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COLORADO DIVISION OF INSURANCE ISSUES
REGULATION REGARDING APPRAISALS

To address industry concerns, the Colorado Division of Insurance has recently revised Bulletin No. B-5.26, Requirements Related to Disputed Claims Subject to Appraisal. The original Bulletin was addressed only to insurers and attempted to ensure that appraisers and umpires conduct the appraisals in a “fair, competent and impartial manner” by forbidding ex parte communications with appraisers and umpires.

The industry raised concerns with the language of the Bulletin, specifically, whether the Bulletin was too broad, as drafted, and might impact normal claims communications. The Division responded by clarifying that the prohibition on ex parte communications applies only after an appraisal is triggered.

Notably, the Division also modified the Bulletin to make it applicable not only to insurers but to policyholders, their representatives and public adjusters.

This comes on the heels of the Colorado Legislature’s adoption of C.R.S. § 10-2-417 which attempts to eliminate significant conflicts of interest by public adjusters. Alarming, prior to the statute it was common practice in Colorado for a public adjuster to represent a policyholder on a claim, and then subsequently perform the repairs which were the subject of the claim. Pursuant to statute, public adjusters are now prohibited from having any financial interest in a claim, beyond their payment as a public adjuster.

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ILLINOIS

CEDING CONTROL OF SETTLEMENT ALONG WITH THE RIGHT TO DEFEND – DEALING WITH POTENTIALLY COLLUSIVE SETTLEMENTS BY INSURED

In most states, when an insurer’s reservation of rights creates a conflict of interest between the insured and the insurer, the insurer is required to cede to the insured the right to control the defense of the case. E.g., Maryland Cas. Co. v. Peppers, 64 Ill. 2d 187, 198-99, 355 N.E.2d 24, 30-31 (1976); Dynamic Concepts v. Truck Ins. Exch., 61 Cal. App. 4th 999, 1006-07, 71 Cal. Rptr. 2d 882 (1998); Public Serv. Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392, 442 N.Y.S.2d 422, 425 N.E.2d 810, 815 (1981); Cal. Civ. Code, § 2860. Specifically, the insurer in this situation is required to advise the insured of the right to choose its own counsel to defend the case, rather than counsel chosen by the insurer. Id. If the insurer elects to control the defense despite the conflict and does not inform the insured of its right to independent counsel, the insurer may be estopped from asserting a defense of noncoverage. Maryland Cas. Co., 64 Ill.2d at 195.

Most insurance companies recognize this, and, when their reservation of rights creates a conflict, agree to provide independent counsel to the insured. Once an insurer relinquishes control of the defense to the insured, the challenge becomes how to resolve the case while still preserving the insurer’s coverage defenses. In many cases, despite the reservation of rights, the insurer works together with the insured to settle the case for a reasonable amount, while attempting to resolve coverage issues at the time of the settlement. In others, the insured and insurer enter into a “fund and fight” agreement, whereby the insurer and insured contribute to the settlement agreement but agree that the insurer can preserve its objections to coverage, which will be resolved in later litigation. Such an arrangement benefits both parties by capping the damages of whoever is ultimately responsible for the loss, while allowing both sides to preserve their coverage arguments.
In other situations, however, the insured may find it advantageous to settle directly with the plaintiff, without contribution from the insurer, and then assign the insured’s rights under the insurance policy to the plaintiff. Often this can be accomplished with no payment by the insured. Instead, the insured stipulates to a judgment and assigns the plaintiff the right to collect under the policy. The insurer is then faced with two challenges: challenging the judgment obtained by the plaintiff and challenging coverage for the judgment in case the judgment is upheld.

That was the situation facing the insurer in *Central Mutual Ins. Co. v. Tracy’s Treasures, Inc.*, 2014 IL App (1st) 123339, 2014 Ill.App. LEXIS 779 (Ill. App. Sept. 30, 2014). In *Central Mutual*, the insurer had denied coverage for a Telephone Consumer Protection Act (“TCPA”) class action suit, based on an earlier agreement with the insured to a “buyout” of the coverage for personal and advertising injury, the fact that there was no “occurrence” giving rise to the property damage alleged, because the damages caused by the faxes were expected or intended, and because the insured knew that its conduct in sending the faxes was prohibited. Despite disclaiming coverage, the insurer agreed to provide a “courtesy defense” to the insured and assigned a lawyer, while also filing an action seeking a declaration of no coverage.

About a month after the insurer assigned defense counsel, another attorney filed a substitute appearance for the insured, and wrote to the insurer advising that he had been retained by the insured due to the conflict of interest between the insurer and the insured in view of the coverage denial. The letter from the new attorney also advised the insurer regarding his defense strategy, and stated that he was transitioning into the suit. The insurer agreed to the substitution of counsel and advised the attorney that it would pay him a reasonable fee to defend the case, subject to its reservation of rights. Notably, a month before advising the insurer of his retention, the new defense attorney had begun discussing settlement with the plaintiff’s attorney, and told the plaintiff’s attorney that he had prepared a draft settlement agreement. The new defense attorney did not disclose this to the insurer.

Six weeks after he first wrote to the insurer, the new attorney filed a motion for approval of a settlement agreement, under which the insured would agree to the entry of a $14 million judgment which would be enforceable only against the insurer’s policies. The insurer was not given notice of this motion, but the court nonetheless approved it.

Although the complaint alleged a putative class of recipients who had received faxes four years prior to the complaint, the proposed settlement agreement defined the class as those who received faxes for earlier years, even though such faxes would have fallen outside the four-year statute of limitations. Without expansion of the class, however, a $5 million excess policy issued by the insurer would not have been triggered. Also, while the evidence indicated that nearly 140,000 faxes were sent during the expanded time period, the insured was only able to produce a list of 10,000 fax numbers. Only those class members whose numbers were known were to receive fax notice of the settlement, while the remaining class members were to receive notice by publication. Ultimately, only 4% of the total class received successful notice of the settlement.

In its declaratory action, the insurer challenged the settlement on the grounds that it was collusive and not reasonable. The insured and underlying plaintiff argued that the insurer could not challenge the settlement because (1) the insurer had no right to consent to the settlement once it ceded control of the defense to the insured; (2) any effort to obtain the insurer’s consent would have been futile; and (3) the court in the underlying case had already approved the settlement, finding it reasonable, so the insurer could not relitigate that issue.
CEDING CONTROL OF SETTLEMENT, CONT’D

The court agreed with the insured that in cases where the insurer’s reservation of rights creates a conflict of interest requiring the insurer to cede control of the defense to the insured and provide independent counsel, the insurer “also surrendered its right to control the settlement of the action and to rely on policy provisions requiring consent to settle.” 2014 IL App (1st) 123339, ¶45. Similarly, the insured’s decision to settle without the insurer’s consent did not contravene the voluntary payments provision of the policy. Id.

However, the fact that the insured is allowed to settle without the insurer’s consent does not automatically make the settlement binding on the insurer. Id., ¶46. The court explained that an insurer which has breached its duty to defend forfeits the right to contest coverage of the settlement, but may still contest the whether it was reasonable to settle and the reasonableness of the amount of the settlement. Id., ¶49. An insurer which has not breached the duty to defend, either because it filed a timely declaratory action or because it defended subject to a reservation of rights, has the right to contest both the reasonableness of the settlement and whether the claims asserted in the action fall within the policy coverage. Id.

Having determined that the insurer had the right to challenge the settlement, the court held that the insured and the underlying plaintiff had the burden of proving that the settlement was reasonable. The court adopted a two part test to ascertain the reasonableness of the settlement: (1) considering the totality of the circumstances, would a reasonable uninsured have settled the action; and (2) is the amount of the settlement what a reasonably prudent person in the insured’s position would have settled for considering the merits of the plaintiff’s claim. Id., ¶55. The second part of the test involves a “commonsense consideration of the totality of the facts bearing on the liability and damage aspects of the plaintiff’s claim as well as the risks of going to trial.” Id. (internal quotations omitted.) Importantly, the plaintiff and insured bear the burden of proof for both aspects of the test, “both out of fairness, since the plaintiff was the one who agreed to the settlement, and out of practicality, since, as between the plaintiff and the insurer, the plaintiff will have better access to the facts bearing upon the reasonableness of the settlement.” Id. The insurer is also entitled to rebut any preliminary showing of reasonableness. Id.

The court rejected the argument that the insurer was bound by the approval of the class action settlement in the underlying action. First, the order approving the settlement was entered by agreement, and the court did not make any substantive findings, and particularly did not determine whether the insured was acting as a prudent uninsured in agreeing to settle or as a reasonable person in negotiating to pay a $14 million settlement. Also, the insurer could not be bound until there was hearing with notice to the insurer where the insurer had the ability to contest the reasonableness of the settlement. Id., ¶56, 57.

With respect to the “prudent uninsured” test for whether to settle, the insurer argued that the hypothetical must include the fact that the insured’s attorneys’ fees were being paid, so that the insured had the incentive to litigate all viable issues. The court rejected this, holding that if the test is whether an uninsured person would settle, then it must also assume that all costs were being borne by the uninsured person, leaving the question whether a hypothetical defendant would reasonably choose to devote a portion of its assets to litigate certain issues to eliminate or circumscribe its liability. Id., ¶62.

The court also rejected the insured’s argument that the hypothetical prudent uninsured should be considered to be a defendant with limited assets (like the real defendant), who must decide whether to spend what little money it had to litigate instead of settling. The court concluded that for the test to have any meaning, it must be assumed that the defendant has assets sufficient to satisfy a large judgment and that it must weigh whether those assets are best used litigating various issues or whether an early settlement, presumably at a discount, is more advantageous. Id., ¶63.
CEDING CONTROL OF SETTLEMENT, CONT’D

The court pointed to several factors that should be considered in assessing the second part of the test, whether the amount is reasonable, including: the chances of success on motion practice regarding the insured’s available defenses; whether the settlement was the result of arm’s length negotiations; what facts were available to the insured’s counsel to enable him to reliably value the claims; and defense counsel’s evaluation of the various available motions. While the court found several troubling facts pointing toward a collusive settlement, it found that there was a fact issue which precluded summary judgment, and remanded the case for trial.

The court acknowledged that if the settlement was in bad faith or collusive, it may be deemed unreasonable. Id. ¶78. A settlement becomes “collusive when the purpose is to injure the interests of an absent or nonparticipating party, such as an insurer or nonsettling defendant.” Id. The indicators of collusion include unreasonableness, concealment, secretiveness, lack of serious negotiations on damages, attempts to affect insurance coverage, profit to the insured, and attempts to harm the interests of the insurer. Id. Collusion occurs when “the insured and the third party claimant work together to inflate the third party’s recovery to artificially increase damages flowing from the insurer’s breach.” Id. ¶80. Factors to consider include:

- The amount of the settlement compared with the value of the case.
- A comparison of awards or verdicts in similar cases.
- The facts known to the insured at the time of settlement.
- The presence of a covenant not to execute as part of the settlement.
- The failure of the settling insured to consider viable defenses.

While the Central Mutual decision helps insurers by giving them the opportunity to contest collusive settlements, such settlements often occur when the insurer has poor communication with the insured before the settlement. This may be an unavoidable byproduct of the fact that the insured has disclaimed coverage. However, even if the insurer has denied coverage, it is still “entitled to have an attorney of its choosing participate in all phases of [the] litigation subject to the control of the case by [the insured’s] attorney.” Id. ¶60, citing Maryland Casualty Co. v. Peppers, 64 Ill.2d 187, 199 (1976). In Central Mutual, this may have at least avoided a hearing on the settlement without notice to the insurer.

There is little question that once an insurer must relinquish control of the defense and settlement to the insured due to a conflict of interest, the insurer is vulnerable to a settlement which may be substantially more than it would have had to pay if it controlled the defense. However, the decision in Central Mutual provides a guide for contesting collusive settlements when they occur.

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MISSOURI

NEW DECISION IMPOSES BAD FAITH LIABILITY IN MISSOURI DESPITE THE ABSENCE OF COVERAGE

Missouri law governing an insurer’s extra-contractual liability continues to evolve - for the worse. In 2013, the Missouri Supreme Court handed down its decision in *Columbia Cas. Co. v. HIAR Holding, L.L.C.*, 411 S.W.3d 258 (Mo. banc 2013). In *HIAR Holding*, the Supreme Court held an insurer can be liable for all damages flowing from the breach of its contract duty to defend, including liability for indemnity for damages in excess of its policy limits, without a showing of bad faith.

The Missouri Court of Appeals’ decision earlier this week in *Advantage Buildings & Exteriors, Inc. v. Mid-Continent Cas. Co.*, No. WD76880 (Mo. App. W.D., Sept. 2, 2014), now adds to the insurance industry’s extra-contractual woes in Missouri by subjecting an insurer to liability for an excess judgment despite the fact that the insurer had obtained a no-coverage declaration for the underlying claim in a separate declaratory judgment action.

The Western District of the Missouri Court of Appeals, in its decision this week in *Advantage Buildings & Exteriors, Inc. v. Mid-Continent Cas. Co.*, No. WD76880 (Mo. App. W.D., Sept. 2, 2014), now adds to the insurance industry’s extra-contractual woes in Missouri by subjecting an insurer to liability for an excess judgment despite the fact that the insurer had obtained a no-coverage declaration for the underlying claim in a separate declaratory judgment action.

The Western District’s decision arises from a construction defect claim and focuses on the insurer’s reservation of rights. Shortly after receiving notice of the claim, the insurer sent two lengthy reservation of rights letters to its insured, appointing defense counsel and advising the insured that the insurer would promptly inform the insured of the outcome of its coverage investigation. Attached as an appendix to the Court’s opinion are the two reservation of rights letters. These letters warrant reading. They are not untypical of the reservation of rights letters issued by many insurers in Missouri.

The Western District, in subjecting the insurer to bad faith, held the insurer had failed to reserve its rights to deny coverage because neither reservation of rights letter timely, fully, or unambiguously explained the insurer’s coverage position or how the cited policy provisions affected the insured’s position. The Western District observed that only after the insurer filed its declaratory judgment action five days before trial did the insurer unambiguously advise the insured that its policy did not cover ‘most’ of the underlying claim. At that time, the insurer also notified the insured that it was withdrawing its defense. Previously, the insurer had failed to respond to any settlement offers made within the policy limits.

According to the Western District, the insurer’s insufficient reservation of rights vitiates its successful declaratory judgment action, holding the trial court did not err in submitting the bad faith claim to the jury despite the declaratory judgment that the insurer’s policy ‘did not expressly provide coverage’ for the claim. Indeed, the Western District held the trial court did not err in barring the insurer from admitting evidence of its successful declaratory judgment action during the trial of the bad faith claim in defense of the claim. The Western District explained, under the case’s circumstances, that the insurer was estopped from denying coverage to the extent of its policy limits because the insurer had failed to effect a proper reservation of rights.

Taken to its logical conclusion, the Western District’s decision suggests that an insurer may not consider covered versus non-covered damages in evaluating a settlement demand for the policy limits.

The Western District also criticized the insurer for failing to “split the file” by having separate adjusters handle the coverage issues and the liability claim until two years into the claim, even though the insurer recognized early in the case that separate adjusters should be appointed to the file.

The Western District’s decision is not final. It will be several months before the post-opinion review process runs its course and the Missouri Supreme Court decides whether to hear the case.
NEW DECISION IMPOSES BAD FAITH LIABILITY, CONT’D

But for the present, the Advantage Buildings decision must be on the forefront of the minds of every insurer doing business in Missouri. The lessons to be drawn from the decision are important and far reaching; the consequences of ignoring them are dire. Insurers must now take even greater care in investigating coverage and issuing timely reservation of rights letters to their insureds. The Western District’s decision raises the bar for the detail that must be incorporated by an insurer into a reservation of rights letter and demonstrates that an insurer should make the decision to file a declaratory judgment action sooner than later. Further, the Advantage Buildings decision makes plain that the avoidance of bad faith requires an insurer to promptly divide its claim file between coverage and liability and appoint separate adjusters for each aspect of the claim.

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UPCOMING DATES & NEWS:

The Insurance Practice Group’s Insurance Law Compendia is currently being updated for 2015. In the meantime, please refer to the 2013 Insurance Law Compendia for all 50 states, Washington, D.C., and Canada on issues relating to Property & Casualty claims.

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