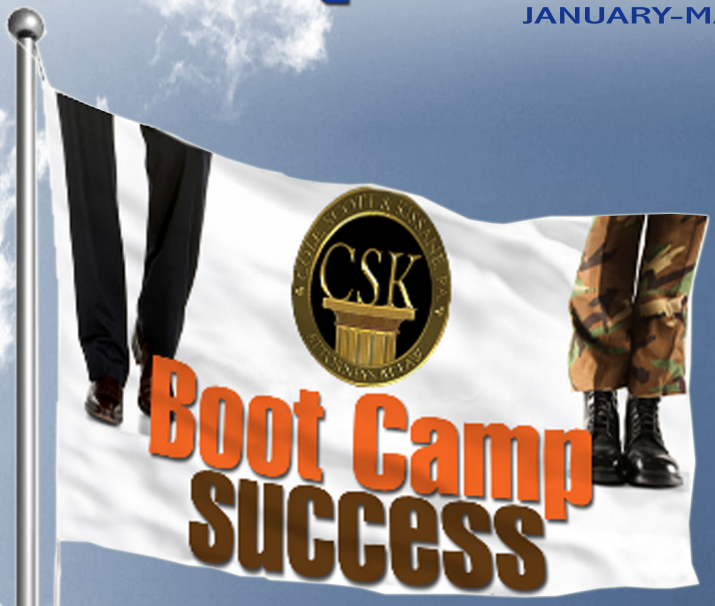
LITIGATION QUARTERLY

JANUARY-MARCH, 2010



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The Bad Faith Boot Camp Was a Success

On October 22, 2009, Cole, Scott & Kissane presented its 2009 Bad Faith Boot Camp. The Boot Camp was attended by 175 insurance professionals from around the country. The seminar was designed to provide attendees with in-depth information on the tactics being utilized by the plaintiff's bar to create excess exposure. The seminar focused on what is occurring at the "street level" to create bad faith exposure and what steps are available and necessary to combat these efforts. It was stressed that pro-active claim handling was necessary to successfully negotiate the currently existing Florida bad faith "minefield".

CSK presenters included Richard Cole, Tom Scott, Gene Kissane, Joe Kissane, Barry Postman, Aram Megerian and Trevor Hawes. Topics included How to Properly Respond to the Multi-Conditional Demand, How to Settle Cases Involving Multiple Claimants and How to Successfully Navigate the Serious Exposure Claim. Tom Scott was also able to provide attendees with a unique perspective from his many years on the bench regarding how a bad faith trial actually looks once presented in the courtroom. The seminar also included a presentation by Fred Cunningham, Esquire, of the law firm of Slawson & Cunningham. Mr. Cunningham presented an informative lecture and PowerPoint on bad faith from the Plaintiff's perspective.

Attendees also received a copy of Cole, Scott & Kissane's 125 page "Tort and Insurance Survival Manual". This manual is the leading guide in Florida on how to avoid bad faith exposure. The reviews from the seminar were outstanding with attendees commenting that this was the "best seminar in the 25+ years of adjusting that I have attended" and "I have been adjusting for over 43 years; all adjusters should be required to attend this seminar". All attendees agreed that they received valuable information that will assist them in preventing excess exposure. Because of the tremendous interest in this subject, the firm intends to make its Bad Faith Boot Camp an annual event.

If you were unable to attend this presentation but are interested in receiving seminar materials please contact Shelly Cartaya at (305) 350-5329 or shelly.cartaya@csklegal.com. If you are interested in having a condensed version of the Bad Faith Boot Camp presented in-house for your claim department, please contact Joe Kissane at (904) 672-4031 or joe.kissane@csklegal.com. This seminar has been fully approved for Continuing Education Credits by the Florida Department of Financial Services.

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A Word of Caution When Contemplating a Refusal to Defend:

Analysis of *Coblentz* Agreements

By Giselle Mammana

Forty years ago, the eyebrows of insurance carriers were raised when Florida courts invalidated an insurance carrier's business decision to deny coverage to its insured. On September 5, 1969, the insured-empowering *Coblentz* Agreement was established in *Coblentz v. American Surety Co. of New York*.[1] A *Coblentz* Agreement is a binding consent judgment between a claimant and the insured after the insurance carrier refused to defend the insured. *Coblentz* Agreements are valid and binding in Florida.

An unwary insurance carrier that hastily issues a reservation of rights runs the risk of inviting the insured to negotiate a *Coblentz* Agreement with the claimant. In doing so, the insurance carrier loses its right to control the defense of the underlying tort claim and loses its right to assert defenses.[2] More importantly, the stipulated judgment between the insured and the claimant may affix damages at a larger figure than the case's actual value.[3] Even worse, the *Coblentz* Agreement may herald the advent of a bad faith action.[4]

I. The Birth of the *Coblentz* Agreement

The *Coblentz* case is a dark tale for the liability insurance industry. Pre-*Coblentz*, an individual/entity was not bound by the terms of a settlement agreement when that individual/entity was not a party to the agreement. Post-*Coblentz*, an exception was created: absent fraud or collusion, a liability insurance carrier will be bound to the settlement agreement between the insured and the claimant if the insurance carrier wrongfully refused to defend its insured.

In *Coblentz*, the insured was the owner and manager of a motel in Miami, Florida. He found a college student loitering the grounds of the motel. In an attempt to frighten the student off the grounds, the insured confronted the student with a pistol and wildly fired several shots as the student fled, with no intention of hurting the student. One of the bullets, however, ricocheted and struck the student, fatally wounding him.[5] Citing intentional conduct, the insurance carrier refused to provide coverage and a defense for the insured, leaving the insured "to his own resources."[6] After retaining separate counsel, the insured entered into a liability judgment. The insured and claimant then stipulated to a consent judgment, providing that the judgment could be satisfied only from the insured's available liability policies.[7] Absent fraud or collusion, the final judgment was rendered enforceable against the insurance carrier. The *Coblentz* court stated:

> It is a well-settled principle that where a person is responsible over to another, either by operation of the law or express contract, and he is duly notified of the pendency of the suit against the person to whom he is liable over, and full opportunity is afforded him to defend the action, the judgment, if obtained without fraud or collusion, will be conclusive against him, whether he appeared or not.[8]

Henceforth, under Florida law, the duty of an insurance carrier to defend its insured is considered continuing in nature, as established in *Coblentz*. The existence of the obligation must be determined by the claims alleged by the pleadings and not on the insurance carrier's evaluation of ultimate liability, or not. Where there is a hybrid of covered and non-covered allegations in the complaint against the insured, the insurance carrier, who refused to provide a defense, is liable for the portion of an excess judgment that is attributable to the covered allegations only.

The *Coblentz* decision empowered an insured to take control of the case and its settlement, and thereafter sue his insurance carrier for the damages he incurred due to the insurance carrier's refusal to provide coverage and a defense. Subsequently, a progeny of bad faith litigation rapidly ensued. *See e.g. U.S. Fire Ins. Co. v. Mikes*, 576 F.Supp.2d 1303 (M.D. Fla. 2007) (stating that when an insurer unequivocally denies coverage that actually exists, the insurer has breached the contract and therefore cannot rely on a contractual provision prohibiting the insured from settling the claim without its consent); *Gallagher v. Dupont*, 918 So. 2d 342 (Fla. 5th DCA 2005) (holding that the liability insurer's denial of coverage was a breach of the insurance contract); *MCO Environmental Inc. v. Agricultural Excess & Surplus Ins. Co.*, 689 So. 2d 1114 (Fla. 3d DCA 1997) (stating that if an insurance company breaches its contractual duty to defend, the insured can take control of the case, settle it and

then sue the insurance company for damages it incurred in settling the action); *Kivi v. Nationwide Mutual Insurance Co.*, 695 F2d 1285 (11th Cir. 1983) (finding that the insurer was liable for bad faith for failing to advise the insured of settlement opportunities, the probable outcome of litigation, and the possibility of an excess judgment); *Campbell v. Government Employees Insurance Co.*, 306 So. 2d 525 (Fla. 1974) (finding the liability carrier to have acted in bad faith because it ignored the injured party's settlement offers within policy limits and misrepresented the gravity of the claim to the insured).

II. Recovery under a *Coblentz* Agreement

For an insured to recover under a *Coblentz* agreement, the insured must bring an action against his insurance carrier and prove coverage, wrongful refusal to defend and that the settlement was reasonable and made in good faith.[9] Attorney fees and other expenses incurred by the insured may also be recovered against the insurance carrier for a wrongful failure to defend.[10]

The initial burden of making a prima facie showing of reasonableness and lack of bad faith rests with the claimant.[11] In *Steil v. Florida Physicians' Insurance Reciprocal*,[12] the Second District held that a claimant seeking to enforce a consent judgment under *Coblentz* must not only prove a wrongful refusal to defend, but also that the claim was ultimately within the policy's coverage.[13] The claimant must further demonstrate that the judgment amount was reasonable and not tainted by bad faith.

The Florida test as to whether a settlement of a claim against an insured is reasonable and prudent is what a reasonably prudent individual in the position of the insurance carrier would have settled for on the merits of the claimant's claim.[14] In determining whether a settlement is reasonable, Florida courts consider objective factors (e.g. the extent of the claimant's injuries) and subjective factors (e.g. the degree of certainty of the tortfeasor's subjection to liability, risks of going to trial, chances that the jury verdict might exceed the settlement offer, etc.).

The insurance carrier can only challenge a settlement if the parties settled in bad faith, fraudulently, collusively or without any effort to minimize the insured's liability.[15] Formerly, the standard for evaluating bad faith claims against insurance carriers was the "fairly debatable" standard, which stated that the bad faith claim against the insurance carrier can succeed only if the claimant can show absence of reasonable basis for denying the claim.[16] Currently, the standard for evaluating bad faith claims against insurance carriers is whether the insurance carrier acted fairly and honestly toward its insured with due regard for the insured's interests.[17]

III. Insurance Carriers' Duties to the Insured

In bad-faith cases, the Florida courts have emphasized the "informational" and communication duties of the insurance carrier. An insurance carrier's duty of care is not imposed directly under the terms of the insurance contract with the insured, but is rather a fiduciary obligation to the insured.[18] In the leading Florida case on common-law bad faith, *Boston Old Colony Insurance Co. v. Gutierrez*,[19] the court stated that the obligations of an insurance company to the insured include: to advise the insured of settlement opportunities; to advise as to the probable outcome of the litigation; to warn of the possibility of an excess judgment; and to advise the insured of any steps he might take to avoid [an excess judgment].

The Florida Supreme Court in *Boston Old Colony Insurance Co. v. Gutierrez* explained that, in handling the defense of the claim against an insured, an insurance carrier "has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business."[20]

Accordingly, the insurance company must investigate the facts, give fair consideration to a reasonable settlement offers, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Throughout the entire course of the claim, there is a continuing duty to keep the insured advised of all significant developments in the case and what actions the insured should take as a result thereof.[21]

In addition to the common-law tort of bad faith, Florida also has a bad-faith statute, Fla. Stat. §624.155. The Florida Supreme Court has basically interpreted this statute as a codification of the Florida common law on bad faith in that, for a violation of the statute to have occurred, there must be a verdict or judgment in excess of the policy limits.[22] For example, Fla. Stat. § 624.155(1)(b)1 provides that an insurer can be held liable for bad faith for "[n]ot attempting in good faith to settle claims when . . . it . . . should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests."[23]

Indeed, Florida courts have held that, if an insurance carrier realizes there is a potential exposure greater than the policy limits, it has an affirmative duty to attempt to negotiate settlement of the case, and if it fails to do so, it can be held liable for bad faith.[24]

Although an insurance carrier does not breach its duty to defend by offering to defend only under a reservation of rights (thereby maintaining the right to deny coverage), Florida law provides that the insured may, at his election, reject the defense and retain its own attorneys without jeopardizing its right to seek indemnification from the insurance carrier for liability.[25] Continuing a case under a "reservation of rights," however, is not a blanket of protection for the insurance carrier. In 1997, the Fourth District considered the conduct of an insurance carrier in attempting to defend an insured under a reservation of rights was tantamount to wrongful refusal to defense when the insurance carrier did not fulfill its statutory duty to select mutually agreeable counsel.[26]

As the law stands today, liability for a judgment against an insured (even to the extent that it exceeds policy limits) will be imposed only if the insurance carrier's conduct amounts to bad faith, in the absence of any breach on the part of the insured relieving the insurance carrier from its responsibilities.[27] Significantly, an insurance carrier's denial of coverage based on a mistaken but honest belief that coverage did not exist does so at its own risk.[28] Having elected to leave the insured to his own defenses, and having been given notice of the procedure that the insured intended to pursue, an insurance carrier cannot later complain about the form of judgment.[29]

IV. Conclusion

An unwary insurance carrier can lose a number of rights if it fails to account for a Coblentz agreement, including, but not limited to, a loss of the right to control the defense of the underlying tort claim, lose its right to assert defenses, incur damages at a larger figure than the case's actual value, and even trigger a bad faith action if it precipitously refuses to deny coverage to its insured, in the absence of any breach on the part of the insured relieving the insurance carrier from its responsibilities. When contemplating a refusal to defend, the well-informed insurance carrier ought to also contemplate the possible existence of a Coblentz Agreement between its insured and the claimant and the long-term consequences of same.

1 416 F2d 1059 (5th Cir. 1969) (coining the term "Coblentz agreement" for a stipulated

judgment or consent judgment entered between a claimant and an insured after the insurer has refused to defend the insured); *see also Wrangen v. Pennsylvania Lumbermans Mut. Ins. Co.*, 593 F. Supp. 2d 1273 (S.D. Fla. 2008); *see also U.S. Fire Ins. Co. v. Hayden Bonded Storage Co.*, 930 So. 2d 686 (Fla. 4th DCA 2006) (stating that negotiated settlement agreements/consent judgments between an insured and a claimant are valid and binding in Florida); *Chomat v. Northern Ins. Co. of New York*, 919 So. 2d 535 (Fla. 3d DCA 2006) (stating that where an injured party wishes to recover under a Coblentz agreement, the injured party must bring an action against the insurer and prove coverage, wrongful refusal to defend, and a reasonable settlement made in good faith); *Gallagher v. Dupont*, 918 So. 2d 342 (Fla. 5th DCA 2005) (same); *Aguero v. First American Ins. Co.*, 927 So. 2d 894 (Fla. 3d DCA 2005).

2 *Gallagher v. Dupont*, 918 So. 2d 342 (Fla. 5th DCA 2005) (stating that once an insurer refused to defend the insured's estate, the insurer lost its right to claim a defense that it otherwise could have raised in the underlying claim against the insured); *Ahern v. Odyssey Re (London) Ltd.*, 788 So. 2d 369 (Fla. 4th DCA 2001) (stating the insurer lost its chance to litigate factual issues surrounding duty, breach, and proximate causation by refusing to provide a defense at trial).

3 *Coblentz, supra*; *see also Florida Physicians Ins. Reciprocal v. Avila, M.D.*, 473 So. 2d 756 (Fla. 4th DCA 1985).

4 *North American Van Lines, Inc. v. Lexington Ins. Co.*, 678 So. 2d 1325 (Fla. 4th DCA 1996) (stating that an insured may bring a bad faith suit for reimbursement, regardless of whether there is excess underlying judgment).

5 *Coblentz*, 416 F.2d at 1060.

6 *Id.* at 1063.

7 *Id.* at 1060.

8 *Id.*

9 *Chomat v. Northern Ins. Co. of New York*, 919 So. 2d 535 (Fla. 3d DCA 2006); *U.S. Fire Ins. Co. v. Hayden Bonded Storage Co.*, 930 So. 2d 686 (Fla. 4th DCA 2006).

10 *Steil*, 448 So. 2d at 591-92; *see also MCO Environmental, Inc. v. Agricultural Excess & Surplus Ins. Co.*, 689 So. 2d 1114 (Fla. 3d DCA 1997) (stating that the insured can sue the insurance company for damages it incurred in settling the action); *North American Van Lines, Inc. v. Lexington Ins. Co.*, 678 So. 2d 1325 (Fla. 4th DCA 1996) (stating that an insured may bring a bad faith suit for reimbursement, regardless of whether there is excess underlying judgment).

11 *Id.*

12 *Steil v. Florida Physicians' Insurance Reciprocal*, 448 So. 2d 589 (Fla. 2d DCA 1984).

13 *Id.* at 592.

14 *Wrangen*, 593 F. Supp. 2d at 1279.

15 *U.S. Auto. Ass'n v. Hartford Ins. Co.*, 468 So. 2d 545 (Fla. 5th DCA 1985).

16 *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So. 2d 55 (Fla. 1995).

17 *Id.*

18 *Doe on Behalf of Doe v. Allstate Ins. Co.*, 653 So. 2d 371 (Fla. 1995).

19 386 So.2d 783, 785 (Fla. 1980); *see also Macola v. Government Employees Ins. Co.*, 953 So. 2d 451 (Fla. 2006); *Shuster v. South Broward Hosp. Dist. Physicians' Professional Liability Ins. Trust*, 591 So. 2d 174 (Fla. 1992); *Contreras v. U.S. Sec. Ins. Co.*, 927 So. 2d 16 (Fla. 4th DCA 2006).

20 *See also Baxter v. Royal Indemnity Co.*, 285 So. 2d 652, 655 (Fla. 1st DCA 1973) ("If the circumstances are such that a reasonable and prudent man with the obligation to pay all the recoverable damages would settle for an amount within policy limits, it is the legal duty of the insurer to do so.").

21 *Powell v. Prudential Property & Casualty Insurance Co.*, 584 So. 2d 12 (Fla. 3d DCA 1991); *Odom v. Canal Insurance Co.*, 582 So. 2d 1203 (Fla. 1st DCA 1991); *see also American Fidelity & Casualty Co. v. Greyhound Corp.*, 258 F.2d 709 (5th Cir. 1958).

22 *State Farm Fire & Casualty Co. v. Zebrowski*, 706 So. 2d 275 (Fla. 1998).

23 Fla. Stat. § 624.155(1)(b) (2009).

24 *Powell, supra*.

25 *Travelers Indemnity Co. of Ill v. Royal Oak Enterprises, Inc.*, 334 F. Supp. 2d 1358, 1370 (M.D. Fla. 2004); *see also Aguero v. First American Ins. Co.*, 927 So. 2d 894 (Fla. 3d DCA 2005).

26 *American Empire Surplus Lines Inc. Co. v. Gold Coast Elevator, Inc.*, 701 So. 2d 904 (Fla. 4th DCA 1997).

27 *See Florida Physicians Ins. Reciprocal v. Avila, M.D.*, 473 So. 2d 756 (Fla. 4th DCA 1985); *Steil v. Florida Physicians' Ins. Reciprocal*, 448 So. 2d 589 (Fla. 2d DCA 1984); *Cosmopolitan Mut. Ins. Co. v. Eden Roc Hotel*, 258 So. 2d 310 (Fla. 3d DCA 1972).

28 *U.S. Fire Ins. Co. v. Mikes*, 576 F.Supp.2d 1303 (M.D. Fla. 2007).

29 *Coblentz v. American Surety Co., of New York*, 416 F.2d 1059 (5th Cir. 1969).

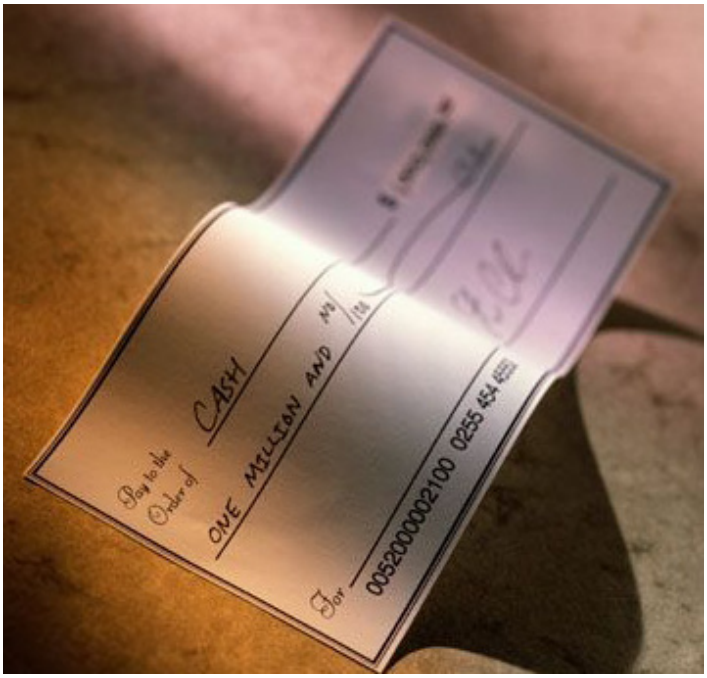
The Million Dollar Question: Non-economic Damages in Medical Malpractice Cases

By Paula Parisi

If it is true that confusion lies at the doormat of creativity, interpretation of Florida Statute 766.118 provides a creative opportunity for attorneys everywhere. In August of 2003, the Florida Legislature enacted sweeping medical malpractice reform. Most importantly, a maximum limit on the amount of noneconomic damages recoverable in any medical malpractice action was codified within Florida Statute §766.118. Section 766.118 sets forth a cap on noneconomic damages between $500,000 and $1,500,000 depending on various circumstances discussed herein. These limitations were enacted because the legislature perceived "a medical malpractice crisis of unprecedented magnitude" that "threatens the quality and availability of health care for all Florida citizens." Laws of Fla. Ch. 2003-416. At the heart of this crisis, according to the legislature, was the escalating cost of medical malpractice insurance in Florida, which is among the states with the highest premiums in the country. *Id.* The legislature found that this high cost of insurance, in turn, forced many physicians to practice medicine without professional liability insurance and forced many to leave Florida, cease performing high-risk procedures, or retire early from the practice of medicine. *Id.*

Florida Statute §766.118 has been criticized as poorly written with ambiguous application and interpretation. To date, Florida courts have yet to resolve many questions associated with interpretation of this statute. As such, this article addresses some of the unresolved and very pertinent interpretation issues.

Florida Statute §766.118 establishes a cap of $500,000 for "practitioners" and a $750,000 cap for "non-practitioners" in cases involving medical negligence. Fla. Stat. §766.118 (2003). At the forefront of this provision is the broad definition of "practitioner." Pursuant to the statute, "practitioner" means any person licensed under chapter 458, chapter 459, chapter 460, chap-



ter 461, chapter 462, chapter 463, chapter 466, chapter 467, or chapter 486 or certified under s. 464.012. *Id.* "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment.[1] *Id.*

The explicit inclusion of associations, corporations, firms, partnerships or other business entities should be argued to include all hospitals, surgery centers, physician groups, clinics and the alike, which are usually thought to be "non-practitioners." For example, private hospitals or walk-in-clinics appear to be encompassed within the statute's broad language when the physician employee is also named in the suit. Further muddling the interpretation of who constitutes a "practitioner" is the lack of any definition of "non-practitioner" within the statute.

It appears only one case has argued this position to the court of appeals, yet the outcome is not yet known. In *Ortiz v. United States of America*, 2008 WL 460528 (N.D. Fla. Jan. 31, 2008), the defendant argued a hospital should be considered a "practitioner" under the clear language of §766.118. The court withheld ruling on the issue until the jury returns a verdict. Despite not yet having precedent on this issue, the arguments in *Ortiz* revolve around well established rules regarding statutory construction. In Florida, statutory language should be read from the perspective of the average reader, and the court need not be concerned with odd scenarios that might test the limits of a statute or leave question about exactly what a certain term might cover. *State v. Darynani*, 774 So. 2d 855 (Fla. 4th DCA 2000). Plaintiffs will likely argue an average reader interpreting §766.118 would clearly consider a medical clinic or facility or private hospital a "non-practitioner" based upon commonly held knowledge that a clinic is not licensed to provide actual care, people provide care. Our courts of appeal should give effect to the clear words the legislature has chosen to use in this statute. *Holmes v. Blazer Financial Services, Inc.*, 369 So. 2d 993 (Fla. 1999). The broad, inclusive language allowing for business entities to be considered practitioners in certain instances is quite compelling even if the legislature chose not to define "non-practitioner."

Section 766.118 also fails to answer a million dollar question significant to all practitioners: Does the noneconomic damages cap increase per defendant when the negligence resulted in a permanent vegetative state or death? Subsection (a) of the statute states:

> With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $500,000 per claimant. No practitioner shall be liable for more than $500,000 in noneconomic damages, regardless of the number of claimants.

Fla. Stat. §766.118. Subsection (b) states:

> Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed $1,000,000.

Id.

Subsection (a) explicitly includes actions for wrongful death. *Id.* Furthermore the last sentence of subsection (a) unequivocally states no practitioner shall be liable for more than $500,000 in noneconomic damages. *Id.* Thus, it is arguable in an action involving a single practitioner resulting in death, the practitioner receives the $500,000 cap. Remaining is the question of whether subsection (b) increases the cap to $1,000,000 in certain circumstances. Subsection (b) sets a limit on the total noneconomic damages recoverable from all practitioners in cases involving permanent vegetative state or death. *Id.* Thus, each practitioner is still entitled to the limit of $500,000 in cases involving death as explicitly stated within subsection (a). Subsection (b) should merely propose a scenario limiting the amount of recovery to $1,000,000 total when there are multiple practitioner defendants. For example, if three practitioners are found liable, each may be assessed up to $500,000 but the total for all three cannot exceed $1,000,000.

Further complicating matters, subsection (c) provides a limit on the total noneconomic damages recoverable by all claimants. *Id.* Specifically, all practitioner defendants under this subsection shall not exceed $1,000,000 in the aggregate. *Id.* For example, if a husband and a wife sue for wrongful death of their child, they may not each receive the $1,000,000 total from all practitioners in subsection (b), rather $1,000,000 total. In sum, subsection (a) applies a practitioner cap on noneconomic damages (including for wrongful death); subsection (b) applies a cap for the total sum of $1,000,000 for all of the practitioners in cases involving death or permanent vegetative state; and subsection (c) applies a cap for the total sum for all claimants.

It is CSK's goal to encompass as many clients within the definition of "practitioner" and thereby limit liability to $500,000 for each practitioner even in cases involving death. We propose filing early pre-trial motions to force trial courts to interpret the language. Should the courts rule in our favor, the value of the plaintiff claims will be dramatically reduced. Should the courts not rule in our favor, this battle will have to be waged in the appellate courts. Either way, the million dollar question remains unanswered and, at least for now, the legislature's confusion will have to continue to lie at the doormat of our creativity.

1 "Practitioner" also includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person being vicariously liable for the actions of the practitioner.

Firing Over Forty: Recent Developments in ADEA Case Law

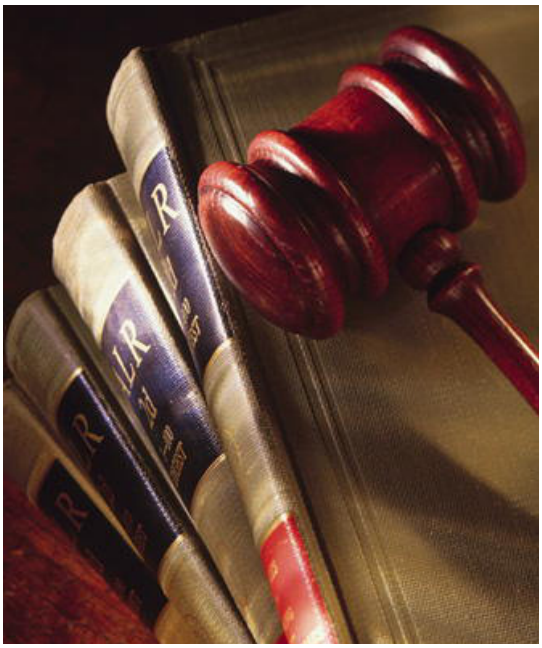
By Yueling Lee

Due to a number of factors, such as baby-boomers reaching retirement age and employers being forced to make some tough economic decisions over the past year, claims under the Age Discrimination in Employment Act (hereinafter "ADEA")[1], which offers certain protections to workers over age 40, rose 29% in 2008 over 2007.[2] While some of these employees may acknowledge that economic factors played a role in the decision to fire them, they also feel that they may have been let go, and their younger co-workers retained, due to age discrimination. Such cases are a classic example of "mixed-motive" claims brought under the ADEA, which in June of 2009 became more difficult to prosecute when the United States Supreme Court decided the case of *Gross v. FBL Financial Services, Inc.*, 129 S.Ct. 2343 (U.S. 2009). In *Gross*, the Court held that plaintiffs alleging intentional age discrimination must prove by a preponderance of the evidence that age was the "but-for" cause of the challenged termination or other adverse employment action. Previously, an employee only had to show that age was a "motivating" factor in their termination, at which point the burden shifted to the employer to show that it would have taken the action without regard to the impermissible consideration, i.e., age.

In *Gross*, a longtime employee of FBL was reassigned to the position of claims project coordinator (from that of claims administration director) when he was 54-years-old. Even though his salary did not decrease, Gross considered the reassignment a demotion because his previous title and duties were given to a woman in her early forties whom he used to supervise. This prompted Gross to file suit under the ADEA. At trial, Gross introduced evidence suggesting that his reassignment was based at least in part on his age. FBL defended the decision on the grounds that Gross' reassignment was part of a corporate restructuring and that his new position was better suited to his skills. At the close of trial, the District Court gave a "mixed-motive" instruction to the jury, instructing that it must return a verdict for Gross if he proved by a preponderance of the evidence that "age was a motivating factor" in his demotion.[3] The trial court also instructed that the jury had to return a verdict for JBL if it proved that it would have demoted Gross regardless of his age.[4]

FBL challenged the instructions on appeal, where the Eighth Circuit found, based on the Supreme Court decision in *Price Waterhouse v. Hopkins*, that the instructions were flawed because they allowed the burden to shift to FBL upon a presentation of a preponderance of *any category* of evidence showing that age was a motivating factor.[5] According to the Eighth Circuit, Gross was required to present "direct evidence," or evidence showing "a specific link between the alleged discriminatory animus and the challenged decision," in order to shift the burden to FBL to "convince the trier of fact that it is more likely than not that the decision would have been the same absent consideration of the illegitimate factor." Gross acknowledged that his evidence of discrimination was circumstantial, not direct, and as a result, the Eighth Circuit concluded that he was not entitled to a mixed-motive instruction.

However, the Supreme Court vacated the Court of Appeals decision based on a textual comparison between the ADEA and Title VII. Subsequent to the *Price Waterhouse* decision, Congress amended Title VII to explicitly authorize discrimination claims in which an improper consideration was "a motivating factor" in the adverse employment decision. By contrast, the Court noted that the ADEA provides, in relevant part, that it shall be unlawful for an employer to discriminate "because of such individual's age." The Court further reasoned that the ordinary meaning of the ADEA's requirement that the employer took adverse action "because of" age meant that age was the "reason" the employer decided to act. As such, to establish a disparate treatment claim under the plain language of the ADEA, a plaintiff must prove that age was the "but-for" cause of the adverse action. Moreover, the burden of persuasion does not shift to the employer to show that it would have taken the action regardless of age, even when the plaintiff has produced evidence that age was one motivating factor in that decision.



On its face, this decision has the potential to dramatically change the landscape for employees as employers motivated only in part by age may not be liable for discrimination. Moreover, its impact ultimately may spread beyond federal ADEA claims as many states also proscribe employment discrimination "because of" certain traits. For example, Florida's Civil Rights Act makes it unlawful for an employer to discriminate against an employee "because of such individual's race, color, religion, sex, national origin, age, handicap or marital status."[6] However, it remains to be seen how state courts will apply the Supreme Court's analysis in interpreting parallel statutes. This decision may also spark legislative action, as Congress previously acted when it felt the courts were imposing too rigid a standard with regard to Title VII. It will be interesting to see whether Congress elects to reconcile the anti-discrimination statutes by now modifying the ADEA in a manner similar to the Title VII amendment. We will address these developments as they occur in future editions of the Quarterly.

1 29 U.S.C. § 623

2 EEOC Litigation Statistics, FY 1997 through FY 2008. EEOC enforcement suits filed in the federal district courts only.

3 *Id.* at 2347.

4 *Id.* at 2347.

5 *Price Waterhouse v. Hopkins*, 409 U.S. 228 (1989)(if a Title VII

plaintiff shows that discrimination was a "motivating" factor in the employer's action, the burden of persuasion should shift to the employer to show that it would have taken the same action regardless of that impermissible consideration; to shift the burned to the employer, the employee must present "direct evidence that an illegitimate criterion was a substantial factor").

6 Fla. Stat. § 760.10.

Can a Payment Due Within Thirty Days of a Final Judgment to an Insured Property Owner Be Stayed Pending Appellate Review?

By John Penton

Florida law generally provides that insurers must pay judgments within thirty (30) to sixty (60) days in property cases, depending upon the type of insurance at issue and whether or not an appeal was pursued or dismissed.[1] However, an issue has arisen as to the meaning of property insurance policy language which states in effect "we will pay for covered loss or damage: [when we receive a sworn proof of loss and] . . . [t]here is an entry of a final judgment . . ." Insurers have argued that this payment language only applies after appeals on the final judgment have been exhausted. Insureds, meanwhile, have asserted that the language is effectively a waiver of the procedural right to stay execution of the final judgment pending appeal by the posting of a supersedeas bond.[2]

While the interpretation of the language within a policy of insurance is treated as the interpretation of a contract, the interpretation of "final judgment" has more than one meaning and is therefore ambiguous.[3] The Supreme Court of Florida has defined "final judgment" different ways in different contexts.[4]

For example, in determining that the statute of limitations on a claim for attorney malpractice does not begin to run until "the final judgment becomes final," the Supreme Court of Florida explained that "a judgment becomes final either upon the expiration of the time for filing an appeal or post-judgment motions, or, if an appeal is taken, upon the appeal being affirmed and either the expiration of the time for filing motions for rehearing or a denial of the motions for rehearing."[5] However, in determining whether a party could appeal an order awarding attorney's fees and costs entered after a voluntary dismissal, the Supreme Court of Florida stated that "[a] final judgment is one which ends the litigation between the parties and disposes of all issues involved such that no further action by the court will be necessary."[6] The Supreme Court in *Caufield* focused upon the trial court completing its judicial labor in holding that the order was final and appealable.[7]

What is clear is that neither of these decisions by the Supreme Court of Florida conclusively determines, as a matter of Florida law, the meaning and effect of the phrase "entry of a final judgment" as used in a policy of insurance.[8] In March, the Eleventh Circuit Court of Appeals in Atlanta certified the question "Does language in an insurance policy mandating payment of benefits upon "entry of a final judgment" require an insurer to pay its insured upon entry of judgment at the trial level?"[9]

To date, we do not have an answer of the question from the Florida Supreme Court, and the stakes are very high. If the Florida Supreme Court determines that payment must be made within thirty (30) days of the trial court's final judgment, based upon policy language, policies will need to be amended to preserve the insurer's right to appellate review. However, if the Florida Supreme Court determines that payment must be made within thirty (30) days of the trial court's final judgment based upon the Florida statute, it will be a tremendous blow to the insurance industry and their right to appellate meaningful appellate review after payment has already been made to the insured prior to the briefing of the appeal. Another option would be simply for the Florida Supreme Court to apply *Silverstrone* language, which would preserve meaningful appellate review for insurers. Until the Florida Supreme Court speaks to the issue, this question will remain hotly contested.

1 *See e.g.*, § 631.051(12), Fla. Stat.

2 *Chalfonte Condominium Apartment Assoc. v. QBE Insurance Corp.*, 561 F.3d 1267, 1274 (11th Cir. 2009).

3 *Id.*

4 *Id.*

5 Silverstrone v. Edell, 721 So.2d 1173, 1175 & n.2 (Fla. 1998).

6 *Caufield v. Cantele*, 837 So.2d 371, 375 (Fla. 2002).

7 *Id.*

8 *Chalfonte Condo*, 561 F.3d at 1274.

9 *Id.*

Foreclosure Matters in First Party Property Claims, Especially With a $250,000 Deficiency

By Ivan J. Tarasuk

As most readers know, real estate prices have seen record declines during the past few years.[1] The declines came on the heels of a dramatic period of rising home values and a "real estate bubble" caused by a wild combination of easy access to capital and speculative fervor on the part of homeowners and investors alike.[2] The aftermath of the real estate bubble resulted in a meltdown of the financial system, and led to the insolvency of old line investment banks Bear Stearns and Lehman Brothers as well as the near collapse of insurance giant AIG.[3]

Here in Florida, where real estate speculation fueled building projects from downtown Miami to the gulf coast, we are at ground zero of the boom and bust cycle in real estate. After seeing sharp price increases during the early part of the decade, for the past few years Florida has experienced steep price declines and an incredible slowdown in real estate sales activity.[4] Although government action and lender assistance programs appear to be slowing the rate of filings, Florida is now experiencing one of the highest foreclosure rates in the country.[5]

By any measure, the foreclosure problem in Florida is simply staggering. Just how staggering, you may ask? Well, to put it in perspective, the Supreme Court of Florida recently established a task force on residential mortgage foreclosure cases because "residential mortgage foreclosure case filings have increased dramatically in the circuit courts, resulting in a tremendous strain on limited judicial resources and reflecting a significant crisis in Florida communities."[6]

Just how many foreclosure filings are there in Florida? For the third quarter 2009 *alone* there were 53,710 new residential foreclosure filings for the metropolitan areas comprising Miami, Fort Lauderdale, and Pompano Beach, FL.[7] This ranks as number 15 out of 203 markets surveyed nationwide by RealtyTrac, a California based company that tracks foreclosure statistics.[8] The problem is not limited to the residential market as commercial properties and even some very well known hotels are being reported as falling delinquent on their mortgage payments.[9]

Just how many foreclosure lawsuits are pending in Florida's courts? Foreclosures now take up 75 percent of the courts' dockets and 266,000 foreclosures have already been reported through August 2009.[10]

For claims managers and attorneys working on first party property claims, foreclosure is presently a very important issue to consider. As a group, CSK's first party property attorneys have recently seen an influx of claims filed by insureds whose properties are, upon closer review, the subject of a pending foreclosure lawsuit. In some cases, we have seen foreclosures completed during the investigative stage of

a claim or in the course of litigation. In at least one case, we discovered an insured who had filed a claim after losing his property to foreclosure.

The fact of a completed or pending foreclosure is certainly troubling and may raise a number of questions for the claim. Can the claim continue? Can the lawsuit continue? Since the insured no longer owns the property, what damages can be pursued? What, if anything, is still owed on the claim? More importantly, to whom does the carrier owe it to? Fortunately, Florida courts have already answered a number of the questions posed above.

In *Lenart v. Ocwen Fin. Corp.*[11], the Third District Court of Appeal held that, in the event of foreclosure and where an insurance policy contains a standard, or New York loss payable clause, the rights of a loss payable mortgagee is determined as of the time of the loss. In *Lenart*, the homeowner-insured reported a claim to his insurer, the Florida Residential Property and Casualty Joint Underwriting Association.[12] The claim was reported due to a fire which occurred in December 1998.[13] Ocwen Financial Corporation ("Ocwen") held the mortgage on the property and was the loss payee on the policy.[14] The insurer denied the claim and the insured then stopped paying the mortgage.[15] Foreclosure proceedings ensued and a final judgment of foreclosure was entered in February 2000.[16]

Some time after the foreclosure sale, the insured settled the claim with his insurer for $90,000.[17] The insurer included Ocwen on the settlement check as the policy contained the standard New York loss payable clause and Ocwen was named as the loss payee on the policy declarations.[18] Ocwen, however, refused to endorse the check and the insured filed a third party action against Ocwen seeking the full amount of the proceeds from the settlement of the insurance claim.[19] The trial court granted summary judgment in favor of Ocwen and awarded the mortgage company the full amount of the $90,000 settlement.

However, the Third District Court of Appeal reversed the trial court's decision. In so doing, the Court reaffirmed the rule that foreclosure has a different effect on the loss payee's interest to a claim based on whether the foreclosure occurs (1) before *or* (2) after the loss. The Third District referenced its prior holding in *Secured Realty Inv. Fund Ltd., III v. Highlands Ins. Co.*[20] and the Supreme Court of Alabama's holding in *Nationwide Mut. Fire Ins. Co. v. Wilborn*[21], and stated that:

> In the "foreclosure prior to loss" situation . . . the foreclosure . . . occurs in the context of the insured property existing in its undamaged condition and the satisfaction of debt takes into account the value of such property in its undamaged condition prior to loss and the need for the insurance to follow the property. In the "foreclosure after loss" situation . . . the foreclosure occurs in the context of the insured property having been damaged and the satisfaction of the debt takes into account the damaged condition of the property at the time of such foreclosure.[22]
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> ***
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> The *Wilborn* Court explained that when the foreclosure precedes the loss, the mortgagee occupies the status of "owner" at the time of the loss, and has an insurance interest in protecting his property from loss . . . On the other hand, where the loss precedes the foreclosure the mortgagee is the *creditor* of the owner at the time of loss, and has an election as to how to satisfy the debt. The mortgagee may either turn to the insurance company for payment as mortgagee under the New York Standard Mortgage Clause and recover, up to the limits of the policy, the mortgage debt; or the mortgagee may foreclose on the property. If the mortgagee elects to pursue the insurance company for payment of the debt, then the debt is fully satisfied and the mortgagee does not have any addition or recourse against the mortgagor. If the mortgagee elects to foreclose on the property and the foreclosure sale does not bring the full amount of the mortgage debt, then the mortgagee may recover the *deficiency* under the insurance policy as owner . . . The Court reiterated that "in no event is the plaintiff-mortgagee due to collect more than the debt secured."[23]

In other words, where the foreclosure occurs *before the loss*, the mortgagee is considered the owner of the property at the time of the loss and is entitled to recover "the full amount of the covered loss provided all other applicable coverage conditions have been met."[24] Since the mortgagee is entitled to a full recovery, it follows that in cases where the foreclosure occurs before the loss the "named insured" should not be entitled to any recovery on the claim.

Conversely, where the foreclosure occurs *after the loss* the mortgagee is the *creditor* of the owner and has an election as to how to satisfy the debt. The mortgagee may either turn to the insurance company for payment under the New York Standard Mortgage Clause or the mortgagee may foreclose on the property. If the mortgagee elects foreclosure, and the foreclosure sale does not bring the full amount of the mortgage debt, then the mortgagee may recover the deficiency from the insurance company.

Therefore, in *Lenart* the Third District Court of Appeal held that Ocwen (i.e., the mortgagee) was entitled to recover the amount of the deficiency plus interest and the insured (i.e., Mr. Lenart) was entitled to the balance of the $90,000 settlement. The deficiency in the *Lenart* case, inclusive of interest, was found to be $11,062.98. As a result, the insured was entitled to recover $78,937.02 from the settlement payment.

Based on the holding of *Lenart* and the number of foreclosure cases now pending in Florida the following considerations may be helpful in handling or litigating first party property claims at this time:

1. **Search the public records.** When a claim is reported or when a new lawsuit is filed, complete a search of the public records to assess for foreclosure judgments relative to the insured property. To do so, it will first be necessary to locate the legal description of the property, which can be found in a number of places including the tax appraiser's records, the deed transferring title to the insured, or the mortgage documents. The public records may not contain a final judgment of foreclosure; however, foreclosure proceedings may be in progress or the final judgment of foreclosure may be on its way to being recorded in the public records. Accordingly, court records should also be reviewed to locate any pending foreclosure lawsuits. Even more useful is searching the public records for any *lis pendens* filed and recorded relative to the insured property. If a *lis pendens* was filed and recorded by the mortgage company, then it's a good bet the property is subject to a pending or completed foreclosure action.

2. **Confirm the date of the foreclosure judgment.** If the judgment of foreclosure has been entered, it is necessary to confirm the date of the judgment. Use that date to evaluate whether the situation is one where the foreclosure occurs *before the loss* or, alternatively, one where the foreclosure occurs *after the loss*.

3. **Confirm the details of foreclosure before entering into a settlement.** Paradoxically, insureds who have lost their properties to foreclosure may still report new claims to their insurance carriers or determine to continue with lawsuits already pending when the judgment of foreclosure is entered. Before settling a case it is very important to check the public records and assess whether the property is in foreclosure or subject to a final judgment of foreclosure.

4. **Consider the claim and the deficiency.** It is important to consider the specific claim at issue and evaluate whether the policy might limit certain claims from being made or pursued. For example, where a claim is for "Coverage A" damages only, the loss settlement clause in the policy may limit payment to the "necessary amount actually spent to repair or replace the damaged building." If the insured lost the property to foreclosure and incurred no costs for repair or replacement prior to the foreclosure, it then follows that the insured may not be able to prove any damages in the case.

   Similarly, where the insured is subject to a very large deficiency judgment there may be no prospect of any recovery for the insured on the claim or in litigation filed in connection with the claim. For example, where the mortgage deficiency is for $250,000 and the claim is for $50,000 any recovery would automatically go to the bank. As a result, the facts and circumstances of the claim and deficiency should be considered before continuing with litigation or agreeing to settle a claim affected by foreclosure.

5. **Consider moving for summary judgment and interplead the bank where appropriate.** As discussed above, when foreclosure occurs *before* the loss the entire claim belongs to the mortgage company when the policy contains the New York loss payable clause. On the other hand, where the foreclosure occurs *after* the loss the mortgage company is entitled to receive payment on the claim up to the amount of the deficiency. Among other things, an insured (or an insured's attorney) might dispute the mortgage company's entitlement to the insurance proceeds or the amount of the deficiency at issue.[25]

Where the foreclosure occurs before the loss and an insured has reported a claim and filed litigation in connection with that claim, a motion for final summary judgment should be filed in the case. In other cases, it may be appropriate to seek partial summary judgment as to the issue of entitlement to the proceeds of the insurance claim. In addition to moving for summary judgment, attorneys should consider an interpleader action under Fla. R. Civ. P. 1.240, in order to bring the bank into the lawsuit as a third party to the case and to require an insured to litigate their position with the bank directly.

Please note the above list represents a few general considerations and the appropriate manner for addressing a first party claim affected by a foreclosure will likely vary depending on the circumstances involved. It is always best to consult one of CSK's first party property attorneys in order to ascertain how to proceed on a claim or lawsuit in the event of a foreclosure of the insured property.

1 Key home price index shows record decline, Associated Press, Feb. 26, 2008, available at http://www.msnbc.msn.com/id/23350937.

2 Rana Foroohar, Boom and Gloom, Investors are bidding up stocks, gold, and oil to dizzying heights. If's déjà vu all over again, Newsweek, November 9, 2009.

3 Lehman Brothers Collapse Stuns Global Markets, CNN, September 15, 2008, available at http://edition.cnn.com/2008/business/09/15/lehman.merrill.stocks.turmoil/index.html.

4 Susan R. Miller and Oscar Pedro Musibay, RealtyTrac: South Florida Foreclosures Fall in Q3, South Florida Business Journal, October 28, 2009.

5 *Id.*

6 In Re Task Force on Residential Mortgage Foreclosure Cases, Supreme Court of Florida, Administrative Order No. AOSC09-8, March 27, 2009.

7 Susan R. Miller and Oscar Pedro Musibay, RealtyTrac: South Florida Foreclosures Fall in Q3, South Florida Business Journal, October 28, 2009.

8 *Id.*

9 Hotel Foreclosure Watch: Miami's Swank Shore Club Goes Delinquent, The Wall Street Journal, October 20, 2009 available at http://blogs.wsj.com/developments/2009/10/20/hotel-foreclosure-watch-miamis-swank-shore-club-goes-delinquent.

10 Annie Butterworth Jones, Courts Brief Lawmakers on Foreclosure Issues, The Florida Bar News, November 1, 2009, at 1.

11 *Lenart v. Ocwen Fin. Corp.*, 869 So. 2d 588 (Fla. 3d DCA 2004).

12 *Id.*

13 *Id.*

14 *Id.*

15 *Lenart*, 869 So. 2d. at 589.

16 *Id.*

17 *Id.*

18 *Id.*

19 *Lenart*, 869 So. 2d. at 589.

20 *Secured Realty Inv. Fund Ltd., III v. Highlands Ins. Co.*, 678 So. 2d 852 (Fla. 3d DCA 1996).

21 *Nationwide Mut. Fire Ins. Co. v. Wilborn*, 279 So. 2d 460 (Ala. 1973).

22 *Lenart*, 869 So. 2d. at 591.

23 *Id.* (citing Wilborn, 279 So. 2d at 463-64).

24 *Secured Realty Inv. Fund Ltd., III v. Highlands Ins. Co.*, 678 So. 2d 852, 856 (Fla. 3d DCA 1996).

25 *See e.g., Pick v. Gilbert*, 605 So. 2d 182 (Fla. 3d DCA 1992).

Medicare Flexes Its Muscles In *United States v. Stricker*

By Alejandro Perez

For nearly two years, the Center for Medicare & Medicaid Services ("CMS") have worked diligently to establish its Mandatory Insurer Reporting program, primarily focused on instructing primary payers or Responsible Reporting Entities to report large sets of data in a particular format via its website, www.https://www.section111.cms.hhs.gov. Cole Scott & Kissane, P.A. has published a number of articles in past issues of the Litigation Quarterly concerning Medicare Secondary Payer Compliance. Rather than discuss compliance, however, this article focuses on the consequences of noncompliance by highlighting the recent complaint filed by the United States in the Northern District of Alabama in the matter of United States v. Stricker, Case No. CV-09-PT-2423E, (N.D. Ala. 2009), and the 2009 opinion in a case styled United States v. Harris from the Northern District of West Virginia.

United States v. Stricker

On December 2, 2009, the United States filed a Complaint against eighteen Defendants, including beneficiaries, plaintiffs' law firms,1 insurance companies, and self-insured entities.2 In this Complaint, the United States seeks to recover costs of medical care (i.e., conditional payments) provided or paid for by Medicare pursuant to 42 U.S.C. § 1395y(b)(2) and regulations promulgated thereunder at 42 C.F.R. § 411.20 et seq. The United States alleged that upon information and belief, certain individuals received settlement payments in one or more of several cases filed against Defendants Monsanto Company (hereinafter "Monsanto"), Solutia, Inc. (hereinafter "Solutia"), and Pharmacia Corporation (hereinafter "Pharmacia"), as part of a $300 million settlement known as the Abernathy Settlement. The United States alleged that approximately 907 recipients of settlement proceeds were Medicare beneficiaries.

While Monsanto and Pharmacia contributed directly to this settlement fund as self-insureds, Solutia was insured by Travelers Companies, Inc., d/b/a The Travelers Indemnity Company (hereinafter "Travelers"), and American International Group, Inc. (hereinafter "AIG"), both of whom also were named in the suit because they contributed to the settlement fund on behalf of their insured, Solutia.

In the Complaint, the United States highlights that under federal law, Medicare may not make payments with respect to any item or service for which payment has been made or can reasonably be expected to be made under a liability policy or plan.3 The United States also claimed an entitlement to notification any time a primary payer learns that Medicare paid for a medical expense that could have been covered by the primary payer. Further, the United States explained that Medicare is entitled to reimbursement from a primary payer even if the primary payer has already paid the beneficiary or other party and can recover double damages.

Essentially, the United States alleges that all persons who received monies under the settlement violated the Medicare Secondary Payer Act and thus, are exposed to liability. Of particular interest, the United States alleges that insurers Travelers and AIG settled this matter on behalf of its insured, Solutia, and thus made primary payments as that term is defined by federal law, but failed to ascertain whether any settlement fund recipients "were Medicare beneficiaries prior to making, or causing to be made, payment of those settlement amounts" and also "did not identify any amount(s) owed the United States as reimbursement for Medicare conditional payments made on behalf of Medicare beneficiaries prior to their payments to the Abernathy Settlement Fund."[4] The Complaint also contains similar allegations against the named corporate defendants, Monsanto, Pharmacia and Solutia.

The Complaint alleges six counts, alleging that all eighteen Defendants are primary payers and/or primary plans that are required to reimburse Medicare. Moreover, the United States seeks double damages against the insurer Defendants, Travelers and AIG. Furthermore, the United States is seeking declaratory relief asserting that Defendants have failed to reimburse Medicare, must do so in the future and must further ensure that any future settlements account for Medicare's interests prior to distribution of funds.

United States v. Harris

Similarly, in *United States v. Harris*, the United States brought an action against Mr. Paul Harris, a plaintiff's attorney, in the United States District Court for the Northern District of West Virginia, who had sued a ladder retailer for injuries that arose after Mr. Harris's client fell off of the ladder.[5]

Mr. Harris and his client received payment from the ladder retailer as part of a $25,000 settlement.[6] Medicare made approximately $22,500 in conditional payments for medical services rendered to Mr. Harris' client.[7] Medicare regulations permit Medicare to recover the full amount of any medical expenses paid, minus "procurement costs" which in this case, consisted of Plaintiff's attorney's fees and costs.[8] Applying this formula, Medicare determined that it was owed $10,253.59 out of the settlement.[9] Plaintiff did not repay this amount and did not appeal this determination.[10] Later on, the United States commenced suit, sought to recover the unpaid $10,253.59, plus interest to be taken out of the attorney's share of the settlement, i.e., Mr. Harris' attorney's fees.[11] The United States prevailed as a matter of law because the Court determined that Mr. Harris' failure to administratively appeal this decision within 120 days in accordance with Medicare regulations precluded Mr. Harris from challenging Medicare's recovery determination.[12]

Note to the Industry – Medicare's Bark has Bite

Both of these cases exemplify that Medicare's interests must be safeguarded anytime a settlement, judgment, or arbitration award is finalized. Most remarkable about these two cases is that while Medicare Secondary Payer compliance has become a frequently discussed topic since the announcement that mandatory insurer reporting obligations would be implemented back in December 2007, the applicable law utilized by the United States in Stricker and Harris is not at all new. In fact, it been in effect since 1980. The insurance industry in particular has benefitted from a three-decade-long policy of selective enforcement that targeted workers compensation. From this point forward, it is clear Medicare will pursue its right to seek reimbursement from liability insurers, corporate, or business entities that opt to self-insure or pay for their litigation costs, and even attorneys who represent Medicare beneficiaries.

There is, however, some potential light at the end of the tunnel. Notably, it appears that Medicare's efforts, to date, have focused on scenarios where a party or primary payer has completely ignored Medicare's interests. This author is presently unaware of any cases where parties or primary payers who engaged in a good faith effort to protect Medicare's interests resulted in a federal lawsuit. However, it is imperative that primary payers remember that Medicare's reach is extensive, and this trend may very well change in the future. In any case, the lesson is clear. Ignore Medicare at your own peril!

Going forward, insurance industry personnel, corporate personnel, and attorneys defending these entities, are encouraged to, at minimum, have detailed and complete answers to each of the following eight questions prior to concluding any matter, whether by settlement, arbitration award or a judgment:

1. Is your client a primary payer/responsible reporting entity?
2. Is the Plaintiff a current Medicare recipient?
3. Did the Plaintiff incur past medical expenses?
4. Were any of these past medical expenses (conditional payments) paid for by Medicare?
5. How much has Medicare paid in conditional payments?
6. If settling a case, does your settlement include language expressly stating that it has accounted for Medicare's past liens?
7. Is it likely that Plaintiff will incur future medical expenses arising out of the claim that is at issue in your settlement, judgment or arbitration award?
8. Will these future medical expenses be covered by Medicare?

Cole, Scott & Kissane, P.A. can assist you in answering these questions, as well as any other questions you may have. Please continue to read our Litigation Quarterly for more updates on Medicare Secondary Payer compliance. In addition, you may contact the author, Alejandro Perez (alejandro.perez@csklegal.com) or Gene Kissane (gene.kissane@csklegal.com) if you have any questions.

1 The law firms that represented the plaintiffs in the $300 million dollar Abernathy Settlement received $129 million dollars in attorney's fees with an additional million each year from 2004 through 2013.

2 The named Defendants are (1) James J. Stricker, (2) Daniel R. Benson, (3) Kasowitz, Benson, Torres & Friedman, LLP, (4) Donald W. Stewart d/b/a as Donald W. Stewart, PC, (5) Don Barrett, (6) The Barrett Law Firm, PA, (7) Charles E. Fell, Jr., (8) Charles L. Cunningham, Jr., (9) Cunningham & Fell, PLLC, (10) Johnston Druhan, LLP, (11) Greg Cusimano, (12) Cusimano, Keener, Roberts & Raley, PC, (13) The Cody Law Firm, PC; (14) Monsanto Company, (15) Solutia, Inc., (16) Pharmacia Corporation, (17) Travelers Companies, Inc., d/b/a The Travelers Indemnity Company, and (18) American International Group, Inc..

3 *See* 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 C.F.R. § 411.20(a)(ii).

4 *See* page 16 of the *Stricker* Complaint, readily available online or upon email request to the author.

5 *U.S. v. Harris*, Case No. 5:08CV102, 2009 WL 891931 (N.D.W.Va. Mar. 26, 2009).

6 *Id.* at *1.

7 *Id.*

8 *Id.*

9 *Id.*

10 *Id.*

11 *Id.*

12 *Id.* at *4

Success Stories

Valerie Jackson obtained a final summary judgment in a significant Hurricane Irene property damage case. The Plaintiff (a condo association) sought over $1,000,000 in damages and Valerie was able to convince the trial court that the damages were unrelated to the hurricane and coverage was not triggered.

Richard P. Cole and Edward S. Polk represented the Defendants in a legal malpractice case that was tried for 2 1/2 weeks in West Palm Beach from September 14-30, 2009. The Plaintiff asserted in excess of $5,000,000 in damages arising from certain business transactions in which the attorneys had provided legal counsel. At the conclusion of the case the Court granted a directed verdict in favor of the Defendants. **Justin Siegwald and Alejandro Perez** participated extensively in the research and drafting of the successful legal arguments.

Henry Salas, Steven Safra and Alejandro Perez obtained final summary judgment as the plaintiff in a bailment matter, where defendant failed to properly secure plaintiff's property, resulting in the theft of the high valued goods. Henry and Alejandro timely amended the complaint to assert a breach of oral contract. This ultimately was the count that Judge Martinez granted summary judgment on, deeming our client entitled to over $400,000 in damages and costs.

Barry Postman and Katie Merwin secured a summary judgment on a Florida Private Whistleblower Act Claim. The Plaintiff argued that the Defendant condominium association's board members were employees of the condominium association for purposes of the Whistleblower Act's requirement that an employer subject to the Act must employ ten or more persons. Barry argued that Florida condominium association board members are volunteers as they receive no remuneration for their services. The Court agreed, and summarily disposed of Plaintiff's claims.

Edward Polk and Romina Marchese obtained summary judgment in a first party property matter involving a plaintiff who claimed that a plumbing backup had extensively damaged her kitchen and other parts of the house. While plaintiff initially maintained this position in discovery, further investigation revealed that work that Plaintiff claimed had been done and paid for was actually not done and never paid for. The Circuit Court in Miami-Dade County dismissed the entire claim for fraud on the court.

Aram Megerian and Howard Scholl obtained a complete defense verdict a trip and fall matter. Plaintiff, a 24 year-old male alleged a defect in a walkway caused him to fall and sustain lacerated tendons and arteries, with resulting nerve damage, after his right arm broke through a window. Though plaintiff presented past medical expenses in excess of $75,000 and asked for an additional $600,000 in compensatory damages, the jury deliberated for less than 45 minutes before determining the defendant was without fault.

Michael Brand and Ashley Sybesma just obtained a complete defense verdict in a negligent security/armed sexual assault case. Their client, "an adult retail establishment," had been robbed at gun point three times previously. On this occasion the gunman not only robbed the plaintiff but also sexually assaulted the sole employee on shift. The entirety of the attack was captured on videotape and presented to the jury.

Joe Kissane, Patrick Snyder and Michelle Dover obtained summary judgment in an admitted liability case involving a man who drove his car off an elevated highway at 100 miles per hour while intoxicated and high on cocaine. Our client, the defendant, died on the scene. The plaintiff was a passenger in this car, which, unfortunately, landed on top of another car, crushing and killing a 12-year-old girl and injuring two others. Plaintiff argued that the two insurers involved did not properly adjust the claim and ultimately intended to file a bad faith case after receiving an excess judgment. However, the Plaintiff did not properly preserve and file a claim against the estate of the driver insofar as Plaintiff did not file a timely "statement of claim" and did not file his action within the applicable limitations period. The trial court agreed and entered summary judgment, thereby barring any claims against the estate of the driver and stripping Plaintiff of any claim of bad faith.

Aram P. Megerian and Abby M. Moeddel obtained a final judgment on a Motion for Final Summary Judgment. Plaintiff obtained insurance coverage for her condominium and alleged that the insurance agency through which she purchases insurance failed to properly advise, review, procure and communicate Plaintiff's insurance needs regarding her insurance needs, resulting in Plaintiff being underinsured. Aram and Abby persuaded the court that Florida law does not provide a generalized duty of an insurance agent to volunteer advice absent special circumstances and that absent such circumstances, the Court should, and ultimately did, enter final summary judgment for Defendants.

Joe Kissane and George Saoud obtained a complete defense verdict in a high speed roll over case with $90,000 in medical costs incurred and where Defendant admitted fault at trial.

Dan Shapiro and Bryan Rotella obtained a dismissal in a personal injury matter where an off duty police officer alleged that a cannon prop that had been placed on a float in a local parade was sounded negligently resulting in significant damage to his hearing. Dan and Bryan aggressively sought the dismissal of their client from the inception of the litigation based on the lack of any evidence that they were in anyway involved with the float and cannon prop. After the filing a motion for summary judgment, including the signed affidavit of the company's representative attesting to their lack of involvement with the floats in the parade, the plaintiff voluntarily dismissed their claim.

Dan Shapiro and Sally Slaybaugh obtained complete defense verdict in a wrongful death/medical malpractice case.

Daniel Klein and Chad Robinson obtained a dismissal for lack of prosecution in personal injury matter where a resident of a condominium complex allegedly tripped into a hole concealed by grass.

Blake Sando and Cody German obtained a dismissal with prejudice on behalf of closing agents in a residential real estate transaction. Our clients had been sued for professional negligence and under the Florida Deceptive and Unfair Trade Practices Act on the basis that they allegedly falsified the buyer's signatures on the closing documents. After successfully arguing to dismiss the Complaint at two prior hearings with leave to amend, Blake and Cody persuaded the Court to dismiss the lawsuit because the privilege to amend has been abused and the proposed amendment was futile.

Jim Sparkman and Lonni Tessler obtained a summary final judgment in favor of a security company client in a catastrophic injury case. The plaintiff was horribly disfigured when a resident threw plumbing acid in the plaintiff's face. The resident was apparently involved in a tryst with the plaintiff's husband that occurred regularly in vacant apartments. Jim and Lonni argued that intentional acts were unforeseeable and could not have been prevented by the security company, who was simply in charge of manning the gatehouse and governing parking issues. The trial judge agreed.

Valerie Jackson recently obtain a summary judgment in a commercial property damage case. The plaintiff, a dentist, was seeking damages for physical loss to his office space, loss rental income, damages for business interruption and mold remediation. Valerie was able to convince the trial court that the damages were caused by the faulty workmanship of a contractor and therefore, excluded by the policy.

Thomas Scott recently obtained summary judgment in a wrongful death action. Plaintiffs and co-defendant entered into a Coblentz Agreement as to damages and fees. Ultimately, the trial court ruled that the Coblentz Agreement was unenforceable and entered judgment.

Michael Brand and **Jami Gursky** recently obtained a complete defense verdict in a case where the plaintiff broke his leg due to an alleged hole in a yard. The plaintiff had an open reduction internal fixation surgery and asked the jury for $750,000. Genna Rupelli assisted substantially in this effort.

Michael Brand and **Trelvis Randolph** recently obtained a complete defense verdict in a case where the plaintiff, a postal worker, claimed that she fell from the defendant's steps as a result of overgrown shrubbery. Due to the fall, she required knee surgery and was deemed 4% whole body impaired. The jury returned a defense verdict after just forty minutes of deliberation, including lunch.

Gene Kissane and **Michael Brand** recently obtained a complete defense verdict after a week-long trial in Sebring, Florida. The plaintiff contended that the defendant's negligently maintained parking lot led to his accident and resulting four surgeries (four-level neck fusion, back surgery and bilateral carpal tunnel release). Plaintiff claimed that as a result of these injuries, he could no longer work and was entitled to over $750,000 in economic damages alone. The jury returned a defense verdict after slightly over an hour of deliberations. Jami Gursky substantially contributed to this effort.

Barry Postman and **Lisa Szulgit** obtained a complete defense verdict for a homeowners association. Plaintiffs alleged that the association improperly amended their Declaration of Restrictive Covenants to allow for a beautification project. Plaintiffs requested, among other things, declaratory judgment requesting that the amendments be declared void and injunctive relief, seeking to have the multi hundred thousand dollar project undone. The court found the association acted within its authority and awarded attorney fees to the association.

Lee Cohen and **Barry Postman** recently obtained a defense verdict in a medical malpractice action related to a breast surgical case. The allegations involved the doctor being the cause of a surgical complication which resulted in a deformity and five follow up surgeries. Defense was that the deformity was the result of a well known complication to the procedure performed. The demand was over $400,000. The jury returned its verdict within an hour.

Jonathan Midwall recently won a case in front of the EEOB on a racial discrimination claim. The Plaintiff contended that a Homeowner's Association refused to allow her to reside within its association and have access to its common elements due to her race. Mr. Midwall successfully defended the Association by arguing that the Plaintiff failed to comply with the Association's by-laws on the approval of new residents and thus, any denial of the Plaintiff's requests were not racially motivated.

Jonathan Midwall and **Lara Dabdoub** recently obtained Final Summary Judgment on behalf of a doctor in a wrongful death case. The plaintiff, personal representative of the decedent's estate, claimed the doctor failed to timely diagnose a pulmonary embolism and the same led to the decedent's subsequent death.

Meet One of Our Attorneys

Benjamin M. Esco

Benjamin M. Esco has practiced as an Insurance Defense Trial Lawyer for more than twenty years. His emphasis is in Directors and Officers Liability for profit and non-profit corporations, Premises Liability Defense, for Commercial, Residential, and Hospitality Industry clients, including hotels, restaurants, and liquor establishments. He also practices in the defense of Nursing Homes, Trucking Companies, Auto Negligence, Condominiums, and Construction Defects, as well as in Insurance Coverage issues. He earned a Business Degree from Florida State University, with high honors, in 1984, then graduated from University of Florida Law School in 1987.

Mr. Esco is admitted to practice before the United States Supreme Court, the United States District Courts for the Southern and Middle Districts of Florida, and all courts within the state of Florida.

Mr. Esco is A.V. rated by Martindale-Hubbell. He is a current member of the Florida Defense Lawyers Association, The Dade County Defense Bar, and The Coral Gables Bar Association.

Cole Scott & Kissane, P.A. is pleased to announce that our In-House Construction Consultant, Robert Knapp, has recently become certified as a Mold Inspector and Mold Remediation Contractor.

Cole Scott & Kissane, P.A. employs both expert counsel and in-house construction experts to serve your construction litigation needs.