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Valuing Plaintiff's Recoverable Damages

When Plaintiff's Insurer Settles a Subrogation Claim with the Responsible Party for Less Than the Claim's Full Amount

By Darren S. Teshima

When an insurer partially compensates its policyholder for a loss caused by a responsible party, it may assert a subrogation claim against the responsible party to recover the amount of the insurance benefits paid. The responsible party then is faced with two actions against it: a tort action and a subrogation action by the plaintiff's insurer. The party may find it in its interests to settle the subrogation action before or during the pendency of the tort action. If the defendant's settlement reimburses the insurer for all the benefits paid to the plaintiff (its policyholder), then any damages award will be reduced to account for the benefits paid.

But what happens when the responsible party settles the subrogation claim for less than the amount of benefits paid by the insurer? Can the party then offset a damages award by the full amount of the subrogation claim, and in so doing, potentially pay less than the full amount of the damages it caused? Only a few courts around the country have addressed this question,

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As the Waves of Superstorms Recede, States Seek to Amend Insurance Laws

By Elizabeth Ahlstrand

From an October 2011 blizzard, to Hurricane Irene, and most recently, Superstorm Sandy, states along the East Coast have endured an unprecedented torrent of intense storms in recent years. The storms have caused tremendous property damage and, as citizens continue to rebuild, legislatures in the affected areas are responding. Indeed, many state legislatures began the 2013 legislative session several months early, with a majority convening in January.

Significantly, legislatures in three Eastern Seaboard states — New York, New Jersey and Florida — have already proposed new bills, which if enacted, would change their state's insurance laws with respect to insurer bad faith. As explained in more detail below, bills proposed in New York and New Jersey emerged in the wake of Superstorm Sandy and, if passed, will amend and strengthen existing bad faith law in favor of policyholders. In contrast, the legislation proposed in Florida, which died in the House Judiciary Committee, sought to clarify existing law and implement legislation favorable to insurers.

New York: Bill No. A05780

In the wake of Superstorm Sandy, the New York Assembly (*i.e.*, the House) introduced Bill No. A05780 on March 6, 2013. Proposed Bill No. A05780 amends Insurance Law § 2601 to provide a private cause of action against insurers for unfair claims practices in the handling of property damage claims in regions where the governor has declared a disaster emergency.

In its current form, § 2601 provides that no insurer doing business in New York shall engage in unfair claim settlement practices and, if the practice is performed with such frequency as to indicate a general business practice, the insurer shall be in violation of § 2601. Section 2601 was enacted to allow New York's Superintendent

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of Insurance to determine "which carriers were comparatively egregious in their claims settlement practices and to give the Superintendent the discretion to take appropriate action against those carriers whose claims settlement practices substantially exceeded industry norms." *See Okslen Acupuncture P.C. v. Dinallo*, 884 N.Y.S.2d 804, 811 (2009). Under its current form, consumers do not have standing to bring a claim under § 2601.

Bill No. A05780 amends § 2601 to add the following additional provision: "where the [G]overnor has declared a disaster emergency pursuant to section twenty-eight of the executive law … any person who has suffered loss or injury by reason of any violation of this section relating to an insurance claim for property damage in an affected area encompassed by the executive order declaring the disaster emergency may bring an action in his or her name as a plaintiff to enjoin such unlawful act or practice and in an action to recover his or her actual damages." The bill also provides that courts may, in their discretion, award punitive damages and attorney's fees where there is a finding of an insurer's willful or knowing violation of § 2601.

In a memorandum accompanying the bill, the drafter and primary sponsor, Assemblywomen Helen E. Weinstein (D-NY-041) who represents constituents in Brooklyn, explained the purpose behind the bill: "insurers have every right to attempt to lawfully deny claims, but all too often these attempts create unreasonable situations for homeowners attempting to simply access the benefits to which they are entitled. This is especially acute in situations where the homeowner may have lost most or even all of their possessions due to a storm declared emergency." She goes on to state that the expansion of § 2601 is warranted due to evidence that "some insurers have taken advantage of insured[s] as concerns the adjusting of losses sustained in disaster emergencies declared by the Governor." Thus, according to Weinstein, "a private right of action is necessary, in addition to the possibility of administrative action, to make certain that insurers are held responsible for unfair claims practices."

Bill No. A05780 has been pending in the Insurance Committee, since March 6, 2013. If enacted, the legislation will take effect immediately and its impact will likely be widespread. Since taking office in 2011, New York Governor Andrew M. Cuomo has issued nine executive orders declaring a disaster emergency in the state of New York.

New Jersey: S-2460

On Jan. 8, 2013, the New Jersey State Senate introduced Bill S-2460, captioned "Consumer Protection Act," which seeks to amend New Jersey Statutes § 17:29B-4 and codify the private cause of action for unfair claims settlement practices articulated by the State Supreme Court in *Rova Farms Resort Inc. v. Investors Ins. Co.*, 65 N.J. 474 (1974).

In its current form, § 17:29B-4 does not provide a private right of action. Rather, it merely provides that the New Jersey Commissioner of Banking and Insurance has the power to examine and investigate into the affairs of an insurer in order to determine whether such company has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice with such frequency as to indicate a general business practice.

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and they are split on the issue. This article examines the most recent decision, a particularly lucid, albeit unpublished, decision by the California Court of Appeal in *De Anza Interiors, et al. v. Hsu, et al.*, 2011 WL 6402146, No. CV-08-2550 (Cal. Ct. App. Dec. 21, 2011), which answers the question in the affirmative.

Summary of *De Anza*

In *De Anza*, the plaintiffs' property was damaged in a fire that spread from the defendants' restaurant. De Anza's property insurer, State Farm Insurance Company, paid De Anza $475,000 under the terms of its insurance policy, which partially compensated De Anza for its loss. 2011 WL 6402146, at *1. De Anza sued the defendants, and State Farm then filed a separate subrogation action for the $475,000 in insurance benefits, which was consolidated with De Anza's suit. Prior to trial, State Farm settled its claim against defendants whereby the defendants' insurer paid State Farm $300,000 — $175,000 less than the insurance benefits State Farm paid to De Anza — in exchange for a release and an assignment of State Farm's subrogation claim. *Id.* De Anza prosecuted the case to trial, and the jury found the defendants liable and awarded De Anza damages of $731,000. In a post-verdict motion, the defendants asserted State Farm's subrogation claim for $475,000 as an offset against the $730,000 damage award. The trial court granted the defendants' motion. *Id.*

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On appeal, De Anza asserted the following main arguments: 1) the collateral source rule prohibited the offset; and 2) defendants' offset should be limited to $300,000, the amount of money defendants paid to settle State Farm's subrogation action. As discussed further below, the California Court of Appeal rejected these arguments, holding that the collateral source rule did not bar the offset, and that the defendants, as assignees of State Farm's subrogation claim, were entitled to offset the entire amount of that claim. *Id.* at *6, *19. The court did agree with De Anza that the setoff amount should be reduced by a share of the attorney's fees incurred to successfully litigate the action, without which the assigned subrogation claim would be worthless. *Id.* at *18. The appellate court remanded the case to recalculate the setoff after deducting a *pro rata* share of the attorney's fees. *Id.* at *19.

Analysis

Overview of Subrogation

In the insurance context, subrogation is the claim of an insurer that pays a policyholder's covered loss to be put in the position of the policyholder and recover the amount paid from the party responsible for the loss. *E.g., Garbell v. Conejo Hardwoods, Inc.*, 193 Cal. App. 4th 1563, 1568 (Cal. Ct. App. 2011); *Plut v. Fireman's Fund Ins. Co.*, 85 Cal. App. 4th 98, 104 (Cal. Ct. App. 2000). Subrogation is an equitable doctrine meant to ensure that the party responsible for causing the loss pays for it. An insurer is said to "stand in the shoes" of the policyholder because the insurer's subrogation claim is purely derivative of, and no greater than, the policyholder's right (a chose in action) against the responsible party. *E.g., Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App. 4th 1279, 1292 (Cal. Ct. App. 1998). Subrogation applies both by operation of law and generally pursuant to the contractual terms of an insurance policy.

As is often the case, a policyholder is not fully compensated for its loss by insurance because of, among other things, deductibles, policy limits, and/or exclusions to coverage. In this situation, the policyholder and the insurer split a single right of action against the responsible party for recovery — the policyholder has a right to the uninsured amounts; the insurer has a right to recover the amounts it paid (subject to its insured being made whole). *See, e.g., Garbell*, 193 Cal. App. 4th at 1571; *Allstate Ins. Co. v. Mel Rapton, Inc.*, 77 Cal. App. 4th 901, 908 (Cal. Ct. App. 2000). The insurer can enforce its claim directly against the responsible party, or it might seek reimbursement out of the damages award obtained by the policyholder. *E.g., Plut*, 85 Cal. App. 4th at 104. Insurers frequently assert their subrogation claim directly by intervening in their policyholder's action or, as State Farm did in *De Anza*, by filing a separate action, which generally is joined with the tort action. Since the insurer and the responsible party are not in privity with each other, and the insurer is too remote for it to be a foreseeable victim for purposes of imposing tort liability, some commentators have characterized the relationship between the responsible party and the injured party's insurer as "non-consensual suretyship," where the insurer effectively acts as a surety for the performance owed by the tortfeasor. *See* Morton C. Campbell, *Non-Consensual Suretyship*, 45 Yale L. J. 69, 76 (1935).

Collateral Source Rule Does Not Prohibit Offset of Subrogation Claim

After the defendants in *De Anza* settled State Farm's subrogation claim, they sought to offset De Anza's damages award by the amount of the subrogation claim. 2011 WL 6402146, at *1. De Anza objected, contending that the collateral source rule barred the offset. The plaintiffs in *De Anza* did not challenge the effectiveness of State Farm's assignment of its subrogation claim to the defendants. 2011 WL 6402146, at *6. The court held that the fact that State Farm's subrogation claim was asserted by the

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defendants as assignees would not change the analysis. *Id.* The court recognized that in California, a chose in action is presumptively assignable, and that this presumption extends to subrogation claims. *Id.* The collateral source rule provides that if an injured party is compensated for its loss from a source wholly independent of the tortfeasor, that payment should not reduce the amount the tortfeasor owes the plaintiff. *E.g., Helfend v. S. Cal. Rapid Transit Dist.*, 2 Cal. 3d 1, 6 (1970). The rationale behind the rule is that a tortfeasor should not be allowed to escape liability for the full amount of the loss and benefit from the injured party's foresight to obtain insurance. *See Id.* at 9. The rule also operates as an evidentiary rule that bars the introduction of evidence of independent payments to the plaintiff as irrelevant and prejudicial.

Since an injured party's insurer is a source wholly independent of the tortfeasor, De Anza argued that its recovery against the defendants should not be reduced by the amount of insurance proceeds it received from State Farm. The Court of Appeal rejected this argument, recognizing that the collateral source rule is inapplicable to subrogation claims. *De Anza*, 2011 WL 6402146, at *4-6. The court reasoned that because both De Anza and State Farm effectively share a single right to damages against the defendants to the extent of State Farm's insurance proceeds, "the insurer's status changes from being a collateral source to that of a co-injured party entitled to damages for the injury; the amount of benefits paid becomes the measure of the insurer's share of the damage award." *Id.* at *4.

The subrogation doctrine "modifies the collateral source rule" and prevents double payment by the tortfeasor to the injured party and its subrogated insurer, who share a single right of action against the tortfeasor. *Garbell*, 193 Cal. App. 4th at 1572. The rule "addresses whether the insured may recover against tortfeasors even though it has been compensated by the insurer; it does not address the insurer's right to recover in a subrogation action for its payments to the insured." *Id.* Once the insurer is subrogated to the claim against the responsible party, "the payment of insurance proceeds is no longer a 'collateral source.'" *Id.* (quoting *Ferraro v. S. Cal. Gas Co.*, 102 Cal. App. 3d 33, 47 (Cal. App. Ct. 1980)).

Courts outside California that have addressed scenarios analogous to the one in *De Anza* have similarly recognized that the collateral source rule does not apply to subrogation claims. For example, in *Ferrellgas, Inc. v. Yeiser*, 247 P.3d 1022 (Colo. 2011), a homeowner suffered property damage when Ferrellgas, Inc. failed to timely deliver propane. The homeowner's insurer covered part of the loss and brought a subrogation action against the gas company. *Id.* at 1024. After it settled its subrogation action, the gas company sought to offset the damages award in the homeowner's suit. The homeowner objected, asserting the collateral source rule. *Id.* at 1027. The Colorado Supreme Court held that the collateral source rule did not apply, since the insurer's subrogation interest allowed it to stand in the homeowner's shoes with respect to that amount, and by settling the subrogation claim, it "extinguished" the homeowner's right to seek that amount from the gas company. *Id.*; *accord Hayes Sight & Sound, Inc. v. Oneok, Inc., et al.*, 281 Kan. 1287 (2006) (holding that collateral source rule does not apply to bar setoff of amount of subrogation claim settled between defendant and plaintiff's insurer); *Sunnyland Farms, Inc. v. Central New Mexico Electric Cooperative, Inc.*, 149 N.M. 746, 781 (N.W. App. Ct. 2011) (cert. granted) (same).

Amount of Offset Not Limited to Defendant's Settlement Payment To Insurer

After holding that an offset was required, the *De Anza* court next addressed the amount of the offset. The plaintiffs argued that the defendants were not entitled to an offset of the entire amount of State Farm's subrogation claim, $475,000, because they settled that claim for $300,000. 2011 WL 6402146, at *18. Instead, the plaintiffs contended that by settling the claim for $300,000, State Farm waived the right to seek reimbursement for more than that amount, and as assignees of that claim, defendants were not entitled to an offset of more than $300,000. *Id.*

The Court of Appeal rejected the plaintiffs' position. First, it found that the elements of a waiver had not been established because, among other things, the settlement agreement did not contain a waiver of any subrogation right, and the fact that State Farm settled for less than $475,000 "was not inconsistent with an intent to assign the full value of that claim." *Id.* at *19. The court then recognized that State Farm and the defendants made calculated decisions about resolving the dispute prior to an uncertain end of the litigation:

> State Farm's agreement to settle more reasonably reflects its calculated determination that it was worth discounting its subrogation claim in order to avoid further litigation expenses and the risk of not recovering anything if the jury found that defendants were not liable for the fire losses. Conversely, the agreement reasonably represented a calculated hedge by [defendants' insurer] against the possibility of a plaintiffs' verdict: if plaintiffs prevailed, then for a discount, [defendants' insurer] obtained for the defendants a substantial subrogation setoff against the damage award. *Id.*

By holding that the defendants were entitled to an offset of the entire value of State Farm's subrogation claim, the court made it theoretically possible for the defendants to pay less than the full amount of

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plaintiffs' loss. Because the court also held that under the common fund doctrine, the defendants, as assignees of the subrogated claim, were responsible for part of the plaintiffs' attorney's fees, and remanded the case to recalculate the offset, *Id.* at *18, this result may not have ultimately occurred.

This result is consistent with the principles of subrogation, since the defendants were asserting the subrogation right of State Farm. Had State Farm not settled its claim, it would have been entitled to recover the full value of its claim from the plaintiffs' award against the defendants. The plaintiffs, therefore, would not have recovered the $474,000 from the defendants. As the *De Anza* court observed, the fact that State Farm made the calculated decision to hedge its risk of an unfavorable outcome and settle its claim for less than its full value should not change the result.

Most of the courts from other jurisdictions that have addressed this situation have agreed with the holding in *De Anza*. In *Brinkerhoff, et al., v. Swearingen Aviation Corp.*, 633 P.2d 937 (AK 1983), the plaintiffs' plane was damaged as the result of defendant's defective manufacturing. The plaintiffs' insurer paid $672,000 to cover those losses and then settled its subrogation claim against the defendant for $375,000. *Id.* at 939. In the plaintiffs' action, the defendant sought an offset in the amount of the insurance payout. The plaintiff objected, contending that the defendant was only entitled to an offset in the amount of its settlement payment to the insurer. *Id.* at 942. The Alaska Supreme Court rejected the plaintiffs' argument: "Although [plaintiff] could have sued to recover the full amount of damage and held the appropriate portion of that recovery … in trust for his insurer whose subrogation rights arose upon payment under the policy … the insurance company's decision to settle its claim foreclosed this option." *Id.* The court also held that an "insurance company is free to settle its subrogation claims for any amount." *Id.*

Similarly, in *Ferrellgas, Inc. v. Yeiser*, 247 P.3d 1022 (Colo. 2011), the Colorado Supreme Court reversed the appellate court and held that the defendant was entitled to offset the entire amount of the subrogation claim, regardless of the fact that it paid less than that amount to settle that claim. *Id.* at 1027. The court held that the settlement between the plaintiff's insurer and the defendant "extinguished [plaintiff's] right to seek [the insurance amount] from [the defendant]." *Id.* Like the *De Anza* court, the Colorado Supreme Court held that the insurer's decision to resolve its subrogation claim for less than its full value did not change the outcome. As a subrogee, the insurer stood in the shoes of the plaintiff and was free to "resolve the claim without litigation by settling for less than the full value, and its doing so had no effect on the inevitable extinguishing of [plaintiff's] interest in [the subrogated amount]." *Id.* at 1028. In a footnote, the court noted that had the insurer not settled its subrogation claim, the plaintiff would have had to reimburse the insurer for the full amount of its insurance payment out of the damages award. *Id.* at n.4.

One decision has gone the other way and limited the offset to the amount paid to settle the subrogation claim. In *Hayes Sight & Sound, Inc. v. Oneok, Inc., et al.*, 281 Kan. 1287 (2006), after the defendants settled the subrogation claim with the plaintiff's insurer, they asserted that they were entitled to an offset against the plaintiff's damages award. *Id.* at 1300. After rejecting the argument that the collateral source rule barred any offset, the Kansas Supreme Court held that the amount of the offset could not be the amount of the insurers' subrogation claim. *Id.* at 1306. Instead, the offset was limited to the amount the defendants paid to settle that claim, and any difference in value would benefit the plaintiffs. According to the court, to do otherwise "would allow the defendants to escape paying the full amount of plaintiffs' damages. The defendants are entitled to a setoff in the amount they paid to the plaintiffs' insurers to settle the subrogation claim. If that payment was less than the amount of the insurers' subrogation claim, the plaintiffs can retain the difference, and to that extent double recovery is permissible." *Id.* at 1306.

The holding in *Hayes Sight & Sound* is based on the notion that the tortfeasor should not pay less than the full amount of the damages he caused. But the result appears to be an outlier, as more courts address the issue as did the California Court of Appeal in *De Anza*.

Conclusion

The holding in *De Anza* that a defendant faced with both a plaintiff's tort action and a subrogation action brought by the plaintiff's insurer is entitled to offset any damages award by the full value of the subrogation claim — even if it pays less than full value for it — presents a tactical consideration for a defendant considering a settlement of an insurer's subrogation claim. Based on *De Anza*, by settling for less than the full value of that claim and then obtaining the subrogation claim by assignment, a defendant would leave open the possibility that it ultimately could pay less than the full amount of the plaintiff's loss. It could assert, as assignee of the insurer's subrogation claim, an offset of the full amount of that claim, even though it paid less to obtain the right to it. Of course, because subrogation is an equitable doctrine, a court may be reluctant to award this benefit to the defendant, even though it is being asserted by the defendant as assignee of the insurer's subrogation claim, not as tortfeasor. Nevertheless, *De Anza* presents a possible strategy for defendants to consider.

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The New Jersey Supreme Court has twice examined whether a private cause of action should be permitted with respect to unfair claims settlement practices under § 17:29B-4, with differing results. The court first considered the issue in the context of a third-party claim. *Rova Farms, supra*. In *Rova Farms*, the court found that, "an insurer, having contractually restricted the independent negotiating power of its insured, has a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy limits and ultimately allowed the plaintiff policy holder to bring a bad faith claim against its insurer for its failure to settle within the policy limits. *Id.* at 479, 496. Nearly 20 years later, the court reached the opposite conclusion with respect to a first-party claim. *Pickett v. Lloyd's*, 131 N.J. 457, 466 (1993). Interestingly, in *Picket*, the court found that while an insurer owes a duty of good faith to its insured in processing a first-party claim, the regulatory framework set forth in § 17:29B-4 does not permit a private right of action.

Bill S-2460 now seeks to codify the *Rova Farms* decision and expand the reach of § 17-29B-4. Specifically, if enacted, Bill S-2460 will allow an insured, regardless of any action by the Commissioner of Banking and Insurance, to file a civil action against its insurer for any violation of the provisions of subsection (9) of N.J.S.A. 17:29B-4, notwithstanding that the insurer did not violate any applicable provision with enough frequency as to indicate a general business practice. It will allow an insured to recover the full amount of damages set forth in the final judgment, as well as prejudgment interest, reasonable attorney's fees, and punitive damages, if he/she can prove actual malice or wanton and willful disregard.

Bill S-2460 was introduced in the New Jersey Senate and referred to the Senate Commerce Committee on Jan. 8, 2013. An identical bill, A3710, was introduced in the Assembly, on Jan. 28, 2013 and was referred to the Assembly Financial Institutions and Insurance Committee. If enacted, this legislation will take effect immediately and apply retroactively to all claims filed on or after Oct. 1, 2012 (the month Superstorm Sandy hit).

In contrast to the tri-state area, Florida has not experienced a significant weather event for a number of years.

Florida: House Bill 813

On March 15, 2013, House Bill 813, "An Act Relating to Civil Remedies Against Insurers," was introduced in the Florida House of Representatives. If enacted, it would have provided great clarity to the existing, but indefinite, bad faith law of Florida. In contrast to the tri-state area, Florida has not experienced a significant weather event for a number of years. Nonetheless, more storms hit Florida than any other U.S. state. Indeed, since 2004, multiple major hurricanes have made landfall, including Hurricane Charley (2004), the strongest since Hurricane Andrew in 1992. Other major hurricanes to hit landfall during that period include Hurricanes Jeanne, Dennis, Wilma, Ivan, and of course Katrina. Thus, while House Bill 813 was not necessarily introduced in reaction to a particular storm, it undoubtedly would have had a major impact in the aftermath of the next storm to inevitably hit.

Like many jurisdictions, Florida currently imposes a common law duty of good faith on insurers when negotiating a third-party claim on behalf of their insureds. As explained by the Florida Supreme Court, in the seminal case of *Auto Mut. Indem. Co. v. Shaw*, 134 Fla. 815, 830-31 (1938), the relationship between an insurer and insured "imposes upon the insurer the duty, not under the terms of the contract strictly speaking, but because of and flowing from it, to act honestly and in good faith toward the insured." 134 Fla. at 830-31. Thus, in the context of third-party claims, it is well established under Florida common law that an insurer is held to "that degree of care and diligence which a man of ordinary care and prudence should exercise in the management of his own business" and must exercise good faith. *Id.* at 830.

In order to determine if an insurer breached the duty of good faith, Florida courts look to the "totality of the circumstances." One common consideration is the amount of time it took for the insurer to investigate the claim and determine whether settlement would be appropriate. This case-by-case approach has led to inconsistent rulings. For example, one Florida court has found that an issue of fact arises as to whether an insurer acted in bad faith in delaying settlement negotiations, when the insurer waited two months to tender its policy limits; while another Florida court found that the dismissal of a bad faith claim was proper where the settlement demand gave a 10-day window in which to accept the settlement. *See Goheagan v. American Vehicle Ins. Co.*, 107 So.3d 433, 439 (Fla. 4th DCA 2012); *and also DeLaune v. Liberty Mut. Ins. Co.*, 314 So.2d 601, 603 (Fla. 4th DCA 1975).

Further complicating matters is the fact that Florida Statute § 624.155 recognizes a statutory claim for bad faith by both first and third-party claimants. Specifically, § 624.155 provides that any person may bring a civil action against an insurer who has: 1) failed to attempt in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests; 2) made claims payments without a statement setting forth the coverage under which payments are being made; and/or

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CASE BRIEFS

Insurer May Disclaim Coverage Years After Commencement of Underlying Litigation

According to a recent decision by the New York Supreme Court, Appellate Division, an insurer is not necessarily equitably estopped from disclaiming coverage to an insured — even years after the commencement of underlying litigation — so long as the insured was not prejudiced by the delay. In *206-208 Main Street Associates, Inc. v. Arch Insurance Company*, 2013 WL 1831452 (N.Y. App. Div. May 2, 2013), the plaintiff, doing business as Sutphin Blvd., LLC ("Sutphin"), hired H&H Builders, Inc. ("H&H") to act as construction manager on a project to construct an office and retail building. H&H procured a CGL insurance policy from defendant Arch naming Sutphin as an additional insured.

During construction, on Aug. 30, 2007, the foundation of a building adjacent to the construction cracked, causing it to collapse and damage surrounding buildings. H&H notified Arch within several days of the incident. H&H was subsequently named in at least four actions beginning in October 2007, including one commenced by Sutphin that alleged the incident was caused by, among other things, "excavation work, underpinning [and] soil testing … [that was] negligent." *Id.* at *1. Arch retained a law firm to defend H&H in each of the actions.

More than two years later, Arch informed H&H for the first time that the incident might fall within a so-called "Earth Movement Exclusion" in the policy for bodily injury and/or property damage "arising out of the subsidence, falling away, caving in, or other movement of earth." *Id.* Arch reserved its right to disclaim coverage based on this exclusion, but confirmed that it would continue to provide H&H with a defense.

Sutphin then commenced a declaratory judgment action against Arch and H&H, seeking a declaration of its entitlement to coverage in the underlying lawsuits as an additional insured under the Arch policy. H&H likewise asserted cross-claims against Arch, claiming that it was also covered under the policy. On motions for summary judgment, the trial court held that "after two years of assuming a defense" Arch was equitably estopped from disclaiming coverage under the Earth Movement Exclusion. *Id.* at *2.

On appeal, the New York Supreme Court, Appellate Division, reversed and held that under New York law, although Arch waited more than two years to reserve its right to disclaim coverage based on the Earth Movement Exclusion, it was not necessarily equitably estopped from disclaiming because neither Sutphin nor H&H were prejudiced by the delay. In particular, the court noted that in the cases relied upon by Sutphin and H&H in which prejudice was found, the insurer had controlled the defense through settlement or trial. Here, by contrast, and by Sutphin's own admission, the underlying litigation was still in its "early phase." *Id.* at *4. Accordingly, the court held that Sutphin and H&H failed to establish that they were prejudiced as a matter of New York law. The court also noted that while other means of prejudice may exist in some cases, such as manipulation of the defense, there was not even a suggestion that had taken place here.

In the end, the court held that Sutphin and H&H had failed to shift their burden on the motions and, accordingly, whether Arch should be equitably estopped from disclaiming coverage (if it decided to do so) was therefore left to the trier of fact. As a consequence, the court's holding shows that, under New York law, an insurer will not necessarily be prevented from disclaiming coverage even if it takes years to reserve its rights to do so. Rather, the focus of any claim of estoppel will be on whether and to what extent an insured was prejudiced by the delay.

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Daren S. McNally, a managing partner, and **Matthew I. Gennaro**, senior counsel, in the New Jersey office of Clyde & Co US LLP contributed this month's Case Brief. McNally, a member of this newsletter's Board of Editors, maintains a practice that is focused on insurance coverage litigation and counseling, with an emphasis in complex insurance and reinsurance litigation, trials and arbitrations in both domestic and foreign arenas. Gennaro focuses his practice in the areas of insurance coverage law and litigation.

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3) failed to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Under § 624.155, however, a claimant must give the insurer 60 days written notice of the violation, prior to filing suit. During that 60-day period, the insurer may pay the damages or correct the circumstances giving rise to the violation and avoid suit. Since first-party bad faith claims exist only by way of statute, a first-party cause of action simply does not exist until the 60-day period expires. Third-party bad faith claims, on the other hand, exist by way of statute and common law; thus, under current Florida law, an insurer cannot guarantee that a third-party bad faith claim will not be initiated during the 60-day period.

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Movers & Shakers

Thompson, Coe, Cousins & Irons, LLP has partnered with **Frances O'Meara** to form **Thompson Coe & O'Meara, LLP** to practice law in California.

The eight trial attorneys who make up this office bring with them experience in practice areas including: insurance coverage, bad faith, professional liability, labor and employment, and business and commercial litigation, among others. O'Meara will be the managing partner. She has defended professionals in California for more than 25 years and is certified by the California State Bar as a Legal Malpractice Specialist.

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The proposed legislation, HB 813, endeavored to rectify some of the inconsistencies outlined above. Specifically, it set forth a clear time period within which an insured and insurer must take certain steps. Namely, HB 813 amends § 624.155 such that, if it had passed, an insured or claimant asserting a cause of action for bad faith — whether based in statute or common law — must provide a written notice of loss to the insurer. Further, if the claimant communicates to the insurer by means other than written notice, within 72 hours of the communication, the insurer must request that the claimant put the communication in writing. If the insurer timely provides a disclosure statement already required under law and offers to pay the claimant the lesser of the amount the claimant is willing to accept or the policy's liability limit within 45 days, in exchange for a full release from liability, then the insurer is not liable for bad faith.

The proposed legislation also provided that common law third-party actions for bad faith are subject to the same requirements as a statutory claim of bad faith. Thus, first-party and third-party bad faith claimants would both be required to provide 60 days' written notice of the alleged violations before filing suit.

If enacted, the HB 813 would have taken effect on July 1, 2013. Unfortunately, however, in early May, HB 813 died in the House Judiciary Committee. At this stage, we can only guess at the reasons why the bill died. Given the muddled state of Florida's bad faith law, it is hard to imagine that it was due to any defects in or squabble over its language. Lack of interest? Maybe. As noted above, the weather has been relatively calm in Florida for the last few years. If waning interest was the cause, it's probably safe to assume that the form and substance of HB 813 will reappear in the wake of Florida's next major weather event. Indeed, the spark may be reignited even sooner, as claims continue to pour in from the intense May storm season that pummeled the Midwest.

Conclusion

The legislation discussed above demonstrates that in the wake of the extreme weather plaguing the United States over the last few years, state legislatures, particularly on the Eastern Seaboard, are beginning to take a harder look at their bad faith laws. Indeed, if passed, the legislation of New York and New Jersey alone will have far-reaching impacts on insurers, policyholders and third-party claimants alike.

While the legislation proposed in Florida sought to provide a necessary limit on bad faith liability, the proposed bills in New York and New Jersey seek to do just the opposite. In fact, they both greatly expand the consumer's ability to pursue claims of bad faith and to collect punitive damages and attorney's fees. Luckily, the New York legislation limits the proposed private cause of action to claims arising from a declared state of emergency. However, if the extreme weather continues, that limitation may be somewhat illusory. The New Jersey bill, on the other hand, sweeps broadly on its face, providing consumers with a private cause of action under any circumstance. It can be expected that if the New York and New Jersey bills pass, insurers operating in those states will be exposed to more frequent, costly and protracted litigation. In states like Connecticut, where a private cause of action for bad faith is well established, plaintiffs routinely allege claims of common law and statutory bad faith, regardless of whether they are viable. Indeed, it now appears to be the standard practice of the plaintiffs' bar to add a claim(s) of bad faith to any complaint asserting breach of contract against an insurer. Thus, it will probably not take long before policyholders in New York and New Jersey follow suit.

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