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# Taxpayers Against Insurance Bad Faith

## *Why Small Businesses Need Their Traditional Remedy Against Bad Faith*

# *Common Questions About Third-Party Bad Faith*

**1. What is "insurance bad faith"?**
Insurance bad faith is the insurer's failure to settle a claim made by a third-party against its customer when, under all the circumstances, it could and should have done so, had it acted fairly, honestly, and with due regard for the interests of its customer. *See* Fla. Std. J. Instr. (Civ.) 404.4.

**2. Why does Florida law recognize a remedy for insurance bad faith?**
Florida liability insurance policies give near absolute power to the insurance companies. When a claim is made against an insurance customer, these policies require the customer to give complete control over all investigation and negotiation of the claim to the insurance company. The insurance company also has the total power to decide whether to settle the claim or risk going to court.

In exchange for this relinquishment of control, the insurer must act in good faith in its investigation, evaluation, negotiation and attempted settlement of liability claims brought against its insured. If an insurance company fails to honor its "fiduciary duty" of good faith, the customer has the right under the traditional common law to hold the insurance company accountable for the harm its bad faith caused its customer.

**3. Can the insured customer just settle the claim on their own?**
Not without risking losing their insurance coverage. Liability policies prohibit it.

**4. Are common law bad faith claims based on a recent Florida Supreme Court decision?**
No. Traditional Florida law, holding insurers accountable for bad faith handling of third-party claims, has been essentially unchanged since 1938. *Auto Mut. Indemn. Co. v. Shaw*, 184 So. 582 (Fla. 1938).

**5. Why do small businesses need their traditional remedy against insurance bad faith?**
Most small businesses go year after year with no major claims ever being made against them. In those years, the insurance company just keeps the premium and adds it to its bottom-line profit. However, even the most careful person or small business can, sooner or later, end up with a major claim against them by a third party.

When facing a claim with significant damages, the insurance customer may face excess liability that can expose even a successful business to bankruptcy and liquidation or cause a successful individual to lose the retirement nest egg he may have accumulated over a lifetime of work. When a small business fails, the economy suffers not only the lost value of the affected business but also the lost income to every employee of the business and the vendors and suppliers they support.

Florida's common law bad faith remedy incentivizes insurance companies to do their job and make reasonable efforts to protect their customers from personal liability. If a liability insurer fails to settle a liability claim in bad faith, it must pay the damages caused by that failure. In most cases, that means the insurer would be responsible for paying the amount of the judgment entered against its customer which exceeds the amount the insurer could have settled the case for earlier – saving the customer from financial ruin.

**6. Is there any need to modify the traditional common law bad faith remedy?**
Absolutely not. For the last 85 years, our bad faith laws have provided a beneficial effect of inducing prompt and fair settlement of claims instead of gambling with the assets and credit of the very customers whose premiums support the company. During all that time, there has been a robust and competitive market for general liability and auto liability insurance in Florida.

There is no justification for taking away the traditional rights small businesses have, and need, against insurance companies who commit bad faith when they are supposed to be protecting their customers. Changes being proposed benefit only liability insurance companies and put at terrible risk the customers who pay the premiums in exchange for a promise of protection from claims.

Small businesses and financially successful individuals particularly, who may have accumulated a nest egg of savings over a lifetime of work, would be especially hurt by any such changes that would put their assets and credit at risk, instead of protecting them, as insurance should.

**7. What is an "excess judgment"?**
An "excess judgment" is a judgment against an insured for more than the availability liability insurance. When a person is catastrophically injured, they have the right to obtain a judgment for all their damages, including earnings losses, medical expenses, and other losses. A person's claim against the individual or small business that is responsible is not limited to the amount of liability insurance purchased by the responsible business. When the value of a claim is greater than the policy limits of the at-fault party's liability insurance, it creates an excess exposure. That can become an excess judgment if the insurance company does not protect its customer by settling the claim.

**8. Do insurance bad faith claims increase premiums?**
No. Payments made to pay bad faith claims against liability insurers cannot be considered in their ratemaking. *See* §§ 627.0651(12) and 627.062(7), Fla. Stat.

**9. What is the difference between "third-party" claims and "first-party" claims?**
*Third-party claims* arise out of liability coverage, which protects the insurance customer from claims made by a third party. The liability insurer owes the customer fiduciary duties. Its sole job is to attempt to protect the customer from a judgment for more than the liability insurance policy limits.

*First-party claims* arise out of a first-party coverage (i.e., uninsured motorist benefits, property insurance on one's home or business, life insurance, health insurance, etc.). The customer is seeking to recover insurance benefits from the insurer. The relationship between the customer and insurer is adversarial in nature.

**10. Does Florida common law recognize a cause of action for bad faith failure to settle a *first-party* claim?**
No. The courts refused to recognize a claim for first-party bad faith because the insurer's action can never result in a judgment *against* the insured, and thus insurers do not owe their insureds a fiduciary duty to settle a first-party claim. However, there is a *statutory* duty of good faith that applies in first-party claims under section 624.155, Florida Statutes.

**11. What is statutory bad faith?**
In 1982, the legislature perceived the benefits that common law bad faith had brought to the handling of *third-party* claims (where the customer is the target of a claim) and passed a statute requiring insurance companies to act in good faith when handling *first-party* claims (where the customer is seeking benefits for himself). *See* § 624.155, Fla. Stat.

**12. Insurers get special "safe harbors" in *first-party* claims. Should they get a safe harbor for *third-party* claims too?**
Absolutely not! Since statutory bad faith was designed principally for *first-party claims*, it provides for an additional 60-day grace period for companies who have acted in bad faith. This time period runs after a Civil Remedy Notice of Insurer Violation ("CRN") is served. If the insurer unconditionally tenders the policy limits within the 60 days, it "cures" the alleged bad faith and the first-party claim is concluded.

But granting insurers "safe harbors" for *third-party claims* makes no sense. The insurance company that committed bad faith could take advantage of the extra grace period (whether its 45, 60, or 90 days) to protect *itself*, but the tender of the money does not automatically protect the insured customer. The injured claimant may not be willing to settle for the policy limits. The customer is left exposed and required to pay an entire excess judgment from their business assets or personal nest egg. Meanwhile, the insurer would be immune from any bad faith claim, even if the insurer failed to settle the liability claim in bad faith and caused the judgment to be entered against the insured.

**13. Is it true that sometimes insurance companies with small policy limits must pay very large amounts in bad faith cases?**
Yes, that can happen, but only if the insurance company acts in bad faith when it has a small policy limit and the claim against its customer is also very large. Those cases are the ones that an insurance company clearly needs to settle, rather than putting its customer at terrible risk.

**14. Does bad faith law require an insurance company to settle every claim, regardless of merit?**
Of course not. The insurer can consider the evidence showing who was at fault and the evidence concerning the amount of damages sustained. Claims that are not legitimate need not and should not be paid. Only if, under all the circumstances, a reasonable person standing in the shoes of the insurance customer would settle the claim, does the insurance company had an obligation to do so.

**15. Can an insurance company be sued for negligently failing to settle a third-party claim?**
No. Surprisingly, insurance companies already enjoy special protection, much more than ordinary people and small business. Unlike ordinary businesses, insurance companies can only be held responsible for failing to settle if they act in BAD FAITH. Insurance companies already have immunity for negligent failures to do their job. *See DeLaune v. Liberty Mutual Ins. Co.*, 314 So. 2d 601 (Fla. 4th DCA 1975). That is why it is so unjustified to further diminish insurance companies' responsibility for the financial harm caused to their customers when they act in bad faith. Of note, unlike Florida, 22 states do allow insurance customers to sue their liability insurer for negligent failure to settle.

**16. Are claimants required to make a settlement offer?**
No. An injured person could theoretically file a lawsuit against the policyholder the day after the injury. The injured person is legally entitled to a jury trial and, after a successful verdict, a judgment in their favor. They are not required to ever make any offer to resolve their case.

Sometimes, though, an injured person will offer to settle the entire claim against the small business for a dramatic discount, even down to the policy limit, in order to avoid the risk, delay, and expense of litigation. That settlement offer, made to the insurance company that controls whether to accept it, represents a tremendous opportunity for the small business whose future is at stake. Often it is, literally, a last-chance opportunity to save an entire business.

**17. When claimants do offer to settle, what are the terms of their offer?**
That is completely up to the claimant. For centuries, it has been the law that the person making the offer is the "master of the offer," meaning that they have the power to determine the time, place, and manner in which the offer may be accepted.

These settlement offers will usually have time limits and may require elements such as affidavits, insurance verifications, or specific terms for the release. As with any other contract offer, if these terms of the offer are met, there is an enforceable settlement agreement. If the terms are not met, that opportunity to settle may be lost, perhaps forever. The injured party will instead continue their claim against the small business, obtain a judgment for the full amount of the claim, and enforce it against the assets of the business or individual insurance customer.

**18. Are insurance companies required to affirmatively initiate settlement negotiations?**
Only if liability is clearly adverse to the insured and the damages are so serious that a judgment in excess of the policy limits is likely. If that is not the situation, insurance companies can sit back and wait for the injured claimant to make a settlement offer before they have an obligation to settle.

**19. What if multiple claimants make a claim against the same insured?**
The insurance company is supposed to try to settle all the claims first. But if that's not possible, the insurer is just supposed to act reasonably to try to minimize the insured's exposure. That does not mean the insurance company acts in bad faith just because it cannot settle all claims within the policy limits. An insurer can settle one claim to the exclusion of others so long as it is acting reasonably to protect the insured.

**20. What if multiple insureds may be liable for the same loss?**
The insurance company is supposed to try to settle the claim against all insureds first. But if that's not possible, the insurer may, after consultation with the insureds, settle the claims against certain insureds to the exclusion of others.

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# *Granting Insurers Special Immunities In Third-Party Claims Puts Small Businesses At Risk Of Financial Ruin*

## I. Understanding Florida's common law remedy for third-party bad faith.

First, it is critical that people understand what is a THIRD-PARTY case. It is *not* about who brings the insurance bad faith lawsuit. It *is* about the type of coverage from which the claim arises.

Most third-party cases are brought by the insured – not the claimant. But it is still called a third-party bad faith case only because it arises from a third party's claim against the insured. These claims arise only from liability insurance claims.

A FIRST-PARTY bad faith case is one that is purely a dispute between an insurance company and their customer. The customer has a claim that the insurer didn't pay. Examples are fire loss claims, life insurance claims, storm damage claims, and so on. The first-party claim that arises in the personal injury context is an uninsured/underinsured motorists ("UM") claim. The insured is injured by a person who has inadequate insurance and brings a claim against his own UM carrier. If the carrier refuses to pay without justification, that can result in a first-party bad faith claim.

THIRD PARTY claims – where an insurer fails to settle a claim brought by a third party against its insured resulting in an excess judgment – are not statutory. They were created by the Florida Supreme Court in *Auto Mutual Indemnity Co. v. Shaw*, 184 So. 852 (Fla. 1938). Laws made by the courts are called "common law" remedies, and third-party bad faith is "common law bad faith."

The courts have always declined to create common law FIRST-PARTY claims, reasoning that an insured (who is bringing a claim against his insurer for first-party benefits) is always in an adversarial relationship with his insurer. But the Legislature created *statutory* bad faith for first-party claims in 1982, when it passed section 624.155. (Technically the claimant has the *option* of bringing a statutory third-party claim, but there is no reason to mess with that, so virtually nobody does. UM bad faith is statutory, and third-party bad faith is common law, in real life).

## II. Although statutory "cure periods" make sense for *first-party* cases, they make no sense for *third-party* cases.

A Civil Remedy Notice of Insurer Violation ("CRN") makes sense in a first-party bad faith setting. A CRN is a condition precedent to a STATUTORY bad faith claim. It can only be served AFTER the insurer has committed bad faith. The insured who thinks the insurer has not treated him fairly has to identify the acts of bad faith, and the people responsible.

The notice is filed on a website maintained by the Department of Financial Services.

Once the CRN is properly served, the carrier has 60 days to "cure" its bad faith. Importantly, *all it has to do* to cure is to pay its policy limits during that 60-day period. No matter what other damages the insured has suffered because of the delay or other bad faith, if the carrier pays its limits, that's the end of it.

And that makes sense for first-party cases. What damages, really, can the insured suffer due to that delay? Some interest? Some attorneys' fees, maybe? Most times it is just de minimis, so if you can get the limits paid just by waiting an additional 60 days, it is worth it. The system works well.

**However, granting the insurer some kind of special "get-out-of-jail free" card for THIRD-PARTY cases makes no sense.** If an insured kills a kid on a bicycle, his exposure is in the millions, and is certainly not limited by his policy limits. The claimant has the option of ignoring settlement negotiations and can file suit the day after the accident if they want to.

Particularly when the defendant is an affluent individual, or is a business that has significant assets, the claimant may not be particularly interested in limiting their claim to policy limits of $300k, $500k or even $1 million. Why should they? If they get a judgment for $3-4 million, they can collect the insurance limits *and* levy on the insureds assets to collect the balance. So, it is not like they must choose between the two.

Fortunately for many businesses, most (but not all) people who have suffered a bad loss are not really interested in jumping into years of litigation – they much prefer a quick settlement. Also, some lawyers are more interested in a quick settlement for easy cash, instead of having to sweat out years of work, while advancing hundreds of thousands of dollars to pursue full value.

In these cases, *as a matter of grace*, the plaintiff may offer to take policy limits. When that happens, the insured customer who has exposed assets can see light at the end their long, dark tunnel. However, the insured's fate remains utterly and entirely in the hands of his insurer, because under the contract the insured *cannot* get involved in negotiations or settlement of a case, except as controlled and directed by the insurer.

Any offer to settle a claim for a fraction of its value will usually come with conditions, such as affidavits from the insured designed to ensure that the insurance limits are in fact what they have been represented to be, etc. These conditions are essentially the due diligence anyone would expect before taking a fraction of the value of their claim. The liability insurance company who has taken control over the claim has a duty to advise the insured of these conditions and assist in meeting them. Settlement offers also generally have a deadline for payment associated with them, and the courts have held this must be longer than 10 days to be considered reasonable.

If an insurance company has a fair opportunity to settle a claim against their insured, when under all the circumstances they should do so if acting fairly and honestly toward the insured and with due regard for his interests, and the insurer UNJUSTIFIABLY FAILS to do so, that is bad faith.

The claimant *may* decide to forgive the failure, and everyone dodges the bullet. However, for any number of reasons, sometimes including nothing more than a simple change of heart, the plaintiff can decide that their forgiveness account is overdrawn – they file suit, march to verdict and get a crushing judgment against the insured. Once judgment is entered, they can levy on the business or personal assets, costing the insured millions of dollars that could have been avoided

had the insurance company settled the claim in good faith. That is the absolute right of the parent whose child was killed in the accident, and nobody should ever fault them for that decision.

In that situation, the failure of the insurer to settle when it should have constitutes bad faith. Florida law, since 1938, has created a remedy in favor of the customer in such situations, and it has worked extremely well. We have weeded out most of the bad actor insurance companies, while still having an incredibly robust auto and liability coverage market.

The insurance companies have been paid, in advance, to investigate, evaluate, negotiate and settle claims against their insureds if it is possible to do so. Therefore, the insurer owes a duty of good faith to the insured in the exercise of that power over the claim and the insured's financial well-being. If the customer who is saddled with an excess judgment can prove that the insurer "failed to settle a claim against its insured when it could and should have done so had it acted fairly and honestly and with due regard for the insureds interests," the insurer is required to pay the judgment, in order to return the insured to the status where it would have been had the claim been settled.

CS/HB 837 and SB 236 say there can be no bad faith in THIRD-PARTY CLAIMS if the insurance company tenders its policy limits within 90 days after the lawsuit is filed. That means that all the insurance company would have to do is pay its policy limits, belatedly, and it would be immune from bad faith.

HB 837/SB 236 (as originally filed) says there can be no bad faith in THIRD-PARTY CLAIMS unless a CRN is filed and the carrier is given 60 days to "cure" its bad faith. During that time all it will have to do is pay its policy limits, belatedly.

If the insurance company is immune from any pre-suit bad faith failure to settle, then the insurance company will have no incentive to EVER tender the policy limits before a lawsuit. As a result, injured claimants will be forced to hire a lawyer in virtually every case. The lawyer, knowing that the insurance company has no incentive to make their "best offer" before a lawsuit is filed, will file suit immediately instead of trying to resolve the case without litigation.

The whole purpose of liability coverage is to protect the insureds from a lawsuit. These bills do the opposite – **they encourage MORE LAWSUITS to be filed against the policyholders.**

Likewise, advocates of tort reform say it is necessary to reduce litigation. But if these bills pass, there will be *tens of thousands* of additional personal injury lawsuits filed each year.

When the insurance company tenders the policy limits on 89th day after suit is filed, there is NO obligation on the claimant to accept the limits at that point. None. The ONLY person who gets benefit from this get-out-of-jail free card is the insurance company who already committed bad faith.

There is NO obligation on the claimant to accept the limits at that point. None. The ONLY person who gets benefit from this get out of jail free card is the insurance company who committed bad faith.

The carrier will cure by belatedly tendering the policy limits, and the claimant who has had a change of heart can now just say no. Or perhaps the claimant is still conditioning settlement on some reasonable non-monetary condition (i.e., an affidavit verifying the amount of insurance coverage), which the insurance company unreasonably refuses to perform. Either way, the case continues to a crushing excess verdict and judgment, and the insured's assets will be levied on, forcing it to

lose millions of dollars because of the insurance company's earlier bad faith failure to settle. But because of the special immunity, and the company's belated, meaningless tender, the insured has NO remedy for all these losses.

**This does NOT HELP ANY BUSINESS IN THE STATE – except, of course, the insurance business.**

Also note that under existing common law, the insurer cannot be held responsible if they are only negligent. *DeLaune v. Liberty Mut. Ins. Co.*, 314 So. 2d 601 (Fla. 4th DCA 1975). Insurance is the only business in the state, other than ER doctors, who may be negligent, cause millions of dollars of harm, and get a complete pass from liability. AND THEY AREN'T SATISFIED?!?

**HB 837/SB 236 SEEKS TO PROTECT BIG INSURANCE AT THE EXPENSE OF SMALL BUSINESSES. STAND UP FOR POLICYHOLDER RIGHTS!**

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# *Personal Injury Lawyers' "Bad Faith" Conduct Should Not Eliminate Policyholder Rights*

**I. HB 837/SB 236's imposition of "good faith" duties on claimants and their attorneys would be DISASTROUS for small businesses and affluent individuals. They grant an immunity to insurers *who act in bad faith*, to the detriment of policyholders.**

The whole purpose of liability insurance is to protect the insurance customer from suffering a judgment for more than the policy limits. The policy requires insureds to surrender control over settlement negotiations to the insurance company and cooperate in the defense of any claim. In exchange, the insurance company must handle the claim in good faith. This is how Florida law has worked since 1938, and it has worked supremely well.

HB 837/SB 236 requires injured claimants and their lawyers to act in "good faith" in "furnishing information regarding the claim, in making demands of the insurer, in setting deadlines, and in attempting to settle the claim." But if they fail to act in good faith, that does not protect the policyholder. Rather, the claimant's lack of good faith *only* protects the insurance company without reducing the policyholder's liability. Confused? Consider the following example:

> *Main Street USA's delivery driver negligently causes a wreck, seriously injuring John. Main Street bought $1 million of liability insurance with Gecko Insurance, who refuses to settle John's claim. As a result, the case goes to trial and a jury awards John $5 million.*
>
> *Main Street then sues Gecko for bad faith. The jury in the bad faith case finds that Gecko acted in bad faith by failing to settle when it could and should have done so, had it been acting fairly and honestly toward Main Street and with due regard for Main Street's interests. Under current law, that means Gecko must pay Main Street's $5 million liability.*
>
> *However, assume Gecko argues John and his lawyers should have been nicer and more cooperative during settlement negotiations, and that Gecko's liability should be reduced by 25% as a result. Under HB 837/SB 236, that would mean Gecko only owes $3.75 million, but Main Street remains liable for the remaining $1.25 million. So, even though the insurance policy required Main Street to surrender all control over claim handling to Gecko and Gecko refused to settle John's claim, Main Street is still forced to declare bankruptcy.*

As the hypothetical demonstrates, HB 837/SB 236 does not protect policyholders from trial lawyers. It only protects insurance companies *from their customers* – the ones the insurance company is paid to protect. In other words, HB 837/SB 236 seeks to punish policyholders for the alleged bad acts of the trial lawyer who is suing them. This makes no sense.

## II. HB 837/SB 236 incentivizes the claimant *not to settle* with a policyholder who has significant assets.

Proponents of HB 837/SB 236 may argue the statutory duty of good faith will incentivize trial lawyers to work cooperatively with the insurance company and settle the claim against the policyholder. Maybe that is true when the policyholder is uncollectible. But that is certainly *not* the case when the policyholder is a small business or affluent individual who may have assets to satisfy an excess judgment.

HB 837/SB 236's broad language suggests the injured claimant must do the insurance company's job for it – i.e., gathering up all the medical records and other investigatory materials for the insurance company as a precondition to offering to settle. However, injured claimants frequently do not want to incur those expenses (often $1 per page for thousands of pages of documents), particularly if the policyholder's policy limits are insufficient to cover the losses. If claimants are deemed to act in "bad faith" by refusing to jump through all the insurance company's hoops, they are more likely to simply sue the small business or affluent individual rather than bother with pre-suit settlement negotiations.

The injured claimant is never *required* to offer to settle. The claimant may sue the policyholder and obtain a judgment against them without *ever* offering to settle the liability claim. The claimant does not have to choose between the insurance policy limits and the policyholder's personal assets. Claimants can, and frequently do, go after both.

Any offer to settle within the liability limits is a *gift* to the policyholder, particularly if the claimant's claim is worth significantly more than the policy limits. That is why Florida law requires the insurance company to act "diligently, and with the same haste and precision as if it were in the insured's shoes, work[ing] on the insured's behalf to avoid an excess judgment." *Harvey v. GEICO Gen. Ins. Co.*, 259 So. 3d 1, 7 (Fla. 2018).

Normally, the insurance company must do more than just tender the limits to settle the case against the policyholder. It is quite common for the claimant to condition settlement upon the insurance company gathering additional information, such as affidavits regarding insurance coverage, the policyholder's assets, and whether the negligent party was in the course and scope of their employment at the time of the accident.

The vast majority of the time, when the claimant's attorney imposes such conditions on settlement, he is simply doing his due diligence. In fact, the claimant's lawyer could be sued for malpractice if he settled the case without first confirming whether there are additional insurance policies or other sources of recovery.

However, HB 837/SB 236 will allow an insurance company to argue the claimant's attorney was acting in "bad faith" by making settlement offer with non-monetary conditions or imposing a deadline for acceptance. And if the insurance company is successful in that argument, it will have an immunity from the harm it caused by its bad faith failure to settle. Meanwhile, the policyholder remains on the hook for the entire judgment.

To recap, under current law, if the insurer fails to settle in bad faith, it is responsible for the damages caused by that failure (the excess judgment). Under HB 837/SB 236, the insurer can decrease its liability by blaming the injured claimant for not providing all the investigatory materials or having conditions on a settlement offer – all while leaving the insured customer exposed to any reduction in the insurer's liability. With these additional hurdles, why would the injured claimant even bother making a settlement offer to a small business or affluent individual? It is more trouble than it is worth.

## III. Liability insurers must protect their customers from trial lawyers – including the aggressive or tricky ones!

The injured claimant and their lawyer are adversarial with the policyholder in a liability claim. They owe the policyholder no duty at all.

That said, most claimant lawyers work cooperatively with insurance companies when trying to settle a claim. They would much prefer to achieve a quick settlement for their client than incur the time, expense and risk associated with litigation.

Other claimant attorneys are more aggressive. But the policyholder pays premiums for the liability insurers to protect them from lawyers of *all kinds* – not just the nice ones! The policyholder is completely reliant upon the insurance company to protect him from the trial lawyer. In most cases, if the policyholder takes steps to protect himself, he breaches the policy and loses his liability contract. So, liability insurers should be extra careful when dealing with an aggressive or tricky lawyer, to ensure their customer is protected.

Why, then, should the insurance company get to reduce its own liability for bad faith failure to settle simply because the claimant's attorney was aggressive or mean? That is what HB 837/SB 236 allows. The policyholder suffers the consequences simply because the insurance company would rather deal with "sheep" claimant attorneys rather than "wolves." Perhaps the insurance company should just do its job and make a good faith effort to protect the policyholder from sheep and wolves alike.

## IV. Florida law already protects insurers from attempted "set ups."

Liability insurers often accuse trial lawyers of attempting to "set up" a bad faith claim – i.e., making a settlement offer which is incapable of being accepted to create a claim for insurance bad faith. However, "an analysis of the relevant case law demonstrates that the courts have properly and consistently defeated attempts to allow 'set-up' bad faith claims which were premised on[:] 1) arbitrary and unrealistic time deadlines for acceptance imposed by claimants, and 2) settlement offers containing unreasonable terms that cannot be complied with (and will not be negotiated)." Rutledge R. Liles, "FLORIDA INSURANCE BAD FAITH LAW: PROTECTING BUSINESSES AND YOU," Florida Bar Journal Vol. 85, No. 3 (Mar. 2011), https://www.floridabar.org/the-florida-bar-journal/florida-insurance-bad-faith-law-protecting-businesses-and-you/.

To prevail in a bad faith claim, the insurance company must be presented with a realistic opportunity to settle the claim. Florida state and federal courts do not hesitate to throw out any attempted "set ups" for that very reason. *See, e.g., DeLaune v. Liberty Mut. Ins. Co.*, 314 So. 2d 601 (Fla. 4th DCA 1975) (noting a policy limits demand with a 10-day deadline was "totally unreasonable under these circumstances" and was a charade designed to "set-up" a bad faith suit); *Johnson v. Geico General Ins. Co.*, 318 Fed. Appx. 847 (11th Cir. 2009) (holding the insurer's offer to settle for policy limits within 33 days of the accident could not be bad faith, as a matter of law, resulting in summary judgment against the claimant on the bad faith claim).

And, even if the claimant's lawyer did attempt to "set up" a bad faith claim, under current law, their conduct is still relevant to the question of whether the insurer had a realistic opportunity to settle the case. *See, e.g., Barry v. GEICO Gen. Ins. Co.*, 938 So. 2d 613, 618 (Fla. 4th DCA 2006) ("The conduct of [the claimant] and her attorney would be relevant to the question of whether there was any realistic possibility of settlement").

As the above cases demonstrate, HB 837/SB 236's imposition of a duty to cooperate on the claimant and claimant's attorney is a solution in search of a problem.

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# *Liability Insurers Are Seeking License To Skirt Their Responsibilities When There Are Multiple Claimants*

## I. Current law just requires insurance companies to act "reasonably" to protect their insureds from the biggest exposure.

Multiple claimant cases are those rare, often terrible calamities where one act of negligence has injured, perhaps badly, more people than there are policy limits. For split limit policies (i.e., 100/300) if there are more claimants than there are split limits (3 in that example), then you have claimants competing for the same money. With a combined single limit policy (common in commercial settings), then any claim with more than one claimant is a multi-claimant case.

The types and combinations of injuries are infinite. Sometimes none of the claimants are catastrophically injured, but sometimes there can be several who are. Perhaps most typically, in serious cases at least, one or two claimants will have losses that stand out above the others, with injuries such as paralysis, brain injury, amputation or death.

In such situations, under current law, the obligations of the liability insurer are straightforward and have not changed since at least 1969. The carrier should use reasonable efforts to investigate all the claims, evaluate them, and then use the policy limits to attempt to blot out the most liability possible for the benefit of the insured. *See Liberty Mut. Ins. Co. v. Davis*, 412 F.2d 475 (5th Cir. 1969); *Farinas v. Florida Farm Bureau*, 850 So. 2d 555 (Fla. 4th DCA 2003).

Insurers are given wide discretion on making these decisions and cannot be sued for bad faith even if, through the exercise of reasoned judgment, some claimants end up with none of the insurance benefits.

If, for example, an insured with a $1 million-dollar combined single limit policy has caused a wreck that results in a spinal cord injury (valued at $15 million), a broken arm (valued at $60,000) and two whiplashes (valued at $20,000 each), and the spinal cord injury claimant offers to settle only if he receives the full $1 million dollar limit within 30 days, that offer should obviously be accepted. The insured will be fortunate to have only the manageable claims to settle from their own funds.

## II. HB 837/SB 236 would completely eviscerate the liability insurer's obligation to investigate and evaluate the most dangerous claim.

Under HB 837/SB 236, the liability insurer can wait for 90 days and do nothing at all. At that point, all the insurance company has to do is write a check to the clerk of the court, file suit against the injured people, and then transfer its work to a judge (who is paid by taxpayers), or an arbitrator, who will then create what they perceive to be a "pro-rata distribution" of the policy limits.

## III. Why this interpleader (or the arbitration equivalent) is a bad idea.

The fundamental flaw in this plan is that the claimants have the option to either participate in these processes or not, and are absolutely not required to accept the proposed "pro-rata" distribution of the policy limits. They have a Seventh Amendment right to a jury trial against the insured, and nothing in this bill can take that right away.

In fact, **nobody is assured of protection by these 'interpleader' proceedings other than the insurance company.**

Of course, if the insured is insolvent, the injured claimants may be likely to accept whatever they are offered. In those cases, the claims of some or perhaps all of the claimants will be resolved and the insured will obtain a release.

However, for the individuals and small businesses with net worths between $2 million to about $30 million (which are the main constituency the law of bad faith is designed to protect), the claimants have other options.

In the example listed above, the insurer can simply ignore the policy limits offer from the quadriplegic, who can then file suit for unlimited damages against the insured. Nothing in the 'interpleader' processes impairs that lawsuit or protects the insured from the consequences of a huge excess judgment against them.

Long before the 90-day period expires (during which the insurance company is literally required to do nothing), the opportunity to settle may be extended and lost forever because of inaction by the insurer. During those critical 90 days, the lawsuit against the insured can be filed and served, and well underway.

And yet, under HB 837/SB 236, the insurer would obtain absolute immunity for its failures simply by initiating the interpleader process.

## IV. HB 837/SB 236 allows liability insurers to abandon settlement efforts at the policyholders' greatest time of need.

Multiple claimant cases are the nightmare scenarios for small businesses. A single act of negligence has injured many people, the value of the claims exceed the limits of the business' insurance (even $10 million umbrellas are inadequate for some cases), and one or more of the claims may be catastrophic.

In such situations, the chances are high the insured will be required to pay *some* amount of money from its own pocket, even if the insurer does everything right. In these multi-claimant cases, more than in any other case, the insureds desperately need their insurance company to live up to their promises to investigate, evaluate and help settle the most liability possible, to *hopefully* keep the insureds excess exposure to a manageable level.

The insurance company's natural instinct, of course, is to do as little work as possible. Although it collected premiums in exchange for the promise of claim-handling expertise, insurers would rather pass their own work off to others whenever possible – particularly once it has decided it will tender its policy limits. After all, once the insurer has decided to pay *its own* money, it no longer really cares about protecting the insured from paying *their* money. The insurers just want out of the claim as quickly as possible, without incurring any additional expense. Maybe insurers will force the claimants to fight among themselves, or worst case they throw the work over to the courts to figure it out (since they are all paid by taxpayers).

That selfish instinct is controlled only by the threat of a bad faith claim against the insurer who shirks their responsibility to stand with their insureds, to help them evaluate and craft a means to settle as much of the liability as possible. This bill would gut that accountability, and leave Florida's small businesses and high net worth individuals to fend for themselves in the settlement process.

**Our Legislature should not deprive those businesses and individuals of the protection and expertise they paid for through their premium dollars.**

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# *The Elimination Of Section 627.428 Leaves Policyholders In Peril*

**I. Most policyholders will be unable to find representation when they are sued by their own insurance company. This is a recipe for insurer abuse!**

Liability insurers weaponize the civil justice system more than any other industry in America. They have teams of high-priced lawyers at 1,000+ lawyer firms who routinely file questionable or downright frivolous lawsuits *against their own customer* to avoid paying policy benefits or escape bad faith liability.

These lawsuits are called "declaratory judgment actions." Whenever the amount in dispute is more than $75,000 and the insurance company is domiciled in another state (as is most often the case), those lawsuits will be filed in federal court. *See* 28 U.S.C § 1332.

Federal court declaratory judgment actions often consume hundreds, if not thousands, of hours of attorney time. No lawyer would agree to handle such a case on a contingency fee because no money is at stake – the case just seeks a "declaration." That means attorneys will require an hourly fee.

Under section 627.428, if the policyholder wins the declaratory judgment action, their liability insurer must pay the policyholder's reasonable attorneys' fees. *See, e.g., Mercury Ins. Co. of Florida v. Cooper*, 919 So. 2d 491 (Fla. 3d DCA 2005).

That has been the law in Florida since 1893. *See* Ch. 4173, at 101, Laws of Fla. (1893); *Tillis v. Liverpool & London & Globe Ins. Co.*, 35 So. 171 (Fla. 1903).

HB 837/SB 236 seeks a wholesale repeal of section 627.428. Without it, it will be impossible for a policyholder to find competent representation unless they are willing and able to spend $250,000 in legal fees. This leaves policyholders exposed to insurance company abuses.

There is nothing preventing insurance companies from filing declaratory judgment actions against their policyholder in literally EVERY CASE. Most policyholders, without section 627.428, will be unable to find a lawyer to defend them and will get defaulted. This would enable insurance companies to not only escape bad faith liability, but also avoid paying out the liability coverage. The insurers could collect years of premiums and then file a declaratory judgment action to avoid paying out the coverage as soon as there is a loss.

**Bottom line – Repealing section 627.428 will allow Goliath to trample David.**

## II. Even if policyholders win the declaratory judgment action, they have no viable procedural mechanism to recover reasonable hourly attorney's fees from the insurer.

When a civil lawsuit is seeking to recover monetary damages, either side may serve a formal "offer of judgment" or "demand for judgment." *See* § 768.79, Fla. Stat. If a plaintiff's demand for judgment is not accepted and the plaintiff wins a judgment of at least 25% greater than the amount of the demand, the plaintiff is entitled to recover reasonable hourly attorneys' fees from the date of the demand. Likewise, if the defendant's offer of judgment is not accepted and the judgment against the defendant is at least 25% less than the amount of the offer, the defendant is entitled to recover reasonable hourly attorneys' fees form the date of the offer.

However, the offer of judgment/demand for judgment statute does not apply to declaratory judgment actions. *See Diamond Aircraft Indus., Inc. v. Horowitch*, 107 So. 3d 362 (Fla. 2013). Thus, there is no procedural mechanism for a prevailing policyholder to force their liability insurer to pay the policyholder's attorney's fees for filing a meritless declaratory judgment action.

## III. Insurers do not provide the policyholder with a lawyer to defend declaratory judgment actions.

Every liability policy requires the insurance company to provide a lawyer to defend the policyholder from a lawsuit brought by a third-party that pleads a covered claim.

However, in declaratory judgment actions, it is not an injured third-party suing the policyholder. Rather, it is the insurance company suing its OWN policyholder.

Of course, insurance companies do not provide the policyholder with a lawyer to defend them from the lawsuit filed by the insurance company. That is why section 627.428 exists – to ensure the policyholder can find competent representation if they are sued by a liability insurer.

Without it, there is nothing preventing insurance companies from trampling the rights of their policyholders in every single case.

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# *Some Liability Insurers Act In Bad Faith As A General Business Practice*

## I. Many liability insurance companies have secret business practices that place systematic pressure on people within the claim department to pay as little as possible on all liability claims.

By way of example, one major insurance company implemented "Average Loss Payments" ("ALP") metrics when evaluating the claim department's performance. ALP (which is sometimes referred to as "average severities" or "average claim payments") is the average of the insurance policy proceeds paid by the insurance company to settle liability claims made against its insureds within a certain time frame.

Every insurance company *tracks* ALP; it is an important factor to know for underwriting purposes. But using ALP when setting *performance targets* for the claims department and its personnel takes it one step further. Directors' and managers' raises, bonuses, and eligibility for promotion are often based, at least in part, on how low they can keep ALP. Sometimes, ALP is weighted more heavily (upwards of 30%) than any other metric in the annual performance evaluation. And to ensure they are meeting their annual targets, the directors and managers pressure (or require) the front-line insurance adjusters to make low-ball settlement offers across the board.

Insurance companies are *supposed* to evaluate a liability claim "from the perspective of a reasonable insured facing unlimited exposure." When settlement decisions are influenced by ALP targets, that is evidence of bad faith. *See Gonzalez v. GEICO Gen. Ins. Co.*, 2016 WL 2759130 (M.D. Fla. May 12, 2016); *Hines v. GEICO Indem. Co.*, 2016 WL 688050 (M.D. Fla. Feb. 19, 2016).

## II. Liability insurers force claims into litigation to try to decrease the average claim payments.

In the past decade, at least one insurance company was **intentionally provoking lawsuits against their insureds to attempt to decrease its ALP**.[1] As one former regional claim manager explained:

- The insurer should "hold the line" and refuse to settle whenever the insurer believed it had any "rational basis" for its valuation of the liability claim.
- Paying more on one claim "simply because an attorney asked for it" could "set the value of the next 100, 1,000, 5,000 claims" higher. So, even where the insurer's "evaluation" of a claim was only a "couple of grand" less than the claimant's settlement offer, the

insurer would force the injured claimant's attorney to file a lawsuit against the insured, without regard for the exposure its insured faced.

• The manager believed his unit of claim managers and adjusters should encourage more cases to go to trial to "send a very strong and clear message to the plaintiff's bar about [the insurer's] attitude and capabilities."

> This was an extreme disappointment for me because I firmly believe that for every time we take a case to trial, we send a very strong and clear message to the plaintiff's bar about our attitude and our capabilities. This, in and of itself, is a tremendous deterrent to filing new suits from those BI attorneys that may not be as aggressive as others, or to those that deep down know their demands/ expectations may be unreasonable. We will never know how many suits were not filed because of our known willingness and ability to try cases.

• The hope was that over the long run, the insurer's refusal to accept pre-suit settlement offers which the insurer deemed too high would have a "dampening effect" on increasing Average Loss Payments.

But when the insurer's strategy failed and the injured claimant refused to accept the insurer's low offer and elects to file a lawsuit against the policyholder instead, the insured is responsible for paying the excess judgment. **Insurance companies are using their policyholders as human shields to try to increase their profits.**

[1] *In most insurance bad faith cases, there is a restrictive "confidentiality agreement" which prohibits the insurance company's internal business policies, guidelines, performance reviews and claim-handling manuals from being disclosed to the public.* HOWEVER, *no such agreement prohibits the sharing of this information.*

### III. Insurance adjusters are trained to make lowball settlement offers.

This is how one insurance company taught their insurance adjusters to negotiate:

**"Question everything"**

> One theme throughout my talk today is to "question everything." Develop a healthy skepticism. Keep in mind no two negotiations are the same. What you did two weeks ago may not work today. How you handled yesterday's claimant may not necessarily apply to the one today.

**"Start negotiation with 'insultingly' low offers."**

> The second theme is to "think big." Now I do not mean to "think big" by giving away "big" money. What I do mean is that people should shoot for the moon on every deal to get the best situation from your side of the negotiation table. Strong positions, whether it means quoting an "outrageously" high price or making an "outrageously" low offer, in our situation that is the lower end of our authorized range. From our side of the table, I urge you to start negotiations with "insultingly" low offers.

**"Start at the 'bargain basement'."**

> Once again, if we view this as the seller/buyer transaction you are the buyer. Thus, always start low. I have touched on this before. Do not be afraid they will not like you when you make an outrageously or insultingly low offer. Remember this is the low end of your authorization range. You can never go back down unless there is a drastic change of circumstances. You only go in one direction that is up. So start at the bargain basement.

### IV. What's wrong with the insurance company being aggressive and offering less than the claimant requests?

Nothing, so long as the exposure to the insured person does not exceed the liability policy limits. But when the claim presents an exposure greater than the policy limits (meaning that the policyholder may owe money out of their own pocket), the insurer is gambling with its insured's livelihood.

If the insurance company's aggressive strategy is successful, the insurer saves money. If the insurer's strategy is unsuccessful, the policyholder bears the consequences. Heads the insurer wins, tails the policyholder loses.

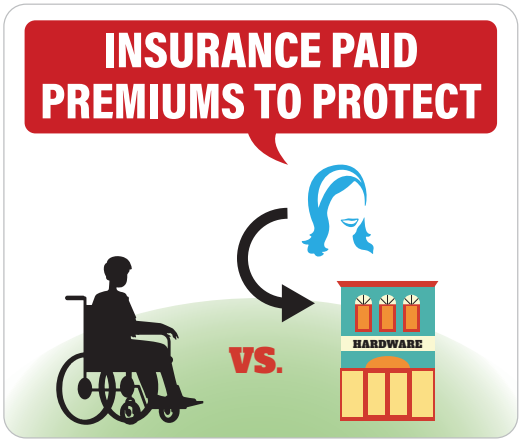
This is why the common law duty of good faith exists. Insurance companies are not allowed to put their own financial interests above their policyholder's interests. They owe a *fiduciary duty* to their insureds and are *supposed* to act reasonably to protect the insureds from an excess judgment.

# TAIBF

## First-Party Claim


60-DAY ADDITIONAL GRACE PERIOD AFTER BAD FAITH MAKES SENSE. THERE IS NO CLAIM AGAINST THE INSURED.

## Third-Party Claim


IMMUNITY AFTER BAD FAITH ONLY PROTECTS THE INSURER - NOT THE CUSTOMER!


## INSURERS SHOULD NEVER HAVE SPECIAL IMMUNITIES IN THIRD-PARTY CLAIMS

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