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IN THE SUPREME COURT OF FLORIDA

Case No. 93,287 (No. 97-2327)

TALAT ENTERPRISES, INC.

d/b/a Billy the Kid's Buffet

Appellant,

v.

AETNA CASUALTY AND SURETY CO.

d/b/a, Aetna Life and Casualty

Appellee.

ON CERTIFIED QUESTION FROM THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Appellant's Initial Brief

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(as framed by the certified question)

If an insured suffered extra-contractual damages prior to giving its insurer written notice of a bad faith violation and the insurer paid all contractual damages, but none of the extra-contractual damages, within sixty days after the written notice was filed, has the insurer paid "the damages" or corrected "the circumstances giving rise to the violation," as those terms are contemplated by Florida Statute § 624.155(2)(d), thereby precluding the insured's first-party bad faith action to recover the extra-contractual damages?

STATEMENT OF THE CASE & FACTS

Appellant accepts the statement of the case and facts set forth in the certification from the United States Court of Appeals for the Eleventh Circuit.

Additionally, the facts and circumstances giving rise to the violations were cited in Exhibit "B" to the Complaint as the following:

> The insurer failed to settle the insured's claim for loss of contents, including equipment, and loss of business income, from fire damage, when it could have done so, and should have done so, had it acted fairly and honestly toward the insured, and with due regarding for his interest, requiring the insured to go through the appraisal process, when its own adjuster had recognized a higher damage amount than the insurer was offering, withholding monies with which to restart the business, or purchase necessary equipment, withholding loss of income payments, all as evidenced by the appraisal award, some seven times greater than any amount proposed by the insurer. Insurer tried to force a settlement by withholding funds and refusing to provide any monetary amounts, over an eight or nine month period. Used unfair claim practice by withholding funds, knowingly and therefore, forcing the insured into Bankruptcy Court. Misrepresenting that they would pay for equipment and thereafter refusing to pay. Withholding photographs of equipment from insured's representative during the appraisal process.

SUMMARY OF THE ARGUMENT

Florida Statute § 624.155 provides a means for policyholders to receive "damages" above and different from the contract amounts owed by insurers. Until the passage of this statute, first party policyholders in Florida could not collect damages for consequences of bad faith claims handling by insurance companies.

The statute, legislative intent and Florida case law support Appellant's position that insurers must pay "damages" caused by their wrongful conduct or correct the circumstances caused by their wrongful conduct within sixty (60) days of the filing of the Civil Remedy Notice. Otherwise, they may be sued under the Civil Remedy Statute 624.155.

Neither the statute, the intent of the statute, nor Florida cases allow an insurer to escape responsibility for the "damages" caused by the wrongful conduct by merely paying the contract damages owed within sixty (60) days of the receiving the Civil Remedy Notice. Under the facts of the instant case, paying only the contract damages does not "correct the circumstances."

ARGUMENT

I. FLORIDA RECOGNIZES THAT EXTRA-CONTRACTUAL DAMAGES WHICH ARE A REASONABLY FORESEEABLE RESULT FOR VIOLATIONS OF § 624.155 MUST BE PAID OR THE CIRCUMSTANCES CAUSED BY THE WRONGFUL CONDUCT CORRECTED WITHIN SIXTY (60) DAYS OF NOTICE OR THE INSURER MAY BE SUED BY THE POLICYHOLDER TO RECOVER THOSE "DAMAGES".

A. THE HISTORY AND DEVELOPMENT OF FLORIDA INSURANCE LAW RECOGNIZED THE NEED FOR A STATUTORY SCHEME TO RECOVER REASONABLY FORESEEABLE EXTRA-CONTRACTUAL DAMAGES.

Abusive insurance claim settlement practices are nothing new. Since the first insurance company opened its doors, well over several hundred years ago, the insurance industry enjoyed a consistently favorable position. An insurer had the luxury to choose between settling the claim against its insured or not paying the claim of the insured. Unfortunately, the insurer knew that if it refused or delayed payment, even on a totally valid claim, the most that the insured could recover on a traditional breach of contract claim would be limited to the terms contained within the policy and possibly interest.[1]

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[1] Ashley, Bad Faith Actions § 1:01 (West 1997).

Even though the policyholder was faced with the harsh reality that the courts and the legal system were affording the insurance industry virtual impunity for breaching their contracts and abusive claims settlement practices, a policyholder faced with non-payment of a valid claim could still explore other common law avenues of recovery. Such avenues were traditionally negligence, fraud or intentional infliction of emotional distress.[2]

These traditional common law extra-contractual remedies, however, were generally only applicable to the most extreme cases. For example, in 1983 the Third District Court of Appeal stated that the Florida Supreme Court had yet to conclusively identify a common law cause of action for emotional distress damages related to breach of an insurance contract.[3] In Dominguez v. Equitable Life Assurance Soc., the Third District Court of Appeal engaged the modern trend allowing emotional distress damages finding "[t]his combination of the unjustified assertion of power by one party [the insurance company], and impotence of the other [the policyholder], would, we think, be viewed by a civilized community as outrageous and not as an indignity, annoyance or petty oppression for which the

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[2] See generally, Johnson v. Hardware Mut. Casualty Co., 108 Vt. 269, 281-282, 187 A 788, 794 (1936) (liability for fraud, negligence or bad faith); see also, Aetna Life Ins. Co. v. Flour City Ornamental Iron Works, 120 Minn. 463, 469, 139 NW 955, 957-58 (1913) (suggesting possibility of liability for negligence).

[3] Dominguez v. Equitable Life Assur. Soc., 438 So. 2d 58 (Fla. 3 DCA 1983), approved 467 So. 2d 281 (Fla. 1985).

law affords no relief."[4] The Court then supported its holding by concluding that the alleged conduct "is outrageous [and] is amply supported by case law."[5] The decision was approved by the Florida Supreme Court.

As a result of cases like Fletcher v. Western National Life Insurance Co.,[6] and Gruenberg v. Aetna Insurance Co.,[7] the majority of state courts this century retracted from the common law protection afforded insurance companies, and recognized common law theories for "bad faith" in a first party contract.[8] The intent behind this modern trend is to protect the rights and interests of the economically inferior party to the contract. Except in third party situations, Florida was not a part of this modern movement.[9]

As a result of the failure of Florida courts to fully recognize a common law bad faith remedy for policyholders to recover for damages inflicted by their insurers failing to act in good faith, the Florida Legislature codified § 624.155

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[4] Id. at 61.

[5] Id. at 61.

[6] Fletcher v. Western National Life Insurance Co., 10 Cal App 3d 376, 89 Cal Rptr 78 (1970).

[7] Gruenberg v. Aetna Insurance Co., 9 Cal.3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973) (justifying an extension of the cause of action for bad faith to first party cases).

[8] Ashley, Bad Faith Actions, § 2:14 (West 1997)

[9] See, Opperman v. Nationwide Mut. Fire Ins., 515 So. 2d 263 (Fla. 1987); see also, Butchikas v. Travelers Indemnity Co., 343 So. 2d 816 (Fla. 1976)

Florida Statutes providing for remedies.[10] Similar to the common law developed in the other states, what the Florida Legislature created by enacting § 624.155 was a means for claimants to receive an avenue of redress so that "damages recoverable . . . 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."[11]

The statute created a cause of action against an insurer, other than the traditional common law theories. Clearly the intent was to remove the protection afforded to the insurer that existed at Florida common law, mandate standards of conduct for the insurance industry, provide new remedies not recognized at common law if insurers breached those specified standards of conduct, and a provide for a possible punitive penalty if the insurer did not pay the "damages" or correct the circumstances within a sixty (60) day period available for it to cure its wrongful conduct.[12]

Summaries prepared for Representative Gustafson in Appendix A to the legislative history of Florida Statute § 624.155, provided in pertinent part.[13]

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[10] See generally, State Farm Automobile Insurance Company v. Laforet, 658 So. 2d 55, 57-60 (Fla. 1995) (describing development of Florida Bad Faith law.).

[11] Fla. Stat. § 624.155 (1997) (as amended and with emphasis added).

[12] Comment, The Other Insurance Crisis: Bad Faith Refusal to Pay First Party Benefits, 15 Fla. St. L. Rev. 521, 541 (1987).

[13] Bill Analysis, HB 607, Appendix A at 12, 13, and 14 (1982).

> The problems are illustrated in the area of unfair claim settlement practices. Insurance is purchased to protect the policyholder from a calamity. The policyholder expects prompt action by the insurance company in protecting him from liability to another person or in paying him for a personal loss. While the vast majority of claims are handled fairly and honorably, the refusal of an insurance company to act leaves many individuals adrift at the time when they particularly need help...
>
> Consequently, the approach taken by the bill is to provide a civil remedy which may be pursued by any policy holder when he has been damaged by the actions of an insurance company which violates 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 be proved by the consumer.
>
> These provisions are necessary in order to balance the rights of the individual of the individual with that of the insurance company. Since insurance companies are fiduciaries and are holding millions of dollars of the public's funds, it is only fair that they be required to face up to the responsibilities of the law. By permitting individuals to act against companies who have harmed them, the consumers of Florida have been provided an adequate remedy without the necessity of increasing the size of the bureaucracy needed to monitor the insurance industry.[14]

The foregoing analysis of Florida law confirms that a party bringing a cause of action under § 624.155 may recover extra contractual damages. Indeed, the enactment of Florida's statutory bad faith scheme is not to serve as a shield for

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[14] House Bill 607, Bill Analysis, Appendix A at 14-15 (January 22, 1982)

insurance companies, but must be viewed as the quintessential use of the legislative process by affording greater remedies which Florida courts, unlike its sister states, failed to recognize at common law.

As stated in Hollar vs. International Bankers,[15]

> § 624.155 changes neither the case law obligation of good faith nor the measure of the damages due an insured once bad faith is proven. Rather than changing the decisional law, § 624.155 simply expands the cause of action to first-party claims, see Cardenas v. Miami-Dade Yellow Cab Co., 528 So.2d 491 (Fla. 3d DCA), review dismissed, 549 So.2d 1013 (Fla. 1989); Opperman v. Nationwide Mut. Fire Ins. Co., 515 So.2d 263 (Fla. 5th DCA 1987); review denied, 523 So.2d 578 (Fla. 1988); Rowland v. Safeco Ins. Co. of America, 634 F. Supp. 613 (M.D. Fla. 1986); see Vega v. Travelers Indem. Co., 520 So.2d 73 (Fla. 3d DCA), review denied, 531 So.2d 169 (Fla. 1988), and adds a procedural first step that requires insureds to notify the insurer of a bad faith claim. Thus, **it provides a cumulative and supplemental remedy.**

B. "DAMAGES" UNDER THE CIVIL REMEDY STATUTE ARE DIFFERENT THAN CONTRACT DAMAGES OWED UNDER POLICY OF INSURANCE.

In 1982, the Florida legislature enacted § 624.155, Florida Statutes, in an effort to provide insureds a civil remedy for "damages" caused by an insurer's violation of specific provisions, and other enumerated acts. Fla. Stat. § 624.155

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[15] 572 So.2d 937, 939 (Fla. 3rd DCA 1990) (emphasis added.)

(1995). The portion of § 624.155, relevant to Appellee's Motion for Summary Judgment provides as follows:

> (1) Any person may bring a civil action against an insurer when such person is damages:
> (b) by the commission of the following acts by the insurer:
> 1. Not attempting in good faith to settle claims when, under all circumstances, it could have and should have done so, had it acted fairly and honestly toward its insured and with due regard for his interests;...
> (2) As a condition precedent to bringing an action under this section, the department and the insurer must be given written notice of the violation. The notice shall state with specificity the facts which allegedly constitute the violation and the law which the plaintiff is relying upon and shall state that such notice is given in order to perfect the right to pursue the civil remedy authorized by this section. No action shall lie if, within 60 days after filing notice, the damages are paid or circumstances giving rise to the violation are corrected.

Fla. Stat. § 624.155 (1995). (Emphasis Added).

Further, in 1990, the Florida legislature amended the statute to include in section 7 the following, in part:

> **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.**

Regarding the amendment, the Florida Supreme Court in McLeod v. Continental Insurance Company,[16] noted:

[16] McLeod v. Continental Insurance Company, 591 So.2d 621, 626, n.9 (Fla. 1992).

> The amendment provides that the insured is entitled to reasonably foreseeable damages arising out of a violation of the statute and that damages may include an award or judgment that exceeds the policy limits. In other words, the policy limits are not to limit the amount of actual damages recoverable under the statute. While it is reasonably foreseeable that the insurer's bad faith refusal to settle will result in an excess judgment, the statute says the insured is entitled to damages which are a reasonably foreseeable result of the violation.

Appellee never paid Appellant "damages" stemming from its violation of Florida Statute § 624.155. As it pertains to action for damages pursuant to § 624.155, "damages" necessarily contemplates something different than contract damages. After all, the policyholder could already sue on the contract for contract damages.[17] The Florida legislature certainly did not create this statute to provide a redundant right already existing under the contract. Instead, an aggrieved party may recover "reasonably foreseeable" compensatory damages as a result of the insurer's bad faith conduct violation of standards set forth in the statute.[18]

Hollar clearly addresses the issue and clearly supports Appellant's legal point:

> 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 from the

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[17] Hollar v. International Bankers Insurance Company, 572 So.2d 937, 940 (Fla. 3d DCA 1990) *rev. dismissed,* 582 So.2d 624 (Fla. 1991).

[18] McLeod Continental Insurance Co., 591 So.2d 621 (Fla. 1992); Rubio v. State Farm Fire and Casualty Co., 662 So.2d 956, 957-58 (Fla. 3d DCA 1995), *rev. denied,* 669 So.2d 252 (Fla. 1996).

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 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. Damages, as both the clear wording of the statute and past Florida case law establish, must be all damages resulting from an insurer's bad-faith actions.

Following the analysis as stated above, we conclude that when the legislature employed the term "damages" in § 624.155(2)(d), it necessarily contemplated the same elements of damages that are viable and extant under the decisional law of the supreme court. Consequently, under the statutory formulation established by § 624.155, a tender of policy limits will not ordinarily satisfy the insured's full claim of damages for a bad-faith claim. Thus, if, upon remand, bad-faith actions by the insurers are proven, the Hollars' damages would equal the amount of the excess judgment for which they are now responsible. See, Jones v. Continental Ins. Co., 716 F. Supp. at 1460. That sum, which is in excess of several hundred thousand dollars over policy limits, was never tendered. Therefore, the civil remedy under § 624.155(1)(b)1 remains unsatisfied and an action under this section remains available to the Hollars. [19]

[19] 572 So.2d at 939, 940.

Significantly, this Court recently indicated that the "damages" referred to under § 624.155 are more than the contract damages[20]:

> Prior to the enactment of § 624.155, the damages recoverable by a health insurance policyholder against an insurance carrier were limited to a breach of contract damages and attorneys' fees. Industrial Fire and Cas. Ins. Co. v. Romer, 432 So. 2d 66 (Fla. 4th DCA 1983); Shupack v. Allstate Insurance Co., 367 So. 2d 1103 (Fla. 3d DCA 1979). **The fact that the legislature has specifically authorized first parties to recover damages in bad faith actions suggests that it may have contemplated more than the recovery of same damages already available in a breach of contract action.** In view of the possibility that an unjustified refusal to pay an insured's medical or hospital bills could result in the inability to obtain health care, we hold 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.[21]

Clearly, if emotional distress damages are allowed for untimely payment, the alleged "lowballing," "stonewalling," and other wrongful conduct by Aetna should give rise to the type of concrete financial "damages" sustained by Talat.

Further, a recent Florida Appellate Court clearly indicated that "damages" are something other than "contract" damages.[22] If Conquest, a third party, could seek extra-contractual damages caused by an insurer's misconduct, it logically

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[20] Time Insurance Company v. Burger, 23 Fla. L. Weekly S 309 (Fla., as corrected June 18, 1998).

[21] Id. at S 311. (emphasis added)

[22] Conquest v. Auto-Owners Insurance Company, 23 Fla. L. Weekly D 928 (Fla. 2nd DCA, April 6, 1998).

follows that policyholders, like Billy the Kid's Buffet, can collect them as well. The Court noted:

> Because we affirm the trial court's directed verdict on compensatory damages, we need not address the arguments raised regarding whether the various compensatory damages sought by Conquest are, in fact, recoverable under § 624.155. **This statute clearly contemplates the award of damages upon proper proof.** However, we leave to a case-by-case determination the question of what those elements of damages may be.[23]

Similarly, in this case, the civil remedy here remains unsatisfied. All that Aetna has done is pay the contract amount owed. It has refused to pay for or acknowledge any wrongdoing. It has not paid for what it caused by its alleged wrongful conduct.

Appellee maintains that "payment of Aetna's full contractual obligations as determined by appraisal in accordance with the contract between the parties is tantamount to the payment by an insurer of its full policy limits". Therefore, Talat is not entitled to bring forth a cause of action for bad faith. (R1-26-7). Based on such reasoning, it would appear that Aetna is under the erroneous belief that "damages" are limited to the insured's contract damages caused by the fire loss. Such an assumption, however, is unfounded. **Policyholders do not need the Civil Remedy statute to obtain contract benefits. They could always sue for those.**

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[23] Id. at 23 Fla. L. Weekly D 929 (emphasis added).

Instead, what is contemplated by the use of the term "damages", is the inclusion of consequential damages stemming from the insurer's bad faith.[24] Payment of "damages" pursuant to § 624.155 requires that the insurer pay **all** damages that resulted from the insurer's bad faith action which the claimant is entitled to recover pursuant to Florida law.[25] Aetna has failed to compensate Talat for all damages pursuant to § 624.155. Indeed, Aetna has possibly exposed itself to the "penalty" provision of the statutory scheme because it refused to pay those damages or correct the circumstances.[26]

As noted in Brookins v. Goodson, [27] a case upon which Aetna relies in support of its position, the court determined that "damages" **include** interest, court costs, reasonable attorney's fees incurred in the resolution of the underlying claim as a result of the insurer's conduct in delaying payment. In Brookins, the insurer tendered the uninsured/underinsured motorist policy benefits following the commencement of litigation by the insured. The Brookins court noted that an insured who may have suffered damages as a result of the insurer's delay in payment, should not be penalized by being legally compelled to forego a bad faith

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[24] McLeod v. Continental Ins. Co., 591 So.2d 621, 622-623 (Fla. 1992).

[25] Hollar v. International Banker's Ins. Co., 572 So.2d 937 (Fla. 3d DCA 1990) *rev. den.*, 582 So.2d 624 (Fla. 1991).

[26] See, e.g. Demarest v. State Farm, 673 So.2d 526, 528 (Fla. 4th DCA) (allowed punitive damage claim to continue despite settlement of compensatory damages).

[27] Brookins v. Goodson, 640 So.2d 110, 113-14 (Fla. 2d DCA 1994).

claim when accepting a settlement. [28] Implicit from the foregoing, is the acknowledgment of the recoverability of consequential damages stemming from an insurer's delay in payment. Most importantly, in Brookins, the court held that the insurer's payment of the policy limits did **not** preclude the insured from pursuing a bad faith claim against its insurer.[29] Based on the foregoing, Brookins further supports Talat's, rather, than Aetna's position.

C. APPELLEE HAS FAILED TO CORRECT THE CIRCUMSTANCES GIVING RISE TO ITS VIOLATION OF § 624.155 BY PAYMENT OF CONTRACT DAMAGES ONLY.

In Paz vs. Fidelity National Insurance, [30] the Third District Court of Appeal decided a case concerning the "correcting the circumstances issue." There, the policyholder "sought compensatory damages, pre-judgment interest, attorney's fees and costs" as a result of non-payment of policy benefits. Paz alleged that the insurer routinely demanded mediation and arbitration as a means to delay or avoid payment.

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[28] Brookins, at 114-115

[29] Id. at 111

[30] Paz v. Fidelity National Insurance, 23 Fla. Law Weekly (Fla. 3rd DCA, July 1, 1998).

The insurer argued that it corrected the circumstances by giving rise to the violation by writing a letter within 60 days of the Civil Remedy Notice agreeing to pay the policy benefits. The trial court held that the insurer "cured" any bad faith within 60 days notice of the bad faith.

The Appellate Court reversed finding:

> Section 624.155(2)(d), Florida Statutes (1995), provides that "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." This statute is clear and unambiguous. It provides that if damages are due, they must be paid within 60 days for no civil action remedy to lie, or if some other circumstances exist giving rise to the violation, they must be corrected within 60 days for no civil action remedy to lie. We reject Fidelity's argument that they corrected the circumstances giving rise to the violation by agreeing to pay the damages due because ascribing such a meaning would render the first portion of the statute requiring damages to be paid within 60 days meaningless. Finlayson v. Broward County, 470 So. 2d 67, 68 (Fla. 4th DCA 1985) ("When interpreting a statute, courts should avoid interpretations which would render part of the statute meaningless."); Fleishchman v. Department of Prof'l Regulation, 441 So. 2d 1121, 1123 (Fla. 3d DCA 1983) ("Every statute must be read as a whole with meaning ascribed to every portion and due regard given to the semantic and contextual interrelationship between its parts."), review denied, 451 So. 2d 847 (Fla. 1984).

Similarly, Appellee has never corrected the circumstances, much less acknowledged them, in this case. Appellant asserts that a "case by case" analysis may find numerous examples where extra contractual damages fortunately have

not occurred as a result of the insurer's misconduct and where payment of the contract damages may correct the circumstances. This is not the situation here.

Aetna cannot be said as a matter of law to have corrected what it did by merely making payments for what is owed on the contract because, as noted in Paz, such an interpretation guts the remedial purpose for which the statute was passed. Statutory construction should not yield an absurd result.[31]

Aetna paid Talat the contractual sum for its losses, approximately **322** days **after** the date of its loss. In spite of the foregoing, Aetna asserts that it acted "promptly, professionally, and in good faith in all aspects." (R1-26-8). Aetna's delay in resolving Talat's claim resulted in the destruction of the business value and bankruptcy of Talat's business. Aetna has not corrected the circumstances.

In Clauss v. Fortune Ins. Co.,[32] involving a third-party claim for bad faith, the injured party's attorney forwarded a letter to the insurer demanding that the policy limits be tendered on July 15, 1985, approximately 23 days after the date of the incident. The injured party's attorney sent a second letter to the insurer on August 5, 1985 demanding the policy limits be paid.[33] The insurer made a request for medical documents on August 7, 1995, and expressed a desire to tender the

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[31] Wollard v. Lloyd's & Companies of Lloyd's, 439 So. 2d 217 (Fla. 1983).

[32] Clause v. Fortune Ins. Co., 523 So.2d 1177 (Fla. 5th DCA 1988).

[33] Id.

policy limits upon verification of medical records.[34] On August 9, 1995, a third letter was directed to the insurer demanding that the policy limits be paid.[35] On August 15, 1985, the injured party's attorney sent a letter to the insurer notifying them that the demand for settlement was revoked and that a lawsuit had been filed. A copy of said letter was forwarded to the Department of Insurance.[36] By letter dated August 16, 1985, **less than two months after the date of the accident**, the insurer sent a letter to the injured party's attorney tendering policy limits and enclosed a release form.[37] Based on the foregoing sequence of events, the court determined that there were insufficient allegations of unreasonable and bad faith allegations.[38] The court noted in its opinion that there was only a one month time span between the initial demand for policy limits and the notice of a bad faith failure to tender same.[39] In addition, during that time span, the insurer expressed its willingness to tender the policy limits, desiring only a verification of damages.[40]

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[34] Id.

[35] Id.

[36] Id.

[37] Id.

[38] Id. at 1178

[39] Id

[40] Id.

The court determined that the insurer corrected "...the circumstances giving rise to the violation" by "timely tendering the policy limits".[41]

Unlike Clauss, Aetna has failed to correct the circumstances giving rise to Talat's allegations of bad faith. Aetna has failed to acknowledge its liability for consequential damages stemming from its failure to act in due regard for Talat's interests. The Florida Supreme Court has recognized that those damages that are a "...natural, proximate, probably, or [a] direct consequence of the insurer's bad faith" are recoverable under § 624.155, Florida Statutes.[42] The primary basis for an award of damages is to make the injured party whole.[43] While Talat has been paid the amount owed under the contract, Talat has yet to be compensated for the full extent of its losses resulting from the handling of the claim by the insurer. Had Talat received proper and expedient compensation for its losses, it would not have suffered such grave financial hardship and ultimate bankruptcy. It also would not have been forced to incur attorneys' fees, court costs, or other such expenses. Appellee's actions therefore merit Talat's entitlement to damages for the resulting ***destruction*** of its business due to Aetna's bad faith actions.[44]

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[41] Id. at 1179

[42] McLeod v. Continental Insurance Co., 591 So.2d 621, 622-23 (Fla. 1992).

[43] Fisher v. City of Miami, 172 So.2d 455, 457 (Fla. 1965).

[44] See, Aetna Life & Cas. Co. v. Little, 384 So.2d 213 (Fla. 4th DCA 1980) (finding the proper measure of damages is the market value of the business destroyed as a result of Aetna's bad faith).

D. EXEMPTING INSURERS FROM LIABILITY TO § 624.155 WHERE PAYMENT OF CONTRACT DAMAGES ONLY IS MADE PRIOR TO THE EXPIRATION OF THE SIXTY (60) DAY PERIOD IS CONTRARY TO LEGISLATIVE INTENT.

Exempting insurers from a cause of action pursuant to § 624.155, Florida Statutes, so long as they provide the contract payment to their insureds prior to the expiration of the sixty (60) day notice period, fosters no incentive for insurance companies to resolve claims quickly and fully. Under Aetna's theory, insurance companies could simply wait until an insured files a Notice of Unfair Claims Practice, then proceed to pay its insured at any time within the sixty (60) day notice period to be absolved of liability pursuant to § 624.155. Thus, insureds would have no means of recouping the consequential "damages", caused by whatever wrongful conduct occurred.

Such unjust results are contrary to the Florida Legislature's intended goals in enacting § 624.155. The Florida Legislature sought to encourage insurers to act fairly, honestly and quickly in safe-guarding their insureds' interests.

> Statutes should be construed to harmonize with existing law. Statutes intending to alter the established case law must show that intention in unequivocal terms. *Law offices of Harold Silver, P.A. v. Farmers Bank & Trust Co.*, 498 So.2d 984 (Fla. 1st DCA 1986). The legislature is presumed to know the existing law at the time it enacts

> a statute. *Ford v. Wainwright*, 451 So.2d 471, 475 (Fla. 1970). We agree with the fifth district's observation in Opperman that there is nothing in § 624.155 which indicates an intent to limit a remedy existing under the decisions of the supreme court. *Opperman*, 515 So.2d at 266. On the contrary, the statute clearly indicates the legislature's intent to expand that remedy.[45]

No where in § 624.155, is it explicitly or implicitly stated that if the insurer pays the insured's "original" claim, that the insured is then barred from bringing a cause of action against said insurer for "damages". This clause should be interpreted as providing the insurer a means of mitigating its culpability and not as a means of avoidance. To hold otherwise, would be to ignore the underlying purpose of the statute – provide a means of legal enforcement for policyholders to collect for damages caused by an insurer's misconduct.

Aetna's contractual payment of the appraisal award prior to the expiration of the sixty day period is one of the factual considerations to be used by the trier-of-fact in determining whether the insurer's actions demonstrate bad faith. Mere payment of the appraisal award within the sixty day period does not absolve Aetna of bad faith liability. It merely absolved it of contractual liability. Such effort, alone, is not sufficient to remedy its bad faith.[46] Aetna's payment of the contract

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[45] 572 So.2d at 939.

[46] See, Dunn v. National Security Ins. Co., 631 So.2d 1103 (Fla. 5th DCA 1993) (finding that payment of the excess judgment did not preclude an action for punitive damages under § 624.155); Hollar v. International Banker's Ins. Co., 572 So.2d 937 (Fla. 3d DCA 1990); *rev. den.* 582 So.2d 624 (Fla. 1991) (determining that the insurer's tendering of the policy limits within the sixty day period was *not*

award amount can *not* be said to exempt it from prosecution pursuant to § 624.155, as a matter of law.

In the 1977 case of Jarret. V. L. Harper & Sons, Inc.[47] Justice Neely, in a concurring opinion, authored the following:

> Insurance is different from any other business. If a man goes into a butcher shop, asks for two pounds of ground meat, and tenders $2.89 in payment, he will expect his meat to be forthcoming from the grinder. Imagine the scene were the customer to ask for his meat, and be answered that the butcher has no intention to deliver the same. "Where is my meat"? the customer would reply, possibly in other than dulcet tones. "I won't give you any meat," replies the butcher firmly. "Then give me back my $2.89 and I shall go elsewhere," says the customer. "I won't give you back the $2.89 either," replies the butcher, "for you must bring a lawsuit to get it from me." Sock! Pow! Blam! And much property damage of a different sort.
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> Yet such a colloquy proceeds with regularity in the area of insurance. The case of fire insurance leaps instantly to mind when companies frequently deny liability under contracts with their own insureds. Furthermore, if a man's car is damaged negligently by another party, the tort-feasors insurance carrier, recognizing full well the liability, may well decline to pay forthwith, relying instead upon its ability to wear the injured victim down with legal expenses and the cost of

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sufficient to remedy bad faith); See also, Conquest v. Auto-Owners Ins. Co., 658 So.2d 928 (Fla. 1995) (holding that even if the injured party's damages do not exceed the policy limits, a person can still maintain an action for unfair claims practices).

[47] Jarret v. L. Harper & Sons, Inc., 160 W. Va. 399, 235 S.E.2d 362 (1977).

> stamps for the exchange of meaningless correspondence.[48]

As the preceding passage makes ironically clear, the insurance industry enjoyed a much more favorable legal position in common law jurisprudence than the purchaser of an insurance policy. In fact, when comparing purchasers of private insurance contracts, whether for auto, property or casualty, against purchasers of commercial contracts in general, one can begin to delineate a fine line distinction. The distinction is that an insurance policy is more than a general contractual obligation. In fact, an insurance policy contains more than a mutuality of obligation, it contains an implied warranty of financial security and peace of mind that one would be indemnified following a future unknown catastrophe.

Unfortunately, the intent behind insurance is not conforming to the reality of its product. This is because, "In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter performance. With insurance this is simply not possible."[49] In fact, the Supreme Court of Arizona has stated,

> [t]he special nature of an insurance contract has been recognized by courts and legislatures for many years... An insurance policy is not obtained for commercial advantage; it is obtained as protection against calamity. In securing the reasonable expectations of the insured under the insurance policy there is usually an unequal

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[48] Id. 160 W. Va. at 405, 235 S.E. 2d at 366.

[49] E.I Dupont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996).

> bargaining position between the insured and the insurance company.... Often the insured is in an especially vulnerable economic position when such a calamity loss occurs. The whole purpose of insurance is defeated if an insurance company can refuse or fail, without justification, to pay a valid claim.[50]

Lately, the press and our cultural media have picked up this bad faith conduct during the claims handling process.[51] Similar to the instant delayed payment and lowball estimates, insurance companies are notorious for refusing to provide insurance coverage or engaging in sloppy, slow or deliberately bad claims handling.[52] It does not take financial genius to figure out that an insurance company can make more money by collecting premiums and not paying claims, than the insurance company can make by collecting premiums and paying claims. Even the pro-industry press has picked up on this.[53]

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[50] Noble v. National Am. Life Ins. Co., 624 P.2d 866, 867-68 (Ariz. 1981).

[51] See generally, Lia B. Royle, Insuring Good Faith, ABA Journal, Oct. 1995, at 86. J. Grisham, The Rainmaker (Doubleday 1995).

[52] See Joseph Segal, Sluggish Claim Process Can Cause Insured Business' Demise, Claims, Feb. 1995, at 86; Jim Urban, Take It Or Leave It, EXEC. REP., Aug. 1996, at 18; Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15 1996, at A1.

[53] Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15 1996, at A1; Robert H. Gettlin, Fighting the Client, Best's Review P/C, Feb. 1997, at 49, 50 (noting that insurance companies spend over $1 billion a year litigating against their policyholders). See also, Charles S. Schmidt, Jr., Industry Executives Receive New Marching Orders, Best's Review P/C, Feb. 1996, at 40 (discussing the industry-wide imperative to stay "sharply focused on the bottom-line results and capital justification").

Clearly "the bargaining power of an insurance carrier vis-à-vis the bargaining power of the policyholder is disparate in the extreme."[54] Moreover, unless an insurance company is confronted with the prospect of paying all damages caused by its wrongful conduct, it will have no incentive to honor its obligations under its existing insurance policies:

> Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to play "play the float" in any dispute. Even where the judicial system acts rapidly and efficiently to provide compensation to wronged policyholders, the carrier may find that it made money by delaying payment of the claim. If its investments have been good, it may even have made enough money to cover any prejudgment interest, costs, or consequential damages award, or counsel fees collected by the policyholder.[55]

The Florida Legislature has attempted to level the playing field by making it less profitable and far riskier for insurance companies to breach their insurance policies by allowing compensation for extra-contractual damages. The prospect of paying damages caused by insurer bad faith conduct adds an element of unpredictability to the insurance company's potential liability. Management must emphasize fair, prompt and honest conduct or pay for the damage it causes.

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[54] Hayseeds, Inc. v. State Farm Fire and Cas., 352 S.E.2d 73, 77 (W. Va. 1986).

[55] Jeffrey W. Stempel, Interpretation of Insurance Contracts: Law and Strategy For Insurers and Policyholders § 19.3, at 466-67 (1994).

Yet while greater risk may deter some insurance companies, the *status quo* is still clear: "The insurance company is in no hurry. It has the money. It has your premium. It has an army of lawyers."[56]

The importance of insurance company conduct is exemplified in the health insurance and "managed care" context, where a denial of insurance coverage can mean the difference between life and death. Bob Herbert, a columnist for the New York Times, touched upon this subject discussing a horrifying instance in which a health maintenance organization ("HMO") and one of its doctors denied specific medical care to a child.[57] This denial came despite the pleas of a specialist who had previously treated the child successfully. The child subsequently died.

This year, Helen Hunt received an Oscar for her performance in AS GOOD AS IT GETS.[58] In part, she portrayed a waitress whose child was refused treatment for a chronic allergic condition which was ruining her private life and causing the child needless suffering. A doctor finally obtained outside her HMO network quickly diagnosed the condition and implied that the treatment should have been approved by her insurance company several years earlier. This scene is significant:

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[56] Herb Denenberg, "How Insurance Companies Avoid Payment of Claims" Reading Eagle, May 26, 1995, at A12 (Mr. Denenberg is a former Commissioner of Insurance for Pennsylvania and Professor of Insurance at the Wharton School of the University of Pennsylvania).

[57] Bob Herbert, "Hidden Agenda", New York Times, July 15, 1996, at A13.

[58] AS GOOD AS IT GETS (Tristar 1997).

Carol Connelly: "They said my plan didn't cover it and said it wasn't necessary anyways."

Carol Connelly: [Pause] "Why, should they have [paid for the treatment]?"

Doctor: "Well" –

Carol Connelly: "Fucking HMO bastard, pieces of shit!!"

Carol's mother: "Carol!"

Carol Connelly: "I'm sorry."

Doctor: "That's ok – I think that's their technical name."

Audiences throughout the nation applauded this exchange.

Appellee, Aetna, a paper entity that has no human emotion -- would have the law limit its liability if it would agree to pay for the doctors bills within sixty days of the civil remedy notice despite either killing the policyholder or inflicting needless pain and suffering. **How can Aetna, part of an industry which sells itself with slogans such as, "A Good Neighbor", "An Umbrella", "I'm Glad I Metcha" and "The Good Hands People", which clearly appeal to the emotional safety and financial security it sells, not expect that liability will result when it creates a second catastrophe by offering far too little and then paying the full contract amount far too late?**

The primary purpose of insurance is to spread the risk among various parties and provide prompt and proper payment for those who suffer catastrophes to their person or property. Natural disasters are prominent in the news. Buildings burn,

airplanes crash, tractor trailers collide, bridges collapse, communities are besieged with riots and devastated by hurricanes. Automobile accidents maim and slaughter hundreds of thousands of people every year. Products malfunction, workers and children are exposed to toxins, and dangerous chemicals are unknowingly consumed by completely innocent victims. These calamities are the reasons why modern insurance companies exist.

The public depends upon skilled professionals to act honestly, promptly and thoroughly to ensure that a just and fair resolution through the mechanism of insurance is made. Indeed, the Florida legislature has mandated this type of behavior by adopting an Adjuster Code of Ethics.[59]

Today, many adjusters are in a "no win" situation. Their employers, large insurance companies, are typically only interested in cutting costs and earning a profit.[60] Adjusters must improperly choose between paying prompt and full indemnity or being criticized by management for not controlling severity of claims payment. Sadly, the adjuster must yield to corporate objectives.

It is not logical that this remedial statute can be interpreted in such a manner to limit liability to zero after an insurer causes disastrous extra-contractual

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[59] Chapter 90-363, Laws of Florida, § 151 (requires that all adjusters subscribe to the Code of Ethics).

[60] S. Sclafawe, Allstate Sees Claims As Crucial to Profits, 41 (Nat. Underwriter, March 31, 1997 (quoting Allstate C.E.O. Jerry Choate, "but the leverage is really on the claims side . . . If you don't win there, I don't care what you do on the front side, you're not going to win.")

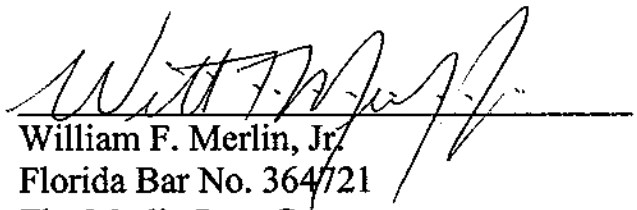
damages, refuses to pay for them or somehow "correct" what it has done to its policyholder. The legislature intended for the statute to be remedial. Public policy dictates a need for the same. Appellee argues that this will lead to greater litigation. Yet, this will only arise if policyholders are treated and damaged in the manner Appellee has done to its policyholder in the instant case.

CONCLUSION

Based on the foregoing legal authority, discussion and facts, Aetna has failed to establish as a matter of law that it is entitled to Summary Judgment on the issue of Talat's entitlement to bring forth a cause of action pursuant to § 624.155, Florida Statutes.

Appellant respectfully requests that this Honorable Court answer "no" to the certified question.

Respectfully Submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the foregoing has been sent by U.S. Mail to: Philip E. Beck, Esq., 2600 Peachtree Street, N.W., 2600 Harris Tower, Peachtree Center, Atlanta, Georgia 30303-1530, this 4th day of August, 1998.

William F. Merlin, Jr., Esquire