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What is Wrong With the Bad Faith Sections of CS/CS/HB 837

I. Section (4) creates immunity for insurers who offer their policy limits within 120 days.

a. Background

Liability insurance companies take complete control over a claim when it is reported to them. Unlike the older "indemnity" policies, a liability carrier has the exclusive right to control settlement decisions, choose the defense lawyer, and, generally speaking, to decide everything that gets done on the claim.

Because insurance companies have control over the financial future of their customer, the law requires them to handle claims in good faith toward the insured and with consideration for the insured's financial interests. This duty involves important elements IN ADDITION to the obligation to pay their limits, including:

1. Investigate – when a claim is reported, the insurer must work on figuring out whether the insured was at fault and generally who was injured as a result.

2. Evaluate – the insurer must use their expertise and experience to put a dollar value on the claims, as best they are able to, with the information they can gather.

3. Negotiate – if liability is clear against the insured and damages are clearly in excess of the available insurance coverage, the insurer must affirmatively reach out to the claimants to attempt to negotiate a settlement.

4. Communicate – the insured is entitled to know the likelihood of an excess judgment, the settlement offers made by the claimants, and the steps the insured needs to take to avoid the excess judgment.

5. Settle – this means obtain the release for the insured. In big cases, this often requires more than just writing a check. The claimant will want to do their due diligence, and since the insured defendant is prohibited from being involved, it is up to the insurer to comply with conditions such as affidavits of no coverage, permitting inspection of the accident vehicle, arranging statements of the insured as to "course and scope" and the purpose of their trip, etc. Every case is different, and the insurer's obligation is only to do what would be reasonably required.

b. This Bill (Lines 291-301)

1. It removes ALL the duties from the liability insurer other than a duty to write its check within 120 days after receiving "sufficient evidence to support the amount of the claim." It is blind to whatever additional requirements may arise in a specific case, such as providing affidavits or communicating an offer to the insured. Even if a golden opportunity to settle a huge, horrible case was screwed up by the insurer on day 75-100, the insurer gets immunity if they later do nothing more than offer their limits. This ONLY protects the insurance company, not the insured.

2. Insurers will argue they NEVER got "sufficient evidence to support the amount of the claim" until months or years after the collision, perhaps even after excess verdict. And if that argument is successful, the carrier could refuse to settle, cause an excess judgment to be entered against the insured, and then be immune from the bad faith claim by its belated, meaningless tender of policy limits.

3. Perhaps most egregiously, the Bill nonsensically says that even if the insurance company does not tender within the 120 days, that is NOT bad faith and cannot be used as evidence in the bad faith case. So, the insurance company can refuse to settle in bad faith, but the jury doesn't get to consider it. Meaning the insurance company can NEVER be liable for acting in bad faith unless it is guilty of a second bad faith failure to settle occurring after the 120-day period.

c. Examples of how this Bill hurts small businesses:

Assume a small trucking company has a **$2 million policy**, but its employee hit a kid in a crosswalk, causing an **$8 million** loss.

Scenario 1: The kind family calls the insurer before they have a lawyer and offers to settle for the limits, if they can do it in 90 days.

The carrier ignores it, and the family gets a lawyer who explains that if they go to trial, they will get the policy limits PLUS all the non-exempt assets of the insured. The family rejects the late offer on day 120 and the insured business gets hit with a crushing $6 million excess.

Scenario 2: The insurance company investigates and quickly offers the money within 20 days.

The claimants hire a lawyer who writes to say "my clients are willing to settle but only if in the next 45 days you also provide us three things:

1. A statement of the insured as to the purpose of the trip their employee was on, in order to verify there are no other derivatively liable parties;

2. A sworn statement from the insured and the insurance company that the $2 million in coverage is in fact all the available coverage; and

3. A statement from the driver about whether the tree near the crosswalk obscured his vision or not, and access to the accident vehicle to determine if the accident-avoidance system was defective."

(These conditions will vary with every case, but generally you will always expect the lawyer to conduct due diligence to avoid later claims of malpractice against HIM).

The policyholder is eager to settle and would happily comply with all these conditions without delay, but the liability insurer just ignores the claimant and never even tells the policyholder.

The time expires and a lawsuit is filed resulting in a $6 million excess judgment, but the insured has NO REMEDY because the carrier offered within 120 days. The insurer is immune for its failure to communicate.

Scenario 3: The insurer offers its policy limit 20 days after the accident, but the plaintiff, having conducted asset investigation realizes that the insured has a substantial net worth. The lawyer for the plaintiff writes to say – we will not accept the $2 million policy limits, but we will settle if the insured kicks in an additional $500,000.

The policyholder, evaluating the situation, would happily pay $500,000 out of its own pocket to settle the case. But instead of communicating this to the policyholder, the carrier just ignores the opportunity to settle. When the insured is hit with the $6 million excess and later learns it could have avoided the claim for $500,000, it has NO REMEDY against its insurer for the failure to communicate. The insurer is immune because it offered its limits within 120 days.

II. Section (6) creates immunity for insurers who file an "interpleader action" within 90 days of receiving notice of competing claims.

a. Background

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.

These cases are where, instead of hitting a single kid, the employee has hit a car with FOUR people, and there are serious injuries that total far more than available coverage. This expertise is never needed more than in these nightmare cases that, while they happen rarely, can be absolutely devastating if the carrier fails to do its job.

The carrier's obligation in multi-claimant cases now is very much common sense. Its obligation is to investigate and evaluate all claims and then thoughtfully use the policy limits to extinguish as much of the insureds liability as it can. Recognizing this is often easier said than done, the carrier is given extreme latitude to use its best judgment and can't be criticized based on those judgment calls.

b. This Bill (lines 322-338)

CS/CS/HB 837 gives immunity to an insurer who within 90 days of receiving notice sues all the claimants in an interpleader action. That requires the insurer to deliver the total policy limits to the clerk and requires the judge to figure out a fair way to divide the money. There is no obligation that the claimants will accept the allocation the judge sets.

c. Example of how this Bill hurts small businesses:

Assume a successful business owner has driven a car at high speed into a car with 4 college students on a field trip. One is quadriplegic with a $40 million claim, one has a broken leg with $80,000 and two have whiplash type injuries worth maybe $15,000 each.

All claimants demand the full value of their claim other than the quadriplegia, who offers to settle for the full $5 million. All threaten to sue if their demands are not met within 30 days. The policyholder learns of the situation, makes a request in writing for the insurer to give the full $5 million to the quad case, understanding his business will remain exposed and uninsured for the remaining $110,000 in claims, which it can afford to pay from its own funds.

The insurer, seeing that it cannot save itself any money, doesn't follow the request of the policyholder and tenders that full policy limits to the court, and sues the claimants for interpleader asking the judge to investigate and evaluate the claims, and attempt to settle them. This essentially transfers the insurance company's work to the judge.

The quadriplegic declines to participate in the interpleader process and instead sues the insured for the full $40 million claim and takes every asset of the business and the successful business owner. The business owner would have absolutely no recourse against the insurer under this bill and even though it could have settled all claims for $110,000 from the insured, had the carrier acted in good faith.

In addition, essentially every scenario described in the single-claimant examples above would apply here too, since a quadriplegic will unquestionably want to conduct similar due diligence before accepting the $5 million limit. The carrier can ignore all those settlement opportunities, ignore its responsibility to communicate to the insured, since it will have absolute immunity under this bill.

III. Section (5) reduces the policyholder's recovery in a bad faith claim based on the adverse party's lack of cooperation or good faith.

a. Background

When we buy liability insurance, we pick our company and pay them, in advance, for their promise to investigate, evaluate, communicate, negotiate and settle claims against us. THEY owe US a duty of good faith, and WE owe THEM a duty of full cooperation to get the claim settled and get us a release.

If the worst happens, and we have caused an accident that has, for example, killed a child, that family has the inherent right to sue us immediately for the full value of the claim, without regard to the limit of our insurance. If they hire a lawyer, that lawyer's only duty is to his clients, and if he had loyalties to us or our insurance company, that would be a prohibited conflict of interest.

Certainly, the claimant's lawyer cannot lie or act dishonestly or illegally – but within those limits, his obligations are to do only what is best for his client.

If the family decides to sue immediately and pursue the case to judgment, nobody has the right to complain about that. If someone's child has been killed, and they are still willing to settle with us for less than full value, that is a matter of grace. If they are willing to do that, they are entitled to put any conditions or stipulations they want or their offer, and they can choose to provide as much or as little information to us as they see fit, in connection with the offer.

Our insurance company should not count on the adverse party to investigate and evaluate the claim. We pay our insurers, in advance, through our policy limit for these services. If sworn statements are needed, they should get them for our benefit, and not count on the adverse party to do it. If inspection of the vehicles is needed, they should do that for our benefit, and not count on the adverse party to do it.

Certainly, the law recognizes that sometimes there is information that the insurer just cannot get without the assistance of the claimant, such as medical records. And if the case is one that cannot be evaluated without this information, and the claimant will not provide it, that is NOT bad faith, and never has been.

Under current law, the conduct of the claimant and their attorney is relevant, and if, despite reasonable efforts, the insurer cannot obtain information to evaluate the case to know that it should settle, then it is not liable.

However, where the insurer has enough information, or can get it through their using their own resources without depending on the adverse party and fails to do so, the fact that the adverse attorney is rude, or uncooperative, or won't return phone calls, or is just generally an ass, does not excuse the insurers duty to attempt to settle when it should. And in that circumstance, when an insurer knows it can settle and should settle under the information it can itself obtain, the recovery to the policyholder who is hit with an excess judgment should not be reduced because the adverse party was a jerk.

b. This Bill (Lines 305-321).

This section imposes a duty of good faith on parties who are adverse to one another in the underlying lawsuit. If an insurer acts in bad faith and failing to settle a claim so that the insured is hit with a $5 million excess judgment, if the adverse party was not cooperative, the insurer will have to pay only part of the excess and force the policyholder – who WAS cooperative in every way – to pay millions of dollars from their own pocket.

c. Example of how this Bill hurts small businesses:

Assume an employee of a successful business driving a truck belonging to the business has turned left in front of a motorcycle and severely brain injured a father of four, who can no longer perform his job as a professional engineer. The company has a $2 million policy, but the claim is worth between $10 and $20 million.

The insured promptly reports the accident to the insurer, who sees from the accident report that the biker was airlifted to the hospital in a coma.

The truck driver tells the insurer he never saw the motorcycle and speculates that he must have been speeding to "come from nowhere." The accident report shows 4 witnesses but does not attach statements.

A newspaper story about the accident indicates that the rider's helmet fractured on impact.

The insured policyholder has its business lawyer write to the carrier and asks them to settle for any amount up to the policy limits if the claimant will accept it.

The insurer has set its reserve at the full $2 million, but the assigned adjuster has determined that if the motorcycle was in fact speeding, and the helmet was defective, that perhaps liability could be split 50 percent to the biker, 25 percent to the helmet, and only 25 percent to the company. If damages were on the low end of the range, the net could be $2.5 million against the company, and perhaps she could then negotiate something below the policy limits.

Sixty days after the accident, the plaintiff's wife has hired an attorney who writes to say that the wife has been appointed as guardian of her husband and their children because of his inability to make decisions for himself. She extends an offer to settle all claims for the husband, wife and their children if the policy limits are paid to his trust account within 30 days, whereupon the lawyer will obtain necessary court approval for the settlement. They attach an MRI of the husband's brain showing a subarachnoid hematoma in for cerebral cortex and a report indicating he has midline shift and diffuse axonal injuries.

The insurance adjuster doesn't tell the insured about the offer, and instead responds by asking the plaintiff's lawyer for:

1. Any witness statements he has;

2. Any accident reconstruction reports he has obtained that would estimate the plaintiff's speed;

3. Any expert reports they have obtained showing whether the helmet performed as expected;

4. A copy of the court order appointing the wife as guardian, and the supporting affidavits that were filed in court saying that say he is incompetent;

5. Medical and tax records for the last ten years;

6. Birth certificates of all the children;

7. Any records of counselling they have received either before or after the accident; and

8. An extension of the settlement offer until 90 days after she has received all this information.

The plaintiff's lawyer ignored the adjuster's requests and filed suit. At trial, the witnesses all affirmed that the biker was not speeding, and the helmet was designed to crack exactly as it did, and probably saved the biker's life. The brain injury had progressed exactly as you would expect it to, and the jury awarded $20 million. The insurer paid only 2 of the 20 million.

In the bad faith case, the jury found that the insured had performed every obligation under the policy and had fully cooperated in every respect.

They also found that the insurer acted in bad faith by failing to settle when it could and should have, and also for failing to communicate the settlement opportunity to the insurer who had asked them to settle. They also found the insurer failed to properly investigate the claim as it should have by obtaining witness statements and accident investigation reports on its own.

Under current law the insurer would be required to pay the judgment against the insured, to allow it to continue in business.

However, if this Bill were passed, the jury could also find that the plaintiff's lawyer was uncooperative because he did not produce all his reports to the insurer. As a result, they diminished the amount the carrier had to pay, by half.

The insured, who had done everything right, would be left with a $9 million excess judgment, and no remedy against the insurer it had paid to protect it.

PROTECTING MAIN STREET NOT WALL STREET

Ensuring Florida Law Protects

Small Businesses, not **Insurance Giants**.