RESTORING THE GOOD FAITH IN FLORIDA'S "BAD FAITH" INSURANCE LITIGATION

Victor E. Schwartz
Shook, Hardy & Bacon L.L.P.
1155 F Street NW, Suite 200
Washington, DC 20004
Phone: (202) 783-8400
Fax: (202) 783-4211
E-Mail: vschwartz@shb.com

Shook, Hardy & Bacon L.L.P.®

www.shb.com

Executive Summary

The handling of insurance claims, as one might expect, can be quite complex. Following an accident or injury, insurers, by law, must thoroughly investigate a claim, identify attempts at fraud, determine whether the damage alleged falls under a particular policy, properly value such damages, and move quickly to resolve the claim for the correct amount. In some states, such as Florida, insurers are under strict time constraints in which to investigate, process, and pay any claim (regardless of complexity), or else they face the prospect of punishment through additional damages beyond contract law in what is called a "bad faith" lawsuit.

In the vast majority of instances, claimants receive payments due to them by either their direct insurer, or, if they make a claim as a "third-party," someone else's insurer, in a prompt and efficient manner. Nevertheless, there are a significant number of claims made in Florida in which the primary objective is not to obtain a prompt and fair payment for damages sustained, but rather to frustrate the insurer's claims handling process enough to trigger a bad faith lawsuit so that windfall damages may be recovered.

Unfortunately, Florida's laws seeking to root out bad faith are very conducive to abuse by plaintiffs' counsel. There are a plethora of games and "gotcha" tactics, ranging in complexity, which effectively allow bad faith lawsuits to be manufactured. This occurs even in instances where the defendant insurer is trying very hard to resolve the claim for exactly what the claimant's attorney has demanded. Thus, the ironic effect of Florida's bad faith law can be that it actually encourages bad faith and halts the fair and efficient handling of claims.

There are a number of relatively simple ways to curb such abuse and help Florida's bad faith law fulfill its intended purpose. Some involve giving insurers more time to get to the bottom of a claim; others clarify the parties' roles and responsibilities. Such specific improvements are explained in this report along with legislation, H.B. 427, the Fair Settlement Act, that has been introduced to curb common abuses.

The long-term consequence of inaction to Florida's worsening bad faith litigation environment is nothing short of an insurance system crisis. Meritless claims will be encouraged, premiums will rise, insurers will leave the state, and responsible consumers will be the ones who ultimately suffer most. The Florida Legislature needs to take action now and enact meaningful reform.

What is Insurance "Bad Faith"?

In any agreement between two or more parties, whether it is to provide specialized services for a fee or purchase property such as a car or house, there is the implicit understanding that each party will abide by the terms of the agreement. Generally speaking, one party promises to make available an item or perform a service and the other party promises payment in full. Occasionally, however, one party will renege on his or her end of the deal, and do so intentionally and without reasonable justification, causing financial injury. This is the essence of "bad faith" law; failing to perform when performance is due and doing so intentionally, or at least with reckless disregard for the consequences.[1]

In the context of an insurance agreement, the same basic principle applies. One party, typically the insurer, fails to abide by the terms of an insurance contract it has entered, and does so purposefully or maliciously. For example, an insurer could fail to provide the proper level of compensation under the insurance contract, or purposefully delay efforts to settle a case. When this occurs, the insurer is said to be acting in "bad faith."

The reason such a finding is important in litigation, and routinely alleged by plaintiffs' counsel, is that a finding of "bad faith" can open the door to an array of harsh penalties against an insurer. These penalties may include punitive damages, compensatory damages (including the maximum policy limit under an insurance contract), extra-contractual damages exceeding a policy's limits, and attorneys' fees and court costs. Thus, insurance bad faith can end up costing insurers millions of dollars for cases in which the insurance coverage agreement is very modest, perhaps only several thousand dollars.

FIRST-PARTY BAD FAITH

There are two basic types of bad faith insurance litigation: first-party and third-party claims. A first-party bad faith claim occurs when an insured directly sues his or her insurer pursuant to an insurance coverage agreement. A common first-party context is when an insurance company underwrites an insurance policy on property that becomes damaged, for instance a house in a severe windstorm. In such a case, the insurer is required to investigate the damage, determine whether the damage is covered, and pay the proper value for the damaged property. Bad faith in the first-party context can occur where the insurance carrier

conducts an improper investigation and valuation of the damaged property, or wrongfully refuses to acknowledge the claim as arising under the insurance policy. An insurer's intentional delay in processing a claim or a failure to defend the insured in litigation if such defense is part of the insured's coverage agreement can also constitute bad faith.

Because a first-party claim involves both parties to the insurance coverage agreement, an allegation of bad faith is typically included with a claim for breach of the contract. This contractual relationship means that the insurance company owes a specific duty of care and good faith to the insured when handling any claim. As stated above, the inclusion of a bad faith claim with an alleged breach of contract functions to expand the scope of damages beyond the traditional law of contracts, and can dramatically increase damages available to a direct insured.

THIRD-PARTY BAD FAITH

The other type of insurance bad faith is a third-party claim, which may involve any other person who is not the direct insured making a claim against an insurer. Stated another way, it is a bad faith claim made by an individual or entity who is not a party to the underlying insurance coverage agreement. Because there is no underlying contractual relationship between the parties, which would ordinarily give rise to a duty of care and good faith, most states are reluctant to authorize such claims.[2]

Where third-party claims are recognized, they are generally made when an insured injures another person (*i.e.* third party) and that injured party sues the insured's insurance company to recover. A classic example would be when a motorist collides with a parked car; the parked car owner has a claim against the motorist and, indirectly, against the motorist's insurance carrier who owes its insured a duty to defend the claim and potentially indemnify the insured for any judgment awarded. If the insurer purposefully delays or denies recovery to the third party, the insurer may be additionally liable to that third party for a range of tort law damages carrying a punitive effect.

ASSIGNMENT AND EXECUTION OF BAD FAITH CLAIMS

In addition to bad faith claims being brought by first or third-party claimants, they may also be assigned to other individuals in some states, including Florida. This means that the

person allegedly injured by an insurer's act of bad faith can effectively transfer that legal basis to sue the insurer to another person, even another party in the lawsuit giving rise to the bad faith claim. The person allegedly injured by an act of bad faith may also enter agreements with other parties to a litigation to decide how the bad faith claim will be handled. In Florida, the majority of bad faith claims are handled in three basic ways:

Scenario 1 – Straight Assignment

When an insured injures another person in an accident, the injured party will typically hire an attorney and sue the insured who is defended in the litigation by her insurance company. If the insured believes her insurer acted in bad faith in this representation, or, alternatively, the injured third-party believes the insurer acted in bad faith in failing to resolve the case, either may pursue their bad faith claim directly or assign the right to bring that claim to someone else. Where the right to bring a bad faith claim is assigned, it is legally the same claim except that it is being brought by another person (*i.e.* the assignee). It is, for example, common for a first-party insured to assign her bad faith claim to the third-party she injured in the accident; insureds often assign away this right so that the person they injured will instead only pursue their case against the insurer, who typically has "deeper pockets," and be able to seek a greater recovery.

Scenario 2 – Coblentz Agreement

A second method of resolving a bad faith claim in Florida is through what is called a "Coblentz Agreement" (named for the case *Coblentz v. Am. Sur. Co. of N.Y.*[3]). This may occur where an insurer is alleged to have acted in bad faith by failing to properly defend or settle a claim. It typically takes place where a serious injury has occurred, such as a fatal auto accident, the insured is clearly at fault, and the damages are likely to exceed the insurance policy limits. Under this agreement, the insured who caused the accident allies with the party they injured and enters a consent judgment that binds the insurer. In effect, the insured agrees to a value for the damages in the case and executes a judgment against herself for that amount. The injured party then goes after the insurer for this amount.

There is a tacit agreement in Coblentz Agreements that in return for the insured executing a judgment against themselves, the injured party (or more accurately the injured party's attorney) will only attempt to collect the judgment from the insurer and not the insured. The insured, therefore, has great incentive to consent to any judgment amount selected by the

injured party's attorney because it will allow the insured to exit the litigation without paying anything out-of-pocket. Rather, the total liability can be pushed on to the insurer.

Scenario 3 – Cunningham Agreement

A third way bad faith claims are often resolved in Florida is through what is called a "Cunningham Agreement" (named for the case *Cunningham v. Standard Guar. Ins. Co.*[4]). Under this agreement, the injured person (*i.e.* third-party plaintiff) and defendant insurer agree on the value of the damages at issue, but do not agree on whether bad faith has occurred. For example, the parties may agree that the value of a case, including the bad faith claim and underlying insurance claim, is $1 million; if the insurer loses in defending the case, it will pay that amount. Hence, the purpose of this type of agreement is for the parties to save time and expense by agreeing upfront on the value of cases and litigating the bad faith issues before the liability and damages issues.

WHY WE HAVE BAD FAITH LAWS

The fundamental purpose behind insurance bad faith law is to create a significant disincentive or deterrent for insurers to engage in activity designed to frustrate, manipulate, or otherwise abuse the just and efficient handling of claims. Bad faith laws accomplish this objective by expanding the scope of available recoveries to effectively punish an insurer for wrongful acts, while allowing an aggrieved party to receive extra compensation for the hardship they endure in getting the insurer to do what it was supposed to do in the first place. Such laws do not exist in most other contexts where a party is wrongfully denied recovery; the nature of insurance, which is in part to provide some level of recovery for often tragic and unforeseen events, has prompted courts and legislatures to make an exception to the general rule permitting only contract damages.[5]

By permitting broader recovery, bad faith laws seek to achieve a more level playing field between insurers, their insureds, and the public. As detailed later, this does not always occur in practice, particularly when the balance shifts too far and provides claimants with an overly potent and easily abused legal claim.[6] Hence, while the execution of these laws leaves room for debate, their basic purpose is a legitimate one.

Another primary justification for bad faith laws is that they can serve to facilitate settlements. The threat of bad faith litigation and possibility of paying not only a party's claim

in full, but punitive damages, additional compensatory damages, attorneys' fees and other costs will often place tremendous pressure on a cost-conscious insurer to settle a claim as quickly as possible. This will often help the insurance system run more efficiently. Unfortunately, this potential benefit can be offset where plaintiffs' lawyers, attuned to the superior bargaining position of plaintiffs with an alleged bad faith claim, commit bad faith in their own right by purposefully frustrating the settlement process in an attempt to enhance the value of a claim. Nevertheless, on balance, properly crafted bad faith laws can align insurers' interests with the public's to make abusive acts highly unprofitable and fraught with risk, and facilitate settlements. For these reasons, states have acted to authorize and clearly define bad faith law.

The Landscape of Bad Faith Law

Recognition of bad faith as the basis for an independent right of action (*i.e.* an action brought by insureds or third parties) is only a product of the last 40 years of American jurisprudence.[7] Over this comparatively short period in legal history, the law of bad faith has witnessed unprecedented growth and development. Today, protections against bad faith insurer conduct are enshrined in the common law and statutes of every state.[8]

COMMON LAW DEVELOPMENT OF BAD FAITH

Beginning in the 1950s, courts first began to impose an extra-contractual duty on an insurer to settle third-party claims that arose when the insured was sued for wrongfully harming another person.[9] This duty covered situations where an "insurer had rejected a settlement offer within the policy limits and the insured thereafter incurred liability in excess of those limits,"[10] thus leaving the insured with the obligation to fund the excess amount owed to the third party out-of-pocket. The Supreme Court of California in *Comunale v. Traders & General Insurance Co.*[11] became the first court of last resort to hold the insurer, and not the insured, liable for such excess damages as a breach of the insurer's implied covenant of good faith and fair dealing.[12] As the court explained, "An insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full

amount which will compensate the insured . . . ."[13]

In 1973, fifteen years after *Comunale*, the Supreme Court of California once again engineered the development of the law of bad faith in *Gruenberg v. Aetna Insurance Co.*[14] by extending tort liability to first-party claims.[15] In the case, an insurer "willfully and maliciously" engaged in a scheme to deprive an insured of benefits from a fire insurance policy.[16] The court built on its third-party jurisprudence[17] and a line of California appellate court rulings that supported first-party tort liability,[18] ultimately reasoning that "[t]hese are merely two different aspects of the same duty."[19] The state high court then reasoned that the breach of such a duty warranted recognition of a new and independent tort cause of action for "bad faith."

Following the *Comunale* and *Gruenberg* decisions, courts in other states applied similar reasoning to recognize tort liability for bad faith in both first-party and third-party claims.[20] Generally speaking, states have shown greater receptiveness to recognizing a cause of action in the first-party context; throughout the 1970s and 1980s, a majority of states adopted a first-party bad faith action as a new addition to their common law.[21] In contrast, only a few states recognize a common law action for third-party claims.

STATUTORY DEVELOPMENT OF BAD FAITH

As the common law basis for bad faith solidified and, in the case of first-party claims, was adopted by a majority of states, states also moved towards statutory codification.[22] State legislatures often set out to protect against insurer bad faith by enumerating unfair practices or, at least, by providing plaintiffs with a statutory bad faith comparison when initiating a common law action.[23] Although state legislatures enacted statutes in an attempt to instill greater definition and support to bad faith law, some statutes have undermined the willfulness, maliciousness, or manifest injustice that provided the foundation of this new tort action in the first place. The idea of inherent unfairness of specific acts has been lost in certain instances and, instead, has been replaced with nebulous elements that have been manipulated to enhance outcomes.

Today, statutes addressing bad faith and unfair insurance claims settlement practices exist, in some form, in every state.[24] These laws are largely a product of model legislation drafted by the National Association of Insurance Commissioners (NAIC) in the

early 1970s to supplement the common law and establish a state regulatory layer of protection against abusive insurer acts.[25] The NAIC's model legislation covered unfair methods of competition and general deceptive practices in the insurance business.[26] In tailoring statutes specific to claims settlement practices, a majority of states have adopted this legislation with only minor changes.[27]

These statutes generally require insurers to communicate promptly with respect to claims, implement reasonable standards for claims investigation, negotiate in good faith, and pay insureds promptly when liability has become reasonably clear. They also prohibit intentional insurer acts such as altering claims forms, making payments without stating the policyholder's coverage, requiring submission of preliminary claims reports with duplicative information to cause delay, and intimidating claimants by making them aware of an insurer's policy of appealing any arbitration award favorable to the insured.[28]

Judicial interpretation of these existing, often identical, bad faith statutes has varied significantly.[29] For example, some state courts have interpreted these laws to allow private enforcement,[30] while others retain exclusive oversight and enforcement through the state insurance commissioner.[31] Even where a private statutory right of action is recognized, a number of state courts have found that this action is only available to those insured and not other third-party claimants.[32] Further, in those states where no private statutory right of action exists, some courts have nevertheless found that unfair claims settlement statutes were useful proxies for identifying instances of bad faith in private actions brought under the common law.[33]

Adding complexity to the landscape of bad faith law is that a number of states have adopted private enforcement provisions and additional prohibited acts that are not part of the model NAIC laws. These enforcement provisions can enable private actions to be brought under statute or common law, and have resulted in inconsistent standards. The presence of additional prohibited insurer acts has also compounded this adverse effect. For instance, additional statutory provisions often include more rigid criteria, which has been used to trigger a bad faith claim regardless of any intentionally wrongful insurer conduct. States such as Missouri, Illinois, and Rhode Island, for example, have statutes prescribing a strict ten- or fifteen-day window in which an insurer must provide claims forms or violate the state's unfair claims settlement act.[34] Some states also set strict and arbitrary deadlines for other

practices, such as when an insurer must respond to a claim[35] or even when a claim must be settled.[36]

Sanctions also vary significantly across states. Oklahoma, for instance, imposes a fine, enforced by the state Insurance Commissioner, between $100 and $5,000 for each violation of its bad faith statute,[37] while Maryland imposes a penalty up to $125,000 for any violation.[38] A number of state statutes also allow private claimants to recover punitive damages.[39] Still others, such as Louisiana, provide additional private recovery beyond the insurance contract by permitting as damages a multiple of any compensatory award.[40]

The differences among states regarding identification of bad faith conduct, enforcement mechanisms, and remedies create a wide range of treatment for bad faith in the handling of insurance claims and close to fifty unique state landscapes. It is against this backdrop that a number of states have sought to enact law to curb well-documented areas of abusive litigation and provide greater clarity, consistency, and fairness in bad faith law.

The chart on the following page summarizes the common law and statutory development of bad faith law.

State	1st Party Bad Faith Under Common Law / Statute	3rd Party Bad Faith Under Common Law	3rd Party Bad Faith Under Statute
Alabama	✓	✓	
Alaska	✓		
Arizona	✓		
Arkansas	✓		
California	✓		
Colorado	✓		
Connecticut	✓		
Delaware	✓		
Florida	✓	✓	✓
Georgia	✓		
Hawaii	✓	✓	
Iowa	✓		✓
Idaho	✓		
Illinois	✓		
Indiana	✓		
Kansas	✓		
Kentucky	✓		✓
Louisiana	✓	✓	✓
Maine	✓		
Maryland	✓		
Massachusetts	✓		
Michigan	✓	✓	
Minnesota	✓		
Mississippi	✓		
Missouri	✓		
Montana	✓		✓
Nebraska	✓	✓	✓
Nevada	✓		
New Hampshire	✓	✓	
New Jersey	✓		
New Mexico	✓		
New York	✓		
North Carolina	✓		✓
North Dakota	✓		
Ohio	✓		
Oklahoma	✓		
Oregon	✓		
Pennsylvania	✓		
Rhode Island	✓		
South Carolina	✓		
South Dakota	✓		
Tennessee	✓		
Texas	✓		
Utah	✓		
Vermont	✓		
Virginia	✓		
Washington	✓		✓
West Virginia	✓		
Wisconsin	✓		
Wyoming	✓		

Problems With Florida's Bad Faith Laws

In Florida, as with most states, the law regarding bad faith implicates both common law and statutory provisions. Individuals can sue their insurer at common law if they believe the insurer committed fraud or acted in bad faith when defending or settling a claim, and the insurer's actions resulted in additional damages and legal costs. Unlike most states, however, this right to sue is not limited solely to the direct insured. In *Thompson v. Commercial Union Ins. Co. of New York*,[41] the Florida Supreme Court determined that third parties can similarly sue an insurer for damages "in excess of the policy limits" as a third-party beneficiary of the contract between the insured and insurer.[42] The Florida Legislature, in 1982, enacted a separate statutory cause of action, which sought to codify specific instances of "bad faith," in part, by referencing some of the model NAIC provisions.[43] This statute broadly provides that "any person" may bring a bad faith cause of action against an insurer.[44]

The dual nature of private enforcement of Florida's bad faith law raises several concerns and avenues for abuse. First, claimants may effectively revive a failed statutory cause of action by bringing the claim again in state court under common law, or *vice versa*. This provides claimants with a "second bite at the apple," which results in wasteful and duplicative litigation costs for the parties and a greater toll on Florida's judicial system. Equally important is that the insurer must essentially plan to defend itself in separate litigations involving the same alleged acts; claimants are able to use this to exert greater pressure to settle frivolous or otherwise unwarranted bad faith claims.

With regard to the statutory right of action, there is a more fundamental issue that its construction opens the door to abusive bad faith litigation. In attempting to identify and codify instances of insurance bad faith, the statute can prove overly inclusive and reach insurer acts that are not wrongful in any way, and, in fact, are very reasonable under the circumstances. As described below, there are several basic problems with Florida's law that have permitted abuses against insurers to become commonplace, especially in the context of third-party claims.

UNREASONABLE TIME FRAMES

Under Florida's current private enforcement statute, an insurer is presumed to have acted in bad faith if it does resolve a claim within a certain period or does not "cure" an alleged bad faith claim within 60 days of receiving a notice of a claimant's intent to sue. As a practical matter, this statute imposes a strict deadline for when an insurer must settle any claim. While this period of time may be reasonable in some situations, in others it represents an insufficient time period for an insurance company to thoroughly investigate and pay out the claim. This is because every insurance claim involves a different set of facts; in some cases the insurer will be able to quickly conduct a thorough investigation and rule out any instance of insurance fraud, but in others the difficulty of locating and speaking with all of the parties and witnesses, investigating inconsistencies, verifying the alleged values for any damaged property, and making good faith follow-ups when red flags exist can stretch an investigation beyond the strict statutory period. The time limit is also particularly problematic where a claimant is attempting to perpetrate insurance fraud because that claimant has an incentive to intentionally delay and frustrate the investigation process so that the insurer faces little choice but to settle the claim as the statutory deadline approaches.

The more prevalent danger occurs where it is the claimant's attorney engaging in tactics designed to manufacture a bad faith lawsuit, and potentially turn a fee award from a $10,000 insurance coverage dispute into a multi-million dollar payday. Plaintiffs' attorneys, for instance, are able to effectively manipulate Florida's statutory deadlines to decrease the insurer's actual timetable for processing a claim. A common practice is for a plaintiffs' attorney to write the insurer demanding payment and serving a notice of intent to sue for bad faith, knowing full well that the insurer will not be in a position to evaluate the loss and claim, and make a correct decision on the claim in time. Some attorneys have resorted to abusive, yet effective, tactics such as purposefully drafting overly-broad and generic notices which fail to state with any specificity the actual facts of the claim, or the precise "cure" or "remedy" sought.

Sometimes, plaintiffs' attorneys will even purposely fail to send notice to the insurance adjuster, and instead, send it to the insurer's corporate home office "in the hope that it gets 'lost' in the bureaucratic mailroom and, therefore, before anyone realizes its significance, the statutorily prescribed 60 day cure period expires, and a

rebuttable presumption that the insurer has committed 'bad-faith' is established."[45] Moreover, the entire claims handling process devolves into a game whereby the plaintiffs' attorneys' principal objective is to leave the insurer in the dark on as many details as possible so that it becomes practically impossible to fully investigate a claim in the prescribed time. As a result, claimants either receive an unwarranted, inflated settlement or manage to successfully trigger a bad faith claim in which the potential recovery is likely to exceed damages under the insurance policy.

"GOTCHA" GAMES WITH MULTI-CONDITIONAL DEMANDS

In addition to relatively simple tactics such as causing delay through intentionally providing insufficient claims information or purposefully mailing materials to incorrect contacts at the same insurance company, some plaintiffs' counsel have devised more complex schemes to push insurers to exceed the statutory "cure" period or otherwise respond to a settlement offer in a manner which can be manipulated into a bad faith lawsuit. This often involves what is referred to as a "multi-conditional settlement demand."

With such a demand, the plaintiff's lawyer typically sends a letter to the insurer insisting upon strict compliance with a multitude of conditions as well as a policy limit tender in order to effectuate a settlement. The types of conditions requested are limited only by the attorney's creativeness. In many instances, these demands effectively preclude any real possibility to settle the claim. Rather, they are, ironically, intended to show that the claimant tried in "good faith" to settle the case, but was unsuccessful because of the insurer's unwillingness to fairly settle the claim.

As the next section illustrates, these types of games using multi-conditional demands inappropriately delay settlement and unfairly force an insurer into a "no-win" situation; the insurer must often choose between settling a claim on unjust terms or facing a statutory or common law bad faith lawsuit for extra-contractual damages.

Case Study 1: *Berges v. Infinity Insurance Company*

The case *Berges v. Infinity Insurance Co.*,[46] is particularly illustrative of problems created by Florida's current bad faith laws. Here, a claim was filed against an insurer as a result of a car accident in which a car driven by a friend of the plaintiff, Mr. Berges,

collided with another car on March 29, 1990, killing the driver and severely injuring her minor daughter. On May 2, 1990, the Infinity Insurance Company (Infinity) received a hand-written letter from the deceased victim's husband, Mr. Taylor, demanding a settlement within 25 days for Mr. Berges' policy limits. The letter demanded a total settlement of $20,000, which included $10,000 for a wrongful death claim and $10,000 for the bodily injury claim. Infinity planned to settle for the policy limits as set forth by Mr. Taylor, and one of the company's adjusters communicated this to Mr. Taylor in a May 11, 1990 phone call and again in a May 24, 1990 letter. However, because of an incorrect zip code, Mr. Taylor did not receive the settlement letter from the insurance company until June 20. Since Mr. Taylor did not receive the letter or settlement payment prior to the 25-day deadline stated in Mr. Taylor's original demand letter to the insurer, his attorney notified Infinity that the offer to settle was revoked.

The case went to trial and a jury awarded the claimant $911,400 for the wrongful death claim and $500,000 for the bodily injury claim of the minor passenger. As a result of the verdict far exceeding the policy limits, the insured, Mr. Berges, immediately filed a bad faith claim against Infinity. The final judgment resulted in the insurer being ordered to pay more than $2 million – $1.9 million for the claims as well as $616,200 in attorney fees – for a $20,000 insurance policy.

While the Florida Supreme Court upheld the result, several justices called into question the inequities and adverse public policy consequences of Florida's bad faith statute. In his dissent, Justice Wells stated,

> [T]here are strategies which have developed in the pursuit of insurance claims which are employed to create bad faith claims against insurers when, after an objective, advised view of the insurer's claims handling, bad faith did not occur. This is a strategy which consists of setting artificial deadlines for claims payments and the withdrawal of settlement offers when the artificial deadline is not met. The goal of this strategy is to convert a policy purchased by the insured which has low limits of insurance into unlimited insurance coverage. . . . Obviously, this strategy worked well for the claimants and their attorneys in this particular case.[47]

RESULT

Policy Limit: $20,000 → **Award: $2,500,000**

Case Study 2: *Snowden v. Lumbermens Mut. Cas. Co.*

The case *Snowden v. Lumbermens Mut. Cas. Co.*,[48] provides another example of how plaintiffs' attorneys seek out windfall recoveries via a bad faith lawsuit as opposed to securing prompt recovery for their client of the appropriate amount owed under an insurance coverage agreement. This case resulted from a December 25, 1996 car accident involving the granddaughter of the insured (Mr. Snowden) and another vehicle driven by a Mr. Smith. Mr. Snowden's granddaughter was killed in the accident, and Mr. Smith suffered serious injuries and was hospitalized. Mr. Snowden reported the accident the following day to his insurer, Lumbermens Mutual Casualty Co. (Lumbermens), but did not report the injury of the third party, Mr. Smith.

On December 31, Mr. Smith's brother reported the accident to Lumbermens, and *that same day* Lumbermens put the insurance policy's maximum limit of $100,000 in a reserve account for payment. The case, therefore, appeared headed towards a fair and efficient resolution. But, on January 16, a personal injury lawyer who had been hired the day before by Mr. Smith's wife sent a letter to Lumbermens complaining that the insurer had not initiated settlement discussions and that no offer of settlement would be accepted. This was in spite of the fact that Lumbermens only learned of Mr. Smith's injury two weeks prior, and only 23 total days had passed since the accident occurred (9 of which included business holidays or the weekend).

A state court entered a judgment against Mr. Snowden for $3,750,000.[49] He, in turn, sued Lumbermens for the entirety of the judgment on the theory that Lumbermens acted in bad faith in failing to pay out the $100,000 policy limit in a matter of days following a fatal multi-car accident, and failing to abide by a settlement "deadline" arbitrarily imposed by the third-party plaintiff's lawyer and announced for the first time in a letter saying it had lapsed. Despite the dubious nature of this bad faith theory, Lumbermens was held liable for the entire judgment, meaning that plaintiff's counsel was able to successfully manufacture a bad faith lawsuit based on nothing more than his own subjectivity in stating a lapsed deadline and unilaterally refusing to entertain settlement offers.

RESULT

Policy Limit: $100,000 → **Award: $3,750,000**

Case Study 3: *United Auto. Ins., Co. v. Levine*

A more recent case, *United Auto. Ins., Co. v. Levine,*[50] provides perhaps the most egregious example of how a bad faith lawsuit can be manufactured even where an insurer acts reasonably at all times and works hard to settle the case for the maximum limit of the policy. Here, an insured driver allegedly under the influence of alcohol crashed his truck into a car, seriously injuring both himself and his passenger and killing the two occupants of the other vehicle. The driver, Mr. Hernandez, had an insurance policy with United Automobile Insurance Co. (United) that covered up to $10,000 per person for bodily injury, with an aggregate limit of $20,000, as well as $10,000 of property damage coverage.

Immediately following the accident, United assigned a claims adjuster to investigate and determine its insured's potential liability. This investigation was delayed and complicated by the fact that Mr. Hernandez initially represented to United that he was not the driver at the time of the accident, and the only other witness, his passenger, was in a coma. Ultimately, the facts surrounding the accident were uncovered. In the meantime, the personal representative of Judge Levine, one of victims killed in the accident, retained a lawyer and filed a claim against Mr. Hernandez, which Mr. Hernandez then communicated to United. *The same day* United learned of the lawsuit, it tendered a check for the $10,000 bodily injury limit to Levine's personal representative. Included with the check was a transmittal letter and release, but nowhere was it stated that acceptance of the check was conditioned on the signing of the release. Rather, Levine's representative could have gone to the bank to cash the check right then and there.

Two months later, without explanation, the estate returned the check. When United inquired why, counsel for the Levine estate indicated that the tender was insufficient because it was accompanied by the general release. At this time, the estate's counsel cut off all communications despite repeated phone calls from United to resolve the claim.

A Florida trial court awarded the Levine estate $5,200,000. Mr. Hernandez, who had initially lied to United as to whether he caused the accident, then assigned all of his rights against United to Levine's estate, so the estate could collect the entire judgment from United under the bad faith theory that United failed to timely settle the estate's claims against Mr. Hernandez. A final judgment was issued against United for the entire award;

this decision was later upheld on appeal. While a majority of the appellate court effectively validated the bad faith claim and the attorney tactics used to engineer such a claim, the dissent recognized what had truly transpired, stating:

> United did everything it could to maximize protection for *its insured*. Without a demand or claim, it promptly paid an amount exceeding policy limits for bodily injuries; it attempted to secure a release from liability for its insured; and it timely attempted to determine who should be paid and in what amount for property damage…. This action presents just such a case where counsel for an injured party refuses to communicate or negotiate following a good faith offer by an insurer and after dodging information requests via vague responses by office staff, brings an action for bad faith.[51]

The result in this case was that a third party was able to collect 270 times the maximum limit of the insurance policy. The allegedly intoxicated insured driver who caused the fatal accident did not pay one dime even though he purchased the legal minimum amount of auto insurance in Florida. Instead, the "deep pocket" insurer who immediately responded to the claim, uncovered the facts, and promptly offered the insured's policy limits was made to pay out several million dollars for such efforts.

RESULT

Policy Limit: $20,000 → **Award: $5,400,000**

THE COMMON THREAD IN MODERN BAD FAITH ACTIONS

Each of the cases above illustrate how Florida's bad faith litigation environment has grown increasingly attorney-driven and increasingly focused on concocting a bad faith claim through any means necessary. The cases courts confront today are often far removed from the acts of a recalcitrant insurer intentionally delaying or denying coverage; rather, insurers are so sensitive to doing anything that could even be misconstrued as bad faith that they error on the side of overpayment.

But this is just the tip of the iceberg. As the next section shows, there are a wide variety of unjust attorney tactics that have developed in Florida to transform any insurer's reasonable efforts into substantial bad faith payouts.

A View From the Trenches: Common Examples of Bad Faith Abuse in Florida

The following 10 illustrations present some of the common abusive strategies designed by plaintiffs' counsel to trigger a bad faith claim against an insurer. As explained above, they often involve use of a multi-conditional demand, intentional misinformation or ambiguity, and other stall tactics.

Illustration 1 – Insistence Upon Specific Language in a Release

Following an accident, the plaintiff's attorney will typically make a settlement demand; however, the demand will often state that the offer is unilateral and can only be accepted by actual performance and not a promise to perform. The plaintiff's lawyer will then specify mandatory language that must be in any release required by the insurance company, and that any deviation from this release language will result in a rejection of the insurer's acceptance. Predictably, the plaintiff's lawyer will refuse to provide a proposed release to the insurer. Instead, the lawyer wants to place the burden upon the insurer to draft the release so that he can later reject it if he deems it non-compliant for any reason.

Often, settlements breakdown over meaningless language contained within the release. This occurs because insurers erroneously forward the standard release which they have been using for many years; releases which may contain some of the language in which the plaintiff's counsel has deemed unacceptable. When this is brought to the insurer's attention, the insurer virtually always attempts to immediately rectify the situation by removing the language at issue; however, at that juncture, the "gotcha" tactic is complete and the plaintiff's lawyer refuses any further settlement overtures.

Complicating this scenario is the fact that after making the initial demand, plaintiff's counsel will typically not return phone calls or respond to inquiries from the insurer. Since these demands are often ambiguous, insurers are left to speculate as to what is necessary for complete compliance.

Illustration 2 – Demand for Mutual Release

It has become commonplace in Florida for claimants to request mutual releases. Again, insurance carriers typically respond to a settlement demand by sending a standard release form. Even if the release is modified to include the specific language requested by the plaintiff's attorney, the insurer often misses the requirement that the release be mutual. When the insurer seeks to include the term "mutual," it can inject confusion and ambiguity into the release, particularly when surrounded by the terms "standard" and "form release"; the strategy is designed to lull the insurer into providing a non-compliant release. Further, providing a mutual release is an unusual circumstance in the settlement of a third-party liability claim. This is particularly true in cases of clear liability as there would be no reason for the claimant to receive a release from a fully at fault defendant. Similar to the strategy regarding other releases in Illustration 1, any subsequent efforts by the insurer to correct any perceived deficiency in the mutual release are rejected by claimant's counsel, and a bad faith claim is initiated.

Illustration 3 – Demand for Insurance Company's Internal Files

As a condition of some settlement demands, the plaintiff's attorney will request certain portions of the insurance company's claim file. This often includes damage estimates, photos, witness statements, etc. This information is not vital to the settlement of the third-party liability claim; rather, the involved lawyers are smart enough to know that an insurer will often object to providing any portion of its internal claim file. When the insurer objects to the demand to turn over this internal information as a condition of the settlement, the claimant will proceed forward to file suit and allege that the reason that the underlying claim was not resolved was because of the insurer's unreasonable refusal to provide portions of its file. The whole purpose is to create a condition in which the insurer will say "no" so that it can later be contended that the insurer unreasonably refused to settle.

Illustration 4 – Bundling Bodily Injury and Inflated Property Damage Claims

An increasingly common tactic of plaintiff's counsel is to tie property damage and bodily injury claims together. Generally, insurers are very good about getting accurate bodily injury tenders out quickly to claimants. However, such tenders are often initially rejected, and given a counter-offer that includes both bodily injury and property damage. In such circumstances,

the property damage amount is often undocumented and grossly inflated. The hope is that the insurer will object to the payment of the undocumented property damage claim. At that point, all offers to resolve the case are withdrawn and the plaintiff's counsel will proceed to judgment on the underlying bodily injury claim. It will then be argued that the claimant is the master of his or her offer and has the ability to tie together both property damage and bodily injury claims. The effect is that the plaintiff's counsel is able to grossly inflate a property damage claim, and the insurer either pays this "graymail" or risks not being able to settle a serious bodily injury claim which may then result in a bad faith lawsuit.

Even in situations where the insurer only provides property damage coverage, it can nevertheless find itself exposed to extra-contractual damages on the bodily injury claim. This will occur where the plaintiff's attorney makes a demand under a property damage only policy to settle both the bodily injury and property damage claims. The demand will state that although bodily injury coverage is not provided, the plaintiff's attorney is going to afford the insurer a chance to protect its insured from both property damage and bodily injury liability exposure simply by paying the property damage policy limits. Often the insurer is lulled into taking counsel up on this offer. This is typically disastrous as the claim will often not settle and it will later be asserted by the plaintiff's counsel that although the insurer had no obligation to resolve the bodily injury claim, after the insurer attempted to do so it had an obligation to perform in a non-negligent fashion. Thus, if the insurer tries to more fully serve the interests of its insured and undertakes any obligation to resolve an aspect of the bodily injury claim, it often finds itself in the predicament where it will be asserted that it has exposed itself to bodily injury extra-contractual damages.

Illustration 5 – Carving "Big Money" Claims Out of Any Settlement

In accident or serious exposure cases in which punitive damages may be implicated, the plaintiff's attorney will often specify that he will only settle the compensatory damage aspects of the case. The insurer thus faces a difficult quandary as to whether it should settle the compensatory damages claim on behalf of its insured and leave open exposure to a potential punitive damage claim, or seek to settle the entire claim and risk having to litigate everything. Also, if the insurer objects to settling only the compensatory damage aspect of the claim, it will likely later find itself sued for bad faith. The bad faith argument will be that since the insured's policy only provided coverage for compensatory damages, the insurer had no

obligation to resolve a punitive damage claim and, therefore, no basis for rejecting the proffered settlement. This is the case even though the insurer was trying to act responsibly and in the best interests of its insured.

Another similar scenario occurs where there is a separate damages claim, such as loss of consortium, made by a relative of the injured party, but the settlement demand is silent as to whether this is included. For instance, there may be a catastrophically injured husband who presents a demand for settlement, yet no mention of his wife's loss of consortium or services claim. Predictably, efforts to contact plaintiff's counsel for an explanation prior to the expiring unilateral time limit demand will be unsuccessful. Accordingly, the insurer is left with the Hobson's choice of either accepting the demand as written and exposing the insured to a significant uninsured consortium claim or including the consortium claim in the proffered release and risking a rejection based upon a non-compliant acceptance of the plaintiff's attorneys' settlement demand.

Illustration 6 – Silence Regarding Lien Holder Payments

Plaintiffs' attorneys are aware that insurers are very concerned, particularly in serious exposure cases, with the claims of lien holders and/or subrogated parties. Such claims are often asserted by Medicare, Medicaid, hospitals, workers' compensation insurers, and health insurance carriers. Consequently, the plaintiff's attorney, attune to this fact, will often be purposely silent on who will bear the responsibility to resolve any such existing claims to settlement funds in a settlement demand. Again, this places the insurer on the horns of a dilemma as it must either accept the settlement demand as written with no existing protection against third-party claimants or add additional parties to the settlement drafts to protect its interests; the former provides inadequate protection and the latter provides a basis to reject the acceptance as not being a mirror image of the offer. Either path could potentially give rise to a bad faith lawsuit.

Illustration 7 – Providing a Time Limit that is Impossible to Meet Due to Outside Factors

Often in wrongful death cases a time limit demand will be made by the plaintiff's attorney prior to an estate ever being set up for the decedent. As a result, the insurer is placed in a position where it has to respond to the demand prior to the appointment of a personal representative. In addition, it is not uncommon for the plaintiff's lawyer to directly assert that

no such estate will be opened. This obviously builds confusion into the process as the insurer is left without any certainty as to whether a valid and enforceable release can be provided. Further, it is not unusual for the plaintiff's lawyer to say to the insurer that it must fund the opening of the estate if it wants a release from the personal representative.

Illustration 8 – Refusal to Meet for Global Settlement Conference

With incidents involving multiple claimants, it is typical for the insurer to receive competing claims for its policy limits. Florida courts have stated that in such cases, an insurer should hold a global settlement conference in an effort to resolve all claims.[52] If those claims cannot be resolved, it is recommended that the insurer try to settle those claims that present the most serious liability exposure to its insured. The problem that occurs is that the insurer is often faced with a refusal, usually from the most serious injured claimants, to attend any type of global settlement conference. Instead, the different claimants' attorneys make unilateral time limit demands for the full policy limits. These time limit demands are often competing and aggregate to more than the available policy limits.

As a result, the insurer is left to try to juggle and manage these competing claims, and if a global settlement conference is not possible, to try to determine which claims present the greatest risk exposure to its insured. The insurer's action in this regard will generally present a jury question concerning whether it acted in the best interests of its insured. This enables the claimants' attorneys who have purposefully declined to meet for a global settlement conference an opportunity to seek extra-contractual damages via a bad faith lawsuit.

Illustration 9 – Taking Unfair Advantage of Honest and Harmless Insurer Mistakes

It is commonplace for many plaintiff's counsel to require strict compliance with Florida's insurance disclosure statute[53] such that any deviation, no matter how incidental or harmless, will result in the rejection of the policy limit tender. The bad faith pretext given for such a rejection is that the plaintiff's counsel was unable to determine the exact available policy limits due to the insurer's non-compliance with the language of the disclosure statute.

The statute, for instance, requires the insurance policy in place to be provided "under oath." Sometimes what the insurer technically provides is a "certified" copy of the policy; a trivial distinction that does not impact the merits of a claim in any way. Nevertheless, the

plaintiff's counsel will reject an insurer's policy limit tender because the policy provided was "certified" and not "under oath." Further, upon receipt of the policy, some plaintiff's counsel will search through it page by page with the goal of identifying any technical error to use to allege bad faith, regardless of its nature or significance. If the policy contains such an error, the plaintiff's attorney will reject the settlement and proceed forward to litigation.

In addition, a major challenge is that there is no mechanism under the existing law to permit the insurer to correct any alleged discrepancy in its statutory disclosure compliance. Once the unilaterally imposed deadline has expired, the "gotcha" game has occurred, and there is no means for an insurer to take corrective action.

Illustration 10 – Settlement Demand Purposefully Not Sent

Florida courts have held that the time period within which an insurer must tender policy limits decreases as the liability exposure to the insured increases. In cases where liability is clear and substantial, the time to tender may be no more than a couple weeks. What makes this abbreviated time period particularly troublesome is that Florida does not have a requirement that the insurer receive a settlement demand. A Florida appellate court reached this conclusion in the 1991 case *Powell v. Prudential Prop. & Cas. Co.*,[54] allowing a bad faith claim to proceed and finding damages of $250,000 on a $10,000 insurance policy where the third-party claimant made no settlement demand whatsoever. Looking back, this case can be credited with seriously exacerbating Florida's bad faith litigation environment and opening the door to other abusive tactics designed to trigger bad faith.

The effect of *Powell* and subsequent rulings is that in serious exposure cases an insurer cannot wait for the presentation of a claim, a letter of representation, a policy limit demand, or anything else for that matter. Instead, while a claimant "plays possum," the insurer must move with extraordinary speed to get the policy limits out of its hands and into the hands of the claimant's representatives in order to avoid extra-contractual liability exposure. Hence, to increase the resulting confusion and potential for insurer errors, the plaintiff's attorney will purposefully choose to remain silent and not send any information regarding a claim. He may then take unfair advantage of insurers racing to get the "check out the door" to meet statutory and other deadlines, and pounce upon any mistake or delay to have a basis to reject a fair settlement offer and pursue a bad faith lawsuit.

GOTCHA GAMES EXPOSED: THE *MENDEZ* CASE

While the above examples provide a window into how bad faith claims are actually generated on a daily basis in Florida, one case in particular stands out for depicting just how absurd the gamesmanship has become and how brazen the attorneys bringing these claims really are. The case *Mendez v. Unitrin Direct Prop. & Cas. Ins. Co.*[55] involved a car accident in which Ms. Mendez, the daughter of the insured Mr. Mendez, collided with another vehicle, killing its driver, Mrs. Ackey. As surviving husband and personal representative of the deceased's estate, Mr. Ackey hired an attorney soon after the accident to handle any third-party claim to insurance proceeds from Unitrin Property & Casualty Insurance Co. (Unitrin).

From the outset of the third-party representation, it was abundantly clear that Mr. Ackey's attorney was far less interested in resolving his client's case for the maximum limits of the insured's policy than he was in concocting a bad faith lawsuit. The attorney was later forced to turn over several emails that show with shocking candor how the bad faith game is routinely played in Florida. Below are excerpts from internal correspondence within Mr. Ackey's attorney's law firm regarding the Mendez case:

> Unitrin insures the defendant. We've made no contact with the defendant or the carrier as yet. . . . Question to be brainstormed is how to proceed in a way that maximizes client's recovery.
>
> You [partner at firm] had previously instructed that suit should be filed immediately. **I'm not sure that gets us where we want to be**. . . . They [Unitrin] do not know about us as yet. If suit gets filed now, the bad faith theory then amounts to them not contacting surviving spouse quickly enough after accident causing him to set up and estate and suing their insured. **I don't think that is good enough. That is what we really should discuss.**
>
> **It may be better to not represent client at this point on the liability claim. . . and have him contact the defendant and see (sic) what they tell him and/or send him. If they offer their limits, and send a release that has improper language in it then that would make for a better bad faith case.**
>
> Another scenario is that we contact the carrier after estate is set up, request disclosure, see what they do, what kind of release they us, etc. If they send an improper release, drag their feet, etc. **then we have a shot that way also**. Anyway some decision needs to be made as to how best to proceed.[56]

Such correspondence shows that the overriding objective of the third-party representation is to do whatever it takes to create a bad faith cause of action as opposed to securing an

appropriate recovery as provided by the insurance agreement. The attorneys here, and in other cases, do not even attempt to reasonably settle their client's case; the whole point is to try and manipulate the system to trigger an arguable bad faith action and open the door to substantial unwarranted damages against the insurer (of which the attorneys will typically receive a third or possibly more).

Further, these shenanigans and improper motives are only part of the total picture. Many claimants' attorneys often believe it is their legal responsibility to try and maximize their client's recovery by seeking a bad faith judgment. Some counsel have even suggested it could be legal malpractice not to assert such claims and merely seek the maximum limit of the applicable insurance policy. While attorneys do owe a duty to zealously represent their clients, they also owe a duty to uphold the principles of justice and not to skirt or undermine the law in that client representation. Nevertheless, these beliefs reveal the scope of how truly broken Florida's bad faith insurance litigation environment is; the desire to manufacture unwarranted heightened recoveries for claimants pervades every aspect of the insurance claims handling system.

Solutions for a Sensible System

Given the considerable problems in how Florida's bad faith laws operate and the inappropriate incentives created, the question presents itself as what can and should be done? A related question is from where should reform come – the judiciary or the Legislature? As explained below, the vast majority of abuses in Florida bad faith law can be curbed with only a few relatively simple legislative changes.

PLACEMENT OF BAD FAITH IN THE HANDS OF THE STATE LEGISLATURE

Florida's bad faith laws currently may be enforced under both common law and via statute, making a comprehensive solution to the state's bad faith abuses difficult to fashion. As explained previously, a failed bad faith claim under the state's private enforcement statute can simply be re-filed as a common law claim and *vice versa*. Because the statutory law makes clear that "any person" can sue an insurer, thereby providing the broadest possible

scope of a bad faith action, and because many of the abuses in the law are a direct result of this statutory action, it is logical for reform to principally come from amendments to the statute. The legislative process is also better suited to make precise modifications to how bad faith may be determined, and clarify how the law is intended to be enforced. The judiciary, in contrast, is unable to enforce the law in a manner inconsistent with the letter of a statute, and thus would be unable to correct many of the ongoing abuses on its own.

A rational solution is to amend Florida's statutory law to house all bad faith claims where the vast majority of abuses can be more effectively controlled. To accomplish this, the state Legislature should amend the law to require that any bad faith claim must be brought exclusively under the statute, and no longer under either statute or common law. With the framework of a singular cause of action, any subsequent amendments to the statute would govern all claims, and the ability of claimants to avoid these improvements by simply re-filing at common law and employing the same abusive tactics would be eliminated. In addition, under a singular cause of action, both claimants and insurers would have a clearer picture as to their responsibilities, creating the more level playing field that is the core purpose of bad faith law.

MORE REASONABLE STATUTORY TIME FRAMES

While statutory deadlines can provide a useful benchmark for determining what is reasonable under the circumstances of a particular insurance claim, and can provide an incentive for insurers to act promptly, they should not, in the event of a missed deadline, necessarily trigger tort liability for bad faith. Rather, strict adherence to a statutory time period imposes a negligence *per se* rule, which fails to provide latitude for the "gotcha" games of plaintiffs' attorneys, or other reasonable insurer excuses or unintentional errors that ordinarily act to preclude liability in a bad faith action.

When statutory time limits are too short, strict adherence to these deadlines as the basis for a bad faith claim represents poor public policy.[57] First, a hard deadline that is too short can remove any determination of culpability, such as whether the insurer intentionally acted to cause an unreasonable delay or denial of a claim; this determination is essential in evaluating the extent of liability and the amount of punishment necessary to deter similar acts in the future. Second, such strict adherence diminishes the vital role of the jury in the civil justice

system, and does so in perhaps the most suitable subject area for a jury to determine; that is, whether something sounds reasonable to an ordinary person. Third, strict enforcement of an insufficient deadline demonstrates a lack of understanding and an attempt at standardization in an industry where every insurance claim is different and requires varying levels of attention. Finally, and most importantly, strict enforcement of a statutory deadline provides an incentive for a claimant to abuse the insurance system, which is already rife with attempts at fraud.[58]

If a claimant can make use of the threat of a bad faith action whenever an insurer fails to meet a statute's arbitrary deadline, the claimant is more likely to engage in delay tactics or otherwise frustrate the insurer's claims-handling process.[59] As the previous section explained, there are a wealth of highly effective strategies, both simple and complex. Where there is an ultimate deadline for payment, the claimant can bolster his or her bargaining position by unreasonably refusing to settle a claim for anything less than the policy limit.

Currently, Florida provides a 60 day period in which a party bringing an action for bad faith must notify the insurer prior to the commencement of the suit. By extending this period, or, alternatively, establishing a reasonable time period to settle a claim that begins to run from the date of the accident – for example 180 days – many of the marginal infractions plaintiffs' attorneys use to try and trigger a bad faith action could be eliminated. As a practical matter, it becomes exponentially more difficult for the plaintiff's attorney to engage in delay tactics over a such period and still plausibly claim that it is, in fact, the insurer frustrating the claims process. Conversely, it also becomes more difficult for an insurer that truly is acting in bad faith to claim that it is the victim of unfair tactics of plaintiff's counsel when it potentially has up to 180 days from the date of the accident to ensure a proper claims investigation and payment. Thus, by extending the time period which raises the presumption of bad faith conduct, both sides are less able to engage in gamesmanship.

Additionally, in the interest of protecting both claimants and insurers from what could be too long or too short of a hard deadline depending on the facts and circumstances of a particular claim, the law should include some ability to modify time limits. For instance, if a claimant showed that an insurer having up to 180 days was being given too much time for what should be a relatively simple and straight-forward claim, a court should have the express authority to decrease that hard deadline. The same would apply to increasing the insurer's statutory deadline for an unusually challenging coverage claim. Such cases would obviously

be exceptions to the norm, but would at least allow a greater measure of flexibility than currently exists in Florida.

EXTENDED PERIOD FOR CIVIL REMEDY NOTICE PRIOR TO BRINGING A BAD FAITH CLAIM

A related issue regarding reasonable time periods for insurers to properly investigate and respond to a claim is the time period for the state Insurance Department to review and respond to a claimant's notice of intent to file a bad faith action (*i.e.* civil remedy notice). Currently, Florida law provides the state Insurance Department with 20 days to review such a notice and return those notices which do not provide specific enough claims information that is required by law. In this regard, the state Insurance Department provides an important "check" on improper bad faith lawsuits and gamesmanship of the insurance system.

An additional period, perhaps even as little as 10 extra days, would relieve pressure on the Florida Insurance Department in carrying out this vital function, and help to ensure that it is able to thoroughly review any allegations of bad faith. Naturally, a longer statutory period, for instance 60 days, would go further in ensuring a comprehensive review of bad faith claims and curtailing manufactured bad faith through various schemes and "gotcha" tactics.

GREATER ABILITY TO CORRECT OR "CURE" ALLEGED BAD FAITH

In addition to extending the state Insurance Department's period of review of a claim, a moderate extension of the time period in which the insurer has to respond to the civil remedy notice would likely greatly improve Florida's bad faith litigation environment. Currently, insurers have 60 days to "cure" or otherwise correct the alleged bad faith stated in a civil remedy notice. By extending that period to 90 days, insurers would have a greater incentive and ability to correct mistakes and negotiate settlements, rather than having all of the parties go through the high, and often inefficient, costs of litigation.

Furthermore, litigating a bad faith claim, particularly if it is the result of improper tactics by plaintiff's counsel, can be a risky proposition, and a claimant may end up recovering nothing. By providing more time for insurers to correct legitimate problems and more time for all parties to weigh the benefits and costs of litigation, Florida's bad faith law would encourage more fair and efficient handling of claims.

A RECIPROCAL DUTY NOT TO ENGAGE IN BAD FAITH

At present, there is no duty on the part of a claimant to cooperate with an insurance company to arrive at a settlement, allowing insureds, third parties, and their attorneys to file bad faith lawsuits and obtain settlements far in excess of the insurance for which the insured has paid premiums. A common sense solution is to include a statutory duty for claimants and their counsel to negotiate in good faith so that the types of inappropriate tactics and "gotcha" games are curtailed because claimants' attorneys recognize that, they too, must conduct themselves in a responsible manner whereby the objective is the fair and efficient resolution of the claim. Only by making both parties responsible and accountable will the common abuses in Florida's bad faith litigation end.

MORE CLEARLY DEFINED RULES AND PROCEDURES

A final, practical solution to Florida's bad faith abuse is to directly confront the frequent practices, discussed in the previous illustrations, which frustrate the claims handling process and incentivize bad faith allegations where, quite frankly, no bad faith conduct has occurred. In many cases, these problems can be solved by more clearly expressing what conduct exhibits bad faith and by more carefully defining parties' responsibilities under the statute. This avoids the uncertainty and needless confusion that has precipitated much of the state's abusive bad faith litigation.

A meaningful way to add clarity to Florida's bad faith law is to state explicitly what is meant by "bad faith": arbitrarily refusing to pay an insurance claim when taking into account all the relevant facts and circumstances. Perhaps surprisingly, Florida's law lacks such a straight forward explanation. Rather, the statutory language provides a more amorphous and malleable definition which fails to account for the malicious and arbitrary nature of bad faith conduct, and potentially opens the door to lesser, unintended conduct such as a typo or other harmless error.

Beyond refining the definition of bad faith, the Florida Legislature should also respond to specific, widely-recognized abuses. One common area in which a claimant's attorney will seek to manufacture a bad faith lawsuit is by including a demand for an insurer's internal claims file (*see* Illustration 3). Again, the objective here is to purposefully make a demand which the insurer will reject, and use that rejection as the basis for a bad faith claim. By

establishing a rule that the insurer's internal claims file is protected under the work-product privilege, and hence generally not subject to discovery, this type of abusive strategy would no longer be tolerated.

Similarly, the Florida Legislature can curb abusive tactics designed to delay a claim and trigger a bad faith lawsuit by instituting a common sense requirement that a claimant submit any correspondence to the correct insurance contact. As mentioned repeatedly, some plaintiff's counsel will purposefully mail correspondence to the incorrect contacts within an insurance company in the hopes it will "get lost in the mail" or otherwise delay the claims handling process so that the statutory time periods expire. Including a simple requirement that a civil remedy notice be mailed to the correct contact and include the claim number would go a long way in preventing this type of inappropriate conduct.

The Florida Legislature can also act to curb unwarranted bad faith litigation by restricting the assignment of such claims. If an individual truly has been a victim of an insurer's bad faith conduct, it is that claimant who should be awarded damages, not some speculating plaintiff who seeks only a return on his or her investment through litigating others' abandoned claims.

Finally, in the context of third-party claims where there is no contractual relationship whatsoever between the parties, there is a particularly strong need for more defined rules and procedures. First, to avoid the situation where a claimant's attorney "plays possum" and makes no attempt to settle the claim in the hopes that the statutory period will expire and permit a bad faith lawsuit (*see* Illustration 10), there should be an express requirement that the insurer receive a written settlement offer. This clarifies who the insurer is dealing with, establishes what the claimant is seeking, and facilitates communication, negotiation, and, ideally, more efficient resolution of the claim.

Second, to avoid any uncertainty over the treatment of any outstanding liens following a successful third-party settlement (*see* Illustration 6), the law should expressly state who bears such responsibility. Because a claimant is in the best position to know of any outstanding liens against him and the claimant's counsel is typically in charge of drafting the settlement demand, responsibility should rest with these parties, and not the insurer, to address this issue and settle any outstanding liens.

Third, in the event of a claim involving multiple parties seeking damages which, in the aggregate, exceed the limits of an insurance policy (*see* Illustration 7), each party should

receive its proportionate share of the policy limit. By including a statutory provision to this effect, it would prevent wasteful litigation among multiple parties seeking more than their appropriate share under a policy, unnecessary delays in claimants receiving compensation, and unwarranted bad faith lawsuits.

If the Florida Legislature approved this small handful of changes, it would likely dramatically curb bad faith abuse throughout the state. All parties would possess a greater understanding of the their rights and responsibilities, and the most harmful avenues for abuse would be closed.

H.B. 427, the Fair Settlement Act, incorporates a number of these recommended solutions into Florida's current civil remedy law:

624.155 Civil remedy.

(1) Any person may bring a civil action against an insurer when such person is damaged:

(a) By ~~a~~ violation of any of the following provisions by the insurer:

1. Section 626.9541(1)(i), (o), or (x);

2. Section 626.9551;

3. Section 626.9705;

4. Section 626.9706;

5. Section 626.9707; or

6. Section 627.7283.

(b) By the commission of any of the following acts by the insurer:

1. Not attempting 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. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing 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. Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(2) Any party may bring a civil action against an unauthorized insurer if such party is damaged by a violation of s. 624.401 by the unauthorized insurer.

(3)~~(a)~~ As a condition precedent to bringing an action under this section **or based on the common-law claim of bad faith**, the department and the authorized insurer must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period shall not begin until a proper notice is filed.

(a)~~(b)~~ The notice shall be on a form provided by the department and shall state with specificity the following information, and such other information as the department may require:

1. The statutory provision **or common law duty**, including the specific language of the statute**, if applicable**, which the authorized insurer allegedly violated.

2. The facts and circumstances giving rise to the violation **and, if the violation includes failure to pay or tender moneys, the amount of such moneys**.

3. The name of any individual involved in the violation.

4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a **third-party** ~~third party~~ claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the **third-party** ~~third party~~ claimant pursuant to written request.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section **or by the common law**.

6. Such other information as the department may require.

(b)~~(c)~~ Within 20 days **after** ~~of~~ receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity shall be exempt from the requirements of chapter 120.

(c)~~(d)~~ No action shall lie if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected. **If the alleged violation is based on this section or on the common-law claim of bad faith, the insurer's tender of either the amount demanded in the notice or the applicable policy limits constitutes correction of the circumstances giving rise to the violation. In third-party liability claims:**

1. If the claimant files the notice, the insured is entitled to a general release from the claimant upon the insurer's tender of the amount demanded in the notice or the applicable policy limits.

2. If the insured files the notice and the claimant accepts the insurer's tender, the insured is entitled to a general release from the claimant.

(d)~~(e)~~ The authorized insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(e)~~(f)~~ The applicable statute of limitations for an action under this section **or based on the common-law claim of bad faith** shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.

(4) Upon adverse adjudication at trial or upon appeal, the authorized insurer shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff.

(5) No Punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are:

(a) Willful, wanton, and malicious;

(b) In reckless disregard for the rights of any insured; or

(c) In reckless disregard for the rights of a beneficiary under a life insurance contract.

Any person who pursues a claim under this subsection shall post in advance the costs of discovery. Such costs shall be awarded to the authorized insurer if no punitive damages are awarded to the plaintiff.

(6) This section shall not be construed to authorize a class action suit against an authorized insurer or a civil action against the commission, the office, or the department or any of their employees, or ~~to~~ create a cause of action when an authorized health insurer refuses to pay a claim for reimbursement on the ground that the charge for a service was unreasonably high or that the service provided was not medically necessary.

(7) In the absence of expressed language to the contrary, this section shall not be construed to authorize a civil action or create a cause of action against an authorized insurer or its employees who, in good faith, release information about an insured or an insurance policy to a law enforcement agency in furtherance of an investigation of a criminal or fraudulent act relating to a motor vehicle theft or a motor vehicle insurance claim.

(8) **Except as provided in paragraph (3),** the civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or this statutory remedy, but shall not be entitled to a judgment under both remedies. This section shall not be construed to create a common-law cause of action. The damages recoverable pursuant to this section shall include those damages which are a reasonably foreseeable result of a specified violation of this section by the authorized insurer and may include an award or judgment in an amount that exceeds the policy limits.

(9) A surety issuing a payment or performance bond on the construction or maintenance of a building or roadway project is not an insurer for purposes of subsection (1).

Long-Term Costs of Inaction

The consequences of allowing abusive bad faith lawsuits to continue would be adverse to both sides of the insurance transaction. When the law allows an insurer to effectively be punished where there is no intent to harm a policyholder or member of the public, and especially when the insurer is earnestly working to promptly investigate a claim and uncover fraud, the dynamics of the insurance system change dramatically. The pressure to settle a case when there is any doubt—no matter how remote—that the insurer *could be* held liable for substantial extra-contractual damages, can become enormous. Plaintiffs' lawyers, knowledgeable of this changed dynamic and its potential to turn a minor insurance claim into a multi-million dollar case, have a clear incentive to manufacture bad faith in every coverage dispute. As a result, the number and amounts of bad faith awards and insurance settlements will continue to inflate, inappropriately and unnecessarily driving up insurance costs.

INCREASED INSURANCE PREMIUMS

Ultimately, the costs of abusive bad faith litigation are borne not by a "wealthy insurer," but rather by individuals, small businesses, and other insurance consumers onto whom higher premiums are passed. As Justice Wells stated in the *Berges* case:

> Just as it is an obvious truth that "there is no free lunch," likewise, there is no free liability insurance. It is an undeniable fact which follows logic and common sense that bad faith judgments against insurers drive up the premium costs for all insureds, particularly for insureds who purchase low-limits liability insurance policies. Liability insurance is a pool of money. The pool is filled by premiums and drained by claims. When an insured purchases and pays premiums on $20,000 of insurance but the insurer pays $2.5 million in claims, someone has to fill up the pool. Initially, this amount may come out of an insurer's profits, but eventually the someones are the other insureds, whose premiums are increased.[60]

Despite this common sense explanation, those wishing to maintain the status quo and continue allowing abusive bad faith litigation in Florida often erroneously claim that bad faith awards do not result in higher insurance premiums. They point to Florida's law excluding the use of any bad faith judgment or settlement in insurance rate-setting.[61] While it is true that such judgments or settlements are not to be directly incorporated into an insurer's rate-setting, the fact remains that these payouts do affect premiums. Quite simply, at some level,

they must. It is not a sustainable business model for any insurer to collect premiums for a $10,000 policy and pay out $10 million in damages; they would quickly become insolvent.

As a practical matter, there are numerous ways in which a bad faith award or settlement can creep into the determination of insurance rates. For example, plaintiffs' attorneys, eager to facilitate a settlement with an insurer, will often offer to re-classify bad faith damages as breach of contract damages or some manner of extra-contractual damages that can go into the direct calculation of rate-setting. These attorneys often will not care how damages are classified or whether insurance rates go up. Rather, they care about securing a substantial settlement and avoiding the costs and risks of litigation.

In addition, the systemic risks associated with the threat of future bad faith litigation can be included in setting insurance rates and premiums. For instance, if all insurers justifiably become increasingly fearful of tort litigation such that the risks associated with doing business in Florida increase, or bad faith lawsuits drive some insurers out of the market, these factors will impact premiums even though they do not relate directly to a particular judgment or settlement. Moreover, the statute preventing bad faith awards or settlements from being included in rate-setting is designed to remove the individual risks associated with that "bad" insurer; it does not disregard the generalized risk that abusive bad faith litigation causes everyone. These risks over time lead to higher insurance premiums.

INCREASED AFFORDABILITY / AVAILABILITY CONCERNS

Increases in insurance premiums produce multiple adverse impacts for consumers and the public at large. First, higher premiums can result in consumers purchasing less insurance than they may reasonably require, leaving them in a precarious financial situation in the event of a serious accident and creating a moral hazard where accident victims are less likely to obtain a complete recovery. Second, higher premiums can price many consumers out of the market for insurance altogether, increasing the number of uninsured and underinsured, and further increasing costs for those able to maintain insurance. Third, higher premiums reducing the demand for insurance can cause insurers to discontinue or substantially curtail their insurance services, penalizing consumers through less insurer competition and fewer coverage choices. Ultimately, these effects further impair the affordability of insurance, hamper the availability of insurance, and hinder the full recovery of accident victims.

INCREASED INSURANCE FRAUD

In addition to the adverse impacts of higher premiums on the affordability and availability of insurance, both insurers and consumers can also be harmed by a greater incidence of insurance fraud. If reforms such as more reasonable time periods are not provided to fully investigate claims, more claimants will soon learn how to manipulate the insurance system by leveraging a bad faith claim to mask their insurance fraud. This problem will only escalate with time, particularly as the strategies and other means employed to frustrate an insurer's claims handling process become more innovative and developed. Insurers will be effectively forced to settle more unmeritorious claims. The resulting increase in costs throughout the insurance system will similarly be passed on to all insurance consumers.

Conclusion

The Florida Legislature should take action to make reasonable, moderate, and common sense changes to its bad faith law. The state's bad faith statute is prone to significant and widespread abuses by plaintiffs' counsel who have been able to successfully extract extra-contractual damages from insurers where the insurer has not purposefully delayed or denied a claim, but rather is, in fact, quite willing to reach a just settlement. This ineffective and unfair system can be greatly improved through simple measures, such as those proposed in H.B. 427, the Fair Settlement Act. This legislation would remove much of the unfair leverage claimants' attorneys currently place on insurers through tactics designed to frustrate the claims handling process. It would also benefit consumers who are made to pay more for their insurance because of the improper and abusive acts of others.

If Florida fails to act, the long term consequences to the state's insurance system will be severe and the abuses will only grow worse. Now is the time to end the games and restore good faith and balance to the law of bad faith.

ABOUT THE AUTHOR

VICTOR E. SCHWARTZ is Chairman of the Public Policy Group in the Washington, D.C. office of the law firm of Shook, Hardy & Bacon L.L.P. Mr. Schwartz, a former Dean at the University of Cincinnati College of Law, co-authors COMPARATIVE NEGLIGENCE (5th ed. 2010), the principal text on the subject. He also authors the most widely used torts casebook in the United States, PROSSER, WADE AND SCHWARTZ'S TORTS (12th ed. 2010). Mr. Schwartz has served on the Advisory Committees of the American Law Institute's RESTATEMENT OF THE LAW (THIRD) OF TORTS: PRODUCTS LIABILITY, APPORTIONMENT OF LIABILITY, and GENERAL PRINCIPLES projects. He received his B.A. *summa cum laude* from Boston University and his J.D. *magna cum laude* from Columbia University.

Endnotes

1. *See* Victor E. Schwartz & Christopher E. Appel, *Common-Sense Construction of Unfair Claims Settlement Laws: Restoring the Good Faith in Bad Faith*, 58 AM. U. L. REV. 1477, 1485 (2009).
2. *See id.* at 1485-86.
3. 416 F.2d 1059 (5th Cir. 1969).
4. 630 So. 2d 179 (Fla. 1994).
5. *See Hadley v. Baxendale*, 9 Ex. 341, 156 Eng. Rep. 145 (1854) (limiting damages to those contingencies within the mutual contemplation of the parties at the time of the contract); *see also* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 7.7 (1988) (discussing the emergence of bad faith laws and the available recourse against insurers for purposeful delays in paying a claim or a failure to pay).
6. *See* Roger Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. MICH. J. L. REFORM 1, 32 (1992) (arguing that while "the new tort remedy [is] necessary in some form, [it] now shows signs of being too oppressive on an industry whose financial vitality and efficiency are essential to social well-being").
7. *See* Schwartz & Appel, *supra* note 1, at 1478; *see also* Henderson, *supra* note 6, at 1 (noting that the development of bad-faith law is noteworthy because courts have only recognized three or four new torts in the past century).
8. *See* Schwartz & Appel, *supra* note 1, at 1485-87.
9. *See* Mark J. Browne, Ellen S. Pryor & Bob Puelz, *The Effect of Bad Faith Laws on First-Party Insurance Claims Decisions*, 33 J. LEGAL STUD. 355, 360-81 (2004); Dominick C. Capozzola, *First-Party Bad Faith: The Search for a Uniform Standard of Culpability*, 52 HASTINGS L.J. 181, 185-86 (2000) (discussing the emergence in *Comunale v. Traders & General Insurance Co.*, 328 P.2d 198 (Cal. 1958), of a duty to settle claims in excess of policy limits).
10. *See* Alan O. Sykes, *Bad Faith Breach of Contract By First-Party Insurers*, 25 J. LEGAL STUD. 405, 406 (1996).
11. 328 P.2d 198 (Cal. 1958).
12. *See id.* at 201 ("When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement . . . [the insurer's] unwarranted refusal to do so constitutes a breach of the implied covenant of good faith and fair dealing.").
13. *Id.* at 202.
14. 510 P.2d 1032 (Cal. 1973).
15. *See id.* at 1037 (holding that an insurer may be liable in tort for failing to compensate insured).
16. *See id.* at 1038 (noting that the plaintiff alleged that the defendants conspired to encourage criminal charges against the plaintiff by wrongly implying that the plaintiff had a motive to commit arson).
17. *See, e.g.*, *Comunale*, 328 P.2d at 201 (distinguishing insurance companies' duty to compensate third parties (which is limited to the policy amount) from insurance

companies' duty to insureds (first parties) for insurance company breach of contract); *see also Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 178 (Cal. 1967) (affirming judgment of emotional damages for third-party plaintiff against insurer).

18. The California Court of Appeal case, *Wetherbee v. United Insurance Co.*, 71 Cal. Rptr. 764 (Ct. App. 1968), *aff'd* 95 Cal. Rptr. 678 (Ct. App. 1971), appears to be the first to permit extra-contractual damages in the first-party insurance context. *See id.* at 767 (insured under disability policy awarded $500,000 punitive damages and $1,050 compensatory damages relating to claim for $150 in monthly benefits). Two years later, the Court of Appeal affirmed after remittitur, punitive and compensatory damages for an insurer's intentional infliction of emotional distress resulting from the insurer's wrongful refusal to pay the insured's disability claim, and stated that independent of that tort, the threatened and actual bad faith acts constituted a "tortious interference to a protected property interest." *Fletcher v. Western Nat'l Life Ins. Corp.*, 89 Cal. Rptr. 78 (Ct. App. 1970). In 1972, the court similarly relied upon this theory to justify a punitive damage award in an uninsured motorist case. *See Richardson v. Employers Liab. Assurance Corp.*, 102 Cal. Rptr. 547 (Ct. App. 1972), *overruled on other grounds by Gruenberg*, 510 P.2d at 1042 n.10; *see also* Kelly H. Thompson, Comment, *Bad Faith: Limiting Insurers' Extra-Contractual Liability in Texas*, 41 Sw. L.J. 719, 719 (1987) ("California pioneered the development of insurers' extra-contractual liability . . . .").

19. *Gruenberg*, 510 P.2d at 1037.

20. *See, e.g.*, *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1156 n.6 (Alaska 1989) (allowing an action in tort for breach of good faith and fair dealing in insurance contracts due to the unequal bargaining power of insurers and insureds); *Chavers v. Nat'l Sec. Fire & Cas. Co.*, 405 So. 2d 1, 6 (Ala. 1981) (refusing to allow insurers to deny claims in bad faith, where insurers know "that the avowed purpose of the insurance contract [i]s to protect the insured at his weakest and most perilous time of need"). A number of states that expressly rejected a common law cause of action for bad faith in first-party claims permit third-party actions. *See, e.g.*, *Johnson v. Fed. Kemper Ins. Co.*, 536 A.2d 1211, 1212-13 (Md. Ct. Spec. App. 1988); *Duncan v. Andrew County Mut. Ins. Co.*, 665 S.W.2d 13, 18-19 (Mo. Ct. App. 1983); *Lawton v. Great Sw. Fire Ins. Co.*, 392 A.2d 576, 581 (N.H. 1978); *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 799 (Utah 1985).

21. State supreme court decisions expanding bad-faith tort actions to first-party claimants during this period include: *Chavers v. Nat'l Sec. Fire & Cas. Co.*, 405 So. 2d 1 (Ala. 1981); *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152 (Alaska 1989); *Aetna Cas. & Sur. Co. v. Broadway Arms Corp.*, 664 S.W.2d 463 (Ark. 1984); *Travelers Ins. Co. v. Savio*, 706 P.2d 1258 (Colo. 1985); *Buckman v. People Express, Inc.*, 530 A.2d 596 (Conn. 1987); *White v. Unigard Mut. Ins. Co.*, 730 P.2d 1014 (Idaho 1986); *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790 (Iowa 1988); *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176 (Ky. 1989); *State Farm Fire & Cas. Co., v. Simpson*, 477 So. 2d 242 (Miss. 1985); *Lipinski v. Title Ins. Co.*, 655 P.2d 970 (Mont. 1982); *Braesch v. Union Ins. Co.*, 464 N.W.2d 769 (Neb. 1991); *United Fire Ins. Co. v. McClelland*, 780 P.2d 193 (Nev. 1989); *State Farm Gen. Ins. Co. v. Clifton*, 527 P.2d 798 (N.M. 1974); *Corwin Chrysler-Plymouth, Inc. v. Westchester Fire Ins. Co.*, 279 N.W.2d 638 (N.D. 1979); *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315 (Ohio 1983); *Christian v. Am. Home Assurance Co.*, 577 P.2d 899 (Okla. 1977); *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313 (R.I. 1980); *Nichols v. State Farm Mut. Auto. Ins. Co.*, 306 S.E.2d 616 (S.C. 1983);

Champion v. U.S. Fid. & Guar. Co., 399 N.W.2d 320 (S.D. 1987); *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165 (Tex. 1987); and *Anderson v. Cont. Ins. Co.*, 271 N.W.2d 368 (Wis. 1978). States continued to recognize first-party bad faith suits into the 1990s. *See Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254 (Del. 1995); *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334 (Haw. 1996); *Erie Ins. Co. v. Hickman*, 622 N.E.2d 515 (Ind. 1993); Marquis v. Farm Family Mut. Ins. Co., 628 A.2d 644 (Me. 1993); *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855 (Wyo. 1990). *See generally* Browne et al., *supra* note 9, at 355; Capozzola, *supra* note 9, at 182; A.S. Klein, Annotation, *Insurer's Liability for Consequential or Punitive Damages for Wrongful Delay or Refusal to Make Payments Due Under Contracts*, 47 A.L.R.3d 314 (1992).

22. *See* Marc S. Mayerson, *"First Party" Insurance Bad Faith Claims: Mooring Procedure to Substance*, 38 TORT TRIAL & INS. PRAC. L.J. 861, 863 n.6 (2003) (discussing state level, non-judicially promulgated standards and rules for insurance company conduct).

23. *See, e.g., DeMaria v. DeMaria*, 724 A.2d 1088, 1091 (Conn. 1999) (noting that "statutes are a useful source of policy for common-law adjudication, particularly when there is a close relationship between the statutory and common-law subject matters").

24. *See* ALA. CODE § 27-12-24 (LexisNexis 2007); ALASKA STAT. § 21.36.125 (2008); ARIZ. REV. STAT. ANN. § 20-461 (2002); ARK. CODE ANN. § 23-66-206 (2001); CAL. INS. CODE § 790.03(h) (West 2005); COLO. REV. STAT. § 10-3-1104(1)(h), 10-3-1115 to -1116 (2008); CONN. GEN. STAT. § 38A-816(6) (West 2007); DEL. CODE ANN. tit. 18, § 2304(16) (2009); FLA. STAT. ANN. §§ 624.155(1) (West 2004), 626.9541(1)(i) (West 2009), 766.1185 (West 2003); GA. CODE ANN. § 33-6-34 (2000); HAW. REV. STAT. ANN. § 431:13-103(a) (LexisNexis 2008); IDAHO CODE ANN. § 41-1329 (2003); 215 ILL. COMP. STAT. ANN. 5/154.6, 5/155 (West 2000); IND. CODE ANN. § 27-4-1-4.5 (LexisNexis 1999); IOWA CODE ANN. § 507B.4(9) (West 2007); KAN. STAT. ANN. § 40-2404(9) (2000); KY. REV. STAT. ANN. § 304.12-230 (2009); LA. REV. STAT. ANN. § 22:1220, 22:1973 (2004); ME. REV. STAT. ANN. tit. 24-A, §§ 2164-D, 2436-A (2000); MD. CODE ANN. INS. § 27-303 to -305, 27-1001 (LexisNexis 2006); MASS. ANN. LAWS ch. 93A, § 9, ch. 176D, § 3 (LexisNexis 2005); MICH. COMP. LAWS SERV. § 500.2026 (LexisNexis 2008); MINN. STAT. § 72A.20(12), 72A.201, 604.18; MO. REV. STAT. § 375.1007 (West 2002); MONT. CODE ANN. §§ 33-18-201, 33-18-242 (2007); NEB. REV. STAT. § 44-1540 (2004); NEV. REV. STAT. § 686A.310 (2007); N.H. REV. STAT. ANN. § 417:4(XV) (2006); N.J. STAT. ANN. § 17B:30-13.1 (West 2006); N.M. STAT. ANN. § 59A-16-20 (LexisNexis 2000); N.Y. INS. LAW § 2601 (McKinney Supp. 2009); N.C. GEN. STAT. §§ 58-63-15(11), 75-1.1 to -16 (2007); N.D. CENT. CODE § 26.1-04-03(9) (2002); OHIO REV. CODE ANN. § 3901.21(P) (LexisNexis Supp. 2009); OKLA. STAT. ANN. tit. 36, §§ 1250.4–.5 (West 1999 & Supp. 2009); OR. REV. STAT. § 746.230 (2007); 40 PA. CONS. STAT. § 1171.5(a)(10) (1999); 42 PA. CONS. STAT. § 8371 (West 2007); R.I. GEN. LAWS §§ 9-1-33 (1997), 27-9.1-4 (2008); S.C. CODE ANN. § 38-59-20 (2002); S.D. CODIFIED LAWS § 58-33-67 (2002); TENN. CODE ANN. § 47-18-109, 56-7-105, 56-8-104(8) (2008); TEX. INS. CODE ANN. § 542.003 (Vernon 2009); UTAH CODE ANN. § 31A-26-303 (2005); VT. STAT. ANN. tit. 8, § 4724(9) (2) (2005); VA. CODE ANN. § 38.2-510 (2007); WASH. REV. CODE ANN. § 48.30.015 (Supp. 2009); WASH. ADMIN. CODE § 284-30-330 (2009); W. VA. CODE R. ANN. §§ 33-11-4(9), 33-11-4a (2006); WYO. STAT. ANN. § 26-13-124 (2007). Mississippi and Wisconsin do not appear to have statutes specific to insurance bad faith or unfair claims settlement practices, but do generally prohibit unfair or deceptive insurance practices and set forth time periods in which claims must be paid.

See MISS. CODE ANN. §§ 83-5-33, -45, 83-9-5 (1999 & Supp. 2008); WIS. STAT. ANN. §§ 424.501, 628.46 (West 2004 & 2005). *But see* Kontowicz v. Am. Standard Ins. Co., 714 N.W.2d 105, 115 (Wis. 2006) (stating that the statute relating to the timely payment of insurance claims was unrelated to the tort action of bad faith).

25. NAIC originally promulgated the Model Unfair Trade Practices Act (MUTPA) in the 1950s with provisions for the regulation of insurer unfair trade practices, and all states had adopted it by 1959. *See* KEETON & WIDISS, *supra* note 5, § 8.1, at 932-34; Schwartz & Appel, *supra* note 1, at 1512, n.169; Henderson, *supra* note 6, at 14. However, the original model act mainly dealt with the marketing practices of insurers. New model legislation dealing with unfair claims settlement practices was developed and incorporated into the MUTPA by amendment in 1972. Proceedings of the National Association of Insurance Commissioners 495 (1972) [hereinafter Proceedings].

26. *See* Proceedings, *supra* note 25, at 495-96.

27. The states adopting NAIC's model legislation near wholesale include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Washington, West Virginia, and Wyoming. *See, e.g.*, Knotts v. Zurich Ins. Co., 197 S.W.3d 512, 528 (Ky. 2006) (stating that Kentucky's Unfair Claims Settlement Practices Act was enacted almost verbatim from the NAIC model act and that the act has been adopted in varying forms in all fifty states and United States territories). Other states have adopted nearly identical language for less substantial portions of their unfair claims settlement statutes. These states include Mississippi, New Mexico, Oklahoma, South Dakota, Texas, and Utah. *See, e.g.*, *Lewis v. Equity Nat'l Life Ins. Co.*, 637 So.2d 183 (Miss. 1994) (stating that Mississippi's unfair claims settlement act was based from model NAIC legislation drafted in 1976).

28. *See, e.g.*, IDAHO CODE ANN. § 41-1329 (2003) (adopting the model legislation without significant modification or additional claims settlement provisions).

29. *Compare* GA. CODE ANN. § 33-4-7 (West 2000) (permitting a claimant to initiate a civil action based on bad faith only after the claimant has attempted to settle with the insurer) *with* ARIZ. REV. STAT. ANN. § 20-461(19)(D) (West Supp. 2004) (noting that although the unfair claims settlement practices statute provides a right to an administrative remedy, it does not provide any private right of action for insureds).

30. *See Lees v. Middlesex Ins. Co.*, 643 A.2d 1282, 1286 (Conn. 1994) (implying a private right of action for violation of the Unfair Insurance Practices Act in cases where the insurer's action rises to the level of a general business practice); *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176, 178 (Ky. 1989) (implying a right of action for first-party claimants based, in part, on a public policy argument for the advantages of permitting recovery when an insurer acts in bad faith); *State Farm Mut. Auto Ins. Co. v. Reeder*, 763 S.W.2d 116, 117-18 (Ky. 1988) (reasoning that a third–party private right of action was permissible, because the insurer had clearly violated the Unfair Claims Settlement Practice Act and the Act did not specifically prohibit such a claim); *Dodd v. Commercial Union Ins. Co.*, 365 N.E.2d 802, 805 (Mass. 1977) (holding that the legislature's failure to specifically provide for a private right of action under the state consumer protection act does not demonstrate an intent to prohibit such a claim), *superseded by statute*, MASS. GEN. LAWS ch. 93A, § 9(1) (2002), *as recognized in Hershenow v. Enter. Rent-A-Car Co.*,

840 N.E.2d 526, 532 (Mass. 2006); *Indus. Indem. Co. of N.W. v. Kallevig*, 792 P.2d 520, 530 (Wash. 1990) (finding that the plain language of the Washington State Consumer Protection Act supported an insured's private bad–faith cause of action against an insurer). In *Royal Globe Insurance Co. v. Superior Court*, 592 P.2d 329, 332 (Cal. 1979), the California Supreme Court was the first to hold that a private cause of action existed for a violation under its version of the model NAIC legislation, but reversed itself almost a decade later. *See Moradi-Shalal v. Fireman's Fund Ins. Co.*, 758 P.2d 58, 68 (Cal. 1988) (arguing that the *Royal Globe* decision was based primarily on public policy, and that resolutions based on competing policy issues are more properly addressed by the legislature). West Virginia also initially implied a private right of action in *Jenkins v. J. C. Penney Casualty Insurance Co.*, 280 S.E.2d 252 (W. Va. 1981), but later enacted legislation superseding the decision. *See* W. VA. CODE ANN. § 33-11-4a (LexisNexis 2006) (abrogating a private cause of action relating to bad-faith settlements of insurance claims). Conversely, in Montana, an implied right of action was superseded by a statute that allowed private enforcement. *See Klaudt v. State Farm Mut. Auto. Ins. Co.*, 658 P.2d 1065, 1067 (Mont. 1983) (finding that the statutory language on its face clearly protected third-party claims), *superseded by statute*, Unfair Trade Practices Act, MONT. CODE ANN. § 33-18-242 (2007), *as recognized in O'Fallon v. Farmers Ins. Exch.*, 859 P.2d 1008, 1014-15 (Mont. 1993) (noting that the new law was more permissive because, to allow for a private right of action, it did not require violations of the code to be so frequent as to rise to a general business practice).

31. *See Spencer v. Aetna Life & Cas. Ins. Co.*, 611 P.2d 149, 158 (Kan. 1980) (finding that the legislature provided multiple detailed alternative remedies, including those related to bad faith on the part of insurer, for a wronged insured); *Lawton v. Great S.W. Fire Ins. Co.*, 392 A.2d 576, 581 (N.H. 1978) (rejecting a private action and noting that the legislature established alternative mechanisms to handle insurer malfeasance); *D'Ambrosio v. Penn. Nat'l Mut. Cas. Ins. Co.*, 431 A.2d 966, 970 (Pa. 1981) (reasoning that allowing a private cause of action in addition to the enforcement mechanisms available to the Pennsylvania Insurance Commissioner would require the court to improperly delve into policy issues), *superseded by statute*, 42 PA. CONS. STAT. § 8371 (2007); *cf. Farris v. U.S. Fid. & Guar. Co.*, 587 P.2d 1015, 1020 (Or. 1978) (explaining that although the need for private enforcement based on bad faith might arise in extraordinary circumstances, traditional contract remedies are almost always adequate for insurance cases).

32. *See, e.g.*, *Bates v. Allied Mut. Ins. Co.*, 467 N.W.2d 255, 258 (Iowa 1991) (arguing that the adversarial nature of the relationship between the insurer and a third-party claimant, unlike the fiduciary relationship between an insurer and the insured does not provide a basis for a good-faith duty to settle a claim); *Dvorak v. Am. Family Mut. Ins. Co.*, 508 N.W.2d 329, 331 (N.D. 1993) (explaining that an insurer's duty to settle in good-faith extends only to insureds, because, unlike third parties, insureds are direct beneficiaries of the insurer's actions); *Kallevig*, 792 P.2d at 528-30 (holding that the statutory language provides a private right of action for first-party claimants only); *Kranzush v. Badger State Mut. Cas. Co.*, 307 N.W.2d 256, 265 (Wis. 1981) (arguing that a bad-faith tort claim, while distinct from a breach of contract claim, still arises from the insurance contract and therefore only extends to the insured).

33. *See, e.g.*, *Wailua Assocs. v. Aetna Cos. & Sur. Co.*, 27 F. Supp. 2d 1211, 1221 (D. Haw. 1998) (stating that although no private right of action exists under Hawaii's unfair

claims settlement statute, it may nevertheless be used as evidence of insurer bad faith in a common law action); *see also Kontowicz v. Am. Standards, Inc. Co.*, 714 N.W.2d 105, 114-15 (Wis. 2006) (supporting an unfair claims settlement, in part, with broad statutory principles from case law on bad-faith tort claims).

34. *See* 215 ILL. REV. STAT. ANN. § 5/154.6(o); MO. REV. STAT. § 375.1007(13); R.I. GEN. LAWS § 27-9.1-4(13).

35. *See, e.g.*, FLA. STAT. ANN. § 626.9541(1)(i)(3)(e); OKLA. STAT. tit. 36, § 1250.4(C); R.I. GEN. LAWS § 27-9.1-4(16); S.D. CODIFIED LAWS § 58-33-67(1).

36. *See, e.g.*, CONN. GEN. STAT. § 38a-816(15)(B) (requiring an insurer to settle claims within forty-five days); N.M. STAT. ANN. § 59A-16-20(F) (characterizing the failure to settle "catastrophic claims" within ninety days as a prohibited unfair claims practice); W. VA. CODE § 33-11-4(9)(o) (requiring claims to be settled within a ninety-day period).

37. *See* OKLA. STAT. ANN. tit. 36, § 1250.14.

38. *See* MD. CODE ANN. INS. § 27-1001.

39. *See* MASS. GEN. LAWS ch. 176D, § 7; MASS. GEN. LAWS ch. 93A, § 9.

40. *See* LA. REV. STAT. ANN. § 22:1973(C).

41. 250 So. 2d 259 (Fla. 1971).

42. *Id.* at 264.

43. *See* FLA. STAT. § 624.155.

44. *Id.*; *see also Opperman v. Nationwide Mut. Fire Ins. Co.,* 515 So. 2d 263, 266 (Fla. 5th DCA 1987)

45. John J. Pappas, *Butler Pappas on Bad Faith*, Mealey's Litigation Report: Insurance Bad Faith, Vol. 18, No. 12 (October 19, 2004).

46. 896 So. 2d 665 (Fla. 2004)

47. *Id.* at 685 (Wells, J., dissenting).

48. 358 F. Supp.2d 1125 (N.D. Fl. 2003).

49. *See id.* at 1126-27.

50. 2011 WL 1135518 (Fl. Ct. App. Mar. 30, 2011).

51. *Id.* at *7.

52. *See Farinas v. Florida Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555 (Fla. 4th DCA 2003), *rev. denied*, (Fla. Mar. 17, 2004).

53. *See* FLA. STAT. § 627.4137.

54. 584 So. 2d 12 (Fla. Ct. App. 1991).

55. Case No. 8:06-CV-563-T24 MAP (M.D. Fla. 2007).

56. Defendant's Motion for Summary Judgment and Memorandum of Law in Support, Mendez v. Unitrin Direct Prop. & Cas. Ins. Co., Case No. 8:06-CV-563-T24 MAP (M.D. Fla. 2007), at 5.

57. One type of strict time restriction, which exists in several states, applies to the payment of claims after the insurer has affirmatively acknowledged liability and should be viewed in a separate light. For example, in Hawaii and Maine, an insurer has thirty days to tender payment after accepting liability. *See* HAW. REV. STAT. § 431:13-103(11)(F) (2008); ME. REV. STAT. tit. 24-A § 2436(1) (2008). This situation is distinguishable because the claim-processing and investigation periods have terminated. The insurer has an undisputed liability, meaning it is less likely that there is a reasonable basis for not paying within the legislatively prescribed period.

58. Some estimates state the loss that results from insurance fraud at around $80 billion annually. *See* How Big is $80 Billion?, Coalition Against Insurance Fraud,

http://www.insurancefraud.org/80_billion.htm.

59. *See* Robert W. Emerson, *Insurance Adjusters and Plaintiffs' Attorneys: From Claims Fraud Consensus to Settlement Reform*, 30 AM. BUS. L.J. 538, 567-68 (1993) (noting that the ease with which claimants can pursue a bad-faith claim adversely impacts insurers' ability to investigate because they are working within shorter time constraints imposed by the claimant).

60. *Berges*, 896 So. 2d at 686.

61. *See* Fla. Stat. Ann. § 627.0651(12).