

# Insurance Bad Faith

## **(Almost) Twenty Years After Powell: Case Studies On A Liability Insurer's Duty To Initiate Settlement Negotiations**

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# Commentary

## (Almost) Twenty Years After Powell: Case Studies On A Liability Insurer's Duty To Initiate Settlement Negotiations

By

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### I. Introduction

For many decades, Florida has had a strong public policy favoring settlement of disputes and avoidance of litigation.<sup>1</sup> In *Powell v. Prudential Property & Casualty Insurance Co.*,<sup>2</sup> Florida's Third District Court of Appeal held that liability insurers have a legal duty to initiate settlement negotiations, even without a demand, where the insured's liability is clear and the claimant's injuries so severe that a judgment exceeding the policy limit is likely.<sup>3</sup> More simply stated, and contrary to the case law of almost every jurisdiction in the country, Florida law does not require a third-party claimant to make a demand for the policy limits as an element of a claim for third-party bad faith. At least one commentator has recently called this "the modern view" — having garnered an increasing number of judicial supporters — and argued that the era of requiring insurers to initiate settlement negotiations in certain cases "has been coming for some time" and, indeed, "is already here."<sup>4</sup> Unfortunately, *Powell* inadvertently created an incentive to delay settlement of disputes and foment needless litigation. *Powell* is the proverbial hard case that made bad law. Few quarrel with the result reached in *Powell* based on the facts

presented in *Powell*, but the precedent it established has done more harm than good to Florida's public policy favoring early settlements and avoidance of litigation.

*Powell* involved a situation in which an insurer did not respond to a bodily-injury claimant's repeated informal settlement demands and requests to engage in settlement discussions, later taking the position that it had no liability for bad faith because these requests did not amount to formal settlement offers. The *Powell* court may have been right to hold that the lack of a demand did not insulate the insurer from liability for bad faith on *Powell's* unique facts involving a third-party claimant's multiple settlement overtures, but subsequent cases have applied the *Powell* holding where third-party claimants were simply silent. In practice, this creates an incentive for claimants to remain silent and/or uncooperative while a tortfeasor's insurer investigates a claim rather than cooperate with the insurer's investigation and work toward the early settlement that Florida's public policy theoretically encourages.

### II. What Happened In Powell

In *Powell*, Lindeerth Powell lent his car to his daughter, who struck two pedestrians from behind and seriously injured one of them.<sup>5</sup> Mr. Powell carried automobile liability coverage of \$10,000 per person.<sup>6</sup> Prudential evaluated the insured's liability at 80-100% within a few days of the accident.<sup>7</sup> Eight days after the accident, Prudential's adjuster noted the condition of one of the pedestrians — Mr. Goldner — as "severe, in I.C.U. [one week], two blood clots on brain, surgery

done on 1/13, internal bleeding, both legs [multiple fractures], lacerations on face and all over body, ear sliced . . . tracheotomy, still being given morphine.”<sup>8</sup> The adjuster set reserves at \$10,000.<sup>9</sup>

Nine days after the accident, Mr. Goldner's attorney sent a letter to Prudential describing Mr. Goldner's injuries and requesting disclosure of the insured's policy limits.<sup>10</sup> Prudential did not respond.<sup>11</sup> Mr. Goldner's attorney sent a follow-up letter three weeks after the accident, advising that Mr. Golder had no other insurance and was “in need of immediate funds” as his medical bills already exceeded \$20,000.<sup>12</sup> The letter also explained that the hospital was planning to transfer him to another hospital as an indigent if Prudential did not accept financial responsibility for Mr. Goldner's treatment.<sup>13</sup> In this second letter, the attorney stated that Mr. Goldner wanted to avoid being transferred and asked that the policy limits be disclosed within ten days “so that we may promptly resolve this matter within policy limits . . . .”<sup>14</sup>

Prudential still had not responded to the second letter within nine days.<sup>15</sup> At that point, Mr. Goldner's attorney sent a third letter explaining Mr. Goldner's desperate financial situation and again stating that it was his goal to “promptly proceed with settlement of this cause within policy limits.”<sup>16</sup> Prudential also did not respond to this letter, nor did it inform the insured of the letters from Mr. Goldner's attorney or the insured's potential liability to Mr. Goldner.<sup>17</sup>

Sixty-two days after the accident, Prudential's adjuster called Mr. Goldner's attorney and left a message with his secretary that Prudential was tendering its \$10,000 policy limits.<sup>18</sup> Mr. Goldner's attorney returned the call two days later, informing Prudential that a lawsuit had already been filed and that the tender of policy limits was being rejected.<sup>19</sup> After a jury trial, the court entered a \$250,000 judgment against Mr. Powell.<sup>20</sup>

Mr. Powell sued Prudential for bad faith, alleging that Prudential failed to explore early settlement opportunities and failed to advise him of the probable outcome of litigation.<sup>21</sup> During his case in chief, Mr. Powell presented expert testimony to the effect that Prudential was aware, from a very early point, that the value of Mr. Golner's claim vastly exceeded the policy limits.<sup>22</sup> The expert testified that settlements

are insurance-industry standard practice where liability is clear, policy limits are minimal, and injuries are severe.<sup>23</sup> At the end of Mr. Powell's case in chief, the trial court entered a directed verdict for Prudential without articulating its reasoning.<sup>24</sup>

Mr. Powell appealed the directed verdict to Florida's Third District Court of Appeal, which reversed the directed verdict on several grounds.<sup>25</sup> First, the *Powell* court held that an offer to settle within the policy limits was not an absolute requirement for a bad-faith claim but was, rather, “merely one factor to be considered.”<sup>26</sup> Instead, the court explained, in a sentence that would later be quoted often in Florida case law, that “[w]here liability is clear, and injuries so serious that a judgment in excess of the policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations.”<sup>27</sup> In another oft-quoted sentence, the *Powell* court stated: “Any question about the possible outcome of a settlement effort should be resolved in favor of the insured; the insurer has the burden to show not only that there was no realistic possibility of settlement within policy limits, but also that the insured was without the ability to contribute to whatever settlement figure that the parties could have reached.”<sup>28</sup>

Further, the *Powell* court held that liability for bad faith could be predicated upon the failure to disclose policy limits, which “deprives the claimant of a basis for evaluating the case, thus hindering settlement.”<sup>29</sup> The court explained that the issue of whether or not the delay in disclosing policy limits foreclosed settlement negotiations and prevented a settlement offer is a relevant and material fact issue,<sup>30</sup> as was the issue of whether Prudential's delay in disclosing the policy limits, and failure to inform the insured of the attorney's ten-day deadline to disclose them, were reasonable under the circumstances.<sup>31</sup>

Lastly, the *Powell* court held that the insurer's failure to disclose settlement overtures to the insured can form the basis for a finding of bad faith.<sup>32</sup> Further, the *Powell* court held that the ultimate tender of the policy limits did not automatically insulate the insurer from liability for bad faith.<sup>33</sup> In light of its holdings, the Florida appellate court held that Mr. Powell had presented sufficient evidence of bad faith to take the case to a jury and that the trial court erred in directing a verdict for the insurer.<sup>34</sup>

### III. **Powell As Precedent: The Evolution (Or Devolution) Of Powell's Holding**

The following section contains analysis of seven cases decided after *Powell* and purporting to apply *Powell's* holding. Examination of these cases reveals a gradual digression from the situation that the *Powell* court intended to address.

#### A. **Snowden v. Lumbermens Mutual Casualty Co. (2003)**

For the first twelve years after the *Powell* decision, *Powell* had little effect on subsequent decisions. During this period, appellate courts' citations to *Powell* tended to be for the general propositions that the failure to disclose policy limits upon request can potentially form the basis for bad-faith liability<sup>35</sup> or that an insurer can be liable for failing to settle a claim.<sup>36</sup> The *Powell* holding received its first significant extension in *Snowden v. Lumbermens Mutual Casualty Co.*<sup>37</sup> In *Snowden*, Jennifer Snowden was driving her grandparents' vehicle and collided with a vehicle driven by Eddie Smith.<sup>38</sup> Snowden was killed, and Smith suffered "grievous" injuries.<sup>39</sup> Lumbermens insured the grandparents with a policy providing \$100,000 in liability coverage.<sup>40</sup>

Lumbermens was notified of the loss on the day after the accident but did not attempt to contact Smith's family.<sup>41</sup> Five days later, Eddie Smith's brother contacted Lumbermens and told Lumbermens the extent of Mr. Smith's injuries.<sup>42</sup> Lumbermens verified this information, verified that Jennifer Snowden was liable for the accident, and sent an excess letter to Mr. Snowden, but as of three weeks after the accident, it still had not contacted Mr. Smith's family about payment of the policy limits.<sup>43</sup> At that point, Mr. Smith's wife retained counsel, who sent a letter to Lumbermens indicating that he had filed suit against the Snowdens and that the Smith family would not accept any offer of settlement from that point forward.<sup>44</sup> Lumbermens offered to settle for the policy limits five months later, which offer was rejected.<sup>45</sup>

As a result of a settlement between the Snowdens and the Smiths, the trial court entered judgement for \$3.75 million against the Snowdens, who then sued Lumbermens for bad faith, "alleging that Lumbermens's [sic] failure to tender policy limits to the Smiths immediately following the accident constituted bad faith."<sup>46</sup> In the bad-faith litigation,

Mr. Smith's wife testified that she would have accepted the policy limits if offered to her prior to her retaining counsel and, the posturing language in her attorney's letter notwithstanding, would have entertained an offer for the policy limits even after her attorney advised Lumbermens that no settlement offers would be accepted.<sup>47</sup> The jury found Lumbermens liable and awarded damages.<sup>48</sup> In denying Lumbermens's post-verdict motion for a judgment as a matter of law, the *Lumbermens* court relied on *Powell* for the proposition that an offer of settlement is not an absolute requirement for an insurer to be found liable for bad faith but, instead, is only one of many factors to be considered.<sup>49</sup>

Notably, *Snowden* was the first of *Powell's* progeny to find liability on the part of the insurer where the insurer neither refused to disclose its policy limits nor ignored a settlement overture. Also notably, though inconsequentially in the *Snowden* case, *Powell's* duty to "initiate settlement negotiations" appeared to have blossomed into a duty to "tender policy limits."

#### B. **Johnson v. GEICO General Insurance Co. (2009)**

*Johnson v. GEICO General Insurance Co.*<sup>50</sup> was the first of the *Powell*-based bad-faith decisions to uphold a summary judgment in favor of the insurer. In *Johnson*, Michael Johnson was involved in an accident that seriously injured Woody Staley.<sup>51</sup> Mr. Johnson initially reported to his insurer, GEICO, that at least one witness claimed to have seen him run a red light, though Johnson believed that the light was green and contested liability.<sup>52</sup>

Ten days after the accident, Mr. Staley's attorney requested that GEICO disclose its policy limits within 30 days, which GEICO did.<sup>53</sup> Meanwhile, GEICO obtained the police report, which indicated that Johnson had run a red light and that Staley had suffered "non-incapacitating" injuries.<sup>54</sup> Nineteen days after the accident, GEICO's adjuster learned that Mr. Staley was still in the hospital and on a respirator in the intensive-care unit.<sup>55</sup> Fifteen days after that, the adjuster learned — on Friday, June 27, 2003 — that Mr. Staley had died as a result of the accident.<sup>56</sup> GEICO authorized tender of the policy limits, but the adjuster was not able to reach Mr. Staley's attorney by telephone until the following Tuesday (33 days after the accident), at which time the attorney

advised the adjuster that suit had been filed that day and rejected GEICO's tender.<sup>57</sup> A wrongful-death judgment in excess of \$2,000,000 was ultimately entered against Mr. Johnson.<sup>58</sup>

In the subsequent bad-faith suit, the trial court entered summary judgment for GEICO, finding that no reasonable jury could find bad faith where GEICO tendered the policy limits a mere 33 days after the accident.<sup>59</sup> In affirming, the *Johnson* court noted that GEICO responded to the request for disclosure of insurance coverage within 30 days and tendered the policy limits immediately upon learning that Mr. Staley had died as a result of the accident.<sup>60</sup> In rejecting the argument that GEICO was obligated to tender its policy limits fifteen days earlier, when GEICO learned that Mr. Staley was still in the hospital, the *Johnson* court noted that the record contains no indication that the adjuster, at that point, knew that Mr. Staley's hospitalization was related to the accident, which GEICO was entitled to take a reasonable amount of time to confirm before tendering the policy limits.<sup>61</sup> In light of this, the *Johnson* court determined that no reasonable jury could find that GEICO breached its duty of good faith.<sup>62</sup>

**C. *Shin Crest PTE, Ltd. v. AIU Insurance Co. (2009)***

*Shin Crest PTE, Ltd. v. AIU Insurance Co.*<sup>63</sup> was the next case involving a summary judgment entered for an insurer arising from an alleged breach of the *Powell* duty to initiate settlement negotiations. In *Shin Crest*, Doreen Blair was sitting on a chair on a dock and fell into a dry lake-bed, rendering her paraplegic.<sup>64</sup> The chair was manufactured and/or distributed by Shin Crest and sold by Sam's Club, which was an additional insured under Shin Crest's \$2-million liability insurance policy with AIU.<sup>65</sup>

Ms. Blair and her husband sued Sam's Club, contending that the chair was defective, and AIU defended under the policy.<sup>66</sup> Defense counsel retained an expert, who determined that there was no defect in the chair and that Ms. Blair had fallen because the chair's legs were placed so close to the edge of the dock that they were able to move off of the edge.<sup>67</sup> Mediation ended in an impasse, with AIU having unsuccessfully attempted to settle for less than the policy limits in exchange for a release of both Sam's Club and Shin Crest.<sup>68</sup> Almost four years after the accident, the

Blairs offered to settle their claim against Sam's Club for the policy limits but adamantly refused to release Shin Crest.<sup>69</sup> AIU, believing that this was the only settlement it could get, ultimately did settle for the policy limits over Shin Crest's objection.<sup>70</sup>

The Blairs then filed suit against Shin Crest, but AIU refused to defend because the policy limits had been exhausted by the settlement of the claim against Sam's Club.<sup>71</sup> Shin Crest and the Blairs then entered into a stipulated judgment for \$12 million wherein the Blairs agreed not to attempt to collect the judgment from Shin Crest on the condition that Shin Crest must pursue a bad-faith claim against AIU.<sup>72</sup> Shin Crest filed suit, contending that AIU should have offered its policy limits at the mediation in exchange for a release of the Blairs' claims against *both* Sam's Club and Shin Crest.<sup>73</sup>

In entering summary judgment for AIU, the *Shin Crest* court acknowledged that *Powell* requires an insurer to initiate settlement negotiations when liability is clear and injuries so serious that a judgment in excess of the policy limits is likely.<sup>74</sup> Distinguishing the case from *Powell*, however, the trial court held that this duty never arose because Shin Crest's liability was not "clear" at the time of the mediation, or ever.<sup>75</sup>

In dictum, the *Shin Crest* court retreated *sub silentio* from the *Snowden*-borne "duty to tender" language, finding that settlement negotiations were indeed "initiated." The *Shin Crest* court explained:

Shin Crest does not allege that settlement negotiations were not initiated or that AIU failed to participate in settlement negotiations; instead, Shin Crest argues that AIU acted in bad faith because it should have offered more money (*i.e.*, the policy limits) when negotiating at the mediation. However, if the Court were to accept this theory, the court would be expanding the scope of bad faith litigation even farther [sic] than it already is, with negative, far-reaching implications.<sup>76</sup>

Shin Crest then moved for reconsideration on several grounds, one of which being that "the affirmative duty to settle is not confined to cases where the insured has

clear liability.”<sup>77</sup> In rejecting this argument, the *Shin Crest* court again held that: “Nowhere in *Powell* does the court state that a duty to initiate settlement negotiations equates to a duty to offer the policy limits.”<sup>78</sup>

#### D. *Gutierrez v. Yochim* (2009)

In *Gutierrez v. Yochim*,<sup>79</sup> Dairyland Insurance Company insured Maria D. Gutierrez through a bodily-injury liability policy providing coverage limits of \$10,000 per person.<sup>80</sup> Ms. Gutierrez collided with a motorcycle driven by Gerald M. Yochim, severely injuring him.<sup>81</sup> Ms. Gutierrez immediately notified Dairyland, which assigned an adjuster to handle the claim.<sup>82</sup> The day after the accident, the adjuster tried without success to contact Mr. Yochim.<sup>83</sup> Unable to reach him, the adjuster contacted the insured, discussed the accident with her, advised her that her policy had a \$10,000 limit, and concluded that the insured was at fault.<sup>84</sup> Six days post-accident, an attorney contacted Dairyland’s adjuster and advised that he represented Mr. Yochim.<sup>85</sup> Eight days post-accident, Dairyland obtained the police report, which indicated only that Mr. Yochim had suffered “incapacitating” injuries.<sup>86</sup> Sixteen days post-accident, Dairyland again contacted Mr. Yochim’s attorney, who advised that he no longer represented Mr. Yochim, that he was asserting an attorney’s lien, and that he wanted his name to be on any settlement draft.<sup>87</sup> The adjuster promptly contacted the new attorney, but a paralegal told the adjuster that they had no record of Mr. Yochim as a client.<sup>88</sup>

There appears to be a dispute within the *Gutierrez* opinion as to when the new attorney’s office first notified Dairyland that it was representing Mr. Yochim. The majority opinion states that the new attorney sent a letter to Dairyland on September 9, 2003 (28 days post-accident) asking for policy information within thirty days.<sup>89</sup> The dissent, however, points out that, though the letter was dated September 9, the record indicated that the letter was not mailed until October 27 and not received by Dairyland until October 29.<sup>90</sup> In either event, the letter was silent on the subject of Mr. Yochim’s injuries.<sup>91</sup>

Regardless, the adjuster called the new attorney’s office on October 9, 2003, and spoke with the new attorney’s paralegal.<sup>92</sup> At this point, there is another discrepancy within the *Gutierrez* opinion. According to the majority opinion, during this phone call,

the paralegal informed the adjuster “that Mr. Yochim sustained a significant spinal cord injury and might be paralyzed.”<sup>93</sup> According to the dissent, the paralegal told Dairyland’s adjuster that he was not allowed to tell him anything but said that Mr. Yochim “might” have a serious spinal injury or even paralysis, but the paralegal was not really sure.<sup>94</sup> During this phone call, the paralegal asked that the adjuster not tell the attorney of the information that he had relayed.<sup>95</sup> Dairyland’s adjuster left his name and number and asked that the attorney return his call, but the attorney did not return the call.<sup>96</sup>

The following day, Dairyland followed up the phone call with a letter to Mr. Yochim’s attorney, in which Dairyland’s adjuster stated that Dairyland desired to settle the bodily-injury claim as soon as possible and requested medical records.<sup>97</sup> At this point, the attorney’s office had the medical records in its possession but did not send them.<sup>98</sup> Instead, Mr. Yochim’s attorney waited over two months — until December 22, 2003 — and sent a medical authorization rather than the medical records themselves.<sup>99</sup> No demand for the payment of the Yochim claim was ever made.<sup>100</sup>

Dairyland received the medical authorization on December 26, 2003 — the day after Christmas.<sup>101</sup> Its adjuster ordered Mr. Yochim’s hospital records on January 13, 2004,<sup>102</sup> and received them seventeen days later on January 30.<sup>103</sup> The following day (roughly five-and-a-half months after the accident), Dairyland made an oral offer to settle Mr. Yochim’s claim against Ms. Gutierrez for the policy limits.<sup>104</sup> Three days later, Dairyland sent a letter to Mr. Yochim’s attorney confirming receipt of the medical records, reiterating the offer to settle for the \$10,000 policy limits, and asking “please indicate if your client will settle his claim for our insured’s policy limit”<sup>105</sup> contingent on placing the first attorney’s name on the settlement check or obtaining an agreement regarding the lien.<sup>106</sup> All of this was done with no indication having ever been made that Mr. Yochim was willing to settle for this amount.<sup>107</sup>

One day after the aforementioned letter, the adjuster sent a status report to Ms. Gutierrez advising that Mr. Yochim had an extended hospital and nursing-home stay due to his serious injuries, which included “a spinal cord injury, rib fractures, a punctured lung, and a scalp laceration.”<sup>108</sup> The letter explained that

Dairyland had offered to pay the bodily-injury liability limit of \$10,000 but also explained that, due to the seriousness of Mr. Yochim's injuries, it might be impossible to settle within policy limits.<sup>109</sup>

A week after the first letter expressing a willingness to settle for the \$10,000 policy limits, the adjuster sent a second, identical letter to Mr. Yochim's counsel.<sup>110</sup> Mr. Yochim's attorney finally wrote back a week after the second letter, stating that "if and when the policy limits are tendered, I will discuss it with my client and advise you of his decision."<sup>111</sup> This letter also stated that Mr. Yochim's new attorney would be responsible for any potential attorney's lien by Mr. Yochim's prior counsel.<sup>112</sup>

At this point, the adjuster exchanged several letters with Mr. Yochim's attorney regarding the definition of the word "tender." In the adjuster's understanding, he had "tendered" the policy limits by offering to settle the case for that amount and asking for confirmation in writing that Mr. Yochim's counsel would settle the first attorney's lien from the proceeds of the check.<sup>113</sup> The responsive letters from Mr. Yochim's counsel advised that the adjuster should check with Dairyland's legal department if he needed clarification as to the meaning of the word "tender" and questioned the significance of the attorney's lien where the first attorney's representation of Mr. Yochim ended only sixteen days after the accident.<sup>114</sup> The adjuster finally sought advice from an attorney on March 26, 2004 (almost two months after receiving the medical records and offering to settle for the policy limits), and was told to send the settlement check immediately.<sup>115</sup> Dairyland delivered a check for the policy limits to Mr. Yochim's counsel on April 1, 2004, but was advised by Mr. Yochim's attorney that "Dairyland's delay caused his client to direct him to file suit against the insured, Ms. Gutierrez."<sup>116</sup> Mr. Yochim's attorney would later testify that his client would have accepted the \$10,000 policy limit at any point through February.<sup>117</sup>

In the ensuing bad-faith claim, the trial court entered summary judgment in favor of Dairyland.<sup>118</sup> In reversing and remanding for a new trial, the *Gutierrez* court dismissed Dairyland's argument that its delay in tendering the policy limits was caused by Mr. Yochim's attorney's decision to send a medical authorization instead of the records themselves, which he had in his possession.<sup>119</sup> Dairyland argued that "it

was trying to verify the full extent of the claimant's injuries and had every right to wait for that medical information."<sup>120</sup> Rejecting this argument, the *Gutierrez* court stated:

Dairyland's argument is unavailing because its fiduciary duty to timely and properly investigate the claim against the insured was not relieved simply because it was waiting to receive information from the claimant's attorney. Based on the record before us, it appears that Dairyland knew that Mr. Yochim's injuries would exceed the policy limits of \$10,000, and its failure to tender the policy limits created a genuine issue of material fact regarding whether it breached its duty of good faith.<sup>121</sup>

Seeing things this way, the *Gutierrez* majority remanded the case for a jury determination as to "whether it was reasonable for Dairyland to insist on additional medical information beyond what it already knew, whether it was reasonable for Dairyland to insist on further verification of the attorney's lien issue, and whether Dairyland reasonably handled the purported 'tender' . . . ." <sup>122</sup> The dissenting judge, to the contrary, would have affirmed the trial court, explaining that:

Courts must ensure that valid claims of an insured are timely paid. Egregious conduct of an insurer in denying or delaying payment of a valid claim should result in bad faith. However, tactics designed to manufacture coverage, when none exists, should never be accepted.<sup>123</sup>

As of the publication of this article, the *Gutierrez* case is still being litigated on remand.

#### **E. Aboy v. State Farm Mutual Automobile Insurance Co. (2010)**

In *Aboy v. State Farm Mutual Automobile Insurance Co.*,<sup>124</sup> after being involved in an accident with Christian Garcia, Rafael Aboy appeared to be paralyzed from the neck down and was rushed to a hospital by helicopter.<sup>125</sup> Mr. Garcia was driving a car insured by State Farm with a \$15,000 liability limit for bodily-injury claims.<sup>126</sup>

Mr. Aboy was discharged from the hospital on the day of the accident, having recovered from his temporary paralysis and complaining only of body soreness and feelings of numbness in his hands.<sup>127</sup> Shortly thereafter, State Farm sent Mr. Aboy a medical-authorization form to enable State Farm to obtain his medical records and later sent him a second one.<sup>128</sup> Mr. Aboy did not provide any medical records in response to this request and never signed or returned a medical-authorization form, either.<sup>129</sup> In the days and weeks immediately following the motor-vehicle accident, State Farm attempted to reach Mr. Aboy by telephone but neither reached him nor had its calls returned. Roughly four months after the accident, State Farm's adjuster spoke with an unidentified woman who answered the phone, who said that Mr. Aboy had received medical treatment "a few times" and had out-of-pocket expenses.<sup>130</sup>

Roughly six months after the accident, Mr. Aboy underwent neck surgery related to the injuries he suffered in the accident.<sup>131</sup> Ten days after the surgery, and without ever informing State Farm about the surgery, he filed suit against Christian Garcia and the owner of the vehicle that Mr. Garcia was driving.<sup>132</sup> Only then did he, through his attorney, inform State Farm of the surgery.<sup>133</sup> State Farm offered Mr. Aboy the \$15,000 policy limits four days later.<sup>134</sup> Nevertheless, Aboy rejected the offer as untimely.<sup>135</sup> He never made a settlement offer or settlement overture to State Farm.<sup>136</sup>

After obtaining a judgment of \$219,182.31 against the insureds, the insureds assigned their bad-faith claim to Rafael Aboy.<sup>137</sup> Mr. Aboy then brought suit against State Farm, alleging that State Farm should have offered to settle for the policy limits at an earlier time.<sup>138</sup> In the bad-faith suit, Mr. Aboy contended that, if State Farm had offered the \$15,000 sooner, he would have accepted it and thereby avoided the \$219,182.31 judgment entered against the insureds.<sup>139</sup> Specifically, Mr. Aboy contended that Christian Garcia was so obviously at fault, that Mr. Aboy's injuries were clearly severe, and that, therefore, State Farm could not have seriously doubted that Mr. Aboy's damages exceeded \$15,000, thereby obligating it to initiate settlement discussions.<sup>140</sup>

State Farm argued that Mr. Aboy was discharged from the hospital on the date of admission and immedi-

ately requested a rental car, indicating that he was able to drive a car and, therefore, not paralyzed.<sup>141</sup> Accordingly, State Farm took the position that a reasonable and prudent person would not have offered to pay \$15,000 without verifying that Mr. Aboy's medical expenses exceeded that amount and that, by failing to sign the medical authorization, Mr. Aboy prevented State Farm from verifying this.<sup>142</sup>

On cross-motions for summary judgment, the *Aboy* court rejected Aboy's argument that State Farm had a duty to move forward without his medical records, explaining:

Aboy (1) walked out of the hospital the same day he was admitted, (2) reported only general body soreness and numbness in his hands, (3) recovered from paralysis in less than 24 hours, (4) immediately requested a rental car, and (5) ignored State Farm's repeated requests for medical records. Under those circumstances, it was certainly reasonable for State Farm to question whether Aboy had incurred over \$15,000 in damages. Therefore, State Farm's insistence on reviewing the medical records, or at least waiting for other reliable information that Aboy's damages exceeded \$15,000, was perfectly reasonable. The Court is convinced that a reasonable fact finder would not conclude that State Farm knew, or should have known, that Aboy's injuries were "so serious that a judgment in excess of the policy limits [was] likely" until June 15, 2006, at the earliest. Accordingly, the Court finds, viewing all the evidence in the light most favorable to Aboy, that State Farm did not have an affirmative duty to initiate settlement negotiations with Aboy until at least June 15, 2006.<sup>143</sup>

In rejecting Mr. Aboy's argument that State Farm should have been more proactive in obtaining Mr. Aboy's medical records, the Court explained that "State Farm was not required to harass Aboy to provide his medical records"; its duty of good faith required only that it send the medical-authorization form and request that it be returned.<sup>144</sup> Specifically



with regard to the telephone conversation with the unknown woman who answered the phone at Mr. Aboy's residence, the *Aboy* court concluded that this certainly "was not a sufficient basis (even in conjunction with the other known facts) to reasonably conclude that Aboy's damages exceeded \$15,000."<sup>145</sup> As of the date of publication of this article, the *Aboy* case is pending on appeal.

#### F. **Tolz v. GEICO General Insurance Co. (2010)**

As of the publication of this article, the most recent decision applying the *Powell* holding was *Tolz v. GEICO General Insurance Co.*<sup>146</sup> In *Tolz*, Jennifer Lee Beebe was driving Mayra Granados's car with Granados as a passenger.<sup>147</sup> Ms. Beebe was insured by Geico by a bodily-injury liability policy with a per-person limit of \$100,000.<sup>148</sup> Geico received a call on August 30, 2005, from Michael May, Granados's live-in boyfriend.<sup>149</sup> May told Geico that Ms. Granados was in the hospital and unconscious and appears to be paralyzed from the waist down.<sup>150</sup> Mr. May would later claim that he told Geico that the vehicle had been T-boned and that the traffic lights were inoperable at the intersection, though Geico disputed this.<sup>151</sup>

Geico immediately began attempting to secure a copy of the police report, which it was not able to do until almost two months later (on October 24, 2005).<sup>152</sup> Geico did learn, however, that the driver of the second vehicle had been arrested and charged with multiple criminal counts for driving his vehicle while intoxicated at the time of the accident.<sup>153</sup> Geico also attempted to arrange for a recorded statement of Beebe, which it was not able to obtain until November 22, 2005.<sup>154</sup> An attorney also contacted Geico on behalf of Granados.<sup>155</sup>

The police report indicated that the traffic lights controlling the intersection were inoperable and that the damage to the vehicles did not appear to match the eye witness testimony.<sup>156</sup> On October 28, 2005 — four days after receiving the police report and roughly two months after the accident — Geico made the decision to tender its \$100,000 policy limits and telephoned Ms. Granados's attorney to advise that it would tender its full policy limits upon receiving verification of Granados's injuries.<sup>157</sup> Though the attorney's office assured Geico that medical records had been sent, they never arrived.<sup>158</sup> Thereafter, on

November 15, 2005, the attorney notified Geico that he was withdrawing his representation of Granados per a conflict of interest.<sup>159</sup>

Geico then contacted Jackson Memorial Hospital, which advised that Granados was hospitalized for almost one month and had medical bills exceeding \$250,000, for which the hospital was asserting a hospital lien.<sup>160</sup> Geico telephoned Granados directly to determine how to address the hospital lien, and Granados told Geico that she would be retaining a new attorney and that Geico should discuss the matter with her new attorney.<sup>161</sup> Unable to reach the new attorney, Geico decided to send Granados a \$100,000 check made out to Granados and Jackson Memorial Hospital to protect the hospital lien.<sup>162</sup> The new attorney then contacted Geico, and Geico canceled the original check and issued a new one that added the new attorney's name.<sup>163</sup> The new attorney ultimately rejected this check and returned it, filing a lawsuit against Beebe that resulted in a \$3-million consent judgment.<sup>164</sup>

The bankruptcy trustee for Jennifer Beebe's bankruptcy estate subsequently filed suit against Geico, contending that Geico acted in bad faith by failing to tender the policy limits in a timely fashion.<sup>165</sup> In denying Geico's motion for summary judgment, the trial court found a material issue of fact as to when "Geico became aware that Beebe could be *potentially* liable for the accident."<sup>166</sup> The opinion explains that the *Tolz* case was different from *Aboy* in that *Aboy* involved undisputed facts showing that State Farm did not know, and could not have known, the extent of the claimant's injuries before a certain date while, in *Tolz*, the undisputed facts do not clearly establish when Geico should have known that Beebe "might be partially liable for the accident that caused Granados' injuries."<sup>167</sup>

#### G. **Boicourt v. Amex Assurance Co. (2000)**

It is somewhat enlightening to compare the way that *Gutierrez* and *Tolz* applied *Powell* to the way in which a California court interpreted *Powell* ten years earlier. In *Boicourt v. Amex Assurance Co.*,<sup>168</sup> an insurer refused to disclose its insureds' policy limits to a third-party claimant, citing a company policy not to disclose policy limits.<sup>169</sup> California law, at least at the time, forbid insurers from disclosing policy limits absent written permission from the insured,<sup>170</sup> but

the insurer never contacted the insureds to determine whether they wanted their policy limits disclosed.<sup>171</sup> After the insurer refused to disclose its insured's policy limits to an attorney for the third-party claimant, the attorney sent the insurer's adjuster information about the extent of the claimant's injuries, confirmed in writing that the insurer was refusing to disclose the policy limits, and declared that the matter might have otherwise been resolved without litigation if the insurer had done so.<sup>172</sup> The attorney filed suit against the insured.<sup>173</sup> Amex eventually did make a settlement offer for the \$100,000 policy limits, which the third-party claimant refused.<sup>174</sup> The case went to trial and resulted in a stipulated judgement of \$2.985 million against the insureds.<sup>175</sup> No settlement demand was ever made.<sup>176</sup>

The claimant took an assignment and brought a bad-faith suit against Amex,<sup>177</sup> during which the claimant's attorney testified that he would have accepted the \$100,000 policy limits at any point before it was made known to him that Amex would not disclose the policy limits.<sup>178</sup> In reversing a summary judgment for Amex, the *Boicourt* court relied on *Powell* to demonstrate that liability for bad faith can, indeed, be premised on a refusal to disclose policy limits<sup>179</sup> and that a formal settlement offer is not an absolute prerequisite to a bad-faith action "when the claimant makes a request for the policy limits and the insurer refuses to contact the policyholder about the request."<sup>180</sup> Significantly, the *Boicourt* court clarified that it was not necessarily deeming the request for policy limits as a genuine opportunity to settle an excess claim within policy limits, only that "the claimant's request for the policy limits *might* have been a settlement opportunity which was arbitrarily foreclosed by the insurer for its own advantages to the insured's detriment."<sup>181</sup>

#### IV. Dissonance Amongst *Powell*'s Progeny

While each of the above-discussed cases traces its reasoning back to *Powell*, harmonizing them with one another is far more difficult. For instance, *Powell*, *Shin Crest*, and *Aboy* require *both* (a) "clear" liability, and (b) injuries so severe that a judgment in excess of the policy limits is "likely," before the *Powell* duty is triggered. Somehow, in nineteen years, the requirement for "clear" liability in *Powell* became diluted to "might be partially liable" in *Tolz*.<sup>182</sup> In reviewing the cases, this does not appear to be the result of any

court's conscious decision to expand the *Powell* holding. The more likely explanation is that *Powell*'s holding has experienced a species of intellectual drift caused by cumulative imperfections the recitation of its holding.

The *Powell* cases also reflect a lack of consensus as to whether the "clear" liability and "likely" excess judgment must be accompanied by a settlement overture from the third-party claimant before the *Powell* duty arises. Such an overture was made in *Powell*, and *Boicourt* seems to suggest that the existence of a duty to initiate settlement negotiations turned on whether or not a jury viewed the claimant's request for disclosure of the policy limits as a settlement overture. At the other end of the spectrum, *Snowden*, *Johnson*, *Gutierrez*, *Aboy*, and *Tolz* all involved situations where the third-party claimant made no settlement overture at all but, instead, simply remained silent and later took the position, with mixed results, that the respective insurers waited too long to initiate settlement negotiations.

Apart from the question of when the *Powell* duty arises, the *Powell*-based cases also lack a consensus as to what, precisely, the insurer must do to discharge the duty. *Shin Crest* and *Powell* itself hold that the insurer has only a duty "to initiate settlement negotiations." Conversely, *Snowden*, *Gutierrez*, and *Tolz* read *Powell* to mean that the insurer has an affirmative duty to tender the insured's policy limits to a third-party claimant. Of these cases, only *Shin Crest* confronted the issue head-on and concluded that *Powell*'s duty to "initiate settlement negotiations" is something less than a duty to tender policy limits.

Additionally, *Powell* involved a situation where the insurer was notified that the third-party claimant would suffer real prejudice — transfer to a different hospital as an indigent — if the policy limits were not made immediately available. *None* of the post-*Powell* cases undertook to determine whether similar prejudice was evident. Instead, in circular fashion, the latter cases suggest that *Powell* was both the reason and the remedy for the rejection of the insurers' offers to settle for policy limits. In other words, where the *Powell* claimant rejected the insurer's offer to settle for policy limits because he had already experienced the prejudice he hoped to avoid by settling for this amount, subsequent third-party claimants rejected of-

fers to settle for policy limits because they subjectively believed that they could recover a greater amount by invoking *Powell* in a subsequent bad-faith claim.

Cumulatively, these inconsistencies in the application of the *Powell* holding do harm to Florida's public policy of encouraging settlements, both in underlying tort claims and in bad-faith claims. For instance, where an insurer has "initiated settlement negotiations" long before "tendering policy limits," a third-party claimant cannot predict with any certainty whether a subsequent bad-faith claim might end up being adjudicated by a tribunal who views the *Powell* duty as requiring the latter or merely the former. When faced with a tender of the policy limits that amounts to less than 100% of a third-party claimant's damages, the third-party claimant would be understandably reluctant to accept it and thereby foreclose the chance of recovering a higher amount if fortune later delivers him to one of the tribunals that believes *Powell* to require tender of policy limits rather than mere "negotiations." This uncertainly likewise prolongs the amount of time necessary to settle the bad-faith claim itself.

#### V. ***Powell's* Effect On Third-Party Claimants' Settlement Strategies: *Gutierrez* As A Case Study**

While the *Powell* court may have reached an equitable result on the unique facts of the *Powell* case, *Powell* effected an undeniable change in Florida's settlement climate. Combining *Powell's* holding with Florida case law holding that "the focus . . . is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured,"<sup>183</sup> the net result is a climate in which an insurer can have an affirmative duty to initiate settlement negotiations while, at the same time, the claimant arguably has no reciprocal duty to invite or cooperate with such negotiations. This creates an incentive for claimants to refrain from meaningful communication with an insurer, attempting instead "to manufacture bad faith claims by . . . starving the insurer of the information needed to make a fair appraisal of the case."<sup>184</sup>

In *Gutierrez*, Mr. Yochim was hospitalized for thirteen days and then transferred to a nursing home.<sup>185</sup> It is safe to assume that payment of the tortfeasor's \$10,000 policy limits would fall far short of making him whole and that, truth be told, it was not in his

best interest to settle for policy limits. While it is important to acknowledge what has been called the "honored and reviled practice of setting up an insurance company for a bad faith claim,"<sup>186</sup> it is equally important to be honest about the realities of settlement negotiations. A claim for insurer bad faith was likely Mr. Yochim's only hope of being made whole. If Dairyland's suspicions about the scope of his injuries were to be confirmed, it would have immediately offered to settle for the insured's \$10,000 policy limits and thereby foreclosed the possibility of a future bad-faith claim. In other words, *Powell* created a financial disincentive to providing Dairyland with information that would facilitate settlement.

Though Dairyland's adjuster left a message for Mr. Yochim's attorney on October 9, 2003, the phone call was not returned. We can only speculate why it wasn't. Given decisions such as *Snowden*, however, the reason could well have been that Mr. Yochim's attorney feared that the adjuster might inquire into whether Mr. Yochim had indeed suffered a spinal-cord injury and, upon receiving an affirmative answer, tender the policy limits.<sup>187</sup> The day after the phone call, Dairyland's adjuster sent a written request for copies of Mr. Yochim's medical records to Mr. Yochim's attorney, which copies were in the attorney's possession and easily could have been provided.<sup>188</sup> Instead of sending the records themselves, however, Mr. Yochim's attorney sent a medical authorization, thereby requiring Dairyland to expend the unnecessary effort of requesting them anew from the hospital and requiring the hospital to expend the unnecessary effort of copying them anew.<sup>189</sup>

The date upon which the medical authorization was sent is also significant. December 22 coincides with a certain holiday during which a number of Americans — including insurance adjusters and the hospital personnel who make copies of medical records — tend to take vacation days and/or travel to visit out-of-town relatives. This particular medical authorization was received by Dairyland on December 26 — the day after Christmas and a date where there was a decent possibility that the adjuster would not be in the office to act on it. The cynics among us might suppose that the medical authorization was purposely mailed on this date in anticipation that doing so would produce the longest response time possible. If that was the intention of Mr. Yochim's attorney, he calculated cor-

rectly, for the adjuster did not request Mr. Yochim's hospital records until January 13, 2004.<sup>190</sup>

Upon seeing medical records that confirmed Mr. Yochim's spinal-cord injury, Dairyland's adjuster wasted no time in offering to settle for the policy limits,<sup>191</sup> and there is no reason to believe that he wouldn't have done the same thing in October of 2003 if the exact same medical records had only been faxed to him then. Providing this information, however, would have encouraged Dairyland to tender Ms. Gutierrez's policy limits, which would have covered only a fraction Mr. Yochim's damages. Putting oneself into his attorney's position on October 10, 2003, the decision whether to send or not send Mr. Yochim's medical records to Dairyland essentially amounted to a decision between \$10,000 now (with no chance of extracontractual recovery) or \$10,000 later (with a chance of extracontractual recovery on a bad-faith claim based on *Powell*). If he consciously decided to dole out information as slowly as possible in hopes of strengthening an eventual *Powell* claim, we can hardly blame him for utilizing the means available to him to maximize the recovery for his client. The Florida courts, however, have yet to seriously confront the question of whether making that means available to him is, in the grand scheme of things, desirable where the cost of that opportunity comes at the expense of countless others.

At the time of this writing, the *Gutierrez* case still is not resolved. There exists a chance that Mr. Yochim may never recover more than Ms. Gutierrez's \$10,000 policy limits and that everything after October 10, 2003, happened for naught. Even if that were the ultimate result, it is easy to understand why Mr. Yochim might reject the minuscule benefit of having the \$10,000 policy limits immediately available for the chance, no matter how slight, that he might recover 100% of his damages in a future *Powell*-based bad-faith claim. Cumulatively, however, an economist would expect that the expense of defending such a claim, multiplied by the number of claims like it, has a significant impact on Dairyland's overhead, and therefore its bottom line, and therefore the premiums paid by its policyholders. Cumulatively, an economist would also expect that the expenses of litigating losing bad-faith cases affects the bottom lines of plaintiffs' attorneys involved in such cases, which costs one would expect to be borne by the higher

contingency fees of the successful plaintiffs. And this is to say nothing of the additional labor and resources that the Florida courts must expend in resolving such disputes, which cost is ultimately borne by the Florida taxpayers. If one of the unspoken goals of bad-faith law is to facilitate full recovery by injured people, one cannot help but ask whether there is a more economical way to do it.

## VI. Conclusion

While *Powell* involved a claimant who expressed a willingness to settle for policy limits and was met with an insurer's inexplicable silence, *Gutierrez* involved an insurer that was engaged in proactive attempts to obtain information meant to facilitate a settlement and was met with a claimant's inexplicable silence. In less than twenty years, *Powell* has become its own mirror image. The cases that purported to apply *Powell*'s holding have eroded away the requirement that the third-party claimant express a willingness to settle within policy limits. The duty to "initiate settlement negotiations" has been effectively inflated to a "duty to tender policy limits." The threshold requirement of "clear" liability by the insured has been gradually diluted to a threshold of "possible" liability. Somewhere along the way, *Powell*-based claims have been allowed to morph, in some instances, into something that they were not originally intended to be. Such *Powell* claims, in their present form, are contrary to Florida's public policy favoring settlement.

This is not to say that *Powell* has had an altogether negative effect. Few deny that *Powell* creates an incentive for insurers to take a proactive role in investigating claims when they otherwise might have opted to await a settlement demand and commence their investigations at that time. The point is that permitting bad-faith liability on facts differing extensively from *Powell* has done more harm than good. To illustrate, *Powell* itself, for instance, involved the following factors:

1. Unequivocal communication from the claimant's attorney that the claimant was willing to settle for the policy limits;
2. Prejudice to the claimant in the event that a quick settlement for the policy limits could not be had, which urgency was communicated to the liability insurer;

3. Clear liability on the part of the insured;
4. Communication of medical information from the claimant sufficient to evaluate the claimant's injuries; and
5. Early subjective recognition by the insurer that the claimant's damages exceeded the policy limits;

Under these unique circumstances, requiring an insurer to initiate settlement discussions makes some sense and, under these unique circumstance, is in harmony with Florida's public policy favoring early settlements.

Conversely, it does injury to Florida public policy to expand a liability insurer's duty from "initiating settlement negotiations" to "tendering policy limits" and to extend the circumstances in which the duty applies to situations where none, or few, of the above-listed factors are present. Though none of the cases expanding *Powell* this far profess designs to encourage claimants to withhold information likely to result in settlement, they have inadvertently created an incentive to do exactly that. In this manner, from claimants' point of view, the opportunity for 100% recovery comes at the mere cost of foregoing the immediate benefit of settlement proceeds that are likely to remain available throughout all negotiation and litigation. Notwithstanding, for every claimant who ultimately benefits by employing such settlement strategies, there are others who needlessly litigate against paupers in pursuit of bad-faith claims that end up yielding nothing. This opportunity cost is borne by countless Florida policyholders and taxpayers to the economic detriment of Florida as a whole.

To undo the mischief caused by *Powell*, the Florida courts or Florida Legislature need to take a serious look at its macroeconomic effect. It is difficult to quantify the cost of *Powell* to Florida taxpayers and policyholders in terms of higher insurer overhead, litigation costs, and court budgets compared with the cost of alternative means by which injured persons might otherwise be made whole. It is, however, a question worth asking and a question that the courts and Legislature have not seriously confronted. The conclusion could well be that *Powell* has proven to be a failed experiment and that Florida would be much better off following the Texas courts' lead in requiring, as an element of a bad-

faith failure-to-settle claim, a demand that proposes to release the insured and meets three prerequisites: (1) that the claim against the insured is within the scope of coverage; (2) that the demand is within policy limits; and (3) that the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.<sup>192</sup>

On the other hand, if the conclusion were that it is better to maintain the benefit of encouraging insurers' vigilance in investigating claims, the only way to do this while avoiding the unintended financial incentive for claimants to withhold meaningful communication with liability insurers is to confine *Powell* to its facts, either judicially or through legislation. Meanwhile, the responsibility for mitigating *Powell's* cost falls upon the courts in exercising their responsibility to restrict the availability of bad faith's limitless damages to egregious circumstances of delay and bad-faith acts<sup>193</sup> and to exercise caution where the gravamen of the complaint is that the insurer has delayed settlement rather than refused to settle.<sup>194</sup> To do otherwise is to "permit bad faith in the insurance milieu to become a game of cat-and-mouse between claimants and insurer, letting claimants induce damages that they then seek to recover, whilst relegating the insured to the sidelines as if only a mildly curious spectator."<sup>195</sup>

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## Endnotes

1. See *Florida East Coast Ry. Co. v. Thompson*, 111 So. 525 (Fla. 1927); *Allstate Ins. Co. v. Chaple*, 774 So.2d 742 (Fla. 3d DCA, 2000); *Abbott & Purdy Group Inc. v. Bell*, 738 So. 2d 1024, 1027 (Fla. 4th DCA 1999).
2. 584 So. 2d 12 (Fla. 3d DCA 1991).
3. See *Powell v. Prudential Property & Casualty Insurance Co.*, 584 So. 2d 12, 14 (Fla. 3d DCA 1991).
4. Dennis J. Wall, *The Era of Initiating Settlement Negotiations: What is a Liability Insurance Company to Do?*, INS. LITIG. REP., Feb 2, 2010.
5. *Powell*, 584 So. 2d at 13.

6. *Id.*
7. *Id.*
8. *Id.* at 13 n.1 (ellipses in original).
9. *Id.* at 13.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.* (ellipses in original).
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.* at 14.
26. *Id.*
27. *Id.*
28. *Id.*
29. *Id.*
30. *Id.*
31. *Id.*
32. *Id.* at 14-15.
33. *Id.* at 15.
34. *Id.*
35. See *Boicourt v. Amex Assurance Co.*, 93 Cal. Rptr. 2d 763 (Ct. App. 2000).
36. See *Robinson v. State Farm Fire & Cas. Co.*, 583 So. 2d 1063 (Fla. 5th DCA 1991).
37. 358 F. Supp. 2d 1125 (N.D. Fla. 2003).
38. *Id.* at 1126.
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. See *id.*
46. *Id.* at 1127 (emphasis added).
47. *Id.* at 1126.
48. *Id.* at 1127.
49. *Id.*
50. 318 Fed.Appx. 847 (11th Cir. 2009).
51. *Id.* at 848.
52. *Id.*
53. *Id.* at 848-49.
54. *Id.* at 849.

55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.* at 850.
61. *Id.* at 850-51.
62. *Id.* at 851.
63. 605 F. Supp. 2d 1234 (M.D. Fla. 2009).
64. *Id.* at 1235.
65. *Id.*
66. *Id.* at 1235-36.
67. *Id.* at 1236.
68. *Id.* at 1237-38.
69. *Id.* at 1238.
70. *Id.* at 1238-39.
71. *Id.* at 1239.
72. *Id.*
73. *Id.*
74. *Id.* at 1241.
75. *Id.*
76. *Id.*
77. No. 07-1433, 2009 WL 1456426, at \*3 n.2 (M.D. Fla. May 22, 2009).
78. *Id.*
79. 23 So. 3d 1221 (Fla. 2d DCA 2009).
80. *Id.* at 1222.
81. *Id.*
82. *Id.*
83. *Id.* at 1226 (Whatley, J., dissenting).
84. *Id.* (Whatley, J., dissenting).
85. *Id.* at 1222. It should be noted that, under Florida law, adjusters are ethically prohibited from negotiating or effecting a settlement with an insured or third-party claimant if the adjuster has knowledge of the party's representation by an attorney and does not have the attorney's express permission to negotiate directly with the insured or third-party claimant. *See* Fla. Admin. Code R. 69B-220.201(3) (i) (2010).
86. *Gutierrez*, 23 So. 3d at 1226-27 (Whatley, J., dissenting).
87. *Id.* at 1227 (Whatley, J., dissenting).
88. *Id.* (Whatley, J., dissenting).
89. *Id.* at 1223.
90. *Id.* at 1227 (Whatley, J., dissenting).
91. *Id.* (Whatley, J., dissenting).
92. *Id.* (Whatley, J., dissenting).
93. *Id.* at 1223.
94. *Id.* at 1227 (Whatley, J., dissenting).
95. *Id.* (Whatley, J., dissenting).
96. *Id.* (Whatley, J., dissenting).
97. *Id.* (Whatley, J., dissenting).
98. *Id.* (Whatley, J., dissenting).
99. *Id.* (Whatley, J., dissenting).
100. *Id.* (Whatley, J., dissenting).

101. *See id.* (Whatley, J., dissenting).
102. *Id.* at 1223.
103. *Id.*
104. *Id.* at 1227 (Whatley, J., dissenting).
105. *Id.* (Whatley, J., dissenting).
106. *Id.* at 1223.
107. *Id.* (Whatley, J., dissenting).
108. *Id.* at 1223.
109. *Id.*
110. *Id.*
111. *Id.*
112. *Id.* at 1223-24.
113. *See id.* at 1223-24.
114. *Id.* at 1223-24.
115. *Id.* at 1224 n.2.
116. *Id.* at 1224.
117. *Id.*
118. *Id.* at 1225.
119. *Id.*
120. *Id.*
121. *Id.* at 1225-26.
122. *Id.* at 1226.
123. *Id.* at 1227 (Whatley, J., dissenting).
124. 22 Fla. L. Weekly Fed. D163 (S.D. Fla. 2010).
125. *Id.* at D163.
126. *Id.*
127. *Id.* at D164.
128. *Id.* at D164, D165 n.2.
129. *Id.* at D164.
130. *Id.* at D165.
131. *Id.* at D164.
132. *Id.* Note that, in Florida, the owner of a vehicle is vicariously liable for the negligence of a permissive driver. *Southern Cotton Oil Co. v. Anderson*, 80 Fla. 441, 86 So. 629, 631-32 (1920).
133. *Aboy*, 22 Fla. L. Weekly Fed. at D164.
134. *Aboy*, 22 Fla. L. Weekly Fed. at D164.
135. *Id.* at D163.
136. *Id.* at D164.
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.* at D165.
143. *Id.* (citations omitted).
144. *Id.* at D164.
145. *Id.*
146. No. 08-80663, 2010 WL 298398 (S.D. Fla. Jan. 19, 2010).
147. *Id.* at \*1.
148. *Id.*



149. *Id.*
150. *Id.*
151. *Id.* at \*6.
152. *Id.* at \*2-\*3.
153. *Id.* at \*2.
154. *Id.* at \*4-\*5.
155. *Id.* at \*3-\*4.
156. *Id.* at \*3.
157. *Id.*
158. *Id.* at \*4.
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.*
163. *Id.*
164. *Id.*
165. *Id.* at \*1.
166. *Id.* at \*6 (emphasis added).
167. *Id.*
168. 93 Cal. Rptr. 2d 763 (Ct. App. 2000).
169. *Id.* at 764.
170. *Id.* at 764, 764 n.1.
171. *Id.* at 764.
172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.*
176. *Id.*
177. *Id.* at 765.
178. *Id.* at 764.
179. *Id.* at 765.
180. *Id.* at 768.
181. *Id.* at 769.
182. In the author's opinion, the *Tolz* decision is clearly erroneous. Where the insured is driving a vehicle that is T-boned by a drunk driver, it is one thing to say that she "might be partially liable" as a result of a malfunctioning traffic light and quite another thing to say that her liability is "clear" in the sense of the car/pedestrian accident in *Powell*.
183. *Berges v. Infinity Ins. Co.*, 896 So. 2d 665, 677 (Fla. 2004).
184. *Wade v. EMCASCO Ins. Co.*, 483 F.3d 657, 669 (10th Cir. 2007).
185. *Gutierrez v. Yochim*, 23 So. 3d 1221, 1222 (Fla. 2d DCA 2009).
186. Rutledge R. Liles, *Insurance Bad Faith: The "Setup Myth,"* 77 Fla. B. J. 18, 18 (2003) (quoting STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* § 7.26 (2d ed. 1998)).
187. Indeed, in *Aboy*, the insurer determined a representation by a member of the Florida Bar as to the amount of Mr. Aboy's medical bills to be sufficiently reliable as to warrant tender of the policy limits. *Aboy v. State Farm Mut. Auto. Ins. Co.*, 22 Fla. L. Weekly Fed. D163, D165 (S.D. Fla. 2010).
188. *Gutierrez v. Yochim*, 23 So. 3d 1221, 1227 (Fla. 2d DCA 2009) (Whatley, J., dissenting).
189. *Id.* at 1227 (Whatley, J., dissenting).

190. *Id.* at 1223. 1234, 1243 (M.D. Fla. 2009) (quoting *Berges v. Infinity Ins. Co.*, 896 So. 2d 665, 685-86 (Fla. 2004) (Wells, J., dissenting)).
191. *Id.* at 1227 (Whatley, J., dissenting).
192. *American Physicians Insurance Exchange v. Garcia*, 876 S.W.2d 842, 848-49 (Tex. 1994).
194. *See Wade v. EMCASCO Ins. Co.*, 483 F.3d 657, 669 (10th Cir. 2007) (citation omitted).
193. *Shin Crest PTE, Ltd. v. AIU Ins. Co.*, 605 F. Supp. 830, 835 (1st Cir. 1990). ■
195. *Peckham v. Continental Cas. Ins. Co.*, 895 F.2d 830, 835 (1st Cir. 1990). ■





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