IN THE SUPREME COURT OF FLORIDA

ALLSTATE INDEMNITY COMPANY, ALLSTATE INSURANCE COMPANY and PAUL COBB,

Petitioners.

CASE NO. SC-01-893

vs.

L.T. CASE NO. 4D00-2047

JOAQUIN RUIZ and PAULINA RUIZ,

Respondents.
_____/

ON PETITION FOR DISCRETIONARY REVIEW FROM THE FOURTH DISTRICT COURT OF APPEAL

AMICUS CURIAE BRIEF OF UNITED POLICYHOLDERS

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INTRODUCTION

United Policyholders, a non-profit organization dedicated to educating the public on insurance issues and consumer rights, submits this brief in support of the position of the Respondents.

United Policyholders hopes that its efforts can be of assistance to both counsel and this Court, by focusing its analysis on the public policy considerations associated with first-party insurance coverage and bad faith issues, and by bringing to this Court's attention the broader implications associated with claims of work product immunity behind which insurers often hide. As a public interest organization, United Policyholders' goal is to assist and to educate the public and courts across the United States on the question of policyholders' insurance rights, and to promote greater understanding of insurance-related issues.

STATEMENT OF THE CASE AND FACTS

As its Statement of the Case and Facts, United Policyholders adopts the relevant portions of the opinion of the district court of appeal, and the Statement of the Case and Facts utilized by counsel for the Respondents, whose position United Policyholders supports.

SUMMARY OF THE ARGUMENT

The district court of appeal properly concluded that work product protection does not apply to documents prepared by an insurer during the normal course of business, and that the mere likelihood of litigation between an insurer and its insured over coverage should not shield the insurer or provide blanket protection from discovery during a subsequent lawsuit for insurer bad faith.

Legislation passed in Florida specifically obligates insurers to act in the utmost of good faith and fair dealing with respect to their insureds. See § 624.155, Fla. Stat., and § 626.9541, Fla. Stat. The enactment of these statutes extends a fiduciary obligation to a first-party situation, when that obligation had been long imposed on liability insurers. These obligations are further evidenced by pertinent portions of the Florida Administrative Code, requiring claims adjusters to provide ethical treatment to policyholders, as well as by textbooks prepared for claims handlers in the insurance industry and internal claims handling documents prepared by individual insurance companies.

In this case, Petitioners rely upon Kujawa v. Manhatten National Life Ins Co., 541 So. 2d 1168 (Fla. 1989), for the theory that the district court of

appeal's decision penalizes the timely investigation of claims by allowing discovery of an insurer's claims file materials up until the point where litigation is "imminent and substantial". However, Petitioners fail to address the fact that an insurer owes a continuing obligation to its policyholders to act in good faith and that, indeed, the so-called "adversarial" relationship between insurer and insured is better characterized as that of a fiduciary obligation. Moreover, where the subject matter of bad faith litigation is the insurer's conduct, the claims files and internal documents are the most truthful and accurate reflection of how an insurer acts toward its policyholder.

In fact, in a first-party insurance context, based on an insurer's continuing obligation to reassess whether payment should be made and to what extent that payment should be forthcoming, an insurer's file materials should routinely be turned over in discovery to the time where the insurer actually makes payment to its insured.

ARGUMENT

I. Florida First Party Insurance Policyholders Are Always Entitled To (and Carriers are Required to Provide) Good Faith and Ethical Claims Handling.

A. Florida Statutory Law Imposes Good Faith Duties on First Party Insurance Carriers.

The Florida Legislature has passed legislation requiring insurance companies to act in good faith. Section 624.155, Fla. Stat., provides in pertinent part:

> (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. §626.9541(1)(i)….
>
> …
>
> (b) By the commission of any of the following acts by the insurer:
>
> 1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;
>
> 2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or
>
> 3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a

> claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage….

The Unfair Trade Practices portion of this act, §626.9541(1)(i), Fla. Stat., defines, in pertinent part, the following as unfair methods of competition and unfair or deceptive acts or practices:

> (i) Unfair Claim Settlement Practices –
>
> 1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;
>
> 2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable 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.

The legislative history of these provisions contains a January 25, 1982 Press Release, issued by the House Insurance Committee (Appendix 1), which notes the significance of this legislation:

> A major change in the state's Insurance Code has been proposed to allow anyone to sue their insurance company when it violates the Code….
>
> …To protect the insurance consumer, most states have passed statutes modeled after the National Association of Insurance Commissioners (NAIC) model legislation. The Act prohibits such diverse subjects as unfair competition, false advertising, and unfair claims settlement practices. However, the Florida Act is watered down and deficient in several areas adequately covered in the Model Act. For example, even though an insurance company is found to have committed an illegal practice, the Insurance Commissioner is required to prove that the company knew that it was doing the illegal act in order to prevail against the insurance company. In other cases, the Commissioner must prove that the company committed the act with such a frequency as to indicate a general business practice. These requirements make effective enforcement of the Act impossible….
>
> Consequently, the approach taken by the Insurance Committee bill is to provide a civil remedy which may be pursued by any policyholder when he has been damaged by the actions of an insurance company which violate the Insurance Code. An insured who successfully sues an insurance company under this provision can recover the amount of damages he has suffered, together with his court costs and attorney's fees. So that an insurance consumer may utilize this provision for his own individual problem, the "business practice" aspect of the unfair claim practices law does not have to proved by the consumer. Additionally, a number of provisions which were in the model NAIC bill but were not enacted in

> Florida have been added to the unfair claim practices law including a prohibition against "not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear."…

By enacting §624.155, Fla. Stat., the Florida Legislature has extended the fiduciary obligation long imposed on liability insurers to bind all insurers; insurance companies now have a legal duty, independent of the contract, to handle the claims of all insureds in good faith. Michael K. Green, Comment, The Other Insurance Crisis: Bad Faith Refusal To Pay First-Party Benefits, 15 Fla. St. U.L. Rev. 521, 544 (1987).

B. Florida Regulatory Law Imposes a Requirement of Good Faith and Ethical Claims Conduct, by way of Florida Administrative Code Chapter 4-220, Requiring Insurance Companies to Provide Fair, Honest, Prompt, Truthful and Ethical Treatment to Policyholders.

Insurance adjusters in the State of Florida are required to be licensed, and they must follow the rules set forth in the Florida Administrative Code as follows:

> 4-220.201 Ethical Requirements.
>
> …
>
> (4) Code of Ethics. The following code of ethics shall be binding on all adjusters.

(a) The work of adjusting insurance claims engages the public trust. An adjuster must put the duty for fair and honest treatment of the claimant above the adjuster's own interests, in every instance.

(b) An adjuster shall have no undisclosed financial interest in any direct or indirect aspect of an adjusting transaction….

(c) An adjuster shall treat all claimants equally; an adjuster shall not provide favored treatment to any claimant. An adjuster shall adjust all claims strictly in accordance with the insurance contract.
…

(f) No adjuster may advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.
….

(i) An adjuster shall not knowingly fail to advise a claimant of their claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state….

(j) An adjuster shall approach investigations, adjustments, and settlements with an unprejudiced and open mind.

(k) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

(l) An adjuster shall handle each and every adjustment and settlement with honesty and integrity and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.

> (m) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition thereof.
>
> (n) An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.
> **…**

C. The Insurance Industry Recognizes that it has a Special Relationship with Policyholders and the Obligation of Good Faith and Ethical Claims Conduct.

Respectfully, for the same reason one would not expect to learn medicine by reading malpractice cases, no person can expect to learn how adjusters are taught to treat policyholders by only reading bad faith case law. Claims representatives are taught honest and honorable ways to handle claims. The standard textbook for claims handlers, which leads to an Associate in Claims designation, is James J. Markham, et al., The Claims Environment (1st ed., Insurance Institute of America 1993). There is now a second edition of The Claims Environment.[1]

[1] Doris Hoopes, The Claims Environment, (2d ed., Insurance Institute of America 2000).

The Markham textbook for claims handlers and students of insurance sets forth simple, clear claims handling principles. Amicus attaches to its appendix excerpts from the entire book. (Appendix 2). Some of these principles are:

> "Claims representatives….are the people responsible for fulfilling the insurance company's promise."

Markham at vii.

> "When a covered loss occurs, the insurance company's obligation under its promise to pay is triggered. The claim function should ensure the prompt, fair, and efficient delivery of this promise."

Markham at 6.

> "Therefore, the claim representative's chief task is to seek and find coverage, not to seek and find coverage controversies or to deny or dispute claims."

Markham at 13.

> "…the insurance company should not place its interests above the insured's."

Markham at 13.

> "The claim professional handling claims should honor the company's obligations under the implied covenant of good faith and fair dealings."

Markham at 13.

> "No honest and reputable insurer has either explicit or implicit "standing orders" to its claim department to delay or underpay claims."

Markham at 274.

> "When an insurance company fails to pay claims it owes or engages in other wrongful practices, contractual damages are inadequate. It is hardly a penalty to require an insurer to pay the insured what it owed all along."

Markham at 277.

> "All insurance contracts contain a covenant of good faith and fair dealing."

Markham at 277.

> "If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well."

Markham at 277.

> "Insurance is a matter of public interest and deserves special consideration by the courts to protect the public."

Markham at 277.

> "Insurance contracts are not like other contracts because insurers have an advantage in bargaining power. Insurers should therefore be held to a higher standard of care."

Markham at 277.

> "Recovery for breach of an insurance contract should not be limited to payment of the original claim."

Markham at 277.

> "The public's expectations are elevated by insurers' advertising, slogans, and promises which give policyholders the impressions that they will be taken care of no matter what happens."

Markham at 277.

> "Policyholders buy peace of mind and are not seeking commercial advantage when they buy a policy. In addition, they are vulnerable at the time of the loss."

Markham at 277.

> "Policy language is sometimes difficult to understand. The benefit of interpretation should be given to the policyholder."

Markham at 277-278.

> "Upper management also has a responsibility to maintain proper claim-handling standards and practices."

Markham at 300.

The Second Edition of The Claims Environment (Appendix 3) explains, in part, various aspects of good faith claims handling:

> **Unbiased Investigation**
>
> Claim representatives should investigate in an unbiased way, pursuing all relevant evidence, especially that which establishes the legitimacy of a claim. Claim representatives should avoid using leading questions that might slant the answers. In addition, they should work with service providers that are unbiased. As mentioned previously, courts and juries might not look sympathetically on medical providers or repair facilities that favor insurers. Investigations should seek to discover the facts and consider all sides of the story. Claim representatives should not appear to be looking for a way out of the claim or for evidence to support only one side.

> **Evaluation**
>
> Claim representatives can evaluate liability claims in good faith if they evaluate claims as if not limit of liability existed. This approach ensures that claim representatives consider the insured's interests at least equally with the insurer's interests. Evaluating liability claims as if there were no policy limit helps claim representatives avoid the mistake of wishful thinking that a claim can be settled for less than the policy limit when it is foreseeably worth more. Prompt, knowledgeable evaluations help insurers to prove their efforts were in good faith.
>
> **Prompt Evaluation**
>
> As described in Chapter 9, unfair claims settlement practices acts often specify time limits within which to complete evaluations of coverage and damages. Claim representatives should be sure to comply with those requirements to reduce their exposure to bad faith claims.

Doris Hoopes, The Claims Environment 10.7 (2d ed., Insurance Institute of America 2000).

It is important to note that there are professional designations in the insurance trade. One group of insurance professionals is the Society of Chartered Property and Casualty Underwriters (CPCU). An individual becomes a CPCU after a course of professional study, passing an examination, and making a professional commitment. To attain professional status, a CPCU must agree to abide by the CPCU Code of Professional Ethics and take this lofty professional oath:

> I shall strive at all times to live by the highest standards of professional conduct; I shall strive to ascertain and understand the needs of others and place their interests above my own; and shall strive to maintain and uphold a standard of honor and integrity that will reflect credit on my profession and on the CPCU designation.

The CPCU Professional Commitment, AICPCU/IIA Catalog, 1999-2000, at 66.

The CPCU Code of Professional Ethics is generally known, accepted, and followed within the insurance trade. The standards the Code sets forth are established standards. The Canons from the Code of Professional Ethics of the American Institute for the CPCU are:

> CANON 1: CPCUs should endeavor at all times to place the public interest above their own.
>
> CANON 2: CPCUs should seek continually to maintain and improve their professional knowledge, skills and competence.
>
> CANON 3: CPCUs should obey all laws and regulations; and should avoid any conduct or activity which would cause unjust harm to others.
>
> CANON 4: CPCUs should be diligent in the performance of their occupational duties and should continually strive to improve the functioning of the insurance mechanism.
>
> CANON 5: CPCUs should assist in maintaining and raising professional standards in the insurance business.

CANON 6: CPCUs should strive to establish and maintain dignified and honorable relationships with those whom they serve, with fellow insurance practitioners, and with members of other professions.

CANON 7: CPCUs should assist in improving the public understanding of insurance and risk management.

CANON 8: CPCUs should honor the integrity of the CPCU designation and respect the limitations placed on its use.

CANON 9: CPCUs should assist in maintaining the integrity of the Code of Professional Ethics.

David H. Brownell & Stephen Herald, Ethics in the Insurance Industry: A Case Study Approach 6-7(Am. Inst. For Chartered Prop. Cas. Underwriters Ins. Inst. Of Am.).

Insurance companies employ most of the nation's CPCUs. Insurance companies should not be exempt from established trade customs, trade standards, and trade usage simply because not all of their employees are CPCUs, nor because only individuals and not insurance companies can earn the professional degree. There are more than 30,000 members of the CPCU Society. See http://www.aicpcu.org/mediacenter/history.html.

D. Allstate Itself Recognizes that it is Obligated to Treat its Policyholders in Good Faith in the Context of a First-Party Claim.

In its standard claims manual, Allstate acknowledges that its relationship to its policyholder is more than that of a "debtor-creditor"; instead, Allstate recognizes its relationship requires good faith and the highest degree of integrity. (Appendix 4). Allstate's Claims Practices and Procedures Manual provides:

> The conduct of our claim personnel is constantly being scrutinized by all of the people with whom we are in daily contact with – our policyholders, third-party claimants, state insurance departments, and other persons connected with the insurance industry. It is therefore important that we make very clear the basic principles which must be adhered to by Allstate's claim employees at all times.
>
> THE INSURING PUBLIC HAS THE RIGHT TO RELY ON ALLSTATE MEN AND WOMEN TO BE HONEST IN EVERY ACTIVITY OF THE COMPANY. TO FULFILL THAT RESPONSIBILITY, ALLSTATE CLAIM EMPLOYEES ARE EXPECTED TO CONDUCT THEIR DEALINGS WITH THE HIGHEST DEGREE OF INTEGRITY. IF ALL CLAIM EMPLOYEES MAINTAIN HIGH STANDARDS OF INTEGRITY, THE INSURING PUBLIC WILL RESPOND WITH THE CONFIDENCE AND RESPECT THAT ARE ESSENTIAL TO ALLSTATE'S FUTURE GROWTH.
>
> THESE BASIC PRINCIPLES OF INDIVIDUAL CONDUCT ALSO REQUIRE THAT ALLSTATE CLAIM PERSONNEL COMPLY WITH ALL PERTINENT LAWS & REGULATIONS GOVERNING THE STATE OR JURISDICTION INVOLVED.

Allstate C-PPP Manual, Vol. I, Chapter 2 (Rev. Aug 31, 1990).

Allstate recognizes the value of its adjusters receiving the type of training provided by certification, and provides monetary "rewards" to its claims personnel who complete either the Associate in Claims certification or CPCU membership (Appendix 5):

> In addition to the Allstate and P-CCSO awards, there are many insurance designations and certification programs that should interest you. A few of them are described in this brochure. Here is a brief summary:
>
> **Chartered Property and Casualty Underwriter (CPCU)**
>
> The CPCU designation is earned by insurance professionals who have passed 10 examinations covering a broad range of risk management and general business topics in the field of Property and Casualty Insurance. The CPCU designation is widely regarded in the insurance industry as signifying a knowledgeable and ethical insurance professional. You may take CPCU examinations in January, June or September. Upon successfully completing the program, you receive a $1,000 cash award and are eligible to attend the national conference with a guest at the company's expense in the year of confirmation.
>
> **Insurance Institute of America (IIA) – Associate in Claims**
>
> The Associate in Claims program is most appropriate for experienced adjusters and claim managers. This program focuses on subjects important to handling all types of claims, including communication, negotiation, workers' compensation issues, laws of contracts, duties under a

> policy of insurance, and many others. The four course program leads to an Associate in Claims designation. Upon successfully completing the program, you will receive a $200 cash award.

Allstate P-CCSO Recognition Program, a Guide to Recognition.

Thus, while Allstate's outside counsel may argue in briefs that the relationship between a policyholder and itself is merely that of a debtor and creditor, its claims personnel are at least on notice and agree that it is much more.

II. Florida Common Law Requires Change to Reflect what Everyone Else Recognizes: The Relationship and Duty of a First Party Insurance Company to its Policyholders is One of Good Faith and Ethical Claims Conduct.

Allstate relies upon Kujawa v. Manhattan National Life Ins. Co., 541 So.2d 1168 (Fla. 1989), to assert that an "adversarial" relationship, rather than a "good faith" or fiduciary relationship, exists between first party insurers and their insureds. Further, Allstate relies upon Baxter v. Royal Indemnity Company, 258 So.2d 652, 657(Fla. 1st DCA 1973), to claim that this policyholder-insurer relationship is merely one of "debtor and creditor."

Florida's common law, which dictates that trial judges analyze work product disputes within the policyholder/insurer relationship categorized as "adversarsial" and merely "debtor and creditor," is completely irreconcilable with Florida statutory law, Florida regulations, insurance industry standards,

and Allstate's own internal standards. Since consumers, insurance regulations and insurance companies all demand that an adjuster's treatment of policyholders be synonymous with the duties of a fiduciary, the Florida common law should reflect this as well.

Florida common law does not reflect the growing majority and recent trend that recognizes a special relationship of the utmost good faith by the insurance company towards its policyholder at common law. In 1973, the Supreme Court of California decided Gruenberg v. Aetna Insurance Co., 510 P.2d 1032 (Cal. 1973), which first found that an implied covenant of good faith and fair dealing was owed by an insurer to its policyholder, such that the breach would give rise to a bad faith claim in tort. Known as "first-party bad faith", this tort allowed insurance claimants to collect extra-contractual damages for an insurer's bad faith refusal to pay an insurance claim.

After 1973, at least twenty-five other states have adopted this new tort. Dominick C. Capozzola, Note, First-Party Bad Faith: The Search for a Uniform Standard of Culpability, 52 Hastings L.J. 181, 182 (2000). See also Stephen S. Ashley, Bad-Faith Actions: Liability and Damages 2-54 (2d. ed., West Group 1997)("A substantial minority of jurisdictions have rejected a common-law tort cause of action for bad-faith in first-party cases."). Professor Ashley notes that every state, except Florida, Georgia, Illinios,

Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, New York, Oregon, Pennsylvania and Tennessee recognize first-party bad-faith at common law based on either a tort or contract theory. See id. at 2-54-55. See generally Roger C. Henderson, The Tort of Bad-Faith in First-Party Insurance Transactions After Two Decades, 37 Ariz. L. Rev. 1153, 1156 (1995)(noting that since Gruenberg, over thirty jurisdictions recognize remedies for first party insurer misconduct when private statutory remedies are considered).

While the suggestion is not being made that Florida adopt a common law bad faith cause of action in the current case, the significance of these decisions is that the majority of states recognize the very special and fiduciary relationship owed by insurance companies to policyholders. The insurance industry, sister courts, consumer advocates, the Florida Department of Insurance, the Florida legislature, and even Allstate all recognize what this court has heretofore failed to acknowledge---- a special duty is owed by an insurance company to its policyholder, and the duty involves more than the typical commercial relationship.

A particularly scholarly discussion explaining why insurance is treated differently by courts is found in an article written by Professor Henderson of

the University of Arizona College of Law, which includes the following discussion:

> In a free enterprise system, economic development steadily increases the number of situations in which individuals can suffer "loss." At the same time, economic development enhances the ability to avoid the prospect of "loss." In other words, in a relatively affluent society, there is much more to lose in the way of property and other economic interests as the human condition improves. In such a society, however, individuals are more likely to have the requisite discretionary income to transfer and to spread the attendant risks of loss. Disruptive losses to society, as well as to the individual, are obviated or minimized by private agreements among similarly situated people. In this way, the insurance industry plays a very important institutional role by providing the level of predictability requisite for the planning and execution that leads to further development. Without effective planning and execution, a society cannot progress.
>
> ….
>
> This perceived social significance has set apart insurance contracts from most other contracts in the eyes of the law. Insurance is purchased routinely and has become pervasive in our society. It protects against losses that otherwise would disrupt our lives, individually and collectively. The public interest, as well as the individual interests of millions of insureds, is at stake. This is the foundation for the general judicial conclusion that the business of insurance is cloaked with a public purpose or interest. This perception also explains the extensive regulation of the insurance industry in the United States, not just through legislative and administrative processes, but also through the judicial process. In fact, as with developments in other areas of tort law, the recognition of the tort of bad faith in insurance cases represents a

judicial response to the perceived failure of the other branches of government to regulate adequately the claims processes of the insurance industry. Had the early attempts at regulation been more effective, the tort of bad faith might never have come into existence.

…

The insureds' disadvantage persisted as insurance took on more and more importance in this country. In order to purchase a home or a car, or commercial property, most people had to borrow money, and loans were not obtainable unless the property was insured. In addition, the lender often required that the life of the borrower be insured. On another front, the cost of medical care was rising beyond the reach of many people and insurance programs were developed to spread that risk. The purchase of insurance was no longer a matter of prudence; it was a necessity. Then losses occurred and the inevitable disputes arose. These disputes, however, were not about an even exchange in value. Rather, they were about something quite different.

Insureds bought insurance to avoid the possibility of unaffordable losses, but all too often they found themselves embroiled in an argument over that very possibility. Disputes over the allocation of the underlying loss worsened the insureds' predicament. In most instances, insureds were seriously disadvantaged because of the uncompensated loss; after all, the insured would not have insured against this peril unless it presented a serious risk of disruption in the first place. The prospect of paying attorneys' fees and other litigation expenses, in addition to the burden of collecting from the insurer, with no assurance of recovery, only aggravated the situation.

These additional expenses could prove to be a formidable deterrent to the average insured. For most insureds, unlike insurers, such expenses were not an anticipated

> cost of doing business. Insureds did not plan for litigation as an institutional litigant would. Insurers, on the other hand, built the anticipated costs of litigation into the premium rate structure. In effect, insureds, by paying premiums, financed the insurers' ability to resist claims. Insureds, as a group, were therefore peculiarly vulnerable to insurers who, as a group, were inclined to pay nothing if they could get away with it, and, in any event, to pay as little as possible. Insurance had become big business.

Roger C. Henderson, The Tort of Bad Faith in First-Party Insurance Transaction: Refining the Standard of Culpability and Reformulating the Remedies By Statute, 26 U. Mich. J.L. Ref. 1, 10-14 (1992).

The man on the street knows that it is far more profitable for an insurance company to take a person's money and not pay, rather than to promptly and fully pay what is owed. That this financial incentive conflicts with the extreme public trust placed in the insurance industry is the reason why codes of ethics, good faith duties and common law remedies are imposed upon insurers. Public policy demands that the common law of Florida recognize these practical and generally-recognized duties so that its own citizens are not mistreated at the very time they need the best treatment from their insurers.

III. **Where the Subject Matter of Bad Faith Litigation is the Insurance Company's Conduct, the Claims Files and Internal Claims Memoranda, Insurance Claims Procedures, Electronic Diaries and E-mails are the Most Truthful and Accurate Reflection of How an Insurance Company Acted Toward its Policyholder.**

A. Claims files are indeed the most crucial evidence in a bad faith case.

Insurance company adjusters are taught that proper documentation in the claims file will establish whether or not good faith and ethical claims conduct occurred. The Claims Environment, 10.5 (2d Ed. 2000) (Appendix 3) provides:

Fair Dealing and Good Communication

> Good claim handling and supporting evidence can help to establish that insurers acted in good faith by dealing fairly with insureds and claimants. Documentation in each claim file demonstrates how insurers conduct the claim investigation, evaluate claims, and negotiate. Activity logs, correspondence, and documentary evidence such as police reports and bills can indicate that claim representatives, supervisors, and managers are doing their jobs properly. Such evidence is part of a successful defense strategy for a bad faith claim.
>
> Fair dealing and good documentation are especially important in two circumstances:
>
> 1. Claim denial
> 2. Errors.
>
> Claim representatives should have a thoroughly documented claim file before denying a claim. Such a file will be useful in defending a bad faith claim. If a claim representative discovers that he or she has made an

> error, fair dealing and good documentation will help the claim representative to explain the error. In such cases, a sincere apology and quick action to fix the error go a long way in avoiding and defending bad faith claims.

Doris Hoopes, The Claims Environment 10.5 (2d ed., Insurance Institute of America 2000). Indeed, claims management reviews the same claims files the Respondents in this matter are seeking through "claim audits" to determine whether the field adjusters are properly performing the claims function. Id. at 11.27-11.29. (Appendix 6).

> **Claim audits** are claim reviews that examine the technical details of claim settlements, ensure that claim procedures are followed, and verify that appropriate, thorough documentation is included.

Id. at 11.27. (Appendix 6).

Claims management is responsible for setting policies, the claims culture and rewarding adjusters for ethical conduct rather than the all too common lowballing and stonewalling that is so prevalent. Claims managers perform these audits of claims files because those files are the best, and only, evidence of what happened during an adjustment and whether the claim function was properly carried out.

> Corporate claim officers establish the claim department structure, set policies relating to authority levels, performance of policy conditions, settlement philosophies, service providers and training and performance review; and review statistical information to assess how the department is performing.

> Claim audits are useful tools for assessing claim department performance. Some organizations use formal audit teams to ensure consistency throughout the organization. Others use a peer-audit process in which managers from one department audit another. Files for audit might be selected at random or with focus on a particular problem. Auditors review decisions on coverage, liability, and damages; reserves; adherence to policies and procedures; appropriate use of resources; and documentation. Audits are learning experiences from which claim departments can improve performance.

Id. at 11.29 - .30.

As explained in Stephen Ashley's treatise on bad faith with respect to document production in a bad faith case:

> Large insurance companies typically have multiple layers of bureaucracy. A claims agent will report to the claims supervisor of manager in his local office; the supervisor or manager will report to a regional office; the regional office will report to the home office, and so on. All up and down the line writers of intra-company memoranda send copies to numerous inhabitants of the corporate hierarchy, so that an incriminating memorandum from a field claims supervisor to a regional office may find its way into a number of files throughout the company. The plaintiff's attorney should first request production of every company file relating to the insured's claim, from the field office through the highest reaches of the home office.
>
> Insurance companies sometimes respond to requests for "the claims file" by supplying the claims file from one level of the corporate hierarchy without providing the files maintained at other levels. The plaintiff's attorney must not settle for one level's file alone. He should carefully specify the files maintained at each level of the

corporate hierarchy. A claims supervisor's memorandum may indicate that he sent a copy to a company vice-president in the home office, but the vice-president's file may omit the same memorandum. Such an omission raises the possibility that the vice-president sanitized his file before producing it. Only by obtaining all the files can the plaintiff's attorney obtain a complete picture of what happened within the company when the plaintiff submitted his claim. Senior personnel sometimes place handwritten notes on their copies of memoranda rather than writing separate memoranda of their own. No single company file will contain all of these notes.

The plaintiff's attorney should request all underwriting files relating to the plaintiff's policy. These files may provide important information about the plaintiff's claim history. (footnote omitted).

The plaintiff's attorney should determine whether the insurer reinsured the risk under the plaintiff's policy. If it did, then the plaintiff's counsel should try to obtain copies of correspondence between the insurer and the reinsurers concerning the plaintiff's claim. These letters sometimes contain damaging admissions by insurers concerning the merits of the plaintiff's case and other helpful information. (footnote omitted).

The plaintiff's attorney should obtain all company claims manuals, policy statements, and intraoffice correspondence relating to the coverages provided in the policy and the adjustment of claims. Auto Owners v. Totaltape, Inc., 135 F.R.D. 199 (M.D. Fla. 1990). These materials sometimes reflect a hostile company attitude toward the payment of claims. Recently, insurance companies have improved these materials so as to manifest their sensitivity to the plight of the insured. The plaintiff can turn such claims manuals to his own advantage by arguing that the company realized the importance of treating its insureds fairly but nevertheless

> broke its own rules in handling the plaintiff's claim. (footnote omitted).

Stephen S. Ashley, Bad Faith Actions- Liability and Damages § 10.30 (West Group 1997).

B. Allstate and Insurance Companies know these Documents are of Extreme Importance and Obviously have Motivations to Hide Them under Claims of Privilege to "Win" the Bad Faith Suit.

> When a party opposes an insurer in litigation, access to the claims file is often a critical issue. The claim file is the best and most obvious record of both the underlying facts and the insurer's handling of the claim. The extent to which it is discoverable may determine whether the case goes forward and which party ultimately prevails. Because the claim file is so valuable, insurers vigorously seek to protect it from discovery. Their most effective shield is the work product doctrine.

Mary Beth B. Young, Comment, The Work Product Doctrine: Functional Considerations and the Question of the Insurer's Claim File, 64 U. Chi. L. Rev. 1425 (1997)(emphasis added).

The importance of the claims file has been noted by one court as follows:

> [B]ad-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, now thoroughly it was considered and why the company took the action it did. The claims file is a unique, contemporaneously prepared history of the company's handling of the claim; in an action such

> as this [for the insurer's bad faith failure to pay a claim for lost earnings] 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 [the insurer] acted reasonably.

Brown v. Superior Court, 137 Ariz. 327, 670 P.2d 725, 734 (1983).

Perhaps, by using examples, Professor Ashley stated why the evidence in the claims file are the most important and why insurers do not want to turn them over:

> Insurance bad faith cases are won or lost on the contents of the insurer's claims files. Insurance claims personnel are voracious note writers, and their files sometimes contain the most amazingly incriminating statements. one adjuster wrote, "In this adjuster's experience, he has never paid a policy limit to date, and does not intend to start with the subject claim." Groce v. Fidelity General Ins. Co., 252 Or. 296, 304, 448, P.2d 554, 558 (1968). An attorney in a third-party case wrote to the insurer's superintendent: "I was disappointed with the verdict but not surprised. [The third party] was a pathetic sight and in view of her initial injuries and permanency of her present condition, I felt that if she was going to get a verdict it could be a very substantial one." Shearer v. Reed, 286 Pa. Super. 188, 195, 428 A.2d 635, 639 (1981). On a memorandum from the attorney in a third-party case urging settlement of multiple claims within the policy limits, a claims supervisor wrote, "I told him No! To try the other cases as we are only gambling with $5,000 [the policy limits]. Henke v. Iowa Home Mut.Cas. Co.,250 Iowa, 1123, 1133, 97 N.W. 2d 168, 175 (1959). In a first-party case, with damages clearly exceeding the policy limits, the adjuster noted, "When I get

> authorization I will attempt to cashout insured for a complete loss. I will start at a low price and work my way up. There is no harm offering a lower amount at first. I can always go up. Davis v. Allstate Ins. Co., 101 Wis. 2d 1, 9, 303 N.W. 2d 596 (1981). An Allstate casualty claims supervisor, in justifying the company's refusal to defend, noted in the claims file, "If [the agent] backs up the cancellation, we are in good hands." Calenda v. Allstate Ins. Co., 518 A.2d 624 (R.I. 1986).
>
> …
>
> The jury is entitled to know what information was in the insurer's files in order to determine whether the insurer acted fairly in handling the claim. U.S. Holmgren v. State Farm Mut. Auto. Ins. Co., 976 F.2d 573, 23 Fed.R.Serv. 3d (LCP) 778 (9th Cir. 1992) reh'g denied, (Nov. 9, 1992); Auto-Owners Ins. Co. v. Total Tape, Inc., 135 F.R.D. 199 (M.D. Fla. 1990).

See also Lee Craig, Ten Stupid Things Insurance Companies Do to Mess up Their Files, 14 Mealey's Litigation Report: Bad Faith 31 (Nov. 21, 2000)(also republished on the web at www.bbplaw.com). (Appendix 7). The author noted that his insurer clients may expose themselves to extracontractual liability by having the following found in their claims files:

1. Delay.
2. Indecision
3. Inconsistency
4. Prejudgment
5. Forms
6. Prosecution
7. Disparagement
8. Prevarication
9. Meanspiritedness
10. Bias

IV. **All First Party File Materials Should Routinely be Turned Over in Discovery at Least up Through the Time of Payment Where the Subject Matter is the Insurance Company's Failure to Act in Good Faith.**

(A) Since Florida law Recognizes that the Underlying Case Must be Resolved in a First-Party Action, the Claims File Materials Should Generally be Produced.

Any considerations about whether the insurer could be prejudiced by turning over its claim file documents when the underlying litigation was ongoing are non-existent under the current status of Florida law. See, e.g., *Vest v. Travelers Ins. Co.*, 753 So. 2d 1270 (Fla. 2000). As such, there is no reason not to turn over these documents, other than to shield the insurer's bad faith conduct. Indeed, discovery in a first-party bad faith action should be treated no differently from that in a third-party situation, and the materials up until the time of payment are crucial to the policyholder's position. As this Court has explained in a third-party case:

> Finally, we note that the permitted discovery of the insurer's claim file is limited to materials related to the insurer's handling of the claim throught the date of the stipulation and agreement that concluded the underlying negligence claim and is the basis of the stipulated judgment. The required discovery does not include any attorney-client communication or work-product material which pertains to the insurer's defense of itself in the bad-faith action and which was generated subsequent to the stipulation and agreement, even though such

> privileged materials are physically included in what is referred to as the claims file.

United Services Auto. Ass'n v. Jennings, 731 So. 2d 1258 (Fla. 1999).

Indeed, Florida courts allow an insurer's litigation conduct in the underlying coverage suit to be used as evidence of the insurer's bad faith. See Hollar (cite?). If the policyholder does not have access to the insurer's internal documents, there is no way to show that this conduct was inappropriate.

(B) Insurers Should not be Encouraged to Delay, Stonewall, or Flex their Litigation Strategies Through Barely Arguable Objections of Privilege.

Allowing an insurer to hide behind a claim of privilege with respect to its claims file materials can, in actuality, perpetuate the insurer's bad faith conduct. Unless the insurer runs the risk of having it conduct throughout the course of the claim being exposed, there is little incentive for change. See, e.g., Campbell v. State Farm Mutual Auto. Ins. Co., 2001 Utah LEXIS 170 (Ut. Oct. 19, 2001)(discussing how the defendant insurer engaged in deliberate concealment and destruction of documents to avoid their disclosure in document requests).

Florida, unlike other states that allow a common law first-party bad faith action, allows an insurer an opportunity to revisit and reconsider its

position in denying a claim under § 624.155, Fla. Stat., through the use of a Civil Remedy Notice. The adequacy of the insurer's evaluation under those circumstances is crucial to a policyholder's claim for bad faith.

As was explained by Justice Shaw in his dissent in Kujawa:

> The legislative creation of a bad faith cause of action, section 624.155(1)(b), Florida Statutes (1985), is nullified if the claimant is denied discovery of the sole source of proof….[I] would adopt the contrary rule that the insurer's good faith obligation to process claims establishes a fiduciary relationship with the insured, thus making the claim processing file discoverable under the bad faith count.

Kujawa, 541 So. 2d at 1169.

CONCLUSION

In conclusion, for the reasons set forth above, the Petitioners' requested relief should be denied by this Court. Rather than restricting access to an insurer's claim file documents in a first-party bad faith context, this Court should, in actually, revisit its previous holdings with respect to the discoverability of these materials. Allowing an insurer to hide behind claims of privilege merely perpetuates the bad faith conduct. Based on the modern trend, and the true relationship of insurer to insured in a first-party context, an insurer should be required to turn over its files up until the time of payment.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of this brief has been furnished by United States Mail to Henry A. Seiden, Esquire, P.O. Box 3067, Salem, MA, 01970, Philip D. Parrish, Esquire, 9130 S. Dadeland Boulevard, Suite 1705, 2 Datran Center, Miami, FL, 33156, David B. Shelton, Esquire, Lori J. Caldwell, Esquire, Rumberger, Kirk & Caldwell, P.O. Box 1873, Orlando, FL, 32802 and Richard Barnett, Esquire, 121 South 61st Terrace, #A, Hollywood, FL, 33023, this ___day of December, 2001.

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 9.210(a)(2), I hereby certify that this brief was prepared using Times New Roman 14-point font.

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