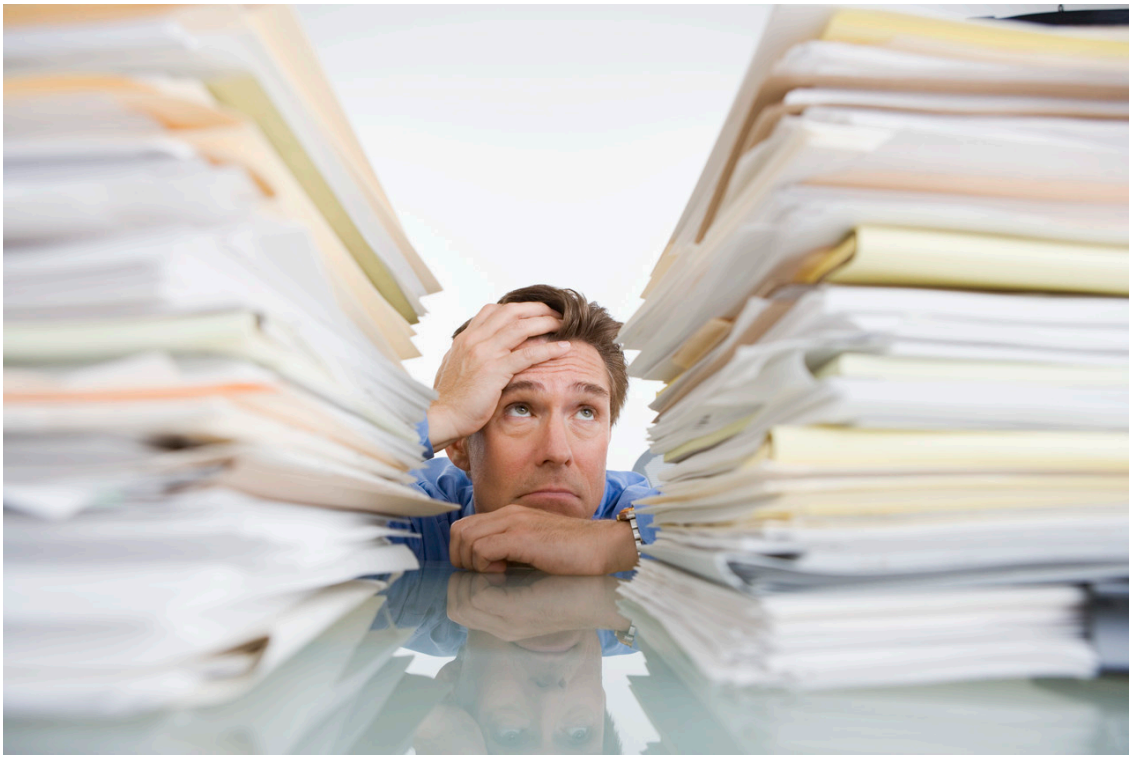
III. Query Search Function to Assist Primary Payers to Ascertain if a Claimant is a Medicare Beneficiary

Establishing whether a claimant is entitled to Medicare is a prerequisite to determining whether a report to CMS is required. To aid in this process, CMS announced during its January 22, 2009 Town Hall Meeting Teleconference that it had obtained approval to establish an on-line Query Search Function that will enable primary payers to determine whether a claimant is a Medicare beneficiary and must be reported. CMS announced that the procedures for using this Query Search Function would be contained in the CMS' User Guide, scheduled to be released in February 2009. However, in the interim, CMS provided the following guidance during its January 22, 2009 and January 28, 2009 teleconferences.

The Query Search Function is essentially a file exchange. Primary payers will be allowed to submit one monthly query (specifically, one monthly query per Responsible Reporting Entity Identification ("RRE ID")). Primary payers will need to submit the following: 1) a Social Security number or health insurance claim number ("HICN") number, 2) the name, 3) date of birth, and 4) gender for each claimant. CMS will review the submission, provide a response either indicating that there are no records that match the request[6] or confirming that the individual is a Medicare beneficiary, and providing the claimant's HICN number. In addition, if primary payers can match three of the four criteria above, CMS will correct the primary payer's submission. For example, if a primary payer submits a correct Social Security number, gender and name, but an incorrect date of birth, CMS include the corrected dated of birth in its response. Free software will be provided by CMS for use by primary payers and their agents.

IV. Computer-Based Training

To assist all primary payers, CMS will prepare online training modules. While the training modules are not



yet ready, interested registrants can contact CMS at (646) 458-6740. This will place registrants in contact with the Electronic Data Interchange ("EDI") Department of CMS' Coordination of Benefits Contractor ("COBC")[7], which will process the request and notify all registrants when the training modules are available. [8]

V. Town Hall Meeting Telecon ferences

CMS has hosted several Town Hall Meeting Teleconferences for the purpose of responding to written questions submitted to CMS and permitting participants to engage in a direct question-and-answer session with CMS. Future teleconferences are scheduled on February 25, 2009, March 24, 2009, and April 22, 2009. These teleconferences typically commence at 1:00 p.m. Eastern Standard Time. Downloads of past teleconferences are available at CMS' website. Written transcripts are also available at<http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage>.

VI. Revised Interim Record Lay out and the Soon-to-be-Released User's Guide

On October 27, 2008, CMS issued an "Interim Record Layout" listing technical and formatting requirements that primary payers must comply with in reporting to CMS. CMS initially revised its Interim Record Layout on November 17, 2008, and most recently on December 5, 2008. Pages 16 through 77 of this document sets forth the file layouts that will be utilized for electronic reporting by primary payers. *See* <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterim120508.pdf>. Pages 1-15 of the Interim Record Layout set forth detailed instructions to guide primary payers in complying with the MSPA. Some of these instructions are summarized below:

- The Interim Record Layout makes clear that all primary payers *must* register and "fully test the data submission process before submitting production files." Thereafter, CMS will assign a seven-day quarterly file submission timeframe for electronic reporting and a RRE ID. Each primary payer will be responsible for submitting one report per quarter within the assigned seven-day time frame assigned. If a primary payer wishes to submit multiple reports for different parts of its business, it can do so, but it must register and obtain separate RRE IDs for each report it intends to file. For example, if a primary payer wants its auto claims unit to submit a report separate and apart from its workers' compensation unit, it must obtain an RRE ID for each unit.

- Primary payers must report on all existing claims and resolved claims for which there is ongoing payment responsibility as of July 1, 2009. Subsequent quarterly submissions should only report new or changed information, or correct information submitted in the prior quarter in error as identified by CMS.

- In instances where multiple defendants are involved in a settlement, all primary payers are responsible for reporting that claim, even if the settlement, judgment. or award is worded to impose payment obligations on only one of the defendants.

- CMS is considering, but has not yet decided, whether to make special provisions for primary payers that are in bankruptcy.

- CMS explained that entities that only incur responsibility for a claim beyond a certain limit, such as reinsurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, or patient compensation funds, are also potentially responsible to submit reports to CMS as a liability insurer. The key is to identify "whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment being made to the self-insured entity to reimburse the self-insured entity." Where payment is being made to reimburse the self-insured entity, it is the self-insured entity that is considered the primary payer. If the payment is made directly to the injured claimant, then a report to CMS is required.

- CMS also explained that while agents may assist primary payers in

most aspects of the MSPA reporting process, the primary payer always retains responsibility for information reported to CMS. Moreover, primary payers must register for electronic reporting themselves.

• Notably, CMS directs primary payers to report on actual Medicare beneficiaries, including a deceased beneficiary, if the individual was deceased at the time of the settlement, judgment, award or other payment.

• Note that when dealing with an individual who is not a Medicare beneficiary for which the primary payer has accepted ongoing payment responsibility, the primary payer is expected to monitor the status of that individual and report if and when that individual becomes a Medicare beneficiary.

• Also, primary payers must report settlements, judgments, awards, or other payments regardless of whether or not there is an admission or determination of liability.

• All claims must be reported, even if their value is *de minimis*. Note: CMS is considering whether to revise this requirement.

• While CMS will honor an allocation of damages made by a jury verdict or after a merits hearing, but will not honor any allocation made by settling parties.

• There is no obligation for liability, no-fault, or self insurers to report on claims where the date of incident was prior to December 5, 1980. For purposes of exposure claims, if any exposure after December 5, 1980 is claimed or released, primary payers must report on this claim even if the date of first exposure was before December 5, 1980.

• The mere closure of a file by a primary payer is not determinative if there is an ongoing payment responsibility for purposes of MSPA reporting. If a file is subject to being reopened, the record should remain open for purposes of MSPA reporting.

• Handling of mass torts or cases in Multi-District Litigation ("MDL") remains under consideration by CMS with special instructions to assist primary payers to follow.

Please note that despite the extensive detail that is only summarized above, CMS continues to characterize this information as preliminary. CMS intends to release a User Guide in February 2009 that will contain additional detail on these and other matters. Primary payers must act diligently in complying with the MSPA's reporting requirements. The alternative is exposure to substantial fines. Primary payers are encouraged to remain abreast of updates and instructions at <http://www.cms.hhs.gov/MandatoryInsRep/> and to communicate regularly with counsel regarding MSPA compliance.

VII. Conclusion

The specter of potentially crippling administrative fines makes compliance with the MSPA critical to the continued financial viability of all primary payers. Please do not hesitate to contact the author of this article if you have any questions and visit <http://www.cms.hhs.gov/MandatoryInsRep/> to stay up-to-date on all MSPA compliance news.

(Endnotes)

1 *See Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1306 (11th Cir. 2006) (*quoting Cochran v. U.S. Health Care Financing Admin.*, 291 F.3d 775, 777 (11th Cir. 2002)).

2 The MSPA authorizes Medicare to make "conditional payments" for covered services if a primary payer is not expected to pay promptly, or within 120 days. 42 U.S.C. § 1395y(b)(2)(A)(i); 42 C.F.R. § 411.21.

3 Pursuant to 42 C.F.R. § 411.37, if the amount Medicare has paid out on behalf of a Medicare beneficiary equals or exceeds the judgment or settlement amount, the recovery is the total amount of the settlement, minus procurement costs. *Id.* If Medicare is owed less money than the value of a settlement, the payment is calculated by determining the ratio of procurement costs to the total judgment or settlement, applying that ratio to Medicare payment to determine Medicare's share of procurement costs, and then subtracting Medicare's procurement costs from the Medicare payments. The remainder is what is owed to Medicare. In short, Medicare has a very substantial authority to assert what is, in effect, a *super lien* on judgments and settlements.

4 CMS uses multiple acronyms to refer to parties that are responsible for complying with the MSPA's reporting requirements. Some of these terms are Responsible Reporting Entities ("RRE") or non-GHP entities (all RREs except for group health plans). Rather than use these terms, this article utilizes the term "primary payers" throughout this article. Again, please note that this article does not address the obligations imposed upon Group Health Plans ("GHP"). GHPs are also subject to the MSPA's new reporting requirements, effective January 1, 2009.

5 42 U.S.C. § 1395y(b)(8)(E)(i).

6 Please note that, according to CMS, a response that indicates that there are no records matching the queried information is more likely to indicate that the information submitted was incorrect and not that a particular claimant is not a Medicare beneficiary. In any case, it is incumbent on primary payers to ensure that they submit correct information for purposes of this Query Search Function. For example, if incorrect data is submitted, and the primary payer or its agent relies on this information in determining that no report should be made for an individual who in fact *is* a Medicare beneficiary, that error will result in penalties.

7 Acronyms are extensively used in discussing Medicare related issues. If you encounter any acronyms in reviewing these or any Medicare related items that you are not familiar with, CMS' website contains a handy acronym finder, available at <http://www.cms.hhs.gov/apps/acronyms/>.

8 For more information, please go to <http://www.cms.hhs.gov/MandatoryInsRep/05_Computer_Based_Training.asp#TopOfPage>.

TRIGGER OF COVERAGE IN CONSTRUCTION DEFECT CASES

THE COVERAGE CORNER

By Valerie Jackson

It is well-established that in order to trigger coverage under an insurance policy, "the accident or injury must occur during the time period of coverage; or stated otherwise, no liability exists if the accident or injury occurs outside the time period of coverage of a liability policy."[1] Nonetheless, the appropriate trigger of coverage in construction defect cases remains unresolved and a hotly contested issue in Florida.

There are four triggers of coverage theories that are generally accepted: (1) exposure; (2) manifestation; (3) continuous trigger; and (4) injury-in-fact.[2] Under the exposure theory, property damage occurs upon installation of the defective product.[3] Under the manifestation theory, property damage occurs at the time damage manifests itself or is discovered.[4] The continuous trigger approach defines property damage as occurring continuously from time of installation until the time of discovery.[5] Finally, under the injury-in-fact trigger, which is also referred to as damage-in-fact, coverage is triggered when the property damage underlying the claim actually occurs.[6]

The appropriate trigger of coverage continues to plague practitioners in Florida due to the broad sweeping statements made by courts when examining this issue. In *Travelers Ins. Co. v. C. J. Gayfer's & Co., Inc,* Travelers issued a policy of liability insurance to a plumbing contractor.[7] While the policy was in effect, the contractor installed a roof drainage system in the attic of Gayfer's Pensacola store.[8] After the policy expired, a joint in the drainage system failed, discharging rain water into the store.[9] Gayfer's filed suit against the contractor under various theories of negligence and implied warranty to recover for property damaged by the leak and for loss of use of undamaged property left idle when the store was closed for a day following the drainage system failure. Gayfer's argued, among other things, that the definition of "property damage" was ambiguous since it may be fairly read as extending coverage "when the causative negligence occurs within the policy period though that negligence is not manifest until damage occurs beyond the policy period."[10] The apellate court disagreed with the insured's argument and stated:

> The phrase' caused by an occurrence' informs the insured that' an identifiable event other than the causative negligence must take place during the policy period.' The term' occurrence' is commonly understood to mean the event in which negligence manifests itself in property damage or bodily injury, and it is used in that sense here.[11]

The curious use of the word, "manifests" has led many, including some of the courts cited below, to hold that Florida is a manifestation state.

In *American Motorists Ins. Co. v. Southern Sec. Life Ins. Co.,* a United States District Court in Alabama interpreting Florida law, held that Florida courts follow the general rule that the time of occurrence, within the meaning of an indemnity policy, is the time at which the plaintiff's injury first manifests.[12] This case involved bodily injury and not property damage.[13]

In 2002, the case of *Auto Owners Ins. Co. v. Travelers Cas. & Surety Co.,* a federal court interpreting Florida law held that the "trigger" of coverage for commercial general liability policies is "when the damage occurs and if damage is continuously occurring, the 'trigger' is the time the damage 'manifests' itself or is discovered."[14] In 2006, another federal court in the middle district ratified the opinion of its sister court in *Essex* Builders Group, Inc. *v. Amerisure Ins. Co.*[15]

By contrast, the case of *Trizec Properties, Inc. v. Biltmore Construction Co.,* a federal appellate court held the potential for coverage is triggered "when an 'occurrence' results in 'property damage.'"[16] Significantly, the court stated, "there is no requirement that the damages 'manifest' during the policy period. Rather, it is the damage itself which must occur during the policy period for coverage to be effective."[17] In *Trizec*, the insured was subcontracted to install a roof deck on a shopping mall.[18] The plaintiff sought damages for faulty workmanship. The complaint alleged the mall was constructed "commencing on or about 1971 and ending in or about 1975."[19] The complaint did not allege when the consequential effects of the improper installation actually began to occur.[20] It did allege that the defects "involve latent

defects" which were not discovered by plaintiff until their "manifestation" in 1979.[21] Finding the insurer had a duty to defend, the court stated:

> The potential for coverage is triggered when an "occurrence" results in "property damage." There is no requirement that the damages "manifest" themselves during the policy period. Rather, it is the damage itself which must occur during the policy period for coverage to be effective. Here, the actual date that the damage occurred is not expressly alleged, but the language of the complaint, "at least marginally and by reasonable implication," could be construed to allege that the damage (cracking and leaking of roof deck with resultant rusting) may have begun to occur immediately after installation, 1971 to 1975, and continued gradually thereafter over a period of time. The complaint's allegations are therefore broad enough to allow the insured to prove that at least some of the damage occurred during insurer's policy period, 1972 to 1976.[22]

Arguably, T*rizec* stands for the proposition that Florida is an injury-in-fact state since the court stated the damage itself must occur during the policy period. Pursuant to injury-in-fact trigger, coverage is triggered when the property damage underlying the claim actually occurs.[23] Others argue that since the court found that there was a potential for coverage because the damage could have occurred from the time of installation and continued gradually over time, *Trizec* makes the trigger of coverage, a continuous trigger. The continuous trigger approach defines property damage as occurring continuously from time of installation until the time of discovery.[24] It should be noted that the court did not use the time of discovery, 1979, as the cut-off point in reaching its decision.[25] Accordingly, it can be argued that *Trizec* does not stand for the proposition that the trigger of coverage is a continuous one. Regardless of whether *Trizec* holds the trigger of coverage is "injury-in-fact" or adopts the continuous trigger approach, it is clear, contrary to the court's holding in *Auto Owners*, *supra*, *Trizec* does not hold that the trigger of coverage is manifestation.[26]

In conclusion, no Florida appellate court has recently addressed the issue as to which trigger of coverage theory applies in Florida. However, a federal court interpreting Florida law has determined that manifestation is the trigger of coverage where the damage is continuous, as in construction defect cases. Furthermore, at least one circuit court judge in Miami-Dade County has held that manifestation is the trigger of coverage.[27] This decision is currently on appeal at the Third District Court of Appeal. Until this case is resolved, and the trigger of coverage issue is specifically addressed, the trigger of coverage issue in Florida remains unsettled.

(Endnotes)

1 *New Amsterdam Casualty Co. v. Addison*, 169 So. 2d 877, 886 (Fla. 2d DCA 1964).
2 *In re Celotex Corp*., 196 B.R. 973, 1000, fn. 187 (Bkrtcy.M.D.Fla.1996)
3 *Id.*
4 *Id.*
5 *Id.*
6 *Id*.
7 *Travelers Ins. Co. v. C. J. Gayfer's & Co., Inc,* 366 So. 2d 1199 (Fla. 1st DCA 1979).
8 *Id.*
9 *Id.*
10 *Id.*
11 *Id. at 1979*
12 *American Motorists Ins. Co. v. Southern Sec. Life Ins. Co,* 80 F.Supp.2d 280 (M.D. Ala. 2000).
13 *Id.*
14 *Auto Owners Ins. Co. v. Travelers Cas. & Surety Co.*, 227 F.Supp. 2d 1248, 1266 (M.D.Fla.2002).
15 *Essex Builders Group, Inc. v. Amerisure Ins. Co*., 485 F.Supp. 2d 1302, 1309 (M.D. Fla. 2006).
16 *Trizec Properties, Inc. v. Biltmore Const. Co*., 767 F.2d 810, 813 (11th Cir. 1985).
17 *Id.*
18 *Id. at 811.*
19 *Id*.
20 *Id*.
21 *Id.*
22 *Id.* at 813.
23 *In re Celotex Corp*., 196 B.R. 973, 1000, fn. 187 (Bkrtcy.M.D.Fla.1996)
24 *Id.*
25 *Trizec*, 767 F.2d at 813
26 *Id.*
27 *Master Plaster, Inc. v. Scottsdale Insurance et al.*, Case No. 08-26260 CA 40.

MEET ONE OF OUR LAWYERS

Henry Marinello

In May 2008, Henry E. Marinello joined Cole, Scott & Kissane. He was recruited to head the construction division for the firm statewide because of his skills in construction litigation, his extensive hands-on experience in many construction trades, and his knowledge of applicable Florida building codes. He has practiced in the area of construction litigation for nineteen years representing many industry leaders in construction litigation, including defect litigation, commercial and residential development, contract disputes, construction financing, construction bonds, construction liens, and commercial foreclosures of construction loans. Henry has developed a legal expertise in many other areas associated with the construction industry. These include, but are not limited to, architects and engineers professional liability, construction transactions and AIA contracts, pre-bid phase of competitive bidding on public construction and road projects, land use and zoning, administrative hearing litigation in bid protests on public projects, and building products liability. He has litigated matters dealing with construction and performance bonds, and Chapter 713 construction liens. He has represented companies on OSHA matters and licensed architects and engineers in complaints filed with the Florida Department of Business and Professional Regulations. He has drafted Prospectuses, Declaration of Condominiums, and Articles of Incorporation for Condominium Associations for development of condominium projects. He also has practiced extensively in areas of general liability, premises liability, auto and products liability, aviation, and medical and professional malpractice. He has represented Homeowners' and Condominium Associations as private counsel.

Henry's strengths in construction litigation stem from his extensive, well-rounded knowledge of construction industry practices, which includes: building plans drafting and review (both commercial and residential), permit processing, standard construction practices, as outlined in the Florida Building Code, and OSHA safety standards. He has extensive knowledge of the scope of work required of general contractors, architects and engineers, and specialty subcontractors involved in large and small commercial and residential construction projects, and how the many different trades work together on these projects.

Because of his extensive undergraduate work in the area microbiology and chemistry, Henry has proven to be an impressive and effective litigator in mold related litigation. His course of study included the many different fungi groups associated with human diceases. He has an extensive background in industrial hygiene, mold contamination, and mold remediation. This has given him the edge in litigation involving commercial and residential mold cases.

Henry has been a resident of Florida since 1961. He earned his Bachelor of Science at Brigham Young University in 1986, with a major in Microbiology and a minor in Chemistry. He earned his Juris Doctor in 1989, also from Brigham Young University. He was admitted to the Florida Bar in 1990 and has since practiced before Florida state trial and appellate courts, the United States District Courts, and the United States Eleventh Circuit Court of Appeals. He was born in 1956 in Havana, Cuba and speaks English and Spanish, both with native fluency.

COLE, SCOTT & KISSANE, P.A.

SUCESS STORIES

James T. Sparkman obtained a complete defense verdict in a case where our client rear-ended the plaintiff's vehicle. The plaintiff alleged she sustained a neck herniation and incurred $10,000.00 in past medical expenses. Plaintiff also alleged that she would incur $30,000.00 in future medical expenses. Plaintiff demanded $25,000.00 at trial.

Michael E. Brand obtained a dismissal for fraud upon the court following a trial in a construction site personal injury case. At trial, the plaintiff testified contrary to his earlier sworn testimony regarding previously undisclosed statements purportedly made by the defendant's employees. The court declared a mistrial, and the defendant subsequently moved to dismiss the case with prejudice for fraud upon the court. The court granted the dismissal with prejudice.

Trelvis D. Randolph obtained a final summary judgment in favor of a construction company in a personal injury case. The case involved a plaintiff who was injured in a condominium complex that was in the final stages of construction. Trelvis successfully argued that the defendant was not responsible for the construction defect and that the defendant was not in custody and control of the premises at the time of the accident.

Dania Arencibia obtained a final summary judgment in a premises liability action. The plaintiff was invited by the defendant to her home to assist in the moving of a boat from a trailer onto the water. While plaintiff's husband was under the boat, the plaintiff alleged that the boat began to move from side to side and she became scared. As a result, she moved towards the boat, but was struck by boat and fractured her fifth metatarsal. Dania successfully argued the condition was open and obvious and that the plaintiff's knowledge was equal or superior to that of the defendant.

Jeffrey Shapiro obtained a final summary judgment on the two counts alleged against our client for negligence and violation of Florida Statute Section 83.51 (a landlord's obligation to maintain rental premises). The plaintiff alleged he suffered damages when he was electrocuted while reaching into a cabinet on defendant's rental property. Jeffrey successfully argued that the plaintiff was a trespasser and the defendant did not breach the duty owed to a trespasser, which is to keep safe or warn from known dangers. The plaintiff was a trespasser because three days before the alleged incident the County Court had executed a default final order of eviction against the plaintiff.

Barry Postman and Lee Cohen obtained a defense verdict in a personal injury case. The plaintiff slipped and fell at a grocery store and the plaintiff alleged that this incident caused damage to his back and neck. The plaintiff underwent surgery and his medical damages exceeded $400,000.00. The plaintiff asked the jury to return a verdict between $700,000.00 and $1,000,000.00.

James T. Sparkman and Dania Arencibia obtained a defense verdict in a premise liability matter. The plaintiff alleged that the defendant negligently maintained its premises and allowed dirty water from a refrigeration unit to fall onto and remain on the floor without any warning to its customers. The plaintiff further claimed that the spilled water caused her to slip and fall injuring her right shoulder, left hip, left knee and lower back.

Luisa M. Linares successfully obtained an affirmance of a Miami-Dade trial court order granting final summary judgment that our defendant, a hotel, did not owe a duty to the plaintiff for the maintenance of a common area of a condominium building for which the condominium association had retained responsibility and control pursuant to the condominium documents.

A Year of Giving Back in West Palm Beach at Cole, Scott & Kissane

In 2008, the West Palm Beach offices of Cole, Scott & Kissane, PA embarked on an ambitious community outreach plan designed to increase the firm's involvement in the community it serves. Through the efforts of volunteers, the West Palm Beach attorneys and staff developed three outreach programs spearheaded by attorneys Jessica Anderson and Brian Pita that were a huge success:

School Supply Drive: As "back to school" season began in Palm Beach County, Cole, Scott & Kissane teamed up with West Riviera Elementary, one of two Title I schools in the area in dire need of assistance for supplies during the school year. The firm pledged to provide supplies for the entire fourth grade class of West Riviera Elementary, as well as provide funds for a "study breakfast" to take place during FCAT week. Attorneys and staff pitched in with cash and supply donations, which were personally handed out to the fourth grade class by a group of attorneys and staff. During the supply presentation, the students received words of encouragement by Cole, Scott & Kissane attorneys. The event was a tremendous success, and no child was left without supplies for the 2008-2009 school year.

Mentoring Program: As a corollary to the school supply drive, several attorneys and staff members enrolled in West Riviera Elementary School's community mentoring program, including Wesley Sherman, Camille Frazier, Brian Pita, Jessica Anderson, and Linda Cohen. The mentoring program is a year long commitment to an assigned group of students for which the mentor is entrusted to help develop character and academic growth. Ultimately, the mentoring process became a mutual learning and growing process for both mentors and mentees as the year progressed.

Holiday "Adopt-a-Family" Drive: During the holiday season, the West Palm Beach Offices of Cole, Scott & Kissane, in association with the Children's Home Society of Palm Beach County, adopted a local family of nine children for the holidays. The families in the Children's Home Society Adopt a-Family program are identified as low income families, with one or both parents incarcerated. The family assigned to Cole, Scott & Kissane was the largest family in the program. Through the generous monetary and gift donations from attorneys and staff, however, the West Palm Beach office was able to completely outfit every child with the clothing and toys on the family's wish list.

In 2009, the West Palm Beach office plans to duplicate these programs and expand upon its volunteerism initiative. We encourage everyone at Cole, Scott & Kissane, the legal community, and the community at large to take advantage of the ample opportunities for volunteerism in their areas.