PROGRESSIVE

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Submitted to the

South Carolina House of Representatives
Insurance Rate Review Ad Hoc Committee

In connection with its August 19, 2025 hearing

I. INTRODUCTION

Good morning, Chairman Brewer and members of the Ad Hoc Committee. My name is Jim Dodrill, and I am the Business Leader of Government Affairs for Progressive Insurance. Thank you for the opportunity to testify today as your Committee reviews insurance rates in South Carolina and explores ways to address insurance availability and affordability for South Carolina businesses and consumers.

Before getting into my testimony, please allow me to share some of my background with you. I have been an attorney for 40 years. I have served as a prosecutor, city attorney for three West Virginia municipalities, and a municipal judge. I began my legal career as a personal injury lawyer representing plaintiffs and suing insurance companies. Through my work representing municipalities I ended up moving to the defense side, representing insureds sued in personal injury and property damage lawsuits. I have been lead trial counsel in more than 100 civil and criminal jury trials, and I have eight published appellate opinions in which I was lead appellate counsel. After almost 15 years in private practice, I joined Progressive and worked for nearly 20 years as Corporate Claims Counsel, overseeing claims litigation including bad faith lawsuits, across the Country, including South Carolina. That is how I became acquainted with one of South Carolina's finest trial and appellate lawyers, J. R. Murphy, cofounder of Murphy & Grantland right here in Columbia. J. R. is with me here today, ready to provide you with insights from his many years of first-hand trial and appellate experience in South Carolina's legal system representing businesses and individuals in insurance claim litigation, as well as insurance companies in *Tyger River* bad faith lawsuits.

I retired, or so I thought, from Progressive in early 2019 and was appointed as West Virginia's Insurance Commissioner by Governor Jim Justice and unanimously confirmed by the West Virginia Senate. After a little more than two and a half years as Insurance Commissioner, I returned to Progressive in late 2021 in my current role of Business Leader of Government Affairs.

Lastly, I am also a retired U. S. Air Force lieutenant colonel, having 21 years on active duty and with the Air National Guard, and I continue to serve with the U. S. Air Force's auxiliary, Civil Air Patrol. I should note that I was fortunate to serve with the Air Force at Myrtle Beach AFB for a brief time in the 1970s and then later, in 1989, I spent several weeks at Charleston AFB in support of the Hurricane Hugo relief effort. More recently, I supported the South Carolina Wing of the Civil Air Patrol, flying damage assessment aerial imagery missions for FEMA in the wake of Hurricane Florence in 2018.

I would like to now turn to the issue at hand, a review of property and casualty insurance availability and affordability in South Carolina. I'll start of with a review of what has occurred in other states in recent years.

II. THE WEST VIRGINIA EXPERIENCE

By 2005, West Virginia's insurance market was in crisis. Insurers were nonrenewing policies, closing offices and leaving the state. If consumers could find coverage it was often not affordable, especially for West Virginia's large lower income demographic. As can be seen in the following chart from the 2008 *Annual Automobile Survey* from the West Virginia Offices of the Insurance Commissioner (OIC), the rates paid by West Virginia consumers were two or three times higher than what they were for identical drivers just across the border in neighboring states.

48 yr. Male, married, principal operator, no accidents or violations,
Commutes to work, 20,000 miles annually.

Preferred/Standard Companies	St. Clairsville, OH	W. Alexander, PA	Wheeling, WV	Marietta, OH	Parkersburg, WV
AIG Centennial Ins Co	183	na	441	190	501
Allstate P & C Ins Co	168	188	320	178	337
American National P & C Co	230	386	340	230	376
Amica Mutual Ins Co	245	298	375	222	399
Erie Ins P & C Co	231	229	313	242	368
First National Ins Co of America	na	660	549	na	587
Geico General Ins Co	174	35	355	186	365
Geico Indemity Co	279	325	515	297	527
Government Employees Ins Co	174	235	355	186	365
Horace Mann Ins Co	262	352	547	243	414
Horace Mann P & C Ins Co	167	220	317	158	255
Metropolitan Drt P & C Ins Co	452	560	485	470	475
Metropolitan P & C Ins Co	570	588	402	611	392
Motorists Mutual Ins Co	258	375	674	312	620
Nationwide Mutual Ins Co	298	276	438	307	473
Nationwide P & C Ins Co	298	276	527	307	573
Progressive Classic Ins Co	292	na	878	350	904
Safeco Ins Co of America	na	448	370	na	395
State Auto P & C Ins Co	157	264	483	207	530
State Farm Fire & Casualty Co	225	411	436	292	484
State Farm Mutual Auto Ins Co	203	353	391	263	434
Teachers Ins Co	204	270	388	226	313
USAA	141	281	288	143	290
USAA Casualty Ins Co	139	292	325	141	326
Westfield Ins Co	182	300	301	198	338

48 yr. Female, married, principal operator, no accidents or violations,
Commutes to work, 20,000 miles annually.

Preferred/Standard Companies	St. Clairsville, OH	W. Alexander, PA	Wheeling, WV	Marietta, OH	Parkersburg, WV
AIG Centennial Ins Co	188	na	453	196	515
Allstate P & C Ins Co	168	188	320	178	337
American National P & C Co	230	386	340	230	376
Amica Mutual Ins Co	245	298	375	222	399
Erie Ins P & C Co	231	229	313	242	368
First National Ins Co of America	na	660	458	na	488
Geico General Ins Co	174	235	340	186	350
Geico Indemity Co	268	325	515	285	527
Government Employees Ins Co	174	235	340	186	350
Horace Mann Ins Co	251	352	547	234	414
Horace Mann P & C Ins Co	159	220	317	152	255
Metropolitan Drt P & C Ins Co	452	560	485	470	475
Metropolitan P & C Ins Co	507	588	402	542	392
Motorists Mutual Ins Co	258	374	674	312	620
Nationwide Mutual Ins Co	298	276	487	307	473
Nationwide P & C Ins Co	298	276	527	307	573
Progressive Classic Ins Co	320	na	960	385	989
Safeco Ins Co of America	na	448	310	na	330
State Auto P & C Ins Co	157	264	483	207	530
State Farm Fire & Casualty Co	225	411	436	292	484
State Farm Mutual Auto Ins Co	203	353	391	263	434
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USAA Casualty Ins Co	139	292	336	141	337
Westfield Ins Co	182	300	301	198	338

The charts above reflect only a few of the comparisons between West Virginia municipalities and those in neighboring states. There are several more comparison charts included in the *Annual Automobile Survey* showing neighboring community comparison rates in Kentucky, Virginia and Maryland. My personal experience was reflected in the rate comparison analysis done by the West Virginia OIC. When I first became employed with Progressive in 1999, I relocated from Putnam County, West Virginia to Henrico County, Virginia. At that time, I was insured by Nationwide and when I moved to Virginia, I changed nothing on my auto insurance policy. I kept the same vehicles, coverages and drivers, even the same agent. The only thing that changed was my residence address…..from West Virginia to Virginia. My auto insurance premium dropped by more than two thirds. Five years later, almost to the day, I moved back to Putnam County, West Virginia from Virginia. Again, I changed nothing other than my residence address. The result? My auto insurance premium went back up by more than two thirds.

When the West Virginia Legislature tackled the insurance availability and affordability crisis in 2005 it looked at the root cause, finding it to be, as other states have much more recently, legal system abuse leading to much higher liability claim costs. For the period 2000-2004, bodily injury liability loss costs in West Virginia were approximately 47% greater than loss costs countrywide.[1] The primary driver of these skyrocketing loss costs was the private cause of action for third-party bad faith, very similar to South Carolina's *Tyger River* Doctrine. In virtually every personal injury lawsuit the insurance company was, along with the tortfeasor, named as a defendant for alleged violations of the *Unfair Claims Settlement Practices Act (UCSPA)*, part of the *Unfair Trade Practices Act*. So, in every lawsuit the insurer was forced to hire two lawyers, one to defend its insured and one to defend itself. And, unless the claims against the separate defendants were bifurcated (a discretionary decision resting with the trial judge), the underlying injury claim and the bad faith claim against the insurer proceeded at the same time. The net result of this abuse of the legal system was a doubling of the costs of defense and, most times, inflated settlements far in excess of the policy limits, all of which was passed on to consumers in the form of higher premiums.

In 2005, as the result of a bipartisan effort to curb these legal system abuses and increase both the availability and affordability of insurance, Senate Bill 418 was passed and signed into law. The impact on claim costs in the ensuing years was astounding. To assess the impact of S.B. 418, the Insurance Research Council (IRC) calculated bodily injury claim frequency and severity loss trends in West Virginia before and after the reforms were enacted. Frequency and severity trends during the five calendar years (2000-2004) before the year in which reforms were enacted (2005) were compared with trends during the five calendar years following enactment (2006-2010). These "before and after" trends in West Virginia were then compared with countrywide experience for the same coverage and for the same time periods. Using

[1] *The Impact of Third-Party Bad-Faith Reforms on Automobile Liability Insurance Costs in West Virginia*, Insurance Research Council, 2011

countrywide experience as a control, the IRC attributed significant differences between West Virginia and countrywide experience to the reforms enacted in 2005. *Id*.

As stated above, between 2000 and 2004, bodily injury liability loss costs in West Virginia were approximately 47% greater than loss costs countrywide. By 2010, however, West Virginia loss costs were only 7% greater than loss costs countrywide. Nearly all of the difference between West Virginia and countrywide experience was due to a moderation in the severity of West Virginia bodily injury claims following the adoption of S.B. 418. As bodily injury claim severity countrywide increased steadily during the period 2006-2010, West Virginia claim severity declined 8%. What this meant for West Virginia businesses and individual consumers was that the elimination of the private cause of action for third-party bad faith alone directly resulted in the reduction of underlying insurance coverage costs by approximately $200 Million ($295 Million in today's dollars) in the five-year period after the reforms were enacted. *Id*.

More recently, West Virginia has continued to improve insurance availability and affordability by making significant changes to comparative fault, joint and several liability, as well as third-party litigation financing. These reforms have continued the downward pressure on insurance rates and have helped knock West Virginia out of the top ten of the "Judicial Hellhole" list of the American Tort Reform Association, a list on which the state traded the number one and number two spots with Mississippi for more than a decade.

III. OTHER STATES' EXPERIENCES

A. Florida

A much more recent example of a state in a dire insurance crisis is Florida. After decades of legal system abuse, property and casualty insurance was increasingly unaffordable if it was even available. Florida's homeowners and businesses, especially those in coastal communities, were increasingly unable to even find insurance and, when they did, it was sometimes unaffordable. Loss costs were astronomical thanks to a legal system in which insurers faced gamesmanship with time-limited settlement demands containing dozens of immaterial conditions designed only to trick insurers into missing a seemingly insignificant condition so the claimant's lawyer could call "foul" and then seek bad faith damages against the insurer.

Florida had a reputation for a litigation climate that incentivized high-volume lawsuits and inflated settlements, particularly in areas like property insurance. The state experienced a disproportionate number of homeowners' insurance lawsuits compared to the number of claims. According to National Association of Insurance Commissioners (NAIC) data mined by the Florida Office of Insurance Regulation (OIR), while Florida homeowners' insurance claims accounted for just over 8% of all homeowners claims opened by U.S. insurers in 2019,

homeowners insurance lawsuits in Florida accounted for more than 76% of all litigation against insurers nationwide.

Florida also had a high number of "nuclear verdicts" - verdicts exceeding $10 million - which significantly impacted businesses and insurance costs.[2] Nuclear verdicts are so named for the devastating effects they can have on businesses, industries, and society. Nuclear verdicts drive up the cost of goods and services, affect the cost and availability of insurance, and compromise fairness and predictability in the legal system.

A recent study showed nuclear verdicts are increasing in both size and frequency. Of nearly 1,400 nuclear verdicts between 2010 and 2019, the median nuclear verdict increased by 27.5% from $19.3 million to $24.6 million - far outpacing general economic inflation. The largest component of nuclear verdicts tends to be non-economic damages such as pain and suffering or punitive damages. *Id.*

Florida barely edged out California as the state producing the most nuclear verdicts during the years studied. In addition to having the highest number of nuclear verdicts, Florida also had the most nuclear verdicts per capita. With about half of the population of California, Florida generated almost twice as many nuclear verdicts per hundred thousand people. Florida nuclear verdicts were also more likely than any other state to include an award of punitive damages. *Id*.

The excessive litigation contributed to rising insurance premiums for drivers, homeowners and businesses. Florida's property insurance market faced instability, with some insurers becoming insolvent or leaving the state due to the high costs associated with legal defense and claims. The rising costs of reinsurance (insurance for insurers) also played a role in driving up premiums.[3]

Advocates for reform argued that the legal system was being abused by some trial lawyers and bad actors who profited from "frivolous lawsuits" and inflated claims. Practices like one-way attorney's fees, which made it easier for plaintiffs to recover attorney's fees from insurers, were seen as contributing to the litigation imbalance.

Businesses faced increased costs, potentially affecting their operations, expansion plans, and even their ability to stay in business. The high cost of litigation and insurance was seen as impacting Florida's competitiveness as a business-friendly state, according to the Florida Chamber of Commerce.[4] The rise of third-party litigation funding, where investors finance lawsuits in exchange for a cut of the settlement or verdict, also raised concerns about potential abuses and incentives for litigation.

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[2] *Legal System Abuse Is Driving Claims Costs Up*, Conroy Simberg, December 18, 2023.
[3] *How Florida's Home Insurance Market Became So Dysfunctional, So Fast*, The Conversation, March 7, 2024.
[4] *Fixing Florida's Broken Legal Climate*, Florida Chamber of Commerce, March 24, 2023.

In response to these pressures, Florida passed comprehensive tort reform measures. Key reforms included eliminating one-way attorney's fees in most property and auto cases, reducing the statute of limitations for negligence claims, and clarifying bad faith frameworks. These reforms were aimed at rebalancing the legal landscape, deterring frivolous lawsuits, and ultimately reducing costs for consumers and businesses. In essence, the changes in Florida's legal system were driven by a desire to address a perceived imbalance in the legal system, curb excessive litigation, stabilize the insurance market, and reduce costs for individuals and businesses.

Florida has begun to realize the fruits of these hard-fought legislative reforms. After years of consecutive underwriting losses, insurers saw overall stability with Florida domestic insurers collectively reporting positive net income in 2024. 14 new companies have been approved to write residential property policies in Florida since the reforms, another residential property company that had been in runoff recapitalized and re-entered the market, and an additional company was acquired to expand its footprint in the state. Insurers continue to take policies out of Citizens (Florida's insurer of last resort) - a total of 477,821 policies were assumed in 2024, and approximately 200,099 policies have been assumed from January to June 2025.[5]

B. Georgia

In recent years it seemed much of what was wrong with Florida's legal system migrated northward into Georgia. The same lawsuit abuse tactics that drove up claim costs in Florida had become well-entrenched in Georgia.

Consider the following recent example of the gamesmanship Georgia insurers faced daily. An eight-page time-limited settlement demand letter containing more than 20 conditions that must be met by the insurer in order to accept the demand was sent via regular mail. The time limit for accepting the demand and meeting all of the conditions was only five days from the date of the letter. By mailing the letter by regular mail, three of the five days were consumed by the U. S. Postal Service in delivering the letter to the local claim office of the insurer, so the insurer had only two days (and not working or business days) to get the letter to the appropriate claim adjuster, review it and its numerous conditions and then meet all of the conditions. Many of the conditions were designed only to hamper the insurer's ability to comply and trick the insurer into failure to comply. The most egregious of these conditions was that the payment of the insured's liability limit of $25,000 had to be paid **IN CASH**, and this cash payment had to be delivered, in person, to the plaintiff attorney's office on the fifth day at an exact time of day. The

[5] *Property Insurance Stability Report*, Florida Office of Insurance Regulation, July 1, 2025. It should be noted that while this *Report* stated there had been 14 new insurers approved to write insurance in Florida by July 1, 2025, in comments made at the Louisiana Department of Insurance Annual Conference on August 7, 2025, Insurance Commissioner Mike Yaworsky announced that there had been another three new insurers approved to write insurance in Florida since July 1, 2025.

problem? The fifth day was a Saturday when the law office would be closed, and they knew it when they made the delivery day and time a condition of the settlement. To nevertheless try to meet even these ridiculous conditions, the insurer sent two claim adjusters to the law office on the designated Saturday at the required time, with an envelope containing $25,000 in cash. One adjuster videotaped the other taping the envelope to the glass office door (the office was located inside an office building lobby) with the date/time stamp showing on the video recording.

It was tactics like this that insurers faced daily in Georgia and which led to the passage of Senate Bill 83 in 2024 which aimed to reduce or eliminate the failure to settle litigation in cases where an insurer accepts a claimant's time-limited demand per the amended statute. Senate Bill 83 made three principal changes to O.C.G.A. § 9-11-67.1:

1. Creation of a Safe Harbor. The amended statute creates a safe harbor from failure to settle litigation for an insurer who purports to accept a time-limited demand in accordance with the terms of the amended statute. O.C.G.A. § 9-11-67.1(i)(1) (as amended) ("[t]here shall be no civil action arising from an alleged failure… to settle… where the [insurer]" accepts a time-limited demand in accordance with the terms of the statute).

2. Enumeration of Material Terms for Acceptance. The amended statute enumerates seven terms that must be in a time-limited demand and defines them as the "only material terms." O.C.G.A. § 9-11-67.1(b)(1) (as amended). The amended statute further clarifies that while a time-limited demand may include terms not enumerated in the statute, any such term is "immaterial." A rejection of it by an insurer "shall not subject [an insurer] to a civil action arising from an alleged failure… to settle" if the insurer otherwise satisfies the terms of the statute. O.C.G.A. § 9-11-67.1(c) (as amended).

3. Creation of Bilateral Contract. Under the amended statute, a time-limited demand will now be considered an offer to enter a "bilateral" - not unilateral - contract. O.C.G.A. § 9-11-67.1(a) (as amended). The aim here is to form a binding contract at the moment of acceptance, such that an insurer's failure to fulfill a condition would constitute, at most, a breach of contract rather than a rejection of the time-limited demand in the first instance.

The 2024 enactment of Senate Bill 83 was a significant step toward fixing Georgia's broken legal system, but much more was needed. In 2025, Governor Kemp introduced two bills: Senate Bill 68, which amends various existing statutes and creates some new statutes that govern the litigation and trial of personal injury claims, and Senate Bill 69, which deals with litigation financing agreements. Senate Bill 68 contains numerous provisions, the most notable of which are that (1) "jury anchoring" to establish a plaintiff's damages for pain and suffering is significantly limited; (2) the double recovery of attorney fees is prohibited and plaintiff attorneys can no longer introduce their contingency fee agreement at trial to prove the reasonableness of

those fees; (3) a defendant can now introduce evidence that a plaintiff was not wearing a seatbelt during a motor vehicle accident; (4) defendants can now counter a plaintiff's claim to "phantom damages," allowing them to show the jury the difference between the "list price" for medical services and the amount actually paid; (5) the issues of liability and damages are now required to be bifurcated in most trials.

Senate Bill 83 has already had a positive impact, reducing the number of time-limited settlement demands and the number of "immaterial" conditions within them. As for the enactment of Senate Bill 68 in the Spring of this year, the effects remain to be seen as its provisions take hold in Georgia. However, based on the real-world experiences in West Virginia and much more recently in Florida, most anticipate similar positive impact on insurance availability and affordability in the Peach State.

C. Louisiana

Another state in crisis, with businesses unable to find affordable insurance coverage and insurers leaving the state, is Louisiana. Both Louisiana's property insurance market and its auto insurance market have been in a worsening crisis for many years. In 2024, the Louisiana Legislature and the Governor worked together to pass landmark property insurance reforms. In 2025, Louisiana lawmakers, along with Insurance Commissioner Tim Temple, tackled the auto insurance market (Louisianans have been paying some of the highest auto insurance rates in the Country) and passed historic changes designed to improve the state's longstanding legal system abuses and lower auto insurance rates. The bills which were signed into law by Louisiana's Governor in June include:

1. House Bill 431: Establishes a ***modified comparative fault*** system, barring plaintiffs from recovering damages if they are found to be 51% or more at fault for an accident. Previously, Louisiana used a pure comparative fault system where plaintiffs could recover damages regardless of their percentage of fault.

2. House Bill 434: Amends the ***"No Pay, No Play"*** statute, increasing the penalty for uninsured drivers involved in accidents. It prevents uninsured drivers from recovering the first $100,000 in bodily injury and property damage, even if they are not at fault. This is a significant increase from the previous thresholds of $15,000 for bodily injury and $25,000 for property damage.

3. House Bill 450: Eliminates the ***"Housley Presumption,"*** which previously presumed that an accident caused a plaintiff's injury if they did not have the condition prior to the accident. Under the new law, plaintiffs must now show that their injuries actually occurred during the accident, placing a higher burden of proof on them.

4. Senate Bill 231: Addresses ***"phantom damages"*** by limiting the recovery of medical expenses to those actually paid to the contracted medical provider by the health insurer or Medicare and any applicable cost sharing amounts paid or owed by the claimant and not the amount billed. At trial, the trier of fact shall be informed of the amounts billed and amounts actually paid for medical expenses that have been incurred by the claimant. This includes amounts paid or pre-negotiated by the plaintiff's attorney, in which the medical provider has agreed to accept as full compensation an amount less than the amount billed. In that circumstance, recoverable amounts are limited to those actually paid or pre-negotiated by the attorney.

5. House Bill 436: Bars ***unauthorized aliens***, as defined under federal law, from recovering general damages and past and future wages arising from an auto accident. The law does not apply to UM/UIM claims when the unauthorized alien is making a UM/UIM claim on a policy in which they are a named insured.

IV. RECOMMENDED REFORMS FOR SOUTH CAROLINA

A. Eliminate or Reform the *Tyger River* Doctrine

Very simply, abuse of the *Tyger River* Doctrine leads to higher insurance costs just as the abuse of the private cause of action for third-party bad faith did in West Virginia. The *Tyger River* Doctrine allows an insured party to sue their insurer for bad faith if the insurer fails to settle a third-party claim within policy limits, and an excess judgment is later rendered. While meant to protect insureds from unreasonable risk exposure, abuse of this doctrine directly contributes to rising insurance costs - for both insurers and policyholders. Here's why:

1. Artificial Pressure to Settle Inflated or Meritless Claims

When plaintiffs' attorneys issue strategic time-limited settlement demands, they often do so not to reach a fair resolution, but to set a trap for the insurer. If the insurer misses the window - which is sometimes as short as only a few days - the plaintiff can orchestrate an excess verdict and trigger a bad faith claim under the *Tyger River* Doctrine. Insurers, to avoid the risk of multimillion-dollar bad faith liability, are pressured into settling quickly - even if the claim has weak or disputed liability. These forced settlements increase claims payouts, which drive up the insurer's loss ratios, leading them to raise premiums to cover their exposure.

2. Increased Litigation Costs from Satellite Bad Faith Lawsuits

Abuse of the Doctrine generates "bad faith" litigation separate from the original liability claim. These lawsuits often involve protracted discovery, complex expert testimony on insurer conduct, and long trials with high potential payouts. Even when insurers win, the cost of

defending these suits is substantial. The result is that insurers build these costs into future premiums, passing them on to policyholders. There is also a wider impact - insurers may even restrict coverage options in certain markets or lines of business, especially those seen as "bad faith hotspots."

3. Incentives for Exaggerated Claims and Padded Settlements

Knowing that the *Tyger River* Doctrine creates pressure to settle early and avoid risk, plaintiffs and insureds may inflate the value of claims or delay resolution to increase pressure on the insurer. Insurers settle high to avoid worse outcomes, even in borderline cases. This normalization of inflated settlements raises the average cost of claims industry-wide. These inflated settlements become part of actuarial data, which insurers rely on to set future premium rates - meaning policyholders pay more even if they never make a claim.

4. Undermining of Predictability and Risk Pooling Principles

Insurance works by pooling risk and using historical data to price premiums. The *Tyger River* Doctrine introduces uncertainty and volatility into this model by making insurers liable for excess judgments based on hindsight. When every third-party claim could turn into a multi-million-dollar bad faith suit, insurers lose the ability to predict their exposure accurately. So, to protect themselves, insurers charge more across the board and reduce policy availability for certain classes of insureds or industries seen as risky.

5. Examples of Abuse of the *Tyger River* Doctrine in South Carolina

Consider this "real world" South Carolina example. The insured was at fault when he struck the claimant's vehicle, causing bodily injury to the claimant, damage to the claimant's vehicle, as well as damage to a police department sign. The claimant hired an attorney who submitted a time limited settlement demand with several conditions that the insurer was required to meet. The police department also pursued a property damage claim against the insured for the damage to the sign. The conditional time limited settlement demand from the claimant's attorney demanded all of the $25,000 bodily injury liability limit as well as all of the $25,000 property damage liability limit, to the exclusion of the police department's claim. To meet the claimant's settlement demand, the insurer would have been required to ignore the police department's claim, thereby leaving the insured personally exposed to it. However, in an effort to fully protect its insured against all the claims, thus putting the interest of its insured ahead of its own, the insurer tendered the $25,000 bodily injury liability limit to the claimant and globally tendered the $25,000 property damage liability limit to both the claimant and the police department. In response, the claimant's attorney rejected the tender, claiming the insurer had acted in bad faith by failing to tender the full property damage liability limit only to the claimant. In the ensuing bad faith action, the insurer ultimately settled the claimant's claim for $750,000,

which included $700,000 of extra-contractual money (which serves to erode profitability and ultimately increase the rates we must charge all South Carolina customers).

In another example, the insurer received a time limited settlement demand on behalf of a claimant seeking the insured's $25,000 bodily injury liability limit as well as the $25,000 property damage liability limit. A condition of the demand was that payment of the aforesaid limits had to be received by the claimant's attorney by October 27th. Interestingly, the evidence, including the police report, indicated the claimant was at fault for the loss because he was speeding and ran a red light. Nonetheless, because the claimant's injuries were catastrophic (including a leg amputation) and the insured's liability limits were minimal, in an effort to protect its insured from personal exposure the insurer tendered both the bodily injury and property damage liability limits in accordance with the demand and mailed payment to the claimant's attorney by regular mail on October 21st. On October 28th, the insurer received correspondence from the claimant's attorney alleging the insurer had acted in bad faith because the settlement payment had not been received until October 28th - one day after the deadline set forth in the time limited demand letter.

Yet another egregious example of time limited demands clearly designed to avoid settlement - to set up the insurer for failure - is illustrative here. J. R. can provide more detail if needed but, in essence, the plaintiff's lawyer included in the time limited demand that the settlement check had to be delivered on Martin Luther King Day, a federal holiday, even though the lawyer's office was closed that day. Since UPS could not deliver the check to the closed office on MLK Day, it delivered the check the following morning. The plaintiff's lawyer deemed the failure to deliver the check on MLK Day a rejection of the settlement demand and pursued a *Tyger River* bad faith claim against the insurer seeking recovery well beyond the insured's auto liability limits.

6. Conclusion

Abuse of the *Tyger River* Doctrine inflates claims payouts, increases legal defense costs, encourages settlement manipulation, and destabilizes insurers' ability to predict risk. All of these effects are ultimately passed on to policyholders through higher premiums, reduced coverage options, and more restrictive policy terms. Eliminating or reforming the Doctrine would restore balance, discourage opportunism, and help keep insurance costs sustainable for everyone.

B. Allow Insurers to Exclude Punitive Damages from Insurance Coverage

South Carolina should allow insurers to exclude punitive damages from liability coverage because doing so upholds the core purposes of punitive damages, discourages morally blameworthy conduct, promotes personal accountability, and helps stabilize insurance markets. Punitive damages are designed to punish or deter, not to compensate. Punitive damages exist to

punish the defendant for egregious, willful, or reckless misconduct and to deter similar behavior in the future - not to compensate the injured party for actual losses. Allowing insurance to cover these damages, as South Carolina does now, undermines their punitive function. If a wrongdoer knows their insurer will pay the punitive damages, the deterrent effect is lost. The insured is shielded from the financial consequences of their most culpable actions, which dilutes personal responsibility.

Exclusion of coverage for punitive damages aligns with the principle that one should not be permitted to insure against the consequences of intentional or grossly negligent misconduct. Allowing coverage for punitive damages essentially forces the public (through pooled premiums) to subsidize wrongful conduct. This is inconsistent with public policy, which generally prohibits insurance for criminal fines or intentional torts.

South Carolina has a vested interest in discouraging misconduct - not making it easier for bad actors to externalize its costs. If punitive damages are insurable, bad behavior becomes a calculable and transferable business risk, rather than a personal or corporate moral hazard. Permitting insurers to exclude punitive damages will send a clear signal that recklessness and willful harm will carry real, personal financial consequences.

Allowing the exclusion of punitive damages promotes insurance market stability and fair pricing. Said another way, including punitive damages in coverage exposes insurers to uncertain, extraordinary losses not based on actual damages but on a jury's subjective assessment of how "punishment" should be imposed, and the "bad actor" is not even the one being punished. These awards are often unpredictable and disproportionately large, complicating risk modeling and premium setting. Aside from unpredictable and disproportionately large punitive damages awards by juries which, admittedly, is a less frequent occurrence, the real cost driver from the inability to exclude punitive damages is that the very frequent mere threat of such an award leads to inflated claim settlements. As with legal system abuse, insurers may respond by raising premiums across the board, limiting coverage availability, or exiting higher-risk markets altogether. Allowing the exclusion of punitive damages enables insurers to offer more stable, affordable, and predictable coverage for legitimate liability risks.

South Carolina is an outlier here. Most U.S. jurisdictions either allow insurers to exclude punitive damages explicitly or hold that such damages are uninsurable as a matter of public policy. By aligning with the majority view, South Carolina would promote consistency with national insurance practices and avoid shifting the cost of punitive damages to insurers which results in upward rate pressure for all South Carolinians.

C. Eliminate Phantom Damages in Injury Lawsuits

Phantom damages do not reflect actual losses. They distort the concept of fair compensation, lead to inflated verdicts, burden defendants with costs that were never actually incurred, and undermine the integrity and efficiency of the civil justice system.

Phantom damages refer to the difference between the amount a medical provider initially billed and the amount actually accepted as full payment - usually a steeply discounted figure negotiated by insurance companies or written off entirely. For example, a hospital may bill $50,000 for treatment but accept $15,000 from an insurer or Medicare as full satisfaction. The extra $35,000…..the "phantom" portion…..was never paid and never will be.

Allowing plaintiffs to recover this nonexistent "loss" creates a windfall, not compensation. Tort law is meant to make plaintiffs whole, not to provide them with unearned profits.

Phantom damages inflate jury awards and encourage litigation abuse. Jurors presented with the full, unadjusted medical bills often assume these reflect the true cost of treatment even though insurers or government programs paid only a fraction. This can lead to inflated damages awards that do not correspond to actual economic loss, higher settlement demands, making resolution more difficult, longer and more expensive litigation, especially when defendants challenge the reasonableness of billed amounts. Eliminating phantom damages would promote more accurate and efficient resolution of injury claims.

Defendants should not be penalized for the plaintiff's use of insurance or negotiated discounts, yet South Carolina's current approach can unfairly penalize defendants by requiring them to pay for amounts no one ever actually paid or owed. This violates basic fairness in that the plaintiff benefits from negotiated discounts, then recovers the full amount as if they had no such benefit. However, the defendant pays the inflated amount, despite the actual cost being far less. This results in a windfall for the plaintiff and a punitive overcharge for the defendant, which goes against the principle of equitable compensation. Most notably, for purposes of this Ad Hoc Committee's consideration, these inflated loss costs are then passed on to other premium paying South Carolinians in the form of higher rates.

Most states have rejected or limited phantom damages, and a growing number of jurisdictions have adopted the "actual amount paid" rule, allowing recovery only for what was actually paid or incurred - not the higher, artificially inflated "sticker price" on a medical bill. These states include California (following the *Howell* decision), Texas, Florida (in many circumstances), North Carolina, Colorado, Georgia (S.B. 68, 2025) and Louisiana (S.B. 231, 2025). South Carolina risks becoming an outlier if it continues to allow recovery of phantom damages, potentially encouraging forum shopping and unfair litigation practices.

Eliminating phantom damages promotes transparency and honesty in the courtroom. Currently, jurors are often misled when South Carolina's trial courts permit introduction of inflated medical bills without context about insurance or negotiated rates. This obscures the truth about the real value of the medical care provided. If phantom damages are eliminated, courts can instead present clear, accurate evidence of the actual cost of treatment. This enhances trust in the legal process, ensures verdicts are grounded in reality, and reduces unnecessary complexity in trial.

In conclusion, eliminating phantom damages would restore fairness, accuracy, and integrity to South Carolina's civil justice system. Plaintiffs should be fully compensated for what they actually lose - not amounts that exist only on paper. By abolishing phantom damages, South Carolina would align itself with the growing national trend favoring reasonable, evidence-based compensation, discourage litigation abuse, and ensure that defendants are not forced to pay damages that no one actually incurred.

D. Foster a Free Market for Rate Level

Lest you think my only goal is to target legal system abuse as the only driver of higher insurance premiums, please allow me to turn your attention to a completely unrelated opportunity to motivate insurers to decrease rates - fostering a free market for rate level by removing current limitations on rate increases.

First, some background - by law (Code §38-73-905), South Carolina is a "prior approval" state where carriers cannot adjust rates without first receiving approval from the Department of Insurance (DOI). By contrast, many other states are "use and file" where carriers can implement rate changes without first receiving regulatory approval, but regulatory bodies can review filings as needed after changes are effective. In addition, South Carolina law limits rate increases to twice per year in auto insurance, one of the only states to put explicit limits on how often rates can be adjusted. Finally, South Carolina has a 7% "flex band" which purportedly allows carriers to raise rates up to 7% without DOI approval. In practice, however, this "flex band" exists in name only, because unlike other "flex band" states, South Carolina law requires carriers to file their "flex" increases at least 30 days in advance, during which time the South Carolina DOI can - and does - deny them or request they be withdrawn or amended.

The limitations discussed above may sound like solid public policy - limiting insurance carriers from price gouging consumers. In practice, however, they have the unintended effect of keeping rates *higher* than they would be otherwise. Insurers are well aware of how difficult it is to raise rates in South Carolina. As a result, they are much less likely to *lower* rates in South Carolina than they are in other states. If an insurer knows they can raise rates when they need to, they're also willing to lower them when the opportunity arises (and, indeed, insurers want to lower rates to win business in the highly competitive insurance marketplace). But in a "rate-

constrained" state like South Carolina, where statutory and regulatory limits make it very difficult to raise rates, insurers are much less willing to reduce them.

This trend is obvious when rate filings are compared across states. From 2020-2024, "use and file" states averaged nearly 70 rate decreases. "Prior approval" states averaged only 24. South Carolina averaged 23. It's also evident in the average amount of rate increases. For the same period, the average rate increase per revision in "use and file" states was 4.5%. In "prior approval" states, it was 6.7%. In South Carolina, it was 7.1%.

When it comes to rate level, "use and file" states have effectively created a free market for insurers that allows them to quickly react to marketplace dynamics of growth and profit. Just as in any free market, the consumer ultimately benefits as competition thrives and pushes prices lower. By contrast, South Carolina's highly regulated market - while intended to protect consumers - hampers insurers' ability to adjust pricing up or down, and ultimately the consumer pays more as a result. Therefore, we urge the Legislature to consider a more free-market approach to rate level in South Carolina.

V. CONCLUSION

Without question, the legal system abuses so rampant in recent years in Florida, and even more recently in Georgia and Louisiana, are now here in South Carolina. I liken it to the migration of Africanized honey bees, "killer bees", observed in Florida as far back as 2005, then later in Georgia around 2010, moving northward at rates up to roughly 100-200 miles per year. Suspected, but never confirmed, populations were found later in South Carolina and quickly eliminated because officials acted proactively with rigorous apiary inspection programs and the state's *Africanized Honey Bee Management Plan* which included surveillance, education, quarantine, public health and beekeeper training.

You have a uniquely similar opportunity to act early and aggressively here. The abuses that became entrenched in other states are not yet dug in here. South Carolina is not yet in the deep crisis the states discussed above experienced, some for many years. However, the time to act is now, learning from the lessons of other states, so that South Carolina can avoid the same torturous path.

Adopting legal system abuse reforms in South Carolina is likely to yield significant benefits for both the availability and affordability of insurance. By curbing excessive litigation, limiting frivolous claims, and reducing inflated settlements driven by procedural exploitation, these reforms can help lower the overall claims costs insurers face. Lower risk and more predictable loss environments encourage insurers to remain in - or even reenter - the South Carolina market, increasing competition. This, in turn, creates downward pressure on premiums while expanding consumer choice, particularly in high-risk sectors that have seen reduced carrier participation.

A fairer, more efficient legal and regulatory climate fosters long-term market stability, making South Carolina a more attractive environment for insurers to invest and grow. Businesses, homeowners, and drivers alike stand to benefit from broader coverage options and more stable rates, while the judicial system is freed to focus on legitimate disputes. In this way, legal system abuse and regulatory reforms do not simply protect insurers - they strengthen the state's economic resilience and ensure that access to affordable, reliable insurance remains within reach for all South Carolinians.