

**FLORIDA BAD FAITH**

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**INTRODUCTION.....3**

**THIRD PARTY COMMON LAW BAD FAITH.....3**

**Overview .....3**

**Florida's Claims Administration Statute.....5**

**Florida Law Governing Estoppel.....9**

**The Tripartite Relationship – Florida style ..... 10**

**FIRST AND THIRD PARTY STATUTORY BAD FAITH – FLORIDA**

**STAT. § 624.155..... 18**

**Failure to Settle and Unfair Trade Practice Element..... 18**

**Procedural Issues..... 20**

*A 60 Day Safe Harbor, with a shoal or two ..... 20*

**Prior Resolution of the underlying coverage claim ..... 24**

**Territorial Effect ..... 25**

**Discovery Implications ..... 26**

*Relevancy Issues – State Law ..... 26*

*Relevancy Issues – Federal Law..... 28*

*Florida Law – Third Party Privileges..... 28*

*Florida Law – First Party ..... 31*

**Unresolved Waiver Issues ..... 33**

**DAMAGES..... 39**

**Getting There - Summary Judgment standard in Florida Bad Faith  
    and the Demise of the “Fairly Debatable” Test ..... 39**

<b>Attorneys' Fees and Costs – Driving Both Ways on the One-Way Street.....</b>	<b>41</b>
<b>Compensatory Damages.....</b>	<b>44</b>
<i>First Party</i> .....	44
<i>Third Party</i> .....	45
<i>Emotional Distress</i> .....	46
<b>Punitive Damages .....</b>	<b>48</b>
<b>HOT ISSUES.....</b>	<b>49</b>
<b>Whether Punitive Damages are Capped by Florida's Tort Reform Act .....</b>	<b>49</b>
<b>Arbitration of Insurance Coverage and Bad Faith Cases: Is Insurance Different?.....</b>	<b>50</b>
<b>ERISA preemption of Florida Stat. §624.155.....</b>	<b>53</b>
<b>Revisions to Florida's Standard Bad Faith Jury Instructions .....</b>	<b>60</b>

## **INTRODUCTION**

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Florida was the first state to legislatively open the Unfair Insurance Claims Practices Act (UITPA) to private enforcement and, though many of its approaches to bad faith will be familiar to other practitioners, it hasn't been shy about statutory innovation. Florida's Supreme Court, moreover, just adopted extensive professional conduct guidelines on the thorny tripartite relationship issue, and no small number of Florida's bad faith procedures and statutes contain unique elements.

We begin, however, with old news — the basic tenets and obligations of Florida's common law of third party bad faith.

## **THIRD PARTY COMMON LAW BAD FAITH**

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### **Overview**

Florida held insurers in third party cases to fiduciary responsibilities ("the management of his own business") as long ago as *Auto Mut. Indemnity Co. v. Shaw*, 184 So. 852, 859 (Fla. 1938). Common law bad faith, however, was limited to third party cases.

Over time, Florida courts have distilled the responsibilities of third party "good faith" to include the duty to: (1) advise the insured of settlement opportunities; (2) advise as to the probable outcome of litigation; (3) warn about the possibility of an excess judgment; (4) advise the insured of precautions that he might take to avoid an excess; (5) investigate the facts; (6) give fair consideration to settlement offers; and (7) where

reasonable, pay the full judgment. *Boston Old Colony Insurance Co. v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980) *cert. denied*, 450 U.S. 922 (1981); *Holler v. Int'l Bankers Ins. Co.*, 572 So.2d 937, 939 (Fla. 3d DCA 1991). Florida law, however, consistently refused to extend bad faith to first party cases.<sup>1</sup>

The Eleventh Circuit Court of Appeals described the purpose and nature of bad faith as follows:

Third-Party bad faith actions by insureds have traditionally been justified as policing a fiduciary relationship between the insured and the insurance company, i.e., the insurance company is contractually obligated to place the insured's interests (in avoiding exposure to an excess judgment) ahead of its own (in paying as little as possible).

*Jones v. Continental Ins. Co.*, 920 F.2d 847, 851 (11<sup>th</sup> Cir. (Fla.) 1991).

The absence of a settlement offer will not defeat bad faith. If liability is so clear and the injuries so serious that an excess judgment is likely, the *insurer* must initiate

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<sup>1</sup> Efforts to secure a judicial evolution of a first party bad faith tort failed, whether founded on UITPA or third party grounds, in *Cycle Dealers Ins. Inc. v. Bankers Ins. Co.*, 394 So. 2d 1123 (Fla. 5th DCA 1981); *Coira v. Florida Medical Assoc.*, 429 So. 2d 23 (Fla. 3d DCA 1982); *Shupak v. Allstate Ins. Co.*, 367 So. 2d 1103 (Fla. 3d DCA 1979); *Midwest Mutual Ins. Co. v. Brasecker*, 311 So. 2d 817 (Fla. 3d DCA 1975), *cert. denied* 327 So. 2d 31 (Fla. 1976); *Baxter v. Royal Indemnity Co.*, 285 So. 2d 652 (Fla. 1st DCA 1973), *cert. discharged*, 317 So. 2d 725 (Fla. 1975). In *Smith v. Standard Guaranty Ins. Co.*, 435 So. 2d 848 (Fla. 2d DCA 1983), the Court held: "At best, Standard's handling of Smith's claim was bungling and arbitrary. In any event, it was sufficiently callous that a jury would be justified in concluding that Standard was guilty of bad faith. However, our Florida courts have consistently held that a suit for punitive damages will not lie against an insurance company for bad faith in failing to pay a first party claim." 435 So. 2d at 849.

settlement negotiations. See *Powell v. Prudential Property & Casualty Ins. Co.*, 584 So.2d 12, 14 (Fla. 3d DCA 1991), *rev. denied*, 598 So.2d 77 (Fla. 1992). But an insurer's one-month delay to verify the claim before tendering the policy limits was found insufficient to support a bad faith claim in *Clauss v. Fortune Ins. Co.*, 523 So.2d 1177, 1178 (Fla. 5<sup>th</sup> DCA 1988). Likewise, it's improper to "set up" an insurer by making a settlement offer with any unreasonably brief deadline, then refusing the offer shortly after the deadline. See *DeLaune v. Liberty Mutual Ins. Co.*, 314 So.2d 601 (Fla. 4<sup>th</sup> DCA 1975), *cert. denied*, 330 So.2d 16 (Fla. 1976).

#### **Florida's Claims Administration Statute**

An insurance company's obligations when faced with a policyholder's request for a defense in a liability action are also imposed by statute. An insurance company is:

[N]ot permitted to deny coverage based on a particular coverage defense unless:

- (a) Within 30 days after the liability insurer knew or should have known of the coverage defense, written notice of reservation of rights to assert a coverage defense is given to the named insured by registered or certified mail sent to the last known address of the insured or by hand delivery; and
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(b) Within 60 days of compliance with paragraph (a) or receipt of a summons and complaint naming the insured as a defendant, whichever is later . . . , the insurer:

1. Gives written notice to the named insured by registered or certified mail of its refusal to defend the insured;
2. Obtains from the insured a nonwaiver agreement following full disclosure of the specific facts and policy provisions upon which the coverage defense is asserted and the duties, obligations and liabilities of the insurer during and following the pendency of the subject litigation; or
3. Retains independent counsel which is mutually agreeable to the parties. . . .

Florida Statute § 627.426(2) (1992). The statute thus compels a reservation of rights letter in the event of a limitation upon the coverage provided, followed by a choice of three options: a refusal to defend the insured, or a non-waiver agreement, or the retention of independent counsel “mutually agreeable to the parties.”

The purpose of a reservation of rights is to afford the insured a defense while protecting the rights of the carrier when the duties to defend and indemnify cannot clearly be determined. It allows both parties to the insurance contract to protection bargained for in connection with the third-party suit and reserves coverage issues to a more appropriate forum and time.

\* \* \*

The specific purpose of a reservation of rights is to preclude the application of estoppel and waiver.

*Truck Ins. Exchange v. Superior Court*, 59 Cal.Rptr.2d 529, 536 (Ct. App. Cal. 1996).  
*See also First United Bank of Bellevue v. First American Title Ins. Co.*, 496 N.W.2d 474, 481 (Neb. 1993).

As the court stated in *Bellevue*, once an insurance company reserves its rights to later deny coverage, the policyholder then acquires the right to reject the reservation of rights “and take over the defense itself. . . . The policy reasons underlying reservation of rights are two-fold: (1) to allow an insured to more ably protect its own interests by retaining control over its own defense, and (2) to avoid conflicts of interest between the insurer and its insured.” *Bellevue*, 496 N.W.2d at 481.

The right of the policyholder to control its own defense in the presence of a timely reservation of rights is established in Florida, where the seminal case is *Taylor v. Safeco Ins. Co.*, 361 So.2d 743 (Fla. 1st DCA 1978). The *Taylor* court found no breach of the policyholder’s duty to cooperate where the policyholder refused to surrender control of his defense to the insurer which, although willing to defend, reserved its rights and thus potentially disclaimed responsibility for any resulting judgment. As the court stated in *Nationwide Mutual Fire Ins. Co. v. Keen*, 658 So.2d 1101, 1103 (Fla. 4th DCA 1995), *rev. dismissed*, 666 So.2d 143 (Fla. 1995) “an insured is always free to refuse a defense

under a reservation of rights.”<sup>2</sup> Of course, if the insurance company fails timely to reserve its rights and instead promises full coverage to its policyholder, *who* controls the defense becomes somewhat of an academic issue because there is no threatened loss of coverage and the insurance company is spending its own money. See also *Nationwide Mut. Fire Ins. Co. v. Beville*, 825 So.2d 999 (Fla. 4<sup>th</sup> DCA 2002) (following *Taylor*).

A timely reservation of rights enables the policyholder to know which coverage defense or limitations on coverage are asserted, giving him the ability to initiate a coverage case seeking to obtain clarification of the policyholder’s rights and obligations before the underlying tort claim gets settled or tried. Additionally,

If the insured refuses [a defense under reservation of rights], the claims administration statute requires that the carrier immediately seek a declaratory judgment as to the rights and obligations and liabilities of the parties.

*Keen*, 658 So.2d at 1103. Last, and as the Court held in *American Empire Surplus Lines Ins. Co. v. Gold Coast Elevator, Inc.*, 701 So.2d 904 (Fla. 4<sup>th</sup> DCA 1997), *rev. denied*, 717 So.2d 527 (Fla. 1998), an insurance company cannot simply pick the lawyer of its choosing in the presence of a reservation of rights. Rather, a liability insurer has a statutory duty to select mutually-agreeable counsel.

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<sup>2</sup> See also *Nationwide Mut. Fire Ins. Co. v. Beville*, 825 So.2d 999 (Fla. 4<sup>th</sup> DCA 2002) (following *Taylor*).



We find the language of the statute to be clear, and that unilateral retention of counsel by the insurer, which was the very antithesis of a mutual selection, did not comply [with the statute].

701 So.2d at 906.

### **Florida Law Governing Estoppel**

While the general rule is that insurance typically cannot be created by principles of estoppel, an exception was pioneered by the court in *Cigarette Racing Team, Inc. v. Parliament Ins. Co.*, 395 So.2d 1238, 1239-40 (Fla. 4th DCA 1981). Florida now follows the majority of jurisdictions which recognize an exception to this general rule when the conduct alleged to constitute the estoppel occurs in connection with an insurance carrier's performance of its defense obligations. "[W]hen an insurance company assumes the defense of an action, with knowledge, actual or presumed, of facts which would have permitted it to deny coverage, it may be estopped from subsequently raising the defense of non-coverage." *Cigarette Racing*, 395 So.2d 1238, 1239-40 (Fla. 4th DCA 1981). This exception, known as equitable estoppel,<sup>3</sup> was expressly endorsed by the Florida Supreme Court in *Doe on behalf of Doe v. AllState Ins. Co.*, 653 So.2d 371 (Fla. 1995):

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<sup>3</sup> Florida law also recognizes that the form of estoppel known as promissory estoppel may be utilized to create insurance coverage where to refuse to do so would sanction fraud or other injustice. See *Crown Life Ins. Co. v. McBride*, 517 So.2d 660,662 (Fla. 1987) (promissory estoppel is usually applied "where the promisor reasonably should have expected that his affirmative representations would induce the promisee into action or forbearance substantial in nature, and where the promisee shows that such reliance thereon was to his detriment").

Thus, when the insurer undertakes the defense of a claim on behalf of one claiming to be an insured, we have recognized substantial duties on the part of both the insurer and the insured. If an insurer erroneously begins to carry out these duties, and the insured, as required [by its obligation to allow the insurer to control the defense], relies upon the insurer to the insured's detriment, then the insurer should not be able to deny the coverage which it earlier acknowledged.

*Id* at 374.

### **The Tripartite Relationship – Florida style**

Generally speaking, no unusual ethical considerations are presented when an attorney represents either the policyholder or the insurance company directly, as in a first-party action. The kitchen temperature rises, however, when an insurer appoints counsel to defend a third-party claim. The “tripartite relationship” lends itself to a colorful selection of ethical dilemmas.

The most frequent scenario begins with a policyholder asserting a right to coverage under a liability insurance policy for a third-party claim. The insurance company, mindful of its duty to defend, appoints counsel to represent the insured, while simultaneously reserving its right to deny coverage. The resulting division of loyalties, conflicts of interest and other ethical concerns faced by the insurer-appointed counsel become so complex and confusing that the conundrum “would tax Socrates.” See *Hartford Acc. & Indem. Co. v. Foster*, 528 So.2d 255, 273 (Miss. 1988).

The issue of “who’s the client” remains unsettled. The insurance industry continues to assert that there is a tripartite relationship between defense counsel and the insurer and insured as “co-clients.” In the other corner, policyholders’ advocates contend that defense counsel can have only one “true” client, the insured, otherwise the insurer’s duty to defend would be meaningless. Perhaps sharpened by cost-cutting measures and litigation guidelines implemented by insurers in the last decade, this question has been the subject of extensive nationwide debate.

Seven states, including Arizona, Arkansas, Michigan, Montana, New York, Pennsylvania and Texas, have expressly rejected the notion of a tripartite relationship between the insured and the insurer, even where the policy language grants the insurer the “right to control.” See *Paradigm Ins. Co. v. Langerman Law Offices, P.A.*, 24 P.3d 593, 598 (Ariz. 2001); *In the Matter of the Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures*, 2 P.3d 806, 813 (Mont. 2000) (insured is attorney’s sole client); *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998) (insurer-appointed attorney owes unqualified loyalty to the insured); *Ingersoll-Rand Equipment Corp. v. Transp. Ins. Co.*, 963 F.Supp. 452, 454 (M.D. Pa. 1997) (the defense attorney’s client is the insured, not the insurer); *Atlanta Int’l Ins. Co. v. Bell*, 475 N.W. 2d 294, 296 (Mich. 1991) (no attorney/client relationship between insurer and attorney, only contractual duty); *First Am. Carriers Inc., v. Kroger Co.*, 787 S.W.2d 669, 671 (Ark. 1990); *Jackson v. Trapier*, 247 N.Y.S.2d 315, 316 (N.Y. Sup. Ct. 1964) (the moment the defense attorney is hired, the insured is the attorney’s client and not the insurance company).

Other states, including Indiana, Mississippi, Kansas, Alabama, Georgia, and California, recognize a tripartite relationship between the defense attorney, the insurer, and the insured. See *Cincinnati Ins. Co. v. Wills*, 717 N.E.2d 151, 161 (Ind. 1999) (even if problematic at times, policyholder-client and insurer-client relationship exists); *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So.2d 1062, 1070 (Miss. 1998) (defense attorney owes duties to both insured and insurer as separate and distinct clients); *Pacific Employers Ins. Co. v. P.B. Hoidale Co., Inc.*, 789 F.Supp. 1117, 1122 (D. Kan. 1992) (agency relationship exists between defense attorney and insurer, unclear whether rises to level of attorney-client relationship); *Mitchum v. Hudgens*, 533 So.2d 194, 198 (Ala. 1988) (defense attorney represents both the insured and the insurer and should further the interests of both); *Coscia v. Cunningham*, 299 S.E.2d 880, 881 (Ga. 1983) (defense attorney owes duty to and represents both the insured and the insurer); *American Mut. Liab. Ins. Co. v. Superior Court of Sacramento County*, 38 Cal.App.3d 579, 592 (Cal. 3rd DCA 1974) (defense attorney has two clients, the insured and the insurer, with overlapping and common interests).

Until the last few years, Florida had not directly addressed the question of whether the insurance defense lawyer serves two clients or one, and the most applicable guidance from the Florida Supreme Court dated back to a 1969 ruling rejecting a petition by the Florida Bar seeking approval for a rule that would greatly limit “in-house counsel” from representing third parties. See *In re Rules Governing the Conduct of Attorneys in Florida*, 220 So.2d 6, 7 (Fla. 1969). Although the court recognized the conflicts that could arise where an attorney represents two masters, it expressed a concern that the

Bar's petition was targeting one class of "masters," the insurance companies, even though the situation complained of could arise not only where the attorney is employed by a third party, but in any situation where there are two "masters." See *Id.*, 220 So.2d at 6.

This question only sharpened with time, however, and a Special Study Committee of the Insurance Practices Special Study Committee of The Florida Bar<sup>4</sup> was formed in May 1999 to investigate allegations that insurers were too influential in the defenses of their insureds, thereby practicing law without a license. The Committee solicited input from all sides, held hearings and issued several findings, but initially went not a lot further than expressing its concern that insurers' attempts to control the costs of litigation and settlement should not compromise appointed counsel's ability to act independently or the quality of representation provided to insureds. Report of the Insurance Practices Special Study Committee, pp. 13-16.

In September 2001, the Bar's Board of Governors approved the appointment of the Insurance Practices Special Study Commission II, which led to an April 25, 2002 adoption by the Florida Supreme Court of Rule 4-1.8(j) into the Rules of Professional Conduct.<sup>5</sup>

In pertinent part, the opening paragraph of Rule 4-1.8(j) provides:

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<sup>4</sup> The *Report of the Insurance Practices Special Study Committee*, published June 2, 2000 and available for downloading from [www.flabar.org](http://www.flabar.org), offers an excellent overview of the ethical issues involved in representing an insured, but explicitly refrains from taking a position on whether the insured or the insurer is the defense attorney's "true" client. See *Report*, p. 10.

(j) Representation of Insureds. When a lawyer undertakes the defense of an insured other than a governmental entity, at the expense of an insurance company, in regard to an action or claim for personal injury or for property damages, or for death or loss of services resulting from personal injuries based upon tortious conduct, including product liability claims, the Statement of Insured Client's Rights shall be provided to the insured at the commencement of the representation. The lawyer shall sign the statement certifying the date on which the statement was provided to the insured. The lawyer shall keep a copy of the signed statement in the client's file and shall retain a copy of the signed statement for 6 years after the representation is completed. The statement shall be available for inspection at reasonable times by the insured, or by the appropriate disciplinary agency. Nothing in the Statement of Insured Client's Rights shall be deemed to augment or detract from any substantive or ethical duty of a lawyer or affect the extra disciplinary consequences of violating an existing substantive legal or ethical duty; nor shall any matter set forth in the Statement of Insured Client's Rights give rise to an independent cause of action or create any presumption that an existing legal or ethical duty has been breached.

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<sup>5</sup> The rule changes were supported by the insurance industry. *See* "Florida Supreme Court Approves Florida Bar Statement of Insured Client's Rights" Florida Bar Organization press release dated May 16, 2002.

The accompanying Statement of Insured Client's Rights only applies to "personal injury and property damage tort cases." See Comment to Rule 4-1.8: Transactions between client and lawyer.

The court reasoned that because of the "highly variable nature of insurance and the responsiveness of the insurance industry in developing new types of coverages for risks arising in the dynamic American economy," it would be impractical to make a general statement that would be applicable in all insurance contexts. *Id.* Further, the Statement was not intended to "augment or detract from any substantive or ethical duty of a lawyer...." The Comment further noted that: "it is specifically provided that the statement shall not serve to establish any legal rights or duties, nor create any presumption that an existing legal or ethical duty has been breached." In so holding, the court implies that Rule 4-1.8(j) is merely an expression of the same duties and obligations always contained in the Rules of Professional Conduct, and that the Rule is mostly a confirming and symbolic gesture.

The Statement of Insured Client's Rights contains nine substantive paragraphs. The most important parts begin at paragraph 3. Titled "Directing the Lawyer," paragraph 3 provides that the insurance company will typically "control the defense of the lawsuit...." On the other hand, the insured is advised that the attorney "at the same time, cannot act contrary to your interests." Paragraph 4 entitles the insured to a copy of the insurance company's litigation guidelines upon request. Paragraph 5 provides that the attorney may have duties to share information with both the insurer and the policyholder. Importantly, however, the paragraph also states that: "[i]f the lawyer learns of

information indicating that the insurance company is not obligated under the policy to cover the claim or provide a defense, the lawyer's duty is to maintain that information in confidence." The inverse of this protection is extended to insurers in paragraph 9, which states that the lawyer cannot advise or represent the policyholder as to claims against the insurer.

In paragraph 6, the attorney is described as representing both the insurer and the policyholder. While no guidance is offered as to which, if either, client is preeminent in the relationship, the paragraph also states that if a conflict of interest arises, the insurer may have to provide the policyholder with substitute counsel. Paragraph 7 addresses settlements and is essentially an embodiment of the established principle that an insurer cannot settle a claim for an amount in excess of the policy limits without the policyholder's approval.

Florida also amended the state's advertising rule (Rule 4-7.10) to resolve the long simmering issue of how to designate lawyers employed by an insurance company. Under the new rule, the "firm" name must include the name of a lawyer with supervisory responsibility over the other staff attorneys, print and electronic communications must disclose that the lawyers in the unit are employees of the company, and the unit's offices, personnel and records must be functionally and physically separate from other operations of the company.

At some insurance companies, staff attorneys and their support personnel are assigned to a single location, share confidential information, and consult with each other on case assignments and strategies. The sign on the door to those offices often bore a



name like “Fogbottom, Mist & Associates,” suggesting the existence of a private law firm.

In-house attorneys employed to represent insureds may not state, and may no longer imply, that they practice in an independent law firm. The relationship between the attorney and the insurer must be disclosed to the client and appear on the letterhead and business card of the attorney. Florida Bar Opinion 98-3 (June 18, 1998), aff’d by the Board of Governors (February 12, 1999).<sup>6</sup> Additionally, Rule 4-7.7(f) prohibits attorneys from implying that they practice in a partnership or other organization unless it is a fact. The Florida Bar opinion, after a thorough review of other state’s stances on autonomous law firms, concluded it is impermissible for in-house attorneys employed to represent insureds to state or imply that they practice in a separate independent law firm.

The amended Florida rules also require that staff attorneys provide the name of the insurer and disclose their employment relationships to all insureds that the lawyers represent or might represent. Additional disclosure should take place when a lawyer knows or reasonably should know that an insured client or prospective client does not fully understand the relationship between the lawyer and the insurance company.

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<sup>6</sup> Despite this opinion, Florida courts apparently still struggle with distinguishing between law firms and insurance agencies, and *Delgado v. Club Atlantis Condo. Assoc.*, 2001 WL 1917974 (Fla. Cir. Ct. 2001), sparked committee investigations into allegedly fictitious firms. An irate Circuit Judge was astonished at the affiliation of firms with insurance companies and ordered all firms to divulge their allegiances in his Division. The Florida Supreme Court quickly vacated his orders. *United Servs. Auto. Assoc. v. Goodman*, 826 So. 2d 914 (Fla. 2002).

**FIRST AND THIRD PARTY STATUTORY BAD  
FAITH – FLORIDA STAT. § 624.155**

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**Failure to Settle and Unfair Trade Practices**

Florida’s statutory bad faith has two main elements — a generalized “failure to settle” provision found in §624.155(1)(b)1, and the creation, in §624.155(1)(a)1, of a private cause of action for violations of selected portions of the UITPA that, along with other provisions not included, had been part of Florida’s Insurance Code since 1974. In shorthand, (1)(b) and (1)(a) actions.

The “statute,” however, is called the bad faith statute only informally. Its title is “Civil Remedies,” and, in abbreviated form, it reads as follows:

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);

\* \* \*

(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;

\* \* \*

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)(a) As a condition precedent to bringing an action under this section, the department and the 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.

\* \* \*

(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.

(e) The 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.

\* \* \*

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

(4) 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 insurer if no punitive damages are awarded to the plaintiff.

(7) 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 insurer and may include an award or judgment in an amount that exceeds the policy limits.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined. —

(i) *Unfair claim settlement practices.*—

\* \* \*

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

- b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- c. Failing to acknowledge and act promptly upon communications with respect to claims;
- d. Denying claims without conducting reasonable investigations based upon available information;
- e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;
- f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;
- g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or
- h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

### **Procedural Issues**

Several procedural issues unique to Florida are found in the statutory scheme.

#### *A 60 Day Safe Harbor, with a shoal or two*

§624.155(2) is a manuscript provision, added by the 1982 legislature in recognition of the fact that it was about to dramatically increase the scope of bad faith in Florida. This provision accords the insurer a 60 day “safe harbor” period following its receipt of the Civil Remedy Notice, and bars a bad faith action if “the damages are paid or the circumstances constituting the violation are corrected” within that period.

The problem, naturally, was deciding just whose definition of “paid damages” and corrected violations is entitled to bar the action. Very little case law discussed this provision for the statute’s first 18 years, a relatively straightforward version of the

question was answered in *Hollar v. International Bankers Insurance Co.*, 572 So.2d 937 (Fla. 3d DCA 1990) *rev. dism.* 582 So.2d 624 (Fla. 1991).

*Hollar* was a third party case where the insurer refused a demand within policy limits, suffered an excess verdict, and then, apparently within the 60 day demand period, tendered only the original policy limits. Although this was enough for the trial court, the appellate court felt it far short of the standard:

In the instant case, insurers' self-serving reading of the term "damages" as being confined to policy limits is an illogical interpretation, a radical departure of the decisional law and, further, an explanation in no way consistent with the legislature's stated desire for insurers to act in good faith towards their insureds. See *Jones v. Continental Ins. Co.*, 716 F.Supp. 1456, 1460 (S.D.Fla. 1989). The function of the bad-faith claim is to provide the insured with an extra contractual remedy. *Opperman*, 515 So.2d at 267, citing 15A Couch on Insurance 2d, § 58:1, p. 248 (1983). Thus, the argument that upon a showing of bad faith, damages should be limited to the insured's contractual policy limits is all the more unreasonable. 572 So.2d at 939.

That statutory notice, however, is an absolute condition precedent to any statutory action. *Allstate Insurance Company v. Clohessy*, 32 F.Supp. 1333 (M.D.Fla. 1998) (insureds barred from bringing counterclaim for bad faith where they failed to serve civil remedy notice.)

The leading case on the notice requirement, which resolved many of the pending questions, is now *Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.*, 753 So.2d 1278 (Fla. 2000). Talat owned a restaurant which suffered a fire loss, and made a claim on its insurer in the total amount of \$432,815. Aetna paid only \$10,000, and its failure to pay more — and more promptly — led Talat into bankruptcy. Talat sued Aetna in bankruptcy court for breach of contract, but the court dismissed the suit pending appraisal. The appraisers awarded Talat \$331,930, which Aetna promptly paid. Only then, with new counsel, did Talat serve a civil remedy notice and file a statutory bad faith suit in federal district court, essentially claiming damages for underpaying its claim and driving it out of business.

The District Court granted Aetna's motion for summary judgment, ruling that it "timely paid 'the damages' and . . . corrected 'circumstances giving rise to the violation' within the meaning of section 624.155(2)(d)" because it had paid the contractual damages even before the civil remedy notice. *Talat Enterprises, Inc. v. Aetna Life & Cas. Co.*, 925 F.Supp. 773 (M.D. Fla. 1996). The Eleventh Circuit certified to the Florida Supreme Court the question of whether payment of the contractual damages but none of the extra-contractual damages -- satisfied the requirements of 624.155(2)(d). *Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.*, 217 F.3d 1318 (11<sup>th</sup> Cir. 2000).

Florida's Supreme Court said it did, and rejected the insured's contention that in order to pay "the damages" or "correct the circumstances giving rise to the violation" the insurer needed to pay the consequential damages arising from the alleged bad faith delay and denial:

The Court rejects as unsupported Talat's contention that the insurer must not only pay the claim with the sixty-day window, but must also pay all compensatory damages that flow from any delay in settling the claim. Section 624.155 does not impose on an insurer the obligation to pay whatever the insured demands. The sixty-day window is designed to be a cure period that will encourage payment of the underlying claim, and avoid unnecessary bad faith litigation. . . . If the insurer may avoid a bad faith action only by paying in advance every penny of the damages that it faces if it loses at trial, the insurer would have no reason to pay. Furthermore, few insureds would restrict their demands to compensatory damages. There is no reason why insureds would not demand also the advance payment of punitive damages and attorney's fees. Section 624.155(2)(d) would have no effect or purpose under such an interpretation. The law does not support such an expansive and illogical reading of section 624.155(2)(d).

*Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.*, 753 So.2d at 1282.

Nor is the *Talat* rule limited to claims under 624.155(1)(b)1, *i.e.*, the generalized "failure to settle," provision, as opposed to the UITPA provisions of Section (1)(a). *Franklin v. Minnesota Mutual Life Insurance Company*, 97 F.Supp. 2d 1324 (S.D.Fla. 2000) (Disability case paid within 60 days after new counsel sent a statutory notice after a year of litigation).

The curious result of these cases is that insurers have, through invocation of a statute seemingly designed for consumer protection, an opportunity to avoid consequential damages for even the foreseeable consequences of a contractual breach if the insured's counsel didn't send a timely statutory notice or, in any case, if the contractual claim is actually paid within the allowable 60 days.<sup>7</sup>

On the other hand, an insurer's failure to provide any response within 60 days creates [vague example how it can "respond"] a presumption of bad faith:

An insurer's failure to respond within the sixty-day period will create a presumption of bad faith sufficient to shift the burden to the insurer to show why it did not respond. An insurer may have good reason for not wanting to settle for the amount demanded, but we find it difficult to articulate a possible reason not to respond within sixty days.

*Imhof v. Nationwide Ins. Co.*, 643 So.2d 617, 619 (Fla. 1994); *Oak Cas. Ins. Co. v. Travelers Indemnity Co.*, 778 So.2d 483 (Fla. 3d DCA 2001)(proper to give jury instruction that failure to respond to notice within 60 days creates presumption of bad faith).

#### **Prior Resolution of the underlying coverage claim**

Until the existence of the insurer's liability is established and, in some sorts of cases, the extent of the plaintiff's damages, a cause of action does not exist for bad faith.

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<sup>7</sup> It is insufficient for an insurer to merely *agree* to pay the damages within sixty days. *Paz v. Fidelity National Ins. Co.*, 712 So.2d 807 (Fla. 3d DCA 1998).



*See Vest v. Travelers Insurance Company*, 753 So.2d 1270, 1275 (Fla. 2000),<sup>8</sup>; *Blanchard v. State Farm Mut. Auto. Ins. Co.*, 575 So.2d 1289 (Fla. 1991); *Doan v. John Hancock Mut. Life Ins. Company*, 727 So.2d 400 (Fla. 3d DCA 1999); *Allstate Insurance Company v. Baugham*, 741 So.2d 624 (Fla. 2d DCA 1999); *General Star Indemnity Co. v. Anheuser-Busch Companies, Inc.*, 741 So.2d 1259 (Fla. 5<sup>th</sup> DCA 1999); *Lane v. Provident Life & Accident Insurance Co.*, 71 F.Supp.2d 1255 (S.D. Fla. 1999) (*Blanchard* rule applied to bad faith claim handling lawsuit and was not limited to bad faith failure to settle cause of action).<sup>9</sup>

The resolution of the underlying claim may be by trial, arbitration, or some other means such as the insurer's decision to pay the claim. *See Brookins v. Goodson*, 640 So.2d 1270 (Fla. 4<sup>th</sup> DCA 1994) (settlement); *Allstate v. Clohessy*, 32 F.Supp.2d 1328 (M.D.Fla. 1998) (payment of \$200,000 UM limits satisfied *Imhof* test). The primary thrust of these cases, however, is not that there must be a to-the-dollar damage allegation, only that coverage has been established so that there is no risk of bad faith liability (and correspondingly expanded discovery) in the absence of coverage.

### **Territorial Effect**

For the statute's first twenty years trial courts routinely held that the underlying coverage case was governed by the laws of the State in which the contract was bound, but

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<sup>8</sup> *Vest* makes clear, however, that "there is no statutory requirement which prevents the insured from sending the statutory notice before there is a determination of liability or damages." 753 So.2d at 1275.

that Florida bad faith law applied to all claims investigations undertaken on Florida residents. There is still no state law on this question, but a federal district court has held to the contrary.

In the disability insurance case of *Pastor v. Union Central*, 184 F.Supp.2d 1301 (S.D. Fla. 2002), the court held, in a matter of first impression, that statutory bad faith sounded in contract, not tort. It then applied the doctrine of *lex loci contractus* to bar any application of Florida bad faith law notwithstanding the insured's residency in Florida for more than ten years. *Pastor* is still in the discovery stage, so it's hard to say what appellate decisions may be forthcoming on this question, or whether the state courts will pay attention. In the meantime, it seems unlikely that the Florida Insurance Commissioner will start asking complaining Florida citizens where their policies were delivered.

### **Discovery Implications**

#### *Relevancy Issues – State Law*

Under Rule 1.280, drawn from its Rule 26 federal counterpart, the notion of relevancy is obviously broader in the discovery context than in the trial context. A party is typically entitled to discover relevant evidence that would be inadmissible at trial, so long as it is “reasonably calculated to lead to the discovery of admissible evidence.” *Amente v. Newman*, 653 So.2d 1030, 1032 (Fla. 1995). A leading treatise described the traditional relevancy standard as follows:

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<sup>9</sup> Compare *Prudential Prop. & Cas. Ins. Co. v. Gerber*, 773 So.2d 571 (5<sup>th</sup> DCA 2000) (Court allowed “bad faith” claim alleging overreaching and fraud in obtaining a

Certainly the requirement of relevancy should be construed liberally and with common sense, rather than in terms of narrow legalism. Indeed, it is not too strong to say that discovery should be considered relevant where there is any possibility that the information sought may be relevant to the subject matter of the action.

*Barron and Holtzoff* (emphasis in original; internal citations, including to Florida cases, omitted).

The respondent bears the burden of showing that the documents requested and interrogatories propounded are neither “reasonably calculated to lead to the discovery of admissible evidence” under the traditional relevancy standard, as well as under the “liberal” relevancy standard for punitive damages allowed in Florida’s tort reform act. Fla. R. Civ. P 1.280(b)(1); Fla. Stat. § 768.72.

Two Florida law cases have held an insurer’s treatment of its insureds in the underlying coverage action potentially admissible -- and thus subject to discovery -- in the bad faith action. *Home Ins. Co. v. Owens*, 573 So.2d 343, 344 (Fla. 4<sup>th</sup> DCA 1991) (holding that in a “bad faith case ... the insurance company’s litigation conduct was admissible, relevant evidence”); *T.D.S. Inc. v. Shelby Mut. Ins. Co.*, 760 F.2d 1520, 1527 (11<sup>th</sup> Cir. (Fla.) 1985) (same). This law is still very ill-formed, however, and using it as a substitute for never-filed sanctions motions or as a way to retroactively govern the other sides’ litigation conduct could be a quick road to ridicule. Used judiciously in the right case, however -- such as cases where the claims department’s decision making

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release to proceed during the pendency of the tort suit.)

responsibilities are transferred entirely to its outside counsel, or where certain litigation conduct is pursued (or not) because of the insurer's instructions to counsel that override her independent judgment - - this sort of evidence can be a valuable addition to the policyholder's evidence and theory of the case.

*Relevancy Issues – Federal Law*

This subject is well-known, and certainly beyond the scope of this paper, so suffice it to say that relevancy is “construed broadly to encompass any matter that bears on, or that reasonably could lead to other matters that could bear on, any issue that is or may be in the case.” *Coker v. Duke & Co., Inc.*, 177 F.R.D. 682, 685 (M.D. Ala. 1998) (quoting *Oppenheimer Fund, Inc. v. Sanders*, 437 U.S. 340, 351, 98 S.Ct. 2380, 2380, 2389 – 90 (1978)); Fed.R.Civ.P. 26(b)(1) (permitting “discovery regarding any matter, not privileged, that is relevant to the claim or defense of any party...”).

*Florida Law – Third Party Privileges*

Much confusion currently exists under Florida law regarding the scope and applicability of the attorney-client privilege and work product immunity in bad faith cases. In matters of privilege – as privileges are creatures of statute (except in New Mexico) – the Florida statute controls and interpretation of the privilege's scope is accomplished by applying Florida law, whether in Federal or State court.

Current Florida law on discovery in third-party claims was largely defined *Dunn v. National Security Fire & Cas. Co.*, 631 So. 2d 1103, 1109 (Fla. 5<sup>th</sup> DCA 1994) (Dunn II):

In bad faith suits against insurance companies for failure to settle within the policy limits, all materials in the insurance company's claim file up to the date of the judgment in the underlying suit are obtainable, and should be produced when sought by discovery. Additional memos or documents in the file after date of the judgment can be obtained with a showing of good cause. Discovery of the insurer's claim file and litigation file is allowed in a bad faith case over the objections of the insurer that production of the file would violate the work product or attorney-client privilege. The rationale (as discussed above) is because the injured third-party "stands in the shoes" of the insured party in a third-part bad faith case and the insurer owes a fiduciary duty to its insured.

(Internal citations omitted)<sup>10</sup>.

Following *Dunn*, cases have simply adopted its holding without examining its reasoning. In *United Services Automobile Ass'n v. Jennings*, 731 So. 2d 1258 (Fla. 1999), the Supreme Court considered whether a *Cunningham* stipulation (to try the bad faith case before the underlying liability action provided a justification for obtaining discovery of the "entire claims file." "We hold that a judgment so stipulated is to be

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<sup>10</sup> The *Dunn* litigation spawned numerous discovery opinions, underlying *Dunn IV*, 652 So. 2d 1188 (5<sup>th</sup> DCA, 1995)(no claim file production between date of final judgment and date of payment to third party); *Dunn V*, 705 So. 2d 605 (5<sup>th</sup> DCA, 1997) (violation of work product privilege to examine other bad faith claim files without showing undue hardship and pursuing information by other methods) and even *Dunn VI*, (751 So. 2d 777 (5<sup>th</sup> DCA, 2000) (affidavit of Plaintiff's counsel showing "need" was insufficient in the face of his continued failure to pursue other discovery methods).

given the same effect in the bad faith litigation as a final judgment reached upon a determination at trial, and this includes discovery.” *Id.* at 1260. Citing with approval to *Dunn*, the Florida Supreme Court noted that the plaintiff in the bad faith action was “entitled to discover the insurer’s entire claim file for the underlying tort up to date of an excess judgment . . . .” *Id.* at 1259. The court did impose a limit -- the required discovery did not include attorney-client communications or work product pertaining to the defense of the bad faith action, and generated subsequent to the *Cunningham* stipulation. See also *Fortune Ins. Co. v. Greene*, 775 So. 2d 338 (Fla. 5<sup>th</sup> DCA 2000); *Allstate Ins. Co. v. American Southern Home Ins. Co.*, 680 So. 2d 1114, 1116 (Fla. 1<sup>st</sup> DCA 1996)(collecting cases); and *General Accident Fire & Life Ins. Corp. v. Boudreau*, 658 So. 2d 1006 (Fla. 5<sup>th</sup> DCA 1994).

Another case in the mix likely to be resolved by the Supreme Courts’ pending decision in *Allstate Indemnity Co. v. Ruiz*, 780 So. 2d 239 (Fla. 4<sup>th</sup> DCA 2001), *rev. granted*, 796 So. 2d 535 (Fla. 2001) (discussed below), is *Florida Form Bureau General Insurance Co. v. Copertino*, 810 So. 2d 1076 (4<sup>th</sup> DCA, 2002), where the court held that the insurer need not produce certain internal memoranda concerning bad faith issues when the response to its declaratory relief action had been an immediate allegation of bad faith and the filing of civil remedy notices. “This was not a case where bad faith litigation was simply foreseeable – it was actually being litigated at the time the memoranda were made.” *Id.* at 1079.

So stands the current state of the law in Florida on third-party bad faith discovery, although these cases fail to answer a number of questions and may all be recast by *Ruiz*.

*Florida Law – First Party*

First-party bad faith discovery is controlled, at least nominally, by the rule in *Kujawa v. Manhattan Nat'l Life Ins. Co.*, 541 So. 2d 1168 (Fla. 1989). The Florida Supreme Court held that the 1982 enactment of the bad faith statute did not abrogate otherwise applicable privileges and immunities, and that the attorney-client privilege would remain intact in a first-party bad faith action. Work product immunity, however, could be overcome under the Florida Rules of Civil Procedure (*i.e.*, substantial need, etc.).

*Kujawa* was recently analyzed and applied in *Allstate Indemnity Co. v. Ruiz*, 780 So. 2d 239 (Fla. 4<sup>th</sup> DCA 2001), *rev. granted*, 796 So. 2d 535 (Fla. 2001), oral argument held March of 2002, with no opinion released as of this writing. The Ruizes purchased auto insurance from Allstate. When the Ruizes purchased another car the agent deleted a Chevrolet Blazer from coverage without notifying them. On renewal, the Blazer was not included in the coverage. Naturally, the Blazer was involved in an accident and Allstate denied coverage.

The Ruizes filed suit including counts alleging bad faith, and Allstate admitted coverage a month later. Since the coverage issue had been resolved<sup>11</sup>, the Ruizes moved to compel production of documents, including claim and investigative file materials, internal manuals and the agent's file. The trial court conducted an *in camera* examination and ordered production of all documents. Allstate appealed.

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<sup>11</sup> Thereby opening access to the bad faith case. *State Farm Mutual Auto Insurance Co. v. Blanchard*, 575 So. 2d 1289 (Fla. 1991).

The court found no error in the trial court's order requiring Allstate to produce the insurance agent's statement, computer diaries and entries from the date of the report of the action through January 10, 1997, as well as an internal memorandum from one adjuster to her boss. Allstate argued that since litigation and coverage issues were presented immediately, these documents were protected from discovery. It did not persuade:

We reject that position as this court distinguishes between material prepared during the normal course of evaluating a claim and materials actually prepared "in anticipation of litigation." [t]he key inquiry is whether the probability of litigation is "substantial and imminent." We recognize that our position conflicts with decisions from other districts finding that statements are privileged and protected as work product when they were taken at a time when it was foreseeable that litigation would arise. We nonetheless adhere to our ruling in *Cotton* that work product privilege attaches to documents prepared in contemplation of litigation and not for "mere likelihood of litigation."

*Ruiz*, 780 So. 2d at 241. It thus appears that the Florida Supreme Court may shortly determine the trigger point for ascertaining the attachment of work product immunity. Its been a year since oral argument, though, which suggests that the court might be contending with something less than unanimous wisdom.



*Unresolved Waiver Issues*

Even presuming the *Dunn* rule, thorny issues on attorney-client privilege remain open. It seems plain that *Dunn* encompasses communications with in-house attorneys placed within the claims file, even if they provide coverage advice. *Dunn*, however, does not discuss what happens when the insurance company retains coverage counsel, apparently treating that as a distinction without a difference.

The issue is most starkly illustrated by the growing number of declaratory actions filed by insurance companies prior to the conclusion of the underlying liability case. Does the insurance company impliedly waive the attorney-client privilege under the at issue doctrine concerning communications to and from its coverage case counsel under these circumstances? To the extent documents from or to coverage case counsel are found in the claim file, *Dunn* would seem to govern. Insurance companies, however, typically open not only a claims file (relating to the underlying case) but also a coverage litigation file, which they seldom label, treat or include within their description of claims file, and unless the capacity for human speech suddenly disappears there will always be ways for insurers to get advice without a record appearing in the file.

Florida courts have, at least in a non-insurance context, discussed the waiver issue. In *Savino v. Luciano*, 92 So.2d 817 (Fla. 1957), the court stated that an accountant-client privilege may be waived both expressly and impliedly. In *Savino* the plaintiff sued for an accounting. The defendant answered alleging that nothing was owed as reflected by an audit of a certified public accountant, and that the plaintiff had embezzled the funds.

There can be no doubt that at the trial the defendant will rely on the audit and report in proof of his defense and counterclaims. The allegations of his pleadings lead inescapably to that conclusion. ... We think the defendant has waived the right to insist upon the privileged nature of the audit as a bar to the discovery motion.

*Id.* at 819. The court found that all personal privileges may be waived. “We hold, therefore, that the defendant in the instant case has either expressly or impliedly waived the right to insist upon the privilege nature, if any, of the audit and report. *Id.* See also, *Volpe v. Conroy, Simberg & Ganon, PA.*, 720 So.2d 537, 539 (Fla. 4<sup>th</sup> DCA 1998) (citing *Savino* with approval).<sup>12</sup>

The seminal decision on this subject remains *Brown v. Superior Court*, 670 P.2d 725 (Ariz. 1983.) After examining the competing lines of cases, and the purpose of the work product doctrine, the court rejected any single test to determine whether material was prepared in anticipation of litigation. After finding some of the materials withheld were entitled to qualified immunity the court turned to substantial need and undue hardship. In oft-quoted language, the court found:

Continental conceded at oral argument that the claims file contains a “blow-by-blow” diary of the insurer’s investigation and decision-making process with regard to Brown’s loss of earnings claim. ... The portions of the claims file which explained how the company processed and

considered Brown's claim and why it rejected the claim are certainly relevant .... Further, bad-faith actions against an insurer, like actions by client against attorney, patient against doctor, can only be proved by showing exactly how the company processed the claim, how thoroughly it was considered and why the company took the action it did. The claims file is a unique, contemporaneously prepared history of company's handling of the claim; in an action such as this the need for the information in the file is not only substantial, but overwhelming. The substantial equivalent of this material cannot be obtained through other means of discovery. The claims file "diary" is not only likely to lead to evidence, but to be very important evidence on the issue of whether Continental acted reasonably. We find, therefore, that the trial courts denial of Brown's Motion to Compel Production of any portion of the claims file compiled after August 21, 1981 was unsupported by the record.

*Id.* at 734-735.

The court also addressed the divisive question of opinion work product: Recognizing that mental impressions and the like are afforded greater protection ... we do not believe such protection can be absolute in a case presenting issues similar to the one at bench. As we explained above, the reasons that the insurance company denied the claim or the manner in

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<sup>12</sup> In *Quarles & Brady, LLP v. Birdsall*, 802 So.2d 1205, 1206 (Fla. 2d DCA 2002), the court noted that neither necessity nor undue hardship entitle a party to

which it dealt with it are central issues to Brown's claim of bad faith. Thus, the strategy, theories, mental impressions, and opinions of Continental's agents concerning the loss of earnings claim are directly at issue. When mental impressions and the like are directly at issue in a case, courts have permitted an exception to the strict protection [of the rule] and allowed discovery.

*Id.* at 735.

*Brown* has been mentioned in Florida only twice. The first was in footnote 4 of the decision in *Fidelity & Casualty Insurance Co. of New York v. Taylor*, 525 So. 2d 908 (Fla. 3d DCA, 1987), *disapproved*, *Kujawa v. Manhattan National Life Ins. Co.*, 541 So. 2d 1168 (Fla. 1989), where the Court based its decision to more or less unconditionally produce the entire claim file — including attorney-client communications -- on the supposition that there was no difference between first and third party claims.

*Kujawa* disapproved the unconditional mixture of first and third party discovery in favor of the balanced approach set forth in the rules, but other courts have waxed rather more enthusiastically. That *Kujawa* rejected *Taylor's* approval of *Brown's* explanation of the importance of claim files was the conclusion of another appellate district in *Vesta Fire Insurance v. Figueroa*, 821 So. 2d 1233 (5<sup>th</sup> DCA, 2002)<sup>13</sup>, where the Court wrote that:

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privileged information.

<sup>13</sup> For a similarly restrictive view, *See Progressive American Ins. Co. v. Lanier*, 800 So. 2d 689 (Fla. 1<sup>st</sup> DCA 2001).

*Kujawa* stands for the proposition that even where the behavior of an adversary is at issue in litigation, if the materials sought were prepared in anticipation of litigation, they are not subject to discovery.

This pronouncement virtually bubbles with poetic license,<sup>14</sup> and in fact, the opinion returns to earth in the very next sentence:

*Kujawa* did, however, affirm that work product in a bad faith case, just like work product in any other case, is not necessarily inviolate.

*Id.* At 1236.

Put another way, the normal discovery procedures have not been suspended in Florida bad faith law, though the search for an absolute rule will doubtless follow the same course as humanity's search for universal truth. *Figueroa* sets forth considerable and stringent *dicta* concerning what is necessary to show the "undue hardship," but its vitality in first-party cases – as well as its criticism of *Brown* - stands limited by the factors discussed above and the simple fact that the claims file is often the *only* source of information on whether the claim investigation was conducted in good faith.

Competently advised insurance companies will hardly be waiting for definitive judicial pronouncements on such questions, particularly since the results will vary from case to case. Rather, they will assume for operational purposes that everything they place in a claim file will be seen by a jury if the case generates an exposure to bad faith liability. And it's hard to imagine a state insurance department that wouldn't expect

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<sup>14</sup> The author was the insurer's counsel in *Kujawa* (in another life, of course), and had no idea he'd been that successful.

insurers it regulates to have their claim files represent a full, complete, and accurate record of the claims investigation and status. Such a duty, after all, is almost universally required by statute (in Florida, by §626.9541(1)(j)). Discovery motions and friendly courts may prevent insurers from having to disclose claim documents they'd prefer to keep confidential, but any insurer counting on this hope in a bad faith case is swimming against the tide (not to mention assuming a level of risk they'd never underwrite themselves).

Next, we turn to where all the roads lead-damages at trial.

## **DAMAGES**

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### **Getting There - Summary Judgment standard in Florida Bad Faith and the Demise of the “Fairly Debatable” Test**

A crucial strategic issue in litigation is the question of whether either of the parties can resolve the case by motion practice. Florida has taken the drama out of this question in bad faith cases -- there's no such thing.

The practical litigation issue involved here might best be seen in a way not yet specifically addressed in our courts - by the potential application in Florida of the "Dutton test," after *National Savings Life Insurance Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982). The *Dutton* court protected the insurer's unsuccessful defense (rescission in that case) because it was nevertheless reasonably legitimate, and held that subsequent bad faith suits could be defeated as a matter of law "if the evidence presented by either side creates a fact issue with regard to the validity of the claim." *Id.* at 1362. In short, the insurer wins the bad faith case as a matter of law unless it lost the underlying case on summary judgment or a directed verdict. But that's not the law in Florida. *Robinson v. State Farm Fire & Casualty Co.*, 583 So.2d 1063 (Fla. 5<sup>th</sup> DCA 1991), a third party failure to defend case, rejected the Dutton standard without naming it:

It makes no sense that an insurer who asserts a coverage issue that, for any reason, withstands summary judgment, but ultimately fails, would be excused from all of the good faith obligations imposed on the insurer who admits coverage.

583 So. 2d at 1066.

The contrary implication, reached in the federal district court decision of *Reliance Insurance Co. v. Barile Excavating & Pipeline Co.*, 685 F. Supp. 839 (M.D. Fla. 1988), purported to adopt the "fairly debatable" test, but did so without citation to Florida law. *Barile* was essentially uncited, however, and looked like another missed guess by a federal district court on which way the law would go.<sup>15</sup> Though dicta in *Imhof v. Nationwide Insurance Co.*, 643 So.2d 617 (Fla. 1994) seemed to view *Barile* approvingly<sup>16</sup>, *Imhof's* implication was expressly discarded by the Court in *State Farm Mutual Automobile Insurance Co. v. Laforet*, 658 So.2d 55 (Fla. 1995), which rejected the "fairly debatable" test in favor of one drawn expressly from the section(1)(b)'s own "fairly and honestly... with due regard for [the insured's] interest" language. To ensure consistency, the Court applied the same standard to common law actions. This is a long way from allowing an insurer a supplemental defense if its position was "fairly debatable," and a sharp reversal of the pro-insurer leaning implied by *Imhof*. In either case, however<sup>17</sup>, it seems unlikely that an insurer can defend specific (1)(a) violations by asserting that it's overall claims position satisfied the good faith settlement obligations of section (1)(b), and if the insurer loses the coverage claim any such violations become fair game.

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<sup>15</sup> The *Dutton* rule, and Florida's contrary position, are discussed in Houser, "Good Faith as a Matter of Law: The Insurance Company's Right to be Wrong," *Tort & Insurance Law Journal*, Vol XXVII, p. 665, 669 (1992).

<sup>16</sup> But not conclusively. The Second district opinion in *John J. Jerue Truck Broker v. INA*, 646 So.2d 780 (Fla. 2d DCA 1994) rejected *Reliance* and distinguished *Imhof*.



The factors important in Section 1(b) “failure to settle” claims, drawn from *Robinson* and *Laforet*, are (1) whether the insurer was able to obtain a reservation of the right to deny coverage if a defense was provided; (2) the efforts or measures taken by the insurer to resolve the coverage dispute promptly or in such a way to limit potential prejudice to the insured; (3) the substance of the coverage dispute or the weight of authority; (4) the insurer’s diligence and thoroughness in investigating the facts pertinent to coverage; and (5) efforts made by the insurer to settle the liability claim in the face of the coverage dispute. First party claims concern only factors (2), (3) and (4), *Robinson, supra*. UITPA violations (Section (1)(a) claims) are not addressed in these factors, and would be supplemental.

#### **Attorneys’ Fees and Costs – Driving Both Ways on the One-Way Street**

Florida has a packet of attorneys’ fees statutes, and appellate judges are sometimes heard to complain that attorneys’ fee litigation has become their steady diet. Much of this litigation has to do with a modified loser pays statute, roughly patterned on the English system, passed as part of the Tort Reform Act during the *last* medical malpractice crisis in 1986. The legislature adopted the then fashionable panacea (today’s version is the damages cap) of authorizing the prevailing side to tax attorneys’ fees at the end of the case. In Florida, this happens if the opposing party doesn’t come within 25% of an Offer of Judgment made under the statute:

768.79 Offer of judgment and demand for judgment. —

(1) In any civil action for damages filed in the courts of this state, if a defendant files an offer of judgment which is not accepted by the plaintiff within 30 days, the defendant shall be entitled to recover reasonable costs and attorney’s fees incurred by her or him or on the defendant’s behalf pursuant to a policy of liability insurance or other contract from the date of

filing of the offer if the judgment is one of no liability or the judgment obtained by the plaintiff is at least 25 percent less than such offer, and the court shall set off such costs and attorney's fees against the award. Where such costs and attorney's fees total more than the judgment, the court shall enter judgment for the defendant against the plaintiff for the amount of the costs and fees, less the amount of the plaintiff's award. If a plaintiff files a demand for judgment which is not accepted by the defendant within 30 days and the plaintiff recovers a judgment in an amount at least 25 percent greater than the offer, she or he shall be entitled to recover reasonable costs and attorney's fees incurred from the date of the filing of the demand. If rejected, neither an offer nor demand is admissible in subsequent litigation, except for pursuing the penalties of this section.

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Although this statute may once have been thought of as a way to stop the profusion of supposedly meritless lawsuits, it obviously has less practical affect if the plaintiff is economically incapable of responding.

The Florida insurance code has awarded attorney's fees to prevailing insureds (not third parties) in coverage litigation since 1893, with the current version of the statute – which limits such entitlement to Florida-based contracts -- found at F.S. §627.428(1):

627.428 Attorney's fee. —

(1) Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

\* \* \*

To complete the circle, §624.155(3) entitles insureds to fees in statutory bad faith cases. Neither of these statutes are expressly bilateral, and the question of whether the

fee-shifting statutes of Florida's insurance code are "one-way streets" or whether the 75% standard of the Tort Reform Act (768.79) can be used against an insured is presently something less than clear. The bilateral approach was upheld as against a constitutional attack in *US Security Ins. Co. v. Cahuasqui*, 760 So.2d 1011 (Fla. 3d DCA 2000), *cert. disp.*, 796 So.2d 532 (Fla. 2001). (*Certiorari* was originally granted on the basis of conflicting case law, then withdrawn).

The *certiorari* dismissal is somewhat mystical, because the alleged conflicting case was a Supreme Court opinion which held unconstitutional a statute (not §768.79) requiring, *inter alia*, a prevailing party standard on attorneys' fees in a PIP case and, to the apparently untrained eye of some observers, seemed to hold that fee shifting provisions favoring insureds were one-way streets. *Nationwide Mutl. Fire Ins. Co. v. Pinnacle Medical, Inc.*, 753 So.2d 55 (Fla. 2000).

Lest we rest, another District Court of Appeal has just written that the insurance fee shifting statutes *are* one-way streets, citing not *Pinnacle*, but *Cahuasqui*!

These sections are a "one-way street" when it comes to attorney's fees.

They allow the beneficiaries of an insurance policy to recover costs and fees if they prevail, but prohibit recovery by the insurance company if it prevails. *See U.S. Security Ins. Co. v. Cahuasqui*, 760 So.2d 1101 (Fla. 3d DCA 2000).

*McCarthy Bros. Company v. Tilbury Construction, Inc.*, 2003 WL 882356 (Fla. 1<sup>st</sup> DCA, March 10, 2003). Looks like more to come.

### **Compensatory Damages**

As a general rule, a bad faith case can seek as compensatory damages any losses proximately caused by the insurer's failure to resolve the claim in good faith. Since such damages will be collected only if the jury finds that the insurer's underlying acts were in bad faith, an operational definition of these damages will include any losses that would not have been suffered had the claim been timely paid or the case settled.

#### *First Party*

In addition to the always-present attorneys' fee in the bad faith case, the insured can recover any still unreimbursed expenses in the underlying suit, which may include interest, litigation expenses not taxable in the coverage case, and probably even any attorneys fees owed by the client in excess of the amount awarded by the court in the underlying case.<sup>17</sup>

Damages in first party actions based on uninsured motorist coverage include the total amount of the claimant's damages, including any amount in excess of the claimant's policy limits, without regard to whether the damages were caused by the insurance company. See Fla. Stat. § 627.727(10); *State Farm Mut. Ins. Co. v. Laforet*, 658 So.2d at 55, 60 (Fla. 1995).

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<sup>17</sup> For example, a first party loss where the insurer reconsidered an earlier claim denial and paid the claim in full after expiration of the safe harbor period. The insured may owe a contractual attorneys fee in excess of the amount awarded by the court (which fees are set after consideration of the standard factors, with the lodestar being center stage) under these circumstances, which could be recoverable as a loss to the insured if the insurer's initial denial was found to be in bad faith.

*Third Party*

In a third party suit under §624.155, compensatory damages include not only the excess judgment amount but also other direct consequential damages as well as attorneys' fees incurred in the bad faith suit. *See Dunn v. Nat'l Security Fire & Casualty Co.*, 631 So.2d 1103, 1106 (Fla. 5<sup>th</sup> DCA 1993). But the third party may also recover its attorneys' fees from the underlying suit. *Id.* at 1108. Third parties must establish, however, damage by the bad faith conduct. In *Conquest v. Auto-Owners Ins. Co.*, 773 So.2d 71 (Fla. 2d DCA 1998 (Conquest II))<sup>18</sup> the injured plaintiff sued the insured's liability carrier for bad faith in failing to settle, even though she had never demanded less than policy limits and the verdict did not exceed them. This was apparently on the ground that the insurer could have settled her claim within six months for about half of the policy limits, but plaintiff's problem with never having offered to take less than the limits proved insurmountable. The court affirmed a directed verdict in favor of the insurer, holding:

the evidence presented by the plaintiff cannot support a finding by the jury that the defendant should have offered any specific amount at any time to the plaintiff. And it is precisely because the jury awarded the plaintiff less than her last demand for settlement that she cannot establish that she was

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<sup>18</sup> *Conquest I*, at 637 So.2d 40 (Fla. 2d DCA 1994), allowed the insured to proceed on a Section (1)(a)(UITPA) theory in her bad faith case. The danger of doing so without an excess judgment, however, was demonstrated by the eventual result.

damaged by some lack of the defendant's investigation standards, some failure of the defendant to act promptly upon communication, or the defendant's denial of her claim without a reasonable investigation.

773 So.2d at 74.

There must be an excess judgment before a third party has a bad faith cause of action under § 624.155(1)(b)(1). *See State Farm Fire & Cas. Co. v. Zebrowski*, 706 So.2d 275 (Fla. 1997) (In subsection (b) the cause of action is predicated on the failure of the insurer to act fairly and honestly toward its *insured*; in the absence of an excess judgment the third party plaintiff cannot demonstrate that the insurer breached that duty.)

#### *Emotional Distress*

Florida imposes a strict standard on damages for emotional distress, and such damages have historically been allowed only where the insurer's conduct meets the "utterly intolerable in a civilized community" test. *Conquest II, supra.*; *Dunn*, 631 So.2d at 1107, *citing Butchikas v. Travelers Indemnity Co.*, 343 So.2d 816 (Fla. 1976). Even a jury award of such damages can be reversed if the appellate court doesn't think the conduct met the test. *Metropolitan Life Ins. Co. v. McCarson*, 467 So.2d 277, 279 (Fla. 1985). Nor is an arbitrary refusal to pay an insurance claim enough to constitute intentional infliction of emotional distress. *See Davis v. Gulf Life Ins. Co.*, 502 So.2d 1012, 1012-13 (Fla. 3d DCA 1987); *McDonald v. Penn Mutual Life Ins. Co.*, 276 So.2d 232, 233-34 (Fla. 2d DCA 1973).

The common law cases allowing such damages involve denial of coverage for some mental or physical disability, together with suitably extreme circumstances. *See Kaufman v. Mutual of Omaha Ins. Co.*, 681 So.2d 747 (Fla. 3d DCA 1996); *Dependable Life Ins. Co. v. Harris*, 510 So.2d 985, 986 (Fla. 5<sup>th</sup> DCA 1987); *Dominguez v. Equitable Life Assurance Society*, 438 So.2d 58, 61 (Fla. 3d DCA).

The bad faith statute makes no direct reference to emotional distress (nor, for that matter, to any other potential element of compensatory damages), but the Florida Supreme Court has held that § 624.155(1)(b)1 “authorizes the recovery of damages for emotional distress in a first party bad faith claim against a health insurance company.” *Time Ins. Co., Inc. v. Burger*, 712 So.2d 389 (Fla. 1998). But not with an open door. The court tightly defined the scope, requiring specific proof that: (1) the bad faith conduct resulted in the insured’s failure to receive necessary or timely health care; (2) based on reasonable medical probability (meaning the insured must be under psychiatric care), the insurer’s conduct caused or aggravated the insured’s medical or psychiatric condition; and (3) the insured suffered mental distress related to the condition or aggravation of the condition. It makes sense that these standards would apply in all statutory bad faith cases, but it’s hard to say.

In *Midland Life Insurance Co. v. Otero*, 753 So.2d 579 (Fla. 3d DCA 1999), *rev. dism.*, 790 So.2d 1106 (Fla. 1999), the court refused to extend *Burger* to the life insurance context where the carrier allegedly refused to insure the Oteros because they were Hispanic.

So. Attorneys' fees were already in the Insurance Code, emotional distress is a thin reed, economic losses will accrue only in certain cases, and excess verdicts only apply in first party cases in the uninsured motorist scenario. Where does the damages train go from there? The answer, and the real key to statutory bad faith in Florida, is punitive damages.

### **Punitive Damages**

Section 624.155(4) sets the standard for imposition of punitive damages based on violation of the bad faith statute:

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; [or]
- (b) In reckless disregard for the rights of any insured.

The "general business practice" cannot consist of isolated acts by the insurer, *Howell-Demarest*, 673 So.2d at 526, 529 (Fla. 4<sup>th</sup> DCA 1996), and must extend beyond the plaintiff's own claim. *Shannon R. Ginn Construction Co. v. Reliance Insurance Company*, 51 F.Supp.2d 1347 (S.D.Fla. 1999). But it's an unusual case where this issue is in legitimate controversy if the policyholder's counsel is awake enough to ask the insurer's representative at deposition whether the claims process at issue contained any acts which were *not* part of its general business practices. More often, the question is not "yes or no" but how widespread.



Because discovery into the business practices of the insurer across many claims is often costly, the insured seeking punitive damages under § 624.155 is required to post in advance the costs of discovery, whatever that means. Fla. Stat. § 625.144(5); *See, Empire Blue Cross & Blue Shield v. Adams*, 729 So.2d 481 (Fla. 4<sup>th</sup> DCA 1999) (cause remanded for the trial court to consider the appropriate amount of costs to be posted in regard to the discovery ordered); *National Security Fire & Casualty Co. v. Dunn*, 751 So.2d 777 (Fla. 5<sup>th</sup> DCA 2000); *Fortune Ins. Co. v. Fernandez*, 560 So.2d 239 (Fla. 4<sup>th</sup> DCA 1999). No decision has ever usefully defined the measure of such costs, however, and as control measures go this requirement has proven a paper tiger. It is, moreover, most certainly unenforceable in cases removed to or filed in federal court, being in conflict with federal rules 8 and 9. *Cohen v. Office Depot*, 184 F.3d 1292, 204 F.3d 1069 (11<sup>th</sup> Cir. (Fla.) 2000). (Second opinion contained revision on other grounds).

Punitive damages provide the statute's only real teeth and they can have quite a bite. Careful practitioners will use this statute only when appropriate, however, and not attempt to force each case into a punitive damages template. Florida's elements of punitive damages under the statute will doubtless require post-*Campbell* scrutiny, but at the moment they provide the only meaningful measure for bad faith damages in non-UM first party cases, and a possible recovery above the excess verdict in UM and third party cases. *State Farm Mutual v. Laforet*, 658 So.2d 55 (Fla. 1995).

## **HOT ISSUES**

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### **Whether Punitive Damages are Capped by Florida's Tort Reform Act**

Section 768.73 of Florida's 1986 Tort Reform Act limits punitive damages to three times that awarded as compensatory damages, but no decision has applied that ratio to a bad faith cause of action. This is likely because §768.71 excludes from the scope of the Act any conflicting and preexisting provisions of Florida law, and (policyholders' lawyers consistently argue) Florida's Civil Remedy statute, 624.155(4), itself delineates the circumstances under which punitive damages may be awarded.

No decision has yet resolved this question, though procedural aspects of the Tort Reform Act have been held inapplicable in federal court. See *e.g.*, *Cohen v. Office Depot, supra*, (11<sup>th</sup> Cir. 2000). The issue may depend on *Campbell's* resolution of the *TXO* question, since any bad faith case turning on the question of what an insurer sought to gain economically by the prohibited conduct would render ratios grandly irrelevant.

### **Arbitration of Insurance Coverage and Bad Faith Cases: Is Insurance Different?**

The national battle over the enforceability of arbitration clauses in standard form contracts has long flirted with insurance in the form of appraisal clauses concerning the amount of a loss, but the once-ironclad notion that questions of insurance coverage are not arbitrable in Florida is now clothed in aluminum foil. Though the results are spotty, appellate courts in Florida have recently compelled arbitration of coverage disputes pursuant to arbitration clauses in international health insurance policies where the insureds are foreign nationals, notwithstanding the fact that the insurance company may be conducting the business of insurance in Florida, or even be headquartered here.

In these cases, the courts have side-stepped the issue by finding Florida common law prohibiting arbitration of insurance coverage disputes to be inapplicable in cases

involving “foreign commerce” (as opposed to interstate commerce), implicating Chapters two and three of the Federal Arbitration Act<sup>19</sup> (“FAA”), 9 U.S.C. §1 *et seq.*, which, unlike Chapter one, are not subject to reverse preemption in favor of state law pursuant to the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* See *Assurance Foreign Skuld et al. v. Apollo Ship Chandlers, Inc. et al.*, Case Nos. 3D02-2385 and 3D02-2245 (Fla. 3d DCA March 19, 2003); *Benefit Ass’n Int’l Inc. v. Mount Sinai Comprehensive Care Ctr.*, 816 So.2d 164 (Fla. 3d DCA 2002); *Antillean Marine Shipping Corp. v. Through Transport Mut. Ins., Ltd.*, Case No. 02-22196 (S.D. Fla. Oct. 31, 2002).

The impending battle will concern the enforceability of an arbitration clause inserted into an insurance policy issued for delivery or delivered to a Florida resident. If such a clause is permitted by the Florida Department of Insurance, it will fall to the courts to definitively resolve the issue. Florida’s Supreme Court spoke, at least tangentially, to this question most recently on September 26, 2002 in *Johnson v. Nationwide Mut’l Ins. Co.*, 828 So.2d 1021 (Fla. 2002), where it approved the Third District Court of Appeal’s decision in *Gonzalez v. State Farm Cas. Co.*, 2000 WL 1671415 (Fla. App. 3 Dist) and confirmed that “[w]hether a claim is covered by the policy is a judicial question, not a question for the appraisers.” *Id.* The question of arbitration is probably far from resolved, however, because *Johnson* begs the question of what happens if the parties “agreed” to arbitrate insurance coverage disputes (as opposed to appraise the amount of

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<sup>19</sup> Chapter two of the FAA is commonly referred to as the “New York Convention” and Chapter three as the “Panama Convention.”

loss), and the line between “causation,” “damages” and “coverage” is not always painted in neon.

The terms “arbitration” and “appraisal” have long been used interchangeably in Florida case law, though with a constant theme that legal issues concerning the existence of insurance coverage and policy interpretation are for the courts, not appraisers or arbitrators. *See State Farm Fire & Cas. Co. v. Licea*, 685 So. 2d 1285, 1287-88 (Fla. 1996) (holding that the appraisal clause at issue required an assessment of the amount of loss but that “a challenge of [insurance] coverage is exclusively a *judicial question*.”) (emphasis in original); *Gonzalez v. State Farm & Cas. Co.*, 2000 WL 1671415 \* 2 (Fla. App. 3 Dist.) (holding that whether the claim is covered by the policy is a judicial question, not a question for appraisers); *Delisfort v. Progressive Express Ins. Co.*, 785 So. 2d 734, 735 (Fla. 4<sup>th</sup> DCA 2001)(holding that “issues of coverage are reserved to the court and are not the subject of arbitration” and noting that issues for arbitration or appraisal are restricted to resolution of specific issues of actual cash values and amount of loss.) (emphasis supplied); *Opar v. Allstate Ins. Co.*, 751 So. 2d 758, 760 (Fla. 1<sup>st</sup> DCA 2000) (recognizing the “well established” rule that the appraisal process cannot be used to determine coverage issues, which are judicial determinations).<sup>20</sup>

While the Florida courts have been willing to enforce arbitration clauses in insurance policies issued for delivery and delivered to non-U.S. residents, a

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<sup>20</sup> In the UM context, Florida courts have long permitted only resolution of the factual issues of liability by arbitrators, not the legal issue of insurance coverage. *See, e.g. Protective Ins. Co. v. Palma*, 507 So.2d 649, 650 (Fla. 3d DCA 1987) (concluding that only the issue of negligence was for the arbitrator).

policyholder's lawyer in Florida should argue that the FAA must yield to Florida common law prohibiting the arbitration of insurance coverage disputes pursuant to McCarran-Ferguson where "foreign commerce" is not involved. See *Apollo Ship Chandlers, Inc.*, *supra*. Florida courts will then have to decide (1) whether Florida common law does, in fact, prohibit arbitration of insurance coverage disputes; (2) whether that prohibition regulates the business of insurance per McCarran-Ferguson; and (3) whether application of the FAA would "invalidate, impair or supercede" that state law. These precise issues were raised by the authors in two cases involving foreign nationals, *American Pioneer Life Ins. Co. v. Gorin*, 829 So.2d 238 (Fla. 3d DCA 2002), *reh'g, reh'g en banc and certification den'd* (Nov. 8, 2002) and *Mayard-Paul v. The Mega Life & Health Ins. Co.*, 2001 WL 1711519 (S.D. Fla.) with mixed results. Given the rationale of the Third District's most recent decision in *Apollo Ship Chandlers, Inc.*, however, the continued vitality of the *Gorin* panel's McCarran-Ferguson analysis is uncertain at best.

#### **ERISA preemption of Florida Stat. §624.155**

Florida's statutory scheme presents unique questions concerning ERISA preemption of Florida's Civil Remedy (or bad faith) statute. Section 624.155 is not a law of general application, but rather extends potential relief solely to those damaged by the conduct of insurers. Should "ordinary" or "defensive" preemption ultimately be held to turn solely on ERISA's saving and deemer clauses, in short, Florida's Civil Remedy statute should not be preempted.

Whether a state law is subject to “ordinary” or “defensive” preemption under ERISA requires analysis of three statutory provisions – 20 U.S.C. §1144(a) [“preemption clause”]; 29 U.S.C. §1144(b)(2)(A) [“saving clause”]; and 29 U.S.C. §1144(b)(2)(B) [“deemer clause”]. These provisions operate as follows: If a state law “relates to” employee benefit plans, it is preempted by ERISA’s broad preemption clause. The saving clause, in turn, excepts from the preemption clause state laws that “regulate insurance.” Finally, the deemer clause makes clear that a state law that “purports to regulate insurance” cannot deem an employee benefit plan to be an insurance company. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987).

In *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), the U.S. Supreme Court clarified the framework for determining whether a state law “regulates insurance” and thus escapes preemption under ERISA’s saving clause. This framework, which the Court drew from earlier decisions, requires resolution of whether, from a “common-sense view of the matter,” the contested state law regulates insurance. *Ward*, 526 U.S. at 367; citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). A state law that “controls the terms of the insurance relationship” by “homing in” on the insurance industry (rather than merely having an impact on that industry) regulates insurance as a matter of common sense. *Ward*, 526 U.S. at 368.

The common sense conclusion is then verified by determining whether the state law regulates the “business of insurance” within the meaning of the McCarran-Ferguson Act. In *Metropolitan Life*, the Court held that mandated-benefit laws regulate the “business of insurance” as contemplated by the McCarran-Ferguson Act, and relied on

prior McCarran-Ferguson Act cases which identified three criteria relevant to determining whether a particular practice falls within the “business of insurance”:

First, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

*Metropolitan Life*, 471 U.S. at 743; citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). See also, *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 2163 (2002).

*Ward*, however, demonstrated that a state law need *not* satisfy all three McCarran-Ferguson factors in order to verify the common sense conclusion that it regulates insurance for purposes of ERISA’s saving clause. *Ward* at 373. *Ward* cast the three factors as “guide posts” or “considerations to be weighed” in determining whether a state law regulates insurance, *Id.*, and rejected with UNUM’s contention that all three factors must be satisfied. The factors are “relevant,” but not “required.” *Ward*, 526 U.S. at 373. In sum, the Supreme Court in *Ward* reinvigorated the saving clause, presumed dead by many lower courts after *Pilot Life*, by reiterating its earlier declination to impose “any limitation on the saving clause beyond those Congress imposed in the clause itself and in the ‘deemer clause’ which modifies it.” *Metropolitan Life*, 471 U.S. at 746.<sup>21</sup>

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<sup>21</sup> The Court recognized that its decision created a distinction between insured and uninsured (self-funded) plans, leaving the former open to indirect regulation by state

A panel of the 11<sup>th</sup> Circuit first considered the applicability of ERISA's saving clause to Fla. Stat. §624.155 in *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11<sup>th</sup> Cir. 1988). *Anschultz*, decided immediately in the wake of *Pilot Life*, involved a claim for wrongful denial of long term disability benefits under a group insurance policy. *Id.* at 1467. *Anschultz* sought benefits allegedly due under the plan as well as compensatory and punitive damages, interest, and attorney's fees under Fla. Stat. §624.155. *Id.* at 1467-1468. Acknowledging that §624.155 arguably regulates insurance as a matter of common sense, the *Anschultz* court nevertheless ruled that the Florida law failed to satisfy *all* of the McCarran-Ferguson factors and accordingly fell outside ERISA's saving clause. *Id.* at 1469.

The 11<sup>th</sup> Circuit next examined the relationship between Florida's insurance statutes and ERISA's saving clause in *Swerhun v. Guardian Life Ins. Co. of America*, 979 F.2d 195 (11<sup>th</sup> Cir. 1992). Swerhun brought suit alleging breach of contract and bad faith denial of benefits under an ERISA plan, *Id.* at 196, and argued that her breach of contract claim was saved from ERISA preemption because Guardian's denial of benefits for chiropractic care violated Fla. Stat. §627.419. The 11<sup>th</sup> Circuit recognized that Fla. Stat. §627.419 (declaring that insurance policies must be construed to include coverage for chiropractic services) "may very well be a law regulating insurance," but held the Florida law irrelevant to Swerhun's breach of contract claim because no private right of action existed for the violation and, moreover, Guardian's policy covered chiropractic services. *Id.* at 198. Expressly relying on *Anschultz*' requirement that all three McCarran-Ferguson

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insurance laws while the latter are not, but concluded that in so doing it was merely



factors be satisfied, the Court restated its prior conclusion that Fla. Stat. §624.155 is not a law regulating insurance, thus fell outside of ERISA's saving clause, and was preempted. *Id.* at 199.

The standard articulated in *Ward*, however, supports the conclusion that both the enumerated provisions of the Florida Insurance Code and §624.155(1)(a), which provides the private right of action for their violation, are saved from ERISA preemption. These provisions of the Insurance Code, includes selected portion of the VITPA, regulate the conduct of insurers (not employers or benefit plans) and are distinct from a claim for benefits or other relief available under ERISA. The dichotomy between a claim for contractual benefits and a cause of action under §624.155 is not novel in this state because settled Florida law requires that the contract case — the sort of claim subject to ERISA preemption — must be finally resolved in the insured's favor *before* a cause of action under §624.155 can proceed. See *Blanchard v. State Farm*, 575 So.2d 1289 (Fla. 1991).

The conclusion that 1(a) cases survive ERISA preemption is supported by the recent U.S. Supreme Court's decision in *Moran* and in this Circuit by *Butero v. Royal MacCabees Life Ins. Co.*, 174 F.3d 1207 (11<sup>th</sup> Cir. 1999). *Butero* principally involved what the 11<sup>th</sup> Circuit has termed “complete” preemption or “superpreemption.” *Id.* at 1211.<sup>22</sup> In this Circuit, “ERISA superpreemption exists only when the ‘plaintiff is

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giving life to the distinction created by Congress in the deemer clause. *Id.* at 747.

<sup>22</sup> The 11<sup>th</sup> Circuit has recognized a distinction between superpreemption – which furnishes subject matter jurisdiction to the federal courts based on Congress comprehensively occupying a field of law – and ordinary or “defensive” preemption

seeking relief that is available under 29 U.S.C. §1132(a).” *Butero*, 174 F.3d at 1212, quoting *Whitt v. Sherman International Corp.*, 147 F.3d 1325, 1330 (11<sup>th</sup> Cir. 1998). If superpreemption exists, it requires that a plaintiff’s state law claims be recast as ERISA claims. *Butero*, 174 F.3d at 1212. In a §624.155(1)(a) case, however, a private right of action exists against an insurance company for selected violations of the Florida Insurance Code, which, of course, are nowhere addressed in ERISA.

The Supreme Court, in *Moran*, recently discussed the issue in dismissing the HMO’s contention that the disputed Illinois law, though regulating insurance, was nevertheless preempted because it impermissibly conflicted with ERISA’s civil enforcement provision. Summarizing its prior decisions concerning the preemptive reach of ERISA’s civil enforcement provision, the Court reiterated its concern that additional state claims or remedies for recovery of contractual *benefits* remain unavailable so as to avoid expanding the potential liability imposed upon *employers* by the ERISA scheme.

The first case touching on the point did not involve preemption at all; it arose from an ERISA beneficiary’s reliance on ERISA’s own enforcement scheme to claim a private right of action for types of damages beyond those expressly provided. We concluded that Congress had not intended causes of action under ERISA itself beyond those specified in § 1132(a). Two years later we determined in *Metropolitan Life Ins. Co. v. Taylor*, *supra*, that Congress had so completely preempted the field of benefits law that an ostensibly state cause of action for benefits was necessarily a “creature of federal law” removable to federal court. *Russell* and *Taylor* naturally led to the holding in *Pilot Life* that ERISA would not tolerate a diversity action seeking monetary damages for breach generally and for consequential emotional distress, neither of which Congress had authorized in § 1132(a). These monetary awards were claimed as remedies to be provided at the ultimate step of plan enforcement, and even if they could have been characterized as products of “insurance

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which is merely a federal defense to a state law cause of action and requires analysis of the ERISA preemption clauses discussed *supra*.

regulation,” they would have significantly expanded the potential scope of ultimate liability imposed upon employers by the ERISA scheme.

*Moran*, 122 S.Ct. at 2166 (Internal citations omitted).

The Eleventh Circuit was presented with the opportunity to confront this question in *Chilton v. Prudential Ins. Co. of America.*, Case No. 01-10362 but elected not to decide whether the Florida statutes were saved from ERISA preemption even though the Magistrate Judge and District Court disagreed on the issue.<sup>23</sup> While the Eleventh Circuit has failed to address ERISA preemption of these Florida statutes post *Ward* and *Moran*, it has held that Alabama’s bad faith law is not saved from ERISA preemption by the saving clause. See *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292 (11<sup>th</sup> Cir. (Ala) 2001).

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<sup>23</sup> See *Chilton*, 124 F.Supp. 2d 673 (M.D. Fla. 2000) (disagreeing with the Magistrate Judge and finding the Florida statutes preempted by ERISA). The authors appeared before the Eleventh Circuit as counsel for Amicus Curiae, the Academy of Florida Trial Lawyers.

### **Revisions to Florida's Standard Bad Faith Jury Instructions**

Florida's Supreme Court was recently provided with proposed revisions to Florida Standard Jury Instructions MI3, Insurer's Bad Faith, after the Florida Bar's Committee on Standard Jury Instructions in Civil Cases had studied the matter since October 1998. The Committee's recommendation left the base instruction — dating from April of 1982, just prior to the statutory enactment of bad faith extending to both first and third party cases — largely intact, and proposed amendments not addressed in the 1982 version.

The revisions address four issues: (1) they add excess carriers to the list of alternative persons to whom a duty may be owed, (2) they delete an instruction which asks the jury to “consider the matter of damages,” since in most (excess) cases the amount of damages will be fixed at the amount of the excess verdict, (3) they accommodate the Supreme Court's decision in *Time Insurance Company v. Burger*, 712 So.2d 389 (Fla. 1998), which defined the parameters for mental distress claims in bad faith cases, and (4) they accommodate punitive damages claims by adopting the general punitive damages instruction to comport with the requirements of §624.155.