Insurance Cases

by Gregory M. Yaffa

Inclusion of Hospital on Insurance Settlement Check Not Deemed a Counteroffer When Insured Did Not Specify Type of Payee When Demanding Settlement Draft. *Marin v. Infinity Auto Ins. Co.*, So.3d , 43 FLW D425b, (Fla. 3rd DCA 2-21-18)

Marin was injured in an automobile accident allegedly caused by Blanco, an Infinity Auto Insurance Company policyholder. Marin was treated at Jackson Memorial Hospital and was subsequently discharged. Thereafter, Infinity sent Marin's then-attorney a letter tendering the $10,000 bodily injury policy limits to settle Marin's bodily injury claim against Blanco. The letter included a standard release and a $10,000 check made payable to Marin, his attorney, and Jackson Memorial Hospital. Infinity explained in the letter that it included Jackson Memorial Hospital on the check because it appeared that the hospital had a lien for the medical services it provided to Marin. Infinity offered to reissue the check if the lien had been resolved.

Marin subsequently hired a new attorney, who notified Infinity in writing that he had been retained to represent Marin and demanded that Infinity tender its full policy limits. The letter stated: "It is my understanding that your insured has $10,000 in available liability coverage, which I am requesting that your company tender by delivering the settlement draft to my office by the close of business on April 28, 2014." On April 25, 2014, Infinity responded by sending Marin's attorney a letter, which specifically stated that it "agree[d] to meet [Marin's] settlement demand." The letter included a $10,000 check made payable to Marin, his attorney, and Jackson Memorial Hospital. Infinity also included a release and an open invitation to submit modifications to the settlement draft. Marin's attorney treated the payment as a counteroffer because of Infinity's inclusion of Jackson Memorial Hospital on the settlement check, and therefore rejected the settlement payment on April 30, 2014. Infinity subsequently filed a motion to enforce the settlement. The trial court granted the motion and dismissed with prejudice Marin's action filed against Blanco subject to the terms of the settlement on agreement. Marin appealed.

On appeal, Marin argued that Infinity's inclusion of Jackson Memorial Hospital on the settlement check added a new essential

term to the agreement, converting Infinity's purported acceptance into a counteroffer. The Third District rejected this argument, because Marin's demand letter only provided two essential terms to reach a settlement: (1) Infinity must tender the $10,000 bodily injury liability limit in the form of a *settlement draft*; and (2) Infinity must do so by April 28, 2014. Because Marin did not state who should be included on the settlement check, and merely demanded that Infinity must submit a "settlement draft" by April 28, 2014, Infinity's April 25, 2014, letter and settlement draft was a valid acceptance of Marin's offer.

Notably, the Third District continued its analysis by reviewing the reasonableness of Infinity's inclusion of Jackson Memorial Hospital as a co-payee on the settlement check. The Third District concluded that Infinity's inclusion of the hospital on the settlement check was reasonable because Marin was a Medicaid patient and, under *State Farm Mut. Auto. Ins. Co. v. Palm Springs Gen. Hosp. Inc. of Hialeah*, 232 So.2d 737, 738 (Fla. 1970), a hospital lien attaches the moment an injured person is admitted as a patient. The court also relied on *Government Employees Insurance Co. v. Gonzalez*, 512 So.2d 269, 270 (Fla. 3rd DCA 1987), which held that one of the options an insurer had for paying its insured's PIP claim was to issue a check for the limits payable to both the hospital and the insured.

When PIP Benefits Sought, Deductible Must Be Subtracted from Total Medical Care Charges Before Applying Statutory Reimbursement Limitations. *Progressive Select Insurance Company v. Florida Hospital Medical Center*, So.3d , 43 FLW D318a (Fla. 5th DCA 2-9-18)

On certiorari review, the Fifth District Court of Appeal considered the proper methodology to determine the application of the deductible authorized under §627.739(2), Florida Statutes (2014), when personal injury protection (PIP) benefits are sought by an insured. The circuit court below concluded that an insured's PIP deductible must be subtracted from the total medical care charges before applying the statutory reimbursement limitations provided in §627.736(5)(a)1.b., Florida Statutes (2014). Progressive Select Insurance Company, however, argued that the statutory limitations must be applied first and the deductible subtracted from that amount.

The Fifth District sided with the circuit court after it engaged in a statutory construction analysis of §627.739. Section 627.739 states in pertinent part:

> Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, and $1,000. The deductible amount *must* be applied to *100 percent* of the *expenses and losses described* in s. 627.736. *After* the deductible is met, each insured is eligible to receive up to $10,000 in total *benefits* described in s. 627.736(1). However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

As the Fifth District explained, the statute distinguishes between "expenses and losses" and "benefits." The statute indicates that the deductible applies to "100 percent of the expenses and losses" whereas "benefits" are only available *after* the deductible is met. Prior to its 2003 amendment, the statute was construed by the Florida Supreme Court in *Govan v. Int'l Bankers Ins.*, 521 So.2d 1086 (Fla. 1988) as requiring the deductible to satisfied from the amount that was actually payable out of the policy benefits. The prior version of the statute, however, did not make any distinction between "expenses and losses" for purposes of applying the deductible and "benefits" due to the insured after the reimbursement limitations are applied. The Fifth District considered the Legislature's 2003 amendment to as indicative of its intent that the deductible be subtracted from the total amount of medical charges before application of the reimbursement limit under §627.736(5)(a)1.b. While the Fifth District ultimately denied Progressive's petition for writ of certiorari, it certified the question it considered to the Florida Supreme Court as a matter of great public importance.

When Insurance Contract Provides for an Appraisal Process, Insured Is Not Obligated to Wait Until that Process Is Completed Before Filing a Civil Remedy Notice Pursuant to Section 624.155, Florida Statutes. *Landers v. State Farm Florida Ins. Co.*, So.3d , 43 FLW D200 (Fla. 5th DCA 1-18-18) (Substituting Original August 11, 2017, Opinion on Motion for Rehearing)

In 2009, Landers' home sustained a loss from suspected sinkhole activity. Landers submitted a claim to his insurer, State Farm Florida Insurance Company. Landers carried a policy in excess of $1 million with State Farm. State Farm hired SDII Global Corporation (SDII) to conduct a subsidence investigation. After SDII confirmed that sinkhole activity was the cause of the damage to Landers's home, State Farm admitted coverage. SDII recommend that grout needed to be injected into 65 holes drilled around the perimeter of the home to properly stabilize it at a cost of approximately $350,000.

Landers obtained an independent opinion from Biller Reinhart Structural Group (Reinhart). Reinhart concluded that proper stabilization required underpinning of the home, which would cost approximately $1 million. State Farm provided Reinhart's report for review by a neutral evaluator from the Department of Financial Services pursuant to §627.7074. The neutral evaluator concluded that underpinning was unwarranted. While State Farm demanded an appraisal under the policy to resolve the parties' disagreement over the amount of the loss, Landers agreed to proceed with SDII's recommended repair plan, despite his belief that the repairs were inadequate. State Farm placed its appraisal demand on hold while the stabilization repairs were made.

After the repairs were completed in September 2011, the home continued to experience damage. State Farm reiterated its request for appraisal of the cosmetic damages to the home. Landers hired Sonny Gulati, a geotechnical engineer to examine the property. In January 2012, while Gulati's report was pending, Landers filed a civil remedy notice (CRN), alleging, among other things, claim

delay, failure to promptly investigate the claim, failure to adjust the loss, and the failure to tender policy limits. Landers contended that State Farm's expert's recommended repairs had been completed but his home remained unlivable. Landers demanded the immediate tender of "the policy limits" of $1,026,500 minus any prior payments that had been made to the insured. In response, State Farm requested that all issues be submitted to appraisal.

In March 2012, Landers brought suit against State Farm for breach of contract. In that suit, State Farm sought to compel appraisal, which Landers opposed. The circuit court compelled appraisal, and Landers appealed from that order, which the Fifth District affirmed. In July 2014, the appraisal panel determined that the amount of loss exceeded the policy limits. State Farm tendered the policy limits in August 2014, without any deduction for the amounts previously paid.

Landers then brought a first-party bad-faith suit against State Farm, alleging10 purported violations of §§624.155(1)(b)1. and 626.9541(1)(i), Florida Statutes (2008), including allegations of claim delay and low-balling. Landers contended that his damages always exceeded the policy limits and that State Farm acted in bad faith by delaying payment of the policy limits until after appraisal.

State Farm moved for summary judgment on the basis that Landers' CRN was a nullity because, when Landers filed the CRN, a condition precedent to payment — determining the amount of loss through appraisal — had not been fulfilled. The trial court granted summary judgment, and Landers appealed.

The question before the Fifth District was whether an insurer's demand for appraisal tolls the filing of a CRN until the amount of the appraisal has been established. State Farm argued that the CRN is not effective until all of the contractual preconditions to suit are met and there has been a final determination of coverage and the amount owed. The Fifth District, however, held that under the plain language of §624.155(3)(d), no time limitation is provided for filing a CRN and no determination of coverage and damages is required before the CRN is filed. As the Fifth District explained, the statute "simply states that 'no action shall lie' if the bad-faith allegation is corrected or the damages are paid within sixty days of the insurer receiving the notice." Under the Florida Supreme Court's decision in *Vest v. Travelers Ins. Co.*, 753 So.2d 1270, 1270 (Fla. 2000), which noted that there is no statutory requirement preventing an insured from sending the statutory notice before a determination of liability of damages, "the purpose of the CRN is to facilitate and encourage good-faith efforts to timely settle claims before litigation, not to vindicate continuing efforts to delay." Accordingly, the Fifth District concluded that once the appraisal process is complete, and a legally sufficient CRN has previously been provided, the conditions precedent to filing a statutory bad-faith claim are met.

Abatement of Third-Party Bad Faith Claim Improper Pursuant to Non-Joinder Statute When Plaintiff Has Not Already Obtained Settlement or Verdict in Underlying Negligence Claim. *Geico General Ins. Co. v. Martinez*, So.3d , 43 FLW D86 (Fla. 3rd DCA 1-3-18).

In 2009, Martinez was injured while she was a passenger in a vehicle driven by Guevara. Guevara was insured under a GEICO policy that provided bodily injury coverage in the amount of $10,000 per person and $20,000 per occurrence. Martinez filed a one-count negligence complaint against Guevara in 2009. In October 2016, Martinez successfully moved to amend her complaint to add GEICO as a party defendant to the action and to add a third-party bad faith claim against GEICO.

GEICO moved to dismiss the third-party bad-faith count. At the hearing on the motion to dismiss, Martinez conceded that the bad-faith count against GEICO was unaccrued and premature because, pursuant to the non-joinder statute (§627.4136, Florida Statutes), the bad-faith claim had not yet accrued and would not accrue unless and until Martinez first obtained a settlement or verdict against Guevara on the underlying negligence claim. The trial court denied the motion to dismiss, and instead abated the bad-faith action until the underlying negligence action was resolved.

GEICO petitioned the Third District Court of Appeal for a writ of certiorari. On review, the Third District quashed the trial court's orders granting Martinez's motions to add GEICO as a party defendant and to add a third-party bad faith claim against GEICO. The Third District's analysis turned on the plain language of the nonjoinder statute, which provides that "No person who is not an insured under the terms of a liability insurance policy shall have any interest in such policy, either as a third-party beneficiary or otherwise, *prior to first obtaining a settlement or verdict against a person who is an insured under the terms of such policy for a cause of action that is covered by such policy.*" §627.4136(2), Fla. Stat. (2016). Because Martinez conceded that her bad-faith claim had not yet accrued and that she was not an insured under the GEICO policy, the Third District concluded that dismissal, not abatement, was the proper remedy for incorrect application of Florida's nonjoinder statute. The Third District expressly distinguished its prior cases that had held abatement was proper for an unaccrued and premature third-party bad-faith claim as those cases involved first-party bad-faith claims, and therefore did not implicate the nonjoinder statute. ■

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