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November 4, 2016

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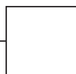

Seminar Agenda

Friday, November 4, 2016

9:15 am – 9:20 am **Welcome and Announcements**
Frederick O. Ferrand

9:20 am – 9:45 am **Two Mysteries in Alabama: What's a Grit? and What Constitutes Bad Faith?**
F. Lane Finch, Jr.

9:45 am – 10:10 am **Bill and Ted's Excellent Reservation of Rights Letter — Tips to Make Your ROR Letters Bodacious!**
Thomas B. Ward

10:10 am – 10:40 am **Rotten Potatoes: Mashed or Twice Baked — Potatometer Rating the Recent Releases by Our Courts**
Thomas D. Martin

10:40 am – 10:55 am **Break**

10:55 am – 11:20 am **Walk the Line: How to Navigate the Tripartite Relationship**
Melissa A. Segel

11:20 am – 12:10 pm **The Verdict: Recent Trends, Trials and Tribulations**
Michael H. Schroder, Mark T. Dietrichs, Stephen M. Schatz, F. Lane Finch, Jr.

12:10 pm – 1:20 pm **Complimentary Lunch**

	Property Breakout Room	General Litigation Breakout Room
1:20 pm – 1:40 pm	**Those Dirty Rotten Scoundrels — Dealing with Vendors Who Commit Fraud** *Frederick O. Ferrand*	**Austin Powers — The Truck That Shagged Me** *Mike O. Crawford, IV*
1:40 pm – 2:00 pm	**Home Alone No More — Changes to Georgia's Valued Policy Act** *Alexander A. Mikhalevsky*	**"Those Aren't Pillows!" — Planes, Trains and Uninsured Automobiles** *Steven J. DeFrank*
2:00 pm – 2:20 pm	**A World of Pure Imagination: Navigating the Tricks and Treats of Magistrate Court Trials** *Jessica M. Phillips*	**Welcome to the Party Pal: Making the Other Guy Die Harder Through Additional Insured Clauses and Indemnification Clauses in Construction Contracts** *Brian C. Richardson*
2:20 pm – 2:40 pm	**Honoring Aunt Edna: How to Conduct Yourself, and Your Claim, When the Named Insured Has Passed** *Audrey S. Eshman*	**The Wolves of Litigation Street: Funding Companies' Investment Stake in Litigation** *Rebecca E. Strickland*
2:40 pm – 3:00 pm	**Mission Impossible: Diminution Protocol** *Amer H. Ahmad*	**Don't Get Slimed: Time-Limited Demands in Georgia** *Shannon L. Schlottmann*

Two Mysteries in Alabama: What's a Grit? and What Constitutes Bad Faith?

By F. Lane Finch, Jr.

F. Lane Finch, Jr.

Partner

Lane Finch has advised on insurance coverage, defended bad faith claims and litigated first-party and third-party insurance claims in Alabama and California for almost 28 years. He has handled insurance coverage claims involving up to $500 million, as well as class action and other liability claims exceeding $100 million.

Mr. Finch authored "Automobile Liability Insurance," New Appleman on Insurance Law Library Edition, Chapter 63, as well as numerous articles on insurance coverage and bad faith. He is a Regional Editor for DRI's Bad Faith and Professional Liability Compendia.

He is Co-Chair of DRI's 2015 Insurance Coverage and Claims Symposium; he previously chaired DRI's Insurance Coverage and Practice Symposium and its Insurance Coverage and Claims Institute. Mr. Finch is a long-standing member of the steering committee for DRI's Insurance Law Committee, among other leadership positions. Mr. Finch is also a frequent speaker at national American Bar Association (ABA) and DRI conferences.

Mr. Finch was adjunct professor at the University of Alabama at Birmingham (School of Business). In 2006, Mr. Finch was a visiting professor at Anshan Normal University in Anshan, People's Republic of China, where he taught American Business Law and Intellectual Property Rights.

Two Mysteries in Alabama: What's a Grit? and What Constitutes Bad Faith?

Alabama has a long and tarnished history of treating out-of-towners (such as insurers) badly; even accusing them unfairly of crimes they did not commit. Luckily, things have changed for the better. This paper will answer:

- How can an insurer stay out of the proverbial County Jail?
- More importantly, what constitutes bad faith in Alabama?
- Who can sue for bad faith?
- When can they sue?
- What can they sue for?
- How can you avoid bad faith?
- What is a grit anyway?

CAUSES OF ACTION

Is There a Common Law Action for Bad Faith?

Yes. The Alabama Supreme Court first recognized the common law cause of action for bad faith in *Chavers v. National Security Fire & Casualty Co.*[1]

Is There a Statutory Basis for an Insured to Bring a Bad Faith Claim?

Not really, but two federal decisions describe Ala. Code § 27-12-24 (1975) as "codification" of Alabama's bad faith law.[2]

That statute provides:

> No insurer shall, without just cause, refuse to pay or settle claims arising under coverages provided by its policies in this state and with such frequency as to indicate a general business practice in this state, which general business practices evidenced by:
> (1) A substantial increase in the number of the complaints against the insurer received by the Insurance Department;
> (2) A substantial increase in the number of lawsuits against the insurer or insureds by claimants; and
> (3) Other relevant evidence.

Additionally, there are Alabama Department of Insurance regulations regarding the handling of insurance claims. However, those are not to be used for civil or criminal purposes to presume any standard of care and are not the basis for a cause of action.[3]

What Cause of Action Exists for an Excess Carrier to Bring a Claim Against a Primary Carrier?

None. An excess carrier cannot bring a bad faith claim against the primary insurer either directly or based on principles of equitable subrogation.[4]

Here, Alabama is in the distinct minority. In 48 other states, an excess carrier can recover against a primary insurer for the latter's bad faith. It now appears that only two states, Alabama and Idaho, have expressly rejected the duty giving rise to such a claim. The question at this point is what specific theories are recognized by each jurisdiction to allow an excess carrier

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1 405 So. 2d 1 (Ala. 1981); *see also State Farm Fire & Cas. Co. v. Brechbill*, 144 So. 3d 248, 258 (Ala. 2013), for a more recent treatment of the tort of bad faith in Alabama.

2 *Hilley v. Allstate Ins. Co.*, 562 So. 2d 184 (Ala. 1990); *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292 (11th Cir. 2001).

3 *See* Ala. Ins. Reg. Ch. 482-1-125-02.

4 *Fed. Ins. Co. & Pearce Constr. Co., Inc. v. Travelers Cas. & Sur. Co.*, 843 So. 2d 140, 143 (Ala. 2002) (holding that "in the absence of contrary contractual obligations, a primary insurer owes no duty of good faith to an excess insurer with respect to the settlement of a lawsuit against an insured . . . . The reasons which undergird Alabama's tort of bad faith, currently available to insureds against their insurers . . . are simply not present in the primary-insurer-excess-insurer scenario where, as here, contractual duties with regard to settlement of a claim are absent").

to maintain a bad faith claim against a primary. The majority of jurisdictions hold an excess carrier's rights are completely derivative of the insured's rights against the primary. These jurisdictions therefore recognize subrogation and assignment theories to the exclusion of a direct duty theory. For example, Missouri recognizes equitable subrogation, conventional subrogation and assignment.[5] In addition, some jurisdictions allow the excess carrier to assert multiple theories. A tiny minority of states hold the primary insurer owes a direct duty to the excess carrier and allow the excess to bring a direct claim.

What Causes of Action for Extra-Contractual Liability Have Been Recognized Outside the Claim Handling Context?

An insured may sue an insurer for fraud if the insurer has no intent to pay a claim at the time the policy was sold.[6]

An insured may sue an insurer for misrepresentation or suppression if an insurer's agent persuades an insured to switch to a policy that costs more and offers less benefits.[7]

An insured may be able to maintain a claim for wrongful cancellation of a policy if the cancellation involved misfeasance rather than simple nonfeasance.[8]

Alabama has recognized a claim for negligence against an insurer arising out of the processing, issuing and later attempted cancellation of an insurance policy.[9] Alabama has also recognized fraud in the inducement where a person is induced to purchase a policy that is materially different from that represented.[10]

An insurer in Alabama can be liable for negligent underwriting.[11]

While Alabama does not recognize a cause of action for negligent claims adjustment, one may allege negligent failure-to-settle a third-party claim.[12]

Can a Third Party Bring a Statutory Action for Bad Faith?

No. Alabama does not allow a third party (i.e., anyone not the insured) to sue for the tort of bad faith based on the handling of an insurance claim asserted by that third party.[13] Once an injured party has recovered a judgment against the insured, the injured party may compel the insurer to pay the judgment.[14] The injured party can bring an action against the insurer only after he has recovered a judgment against the insured and only if the insured was covered against the loss or damage at the time the injured party's right of action arose against the insured tortfeasor.[15]

DAMAGES

Are Consequential Damages Recoverable?

Yes. Alabama courts have recognized consequential damages arising out of bad faith claims. Specifically, an Alabama court has stated that "[r]ecoverable damages may include mental distress and economic loss."[16]

There is no fixed standard to measure the amount of compensatory damages recoverable for physical pain and mental suffering. The amount of such an award is left to the sound discretion of the jury, subject only to correction by the court for clear abuse. The Alabama Supreme Court has consistently held that a trial court cannot interfere with a jury verdict merely because it believes the jury gave too little or too much.[17]

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5 *See Scottsdale Ins. Co. v. Addison Ins. Co.*, 448 S.W. 3d 818 (Mo. 2014).

6 *Old S. Life Ins. Co. v. Woodall*, 295 Ala. 235, 241, 326 So. 2d 726 (Ala. 1976).

7 *Boswell v. Liberty Nat'l Ins. Co.*, 643 So. 2d 580, 584 (Ala. 1994).

8 *See Ex parte Certain Underwriters of Lloyd's of London*, 815 So. 2d 558, 563 (Ala. 2001).

9 *Reliance Ins. Co. v. Substation Prods. Corp.*, 404 So. 2d 598, 608 (Ala. 1981).

10 *See Williamson v. Indianapolis Life Ins. Co.*, 741 So. 2d 1057, 1065 (Ala. 1999); *Mass. Mut. Life Ins. Co. v. Collins*, 575 So. 2d 1005 (Ala. 1990).

11 *Reliance Ins. Co. v. Substation Prods. Corp.*, 404 So. 2d 598, 609 (Ala. 1981).

12 *Kevin v. Southern Guar. Ins. Co*., 667 So.2d 704 (Ala. 1995); *Mut. Assurance Co., Inc. v. Schulte*, 970 So. 2d 292 (Ala. 2007).

13 *See Stewart v. State Farm Ins. Co.*, 454 So. 2d 513 (Ala. 1984).

14 Ala. Code § 27-23-2 (1975).

15 *Maness v. Ala. Farm Bur. Mut. Cas. Co*., 416 So. 2d 979, 981-82 (Ala. 1982) (however, that is not a bad faith claim).

16 *Chavers v. Nat'l Sec. Fire & Cas. Co*., 405 So. 2d 1, 7 (Ala. 1981); *Gulf Atl. Life Ins. Co. v. Barnes,* 405 So. 2d 916, 925 (Ala. 1981); *see also* Jenelle M. Marsh and Charles W. Gamble, *Alabama Law of Damages* § 27-6(b) (Harrison Company 1999).

17 *Nat'l Ins. Ass'n v. Sockwell,* 829 So. 2d 111, 135 (Ala. 2002) (citation omitted).

Can a Plaintiff Recover Damages for Emotional Distress?

Yes. As stated above, recoverable damages may include mental distress and economic loss. "The tort of bad faith had as its genesis the very idea of providing a plaintiff who had been victimized by the intentional, wrongful handling of a claim by the insurer, the right to recover not only contract damages but for the loss occasioned by emotional suffering, humiliation, and embarrassment in addition to punitive damages."[18]

In *Sockwell*, an award of $201,000 for compensatory damages, including mental anguish, was supported by the insured's testimony that she suffered both physical pain and mental anguish as a result of her automobile insurer's bad faith in investigating and denying her claim for underinsured motorist (UIM) benefits. There, the insured also testified about her anger and lack of sleep, and even though her physical injuries did not originally arise from the insurer's tortious conduct, she testified that those injuries worsened. The fact that the insured was already suffering from some degree of physical pain at the time of her automobile insurer's bad faith did not insulate the insurer from liability for its wrongful actions that directly worsened her pain and caused her mental anguish; the insurer was required to take the insured in whatever condition it found her.[19]

Are Punitive Damages Available?

Yes; however, there is a higher standard of proof that must be met before punitive damages are recoverable. Punitive damages require a finding "by clear and convincing evidence that the defendant consciously or deliberately engaged in oppression, fraud, wantonness, or malice with regard to the plaintiff."[20]

Are Attorneys' Fees Recoverable?

No. Without a statute authorizing attorneys' fees, a contract providing for attorneys' fees or some special equity, attorneys' fees are not recoverable.[21] The insured has no right to recover attorneys' fees even if he or she proves a breach of the insurance contract or bad faith.

ELEMENTS OF PROOF

What is the Legal Standard Required to Prove Bad Faith in a First Party Case?

There is a single cause of action for the tort of bad faith refusal to pay an insurance claim, but with several elements of proof.[22] The four or five elements are:

1. Breach of insurance contract;
2. Refusal to pay claim;
3. The absence of an arguable reason; and
4. The insurer's knowledge of the absence of an arguable or debatable basis for denial of the claim.
5. There is a conditional fifth element which represents the "abnormal" case: if the insured asserts an intentional failure to determine the existence of a lawful basis to deny the claim, the insured must prove the insurer's failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim was intentional.

More than bad judgment or negligence is required for a bad faith action in Alabama; bad faith, dishonesty, self-interest or ill will are inherent in bad faith conduct.[23] "Bad faith, then, is not simply bad judgment or negligence. It imports a dishonest purpose and means a breach of known duty, i.e., good faith and fair dealing, through some motive of self-interest or ill will."[24] An action alleging bad faith must be supported by evidence showing the insurer had no debatable reason to deny the claim.[25]

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18 *Aetna Life Ins. Co. v. Lavoie*, 470 So. 2d 1060, 1073–74 (Ala. 1984), vacated, 475 U.S. 813, 106 S. ct. 1580 (1986).
19 *Sockwell*, 829 So. 2d at 134.
20 Ala. Code § 6–11–20(a) (1975).
21 *Green v. Standard Fire Ins. Co. of Ala.*, 477 So. 2d 333 (Ala. 1985); *Cincinnati Ins. Co. v. City of Talladega*, 342 So. 2d 331 (Ala. 1977); *Alliance Ins. Co. v. Reynolds*, 504 So. 2d 1215 (Ala. Civ. App. 1987).
22 *Brechbill*, 144 So. 3d at 258.
23 *Id.* at 259.
24 *Id.* at 259-60 (citing *Gulf Atlantic Life Ins. Co. v. Barnes,* 405 So. 2d 916, 924 (Ala. 1981)).
25 *Brechbill,* 144 So. 3d at 259.

To receive an award of compensatory damages, a plaintiff must prove each of the elements of bad faith by substantial evidence.[26] "Substantial evidence" is defined as "evidence of such quality and weight that reasonable and fair-minded persons in the exercise of impartial judgment might reach different conclusions as to the existence of the fact sought to be proven."[27]

In order to prove a bad faith failure to investigate claim, the insured must prove a proper investigation would have revealed the insured's loss was covered under the terms of the contract.[28] A proper investigation can be as simple as the claim representative's personal observation and subsequent phone call to an independent contractor on a property claim.[29] Obviously, circumstances matter. For example, "[t]he [life] insurer is not under any duty to investigate the mental competency of the insured to change the beneficiary unless it knows of circumstances reasonably suggesting the probability of his or her mental incompetency."[30]

An insurer cannot selectively consider only favorable information and discount unfavorable information as a part of its investigation.[31] Moreover, an insurer may not deny a claim in hopes that it can later gather information to support the denial. Whether the insurer committed bad faith must be viewed at the time the denial was made. The court will look at the information available to the insurer at the time the decision is made.[32] There is, however, no duty to investigate until the claim is submitted.[33]

Is There a Separate Legal Standard that Must be Met to Recover Punitive Damages?

Yes. In order for a jury to award punitive damages, the jury must find by "clear and convincing evidence" that the defendant engaged in "fraud," "oppression," "wantonness" or "malice" with regard to the plaintiff. Alabama law commonly refers to bad faith as a species of fraud.[34]

Does a Bad Faith Claim Require Evidence of a Pattern or Practice of Unfair or Deceptive Conduct?

No; however, because Alabama recognizes bad faith as a species of fraud, an allegation of bad faith opens the door for a plaintiff to discover other instances of an insurer's conduct.[35]

On What Issues is Expert Evidence Required to Establish Bad Faith?

None. Although there is no requirement that a plaintiff present expert testimony in order to proceed on a bad faith claim, it is not uncommon for a plaintiff to utilize an expert in order to meet the heavy burden of proof.[36] It is uncommon for the insurer to offer expert testimony. However, whether to offer expert testimony must be decided on a case-by-case basis. In civil cases, Alabama courts evaluate the threshold admissibility of expert testimony under the "general acceptance" test stated in *Frye*.[37] Alabama has not yet adopted the more stringent standards of *Daubert*.[38] The questions of whether a witness is qualified as an expert and whether, if so qualified, a witness may give expert opinion or testimony on the subject in question remain largely within the discretion of the trial judge.[39]

On What Issues is Expert Evidence Precluded?

Alabama law is quite liberal in the allowance of expert testimony, maintaining adherence in civil cases to the general acceptance test enunciated in *Frye*[40] rather than the more stringent standard employed by the United States Supreme Court in

[26] Ala. Code §12-21-12 (1975).
[27] Ala. Code §12-21-12(d) (1975).
[28] *State Farm Fire & Cas. Co. v. Slade*, 747 So. 2d 293, 318 (Ala. 1999).
[29] *Singleton v. State Farm Fire & Cas. Co.*, 928 So. 2d 280 (Ala. 2005).
[30] *Fortis Benefits Ins. Co. v. Pinkley*, 926 So. 2d 981 (Ala. 2005) (emphasis added).
[31] *Continental Assurance Co. v. Kountz*, 461 So. 2d 802 (Ala. 1984).
[32] *Nat'l Sav. Life Ins. Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982).
[33] *Huff v. United Ins. Co. of Am.*, 674 So. 2d 21 (Ala. 1995); *United Ins. Co. of Am. v. Cope*, 630 So. 2d 407 (Ala. 1993).
[34] *See* Ala. Code § 6-11-20; *Dumas v. S. Guar. Ins. Co.*, 408 So. 2d 86 (Ala. 1981).
[35] *See Ex parte O'Neal*, 713 So. 2d 956 (Ala. 1998) (wider latitude is given to a bad faith plaintiff in the discovery process); *Ex parte Finkbohner,* 682 So. 2d 409 (Ala. 1996) (because intent is an element and because bad faith is so difficult to prove, other bad faith actions are discoverable).
[36] *See Acceptance Ins. Co. v. Brown*, 832 So. 2d 1 (Ala. 2001) (two experts testified in support of plaintiff's bad faith action).
[37] *Frye v. U.S.*, 54 App. D.C. 46, 293 F. 1013 (D.C. Cir. 1923).
[38] *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 113 S. Ct. 2786 (1993).
[39] *Bagley v. Mazda Motor Corp.*, 864 So. 2d 301 (Ala. 2003).
[40] 293 F. at 1013.

Daubert.[41] As Rule 704 of the Alabama Rules of Evidence precludes an expert from testifying on the "ultimate issue" to be decided by the trier of fact, an expert would be precluded from offering an opinion that a denial of a claim was made by the insurer in bad faith.

Is a Bad Faith Claim Viable if the Coverage Decision Was Correct?

No, coverage for the underlying claim is a prerequisite to a claim for bad faith.[42] In the UM/UIM context, there can be no breach of contract/bad faith until liability and damages have been fixed (i.e., where there is no longer a legitimate dispute).[43] In such cases, the bad faith claims are subject to dismissal for lack of subject matter jurisdiction.[44]

PRACTICE AND PROCEDURE

Statute of Limitations

Bad faith claims in Alabama have a statute of limitations of two years.[45]

The cause of action for bad faith refusal to honor insurance benefits accrues upon the event of the bad faith refusal or upon the knowledge of facts which would reasonably lead the insured to a discovery of the bad faith refusal. A letter denying insurance coverage should be sufficient to put a reasonable mind on notice of the possible existence of fraud and to trigger the running of the statute of limitation for a bad faith refusal claim.[46]

Under What Circumstances Will Bad Faith Claims be Dismissed or Stayed Pending the Resolution of the Underlying Claim?

Alabama decisions have not delineated under what circumstances a bad faith claim will be dismissed or stayed pending the resolution of an underlying claim (although, it is generally left to the discretion of the trial judge).

Under What Circumstances Will Bad Faith Claims be Severed for Trial from the Underlying Claim?

A bad faith claim is commonly bifurcated from the trial of the underlying claim based on Alabama Rule of Civil Procedure 42(b), which governs bifurcation generally. Alabama Rule of Civil Procedure 18, which permits the joinder of liability coverage claims with the underlying dispute, provides that "[i]n no event shall this or any other rule be construed to permit a jury trial of a liability insurance coverage question jointly with the trial of a related damage claim against an insured."[47]

Under What Circumstances Will the Compensatory and Punitive Damages Claims be Bifurcated?

None. The Alabama Supreme found bifurcation of trials on the merits and punitive damages is not necessary to assure that tortfeasors receive due process.[48] The jury is allowed to assess punitive damages, but where the jury's verdict is challenged as excessive, the trial court will continue to conduct hearings pursuant to *BMW of North America, Inc. v. Gore*,[49] *Hammond v. City of Gadsden*,[50] *Green Oil Co. v. Hornsby*[51] and Ala. Code § 6–11–23(b). Then, the trial court — and ultimately the appellate court — will determine whether the amount of punitive damages awarded are justified.

[41] 509 U.S. at 579.

[42] *See State Farm Fire & Cas. Co. v. Slade*, 747 So. 2d 293 (Ala. 1999); *Ex parte Alfa Ins. Co*., 799 So. 2d 957 (Ala. 2001); *Congress Life Ins. Co. v. Barstow*, 799 So. 2d 931 (Ala. 2001).

[43] *Pontius v. State Farm Mut. Auto. Ins. Co*., 915 So. 2d 557 (Ala. 2005).

[44] *Ex parte Safeway Ins. Co. of Alabama*, 990 So. 2d 344 (Ala. 2006).

[45] *See* Ala. Code § 6-2-38(1); *Alfa Mut. Ins. Co. v. Smith*, 540 So. 2d 691 (Ala. 1988).

[46] *Toffel v. Nationwide Mut. Ins. Co*., No. 2:15-cv-01669-KOB, 2016 WL 4271837, at *7 (N.D. Ala. Aug. 15, 2016) (citations and internal quotations omitted).

[47] Ala. R. Civ. P. 18(c); *see, e.g., Universal Underwriters Ins. Co. v. East Cent. Ala. Ford-Mercury, Inc*., 574 So. 2d 716, 723-24 (Ala. 1990) (addressing where the personal injury and coverage claims are joined, neither the jury nor the judge would consider the insurer's participation or the coverage issue in the first phase of the trial which would determine the personal injury claim. The judge or jury would consider coverage and any bad faith issues only if there is a plaintiff's judgment in the first phase. In the second phase, the same jury or judge would hear and decide the coverage issue between the defendant insured and the insurer.).

[48] *Life Ins. Co. of Ga. v. Johnson*, 701 So. 2d 524, 532 (Ala. 1997).

[49] 517 U.S. 559, 116 S. Ct. 1589 (1996).

[50] 493 So. 2d 1374 (Ala. 1986).

[51] 539 So. 2d 218 (Ala. 1989)

Under Ala. Code § 6-11-23, there is "[n]o presumption of correctness" applied to the jury's punitive damage award. Instead, upon the motion of any party, the trial court must conduct hearings or receive additional evidence concerning the amount of punitive damages. The evidence to be considered includes: (1) the economic impact of the verdict on the defendant or the plaintiff; (2) the amount of compensatory damages awarded; (3) whether the defendant was guilty of the same or similar acts in the past; and (4) the nature and the extent of any effort the defendant made to remedy the wrong and the opportunity or lack of opportunity the plaintiff gave the defendant to remedy the alleged wrong. The court can reassess the nature, extent and economic impact of such an award of punitive damages and reduce or increase the award if appropriate in light of all the evidence.

Abatement of Coverage Actions

Ex parte Canal Ins. Co.[52] and *Ex parte Brooks Ins. Agency*[53] hold that where the insurer files a declaratory judgment action first, a later filed case by the insured must be abated or dismissed pursuant to Alabama's abatement statute, Ala. Code § 6-5-440. However, without explanation, the Alabama Supreme Court recently refused to follow this general rule, suggesting that the application of Alabama's abatement statute requires a more nuanced evaluation and consideration.[54]

DEFENSES AND COUNTERCLAIMS

Is Evidence Regarding the Reasonableness of the Conduct of the Insured or Third Party Claimant Admissible?

This issue has not been considered in any reported decision. However, the insured's or the third party claimant's actions relative to presenting the claim may be relevant to the bad faith claim. Thus, such evidence should be admissible.

Is "Advice of Counsel" a Recognized Defense?

Yes.[55] But, while advice of counsel, along with all other relevant factors, may be considered, it is not necessarily an absolute defense.[56] If "the advice of insurer's counsel is not founded on professional evaluation of the credibility of admissible evidence, but instead is confined totally to inadmissible and unproved hearsay evidence, absent any ongoing investigation relative thereto, such advice cannot serve, as a matter of law, to insulate the insurer client from bad faith liability."[57]

What Other Defenses Are Available?

Any claim of bad faith for wrongful refusal to pay will fail if the evidence demonstrates that the coverage for the claim was "fairly debatable."[58]

When the bad faith claim is predicated on the investigation of the claim, "[t]he relevant question before the trier of fact would be whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review. Implicit in that test is the conclusion that the knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred to an insurance company when there is a reckless indifference to facts or to proof submitted by the insured . . . . [However a bad faith claim] 'cannot follow when an insurance company in the exercise of ordinary care makes an investigation of the facts and law and concludes on a reasonable basis that the claim is at least debatable.'"[59]

Other defenses are available in certain cases. For example, in a fire case, an insurer can assert arson or concealment.[60] Misrepresentation on an application by an insured also is a defense.[61]

52 534 So. 2d 582 (Ala. 1988).
53 125 So. 3d 706 (Ala. 2013).
54 *See Ex parte FCCI Ins.*, Ala. Sup. Ct. Case No. 1150230 (July 8, 2016) (no opinion order denying writ of mandamus directing the State Circuit Court to dismiss a declaratory action filed by the insured subsequent to the filing of a federal court declaratory action filed by the insurer).
55 *See Davis v. Cotton States Mut. Ins. Co.*, 604 So. 2d 354 (Ala. 1992) ("Crucial to the insurers' showing that they did not act in bad faith is their employment of a lawyer in private practice to research the coverage of the motor vehicle.").
56 *Chavers*, 405 So. 2d at 8.
57 *Id.*
58 *Barnes,* 405 So. 2d at 924; *Sockwell,* 829 So. 2d at 126-27; *Nat'l Sec. Fire & Cas. Co. v. Bowen*, 417 So. 2d 179 (Ala. 1982).
59 *Barnes,* 405 So. 2d at 924.
60 *S&W Props., Inc. v. Am. Motorists Ins. Co.*, 668 So. 2d 529, 531 (Ala. 1995).
61 *Am. Gen. Life Ins. Co. v. Lyles*, 540 So. 2d 696, 699 (Ala. 1988).

Is There a Cause of Action for Reverse Bad Faith?

No.

OTHER SIGNIFICANT CASES INVOLVING BAD FAITH AND EXTRA-CONTRACTUAL CLAIMS

Defense Under Reservation of Rights

In *L & S Roofing Supply Co. v. St. Paul Fire & Marine Insurance Co.*,[62] the Alabama Supreme Court adopted a standard of "enhanced obligation of good faith" that the insurer and defense counsel must follow when the carrier is defending under a reservation of rights.[63] This enhanced obligation of good faith is fulfilled by:

- Thoroughly investigating the cause of the insured's accident and the nature and the severity of the plaintiff's injuries.
- Retaining competent defense counsel for the insured. (Both retained defense counsel and the insurer must understand that only the insured is the client.)
- Fully informing the insured not only of the reservation of rights defense itself, but of all the developments relevant to his policy coverage and the progress of this lawsuit. This includes disclosure of all settlement demands and offers.
- Refraining from any action that demonstrates a greater concern for the insurer's monetary interest than for the insured's financial risk.[64]

The enhanced duty of good faith is "read into" the insured's reservation of rights. Under this duty, the "[defense] counsel represents only the insured, not the insurer."[65]

Bad Faith Claim Cannot be Assigned

Alabama does not permit the assignment of bad faith actions.[66] Any purported assignment of the bad faith claim against an insurer violates public policy and is unenforceable.

CONCLUSION

Alabama has come a long way since the wild and dangerous days of the 1980s, 1990s and early Aughts. Back then, any perceived unfair decision by an insurer was likely to be called bad faith and a jury was likely to award millions!

Today, the standard for bad faith, which has been in effect since 1981, is applied more fairly to the insurers. Now, as long as the insurer can prove to the jury it had an arguable or debatable basis for denial of the claim at the time the claim was denied, the insurer should receive a defense verdict, or at least get satisfaction at the Alabama Supreme Court. Even when the wheels come off, punitive damages are generally limited by the Alabama Supreme Court to a multiple of 2-3 times the compensatory damages. However, all is not rosy. The insured can still recover mental anguish or emotional distress damages for any bad faith. Those are "squishy" and a jury can award big numbers; subject, of course, to remittitur by the appellate courts. But, unlike some states, notably Texas, the insured cannot recover his/her/its' attorneys' fees incurred in proving the contract claim or the bad faith. Also, there is no third party bad faith in Alabama.

All-in-all there are worse places to be sued for bad faith and an insurer can protect itself by subjecting all claims and all settlement opportunities to a rigorous – and well documented – analysis and can safely deny claims when there is an arguable or reasonably debatable reason to do so.

[62] 521 So. 2d 1298 (Ala. 1987).
[63] *Id*. at 1304.
[64] *Id.* at 1303 (citation omitted).
[65] *Lifestar Response of Ala., Inc. v. Admiral Ins. Co.*, 17 So. 3d 200, 219 (Ala. 2009) (citation omitted).
[66] *Cash v. State Farm Fire & Cas. Co.*, 125 F. Supp. 2d 474, 477 (M.D. Ala. 2000).

Bill and Ted's Excellent Reservation of Rights Letter — Tips to Make Your ROR Letters Bodacious!

By Thomas B. Ward

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Partner

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Bill and Ted's Excellent Reservation of Rights Letter — Tips to Make Your ROR Letters Bodacious!

The 2012 Georgia Supreme Court decision *Hoover v. Maxum* is viewed by many as a stark departure from Georgia's previously well-established rules governing reservation of rights (ROR) letters.[1] While the holding can be articulated narrowly, the opinion's broad pronouncements about ROR letters could reshape Georgia law. It will take years, however, to clarify the full reach and import of *Hoover*. The confusion is compounded by the reality that federal and state courts often take a different approach to reservation of rights letters, with Georgia courts seeming to take a stricter approach and finding waiver where federal courts may not.

In the meantime, insurers cannot just sit back and wait for clarity from future appellate decisions before taking action. New claims arrive daily, and decisions must be made on an ongoing basis, whether to defend an insured against claims that may not be covered under a policy, in which case coverage rights need to be reserved. In most circumstances, insurers choose to defend questionable claims under a reservation of rights, which is basically a way for an insurer to delay making an ultimate coverage decision until later.[2] But in order to delay taking a position about coverage, an insurer must "fairly inform" its insured what is happening by explaining which claims may not be covered and why.[3] Unfortunately, many practitioners and insurance experts view *Hoover* as potentially changing the fairly inform requirement to a strict liability standard requiring perfection, or else. This lack of certainty presents a dilemma to insurers faced with the daily problem of having to draft ROR letters, particularly when so much is at stake. How should an insurer act when the old way of doing things may, in the not so distant future, be denounced as completely wrong? This paper breaks down the essential elements that should be considered when drafting an ROR letter, and provides specific guidance for each element. It is in the nature of a tutorial, a checklist or a manual for writing the perfect ROR letter designed to come in handy for years to come.

Before getting to specific requirements, it is important to step back and understand the overarching purpose of ROR letters, which is to avoid giving the insured a false sense of security when being told the carrier will provide a defense. The goal is to fairly inform the insured, however, many ROR letters are woefully inadequate and routinely miss the mark. Remember, ROR letters are for the benefit of the insured, who is almost always a newcomer to litigation and very much a layman when it comes to understanding the nuances of lawsuits and insurance policies. Such laymen are often unsophisticated, prone to over generalize and most certainly frightened at having been sued.

Amidst this confusion, uncertainty and fear, the insured receives a letter acknowledging the lawsuit, informing him the carrier has retained counsel of its own choosing to defend him and requesting he communicate and cooperate with counsel. The insured is no doubt grateful he will not be bled to death by legal fees, but the insured is quickly dismayed to learn that such a benefit comes at the loss of control of his case. Worse, the insured is then directed to pages of confusing insurance language followed usually by an unintelligible coverage discussion, or sometimes even no explanation at all. The insured may attempt to read it, but no doubt understands none of it. The ROR letter likely closes with a discussion that the carrier may not have any coverage and therefore may not have any duty to indemnify, whatever that means. At this point, the insured is thoroughly confused and vaguely senses something may be amiss. But then again, maybe not, since the carrier has assigned an attorney and there is no way the carrier would do that unless it had to. And so the insured files the ROR letter away, blithely unaware the policy likely does not cover the claim.

So, to summarize the predicament argued by attorneys for policyholders, the insured is at the mercy of a carrier who is allowed to give equal consideration to its own interest in defending a case — a case in which the carrier may not have to pay any judgment at the end. In fact, the carrier may not even have to defend the insured through trial, but may end up withdrawing the defense before then, sometimes on the eve of trial. Thus, the ROR letter must fairly inform the insured of this possibility, and any shortcomings in that endeavor will be resolved in favor of the insured.[4]

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1 *Hoover v. Maxum Indem. Co.*, 291 Ga. 402, 730 S.E.2d 413 (2012).

2 *Id.* ("A reservation of rights is a term of art in insurance vernacular and is designed to allow an insurer to provide a defense to its insured while still preserving the option of litigating and ultimately denying coverage.").

3 *Facility Invs., LP v. Homeland Ins. Co. of N.Y.*, 321 Ga. App. 103, 741 S.E.2d 228 (2013) (stating that the ROR letter must fairly inform the insured that, notwithstanding the insurer's defense of the action, it disclaims liability and does not waive the defenses available to it against the insured).

4 *World Harvest Church, Inc. v. Guideone Mut. Ins. Co.*, 287 Ga. 149, 695 S.E.2d 6 (2010) (stating that an ROR letter must be unambiguous to be effective,

If you want to ensure you do not lose your coverage defenses when providing your insured a defense under a reservation of rights, make sure each letter you send addresses the following issues. It is also vitally important to note this checklist is just that — an issue spotting guide and not an encyclopedia of answers. It is intended to raise issues without necessarily providing precise "one-size fits all" answers. This is so because legal issues often turn on subtle and nuanced facts, and it is simply impossible to provide actionable legal advice without first considering the specific facts involved. The goal is to assist you in spotting the issues and provide basic guidance in resolving them.

THE STUFF AT THE TOP OF THE LETTER THAT NO ONE READS

1. **Date** — The crucial issue is not the fact the letter is dated (although that is important too), but rather the timing of the ROR letter relative to assigning defense counsel. If you remember nothing else, know this: **THE ROR LETTER MUST BE SENT BEFORE UNDERTAKING A DEFENSE OF THE INSURED, MEANING DO NOT EVEN ASSIGN DEFENSE COUNSEL UNTIL A ROR LETTER HAS BEEN SENT.** There is only one exception to this rule. A very specific oral reservation of rights will suffice if an insurer is under time constraints to file an answer to a complaint, but such oral reservation of rights should be immediately followed by a written one.
2. **Whose Letterhead?** — Obviously, the ROR letter will be on letterhead, but the question is: whose letterhead? In other words, should the carrier send the ROR letter or should coverage counsel? The default rule is that the ROR should come from the insurance carrier, but there are times when an ROR letter should come instead from counsel.
3. **Identify the Recipient** — It is vitally important to send the ROR letter to the correct recipient, and this issue is not always as simple as it might first appear. As a default rule, any party being defended under a reservation of rights needs to receive a ROR letter. Mistakes normally happen when people or entities other than the named insured are given a defense, such as when managers for an LLC qualify as an additional insured, or when members of the named insured's household also qualify as an additional insured. In those situations, it is common for only the named insured to receive an ROR letter, even though the additional named insured is entitled to the same rights and subject to the same reservations. Because some cases hold that the reservation of rights letter has to be provided directly to each insured, that is the prudent course to take.[5] Also, as a general rule, it is best to send the ROR letter directly to each insured, rather than sending it only to an authorized representative of the insured, such as insured's counsel.[6]
4. **Method of Transmission** — Consideration must be given to the method of delivery, and you must transmit it in a way so you can confirm receipt. The most common method is to use certified mail, but other viable methods exist, such as FedEx. It is also appropriate to use multiple methods, such as certified mail and either email or fax, as long as at least one delivery method can be verified. You must document your file with proof of delivery. Unfortunately, sometimes the insured cannot be located, or has fled the country, in which case you should seek legal advice.
5. **Caption** — The caption is often referred to as the "re" line of the letter. Here, less is actually more, and it is best to stay silent if there is uncertainty about any of the usual elements. With that said, most captions contain the following elements:
    - The named insured – The named insured should be included;
    - The claim number – The claim number(s) should be included;
    - Case name – The name of the case should probably be included, but not always;
    - Loss date – The loss date should be included, but be careful, because the date of loss may not be clear and what you put here could impact coverage. In such situations, you can usually state "date of loss reported as ______" or just omit this element altogether; and
    - Policy numbers – The policy number should also be included, just be aware there may be an open issue about which policy has been triggered.
6. **The Salutation —** This is the "Dear Insured" part of letter. Formality and decorum is the goal, as it is imperative that you treat the insured with courtesy and respect. But even if, for some reason, you are on a first name basis,

and any ambiguity will be construed strictly against the insurer and liberally against the insured).

5 *See, e.g. KnoxTenn Rental Company*, 2 F.3d 678 (6th Cir. 1993).

6 *Equity Gen. Ins. Co. v. C&A Realty Co., Inc.*, 715 P.2d 768 (Az. Ct. App. 1985) (sending the reservation of rights letter to the policyholder rather than the firm representing the policyholder constitutes proper communication to the policyholder).

err on the side of formality, because one day your actions and words may be scrutinized by a judge and jury, and you do not want anything you say and do to be misconstrued.

THE INTRODUCTORY PARAGRAPH

7. **Introduce Yourself** — Start off the letter by introducing yourself. You should include "letterhead" substance in your introduction, such as: "I am Theodore Logan, and I am a claims manager for Bill and Ted's Excellent Insurance Company."
8. **Purpose of Letter** — Next, tell the reader why you are writing which is basically to inform the insured the claims may not be covered. For example, "this will serve as Bill and Ted's Excellent Insurance Co.'s determination of its potential obligation, if any, to provide coverage to you for defense and any liability for damages arising out of a complaint filed against you in the action . . . ." Be careful about your tone and word choice. Many ROR letters use indecisive words like "position" instead of using more definitive words like "determination." Be decisive.
9. **Introduce Policy** — Be sure to introduce the policy towards the beginning of the letter, or at least acknowledge the fact that the policy exists. Remember, it is not always clear which policy or policies may apply, particularly with continuous trigger claims that are common in the construction and environmental realm.

THE "AVOIDING A FALSE SENSE OF SECURITY" PARAGRAPH

10. **Acknowledge the Defense** — Let the reader know that a defense is being provided, and most importantly, that the defense is being provided subject to a reservation of rights. In fact, if the ROR letter does not talk about a defense obligation, there should be a really good reason why not.
11. **Identify Counsel** — The ROR letter should identify the insurer's panel counsel and remind the insured of the duty to cooperate and communicate with panel counsel.
12. **Right to Reimbursement of Defense Costs and Settlement if No Defense Owed** — This is an area where insurance companies often run into trouble because Georgia courts often find waiver on these issues if not included in the very first ROR letter.[7]
13. **Right to Withdraw from Defense/File a DJ** — It is a good practice to inform the insured you have a right to withdraw the defense and to file a declaratory judgment action to obtain a ruling from the court that you do not have to continue defending and do not have to indemnify the insured.
14. **Address Covered v. Uncovered Claims and Damages** — You also need to explain it is possible the jury will award damages that are not covered, in which event the insured, and not the insurance company, will have to pay those damages.
15. **Right to Independent Counsel** — In Georgia, the issuance of an ROR letter does not automatically trigger the right to independent counsel, and thus it is usually best to avoid the issue altogether. Occasionally, however, the insured may demand the insurance company use and pay for an attorney of the insured's own choosing, instead of using panel counsel. If so, seek legal guidance, as that issue can get tricky. So, to summarize, consider whether this might be an independent counsel case, but don't bring it up unless the insured has already opened that door.

THE COVERAGE ANALYSIS

16. **Summary of Allegations** — At this point, summarize the allegations. It is important to begin by telling the insured the underlying allegations are lengthy, and you are just summarizing those allegations. Also, remind the insured that even though the ROR merely summarizes the allegations, the totality of the allegations were considered in determining any obligations. A few tips should be heeded:
    - Relevance — Only focus on those facts that actually matter. There is no need to get bogged down reciting irrelevant detail, because doing so wastes time, confuses the reader and distracts from the purpose of the ROR letter.

[7] *Facility Investments, LP v. Homeland Ins. Co. of New York*, 321 Ga. App. 103, 741 S.E.2d 228 (2013); *Illinois Union Ins. Co. v. NRI Constr. Inc.*, 846 F. Supp. 2d 1366 (N.D. Ga. 2012).

- Tailor the facts — Focus on the various defendants individually, which is particularly important if multiple defendants will be defended under a reservation of rights. In such situations, it is not uncommon for the allegations to differ in subtle, but significant ways as to each defendant, and thus the salient allegations for coverage will likely be different for each defendant.
- Discuss legal claims and damages too — Do not just focus on the facts but be sure to also address the causes of action and the damages sought, as all three things (i.e., 1. facts, 2. causes of actions and 3. relief sought or damages) are all important in determining coverage.

17. **Policy Language** — Now that the salient allegations have been addressed, it is time to focus on the policy. This is where most ROR letters fall woefully short of the goal. Often, page upon page of policy language is dumped into the letter, followed by a cursory sentence that there may not be coverage, which rarely suffices. Remember, the whole point of this exercise is to "fairly inform" the insured in detail why coverage may not be owed, which requires you to apply the policy provisions to the relevant facts, and do so in plain English.[8] Keep that purpose in mind at all times, especially here.

- Identify the policy — Begin by identifying the policy in detail, including the policy number, policy period, named insured, relevant limits and so on. Also, take a moment to make sure you are citing from the correct form and version of that form. The forms change every so often and you would be surprised to know how often the wrong policy language is cited.
- Limits — Is there a limits issue? If so, address it in detail here. The limits issue can be particularly important, as there may be a limits issue due to multiple claimants competing for a single limit, or the limit may apply separately to each insured, or there may be questions about the number of occurrences and whether the limit applies to each occurrence.
- Reiterate purpose — Once the parameters of the policy have been discussed, it is usually best to reiterate the purpose of the ROR letter to the insured, which is to inform the insured that coverage may not be owed. This reminder typically serves as a convenient transition to the specific provisions of the policy at issue.
- Basic rule — When discussing policy language, the insuring agreement comes before exclusions and conditions. While there are exceptions, most of the time you should discuss the insuring agreement, then the exclusions, then applicable conditions and other miscellaneous details.
- Focus — Focus on the policy language that matters, and eliminate the irrelevant language when possible and safe to do so. You will be walking a fine line here because there is a tendency to over include out of an abundance of caution. After all, a ROR letter is, by definition, an exercise in caution in order to avoid waiver. Even so, you can waive rights by saying too much just as easily as by saying too little. If that were not the case, insurance companies would simply enclose a copy of the policy and complaint to the insured with a terse note saying: "We think there may not be coverage. Read these yourself to find out why." Thus, do not cite each and every word and subpart of a lengthy and detailed exclusion when only one short subpart applies. When in doubt, over-include language. But when the policy language clearly is not at issue, leave it out.
- Analysis — The policy language needs to be applied to the allegations. Whenever possible and practical, do this each time new policy language is cited. That way, the insured will be provided an excerpt of relevant language, followed immediately with an explanation of how that policy language applies to the allegations and what that means for the insured, as opposed to having to first wade through pages of policy language before reaching the explanation. Take care when paraphrasing policy language. It is best to use a conversational tone, meaning use plain English, but also make sure to keep proper names.

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8 *Hoover*, 291 Ga. at 407 ("A reservation of rights is not valid if it does not fairly inform the insured of the insurer's position.").

CLOSING DETAILS

18. **Give Homework** — The benefits of the policy also come with some responsibilities, and now is the time to tell the insured what needs to be done.

    - Insured's obligation to cooperate — The insured needs to cooperate with the defense, with defense counsel, and with the coverage investigation. It is important to remind the insured of this policy condition and the consequences of not cooperating.
    - Give notice to other insurers (including excess insurers) — The insured may have other policies. Remind the insured to give notice to those insurers as well, especially excess insurers.

19. **Undertaking the Coverage Investigation** — If you will be undertaking a coverage investigation, it is appropriate now to say so and include specific questions to the insured. Be careful, however, about what you say. Do not say you are going to affirmatively investigate unless you actually do so. Also, remind the insured to keep you apprised of developments and facts pertaining to coverage.

CONCLUSION

20. **Non-Waiver Statement** — When wrapping up the letter, make sure to include the catch all "we reserve all rights." Further, be sure to get specific and state you are not waiving any term of the policy.
21. **Solicit Questions** — Invite the insured to contact you if there are any questions whatsoever about the ROR letter.

ODDS AND ENDS

22. **Parties to CC** — Consider who else should receive a copy of the ROR letter. Defense counsel should get a copy because defense counsel needs to know the coverage issues in order to protect the insured as well as know what issues he cannot be involved with. It is also fairly common but not necessary to copy the broker.
23. **Signed Copy of ROR** — Whenever possible, place a signed copy of the ROR letter in the file.
24. **Choice of Law** — Be aware that the choice of law can be a significant coverage issue. When everyone and everything about the claim is in the same state, there is probably not going to be a choice of law problem. But the moment more than two states are implicated, be careful. Things can get out of hand very quickly and it is possible the liability will be governed under the law of one state, while coverage questions are governed under the laws of another state. Choice of law questions are the most vexing issues you will encounter, and it is best to get outside counsel involved to help navigate these baffling issues.
25. **ROR Follow-Up** — It is all too easy to send the initial ROR letter and forget about it. If that happens, you run the risk of waiving defenses if later developments raise new issues, such as when the complaint is amended to add new claims that are likely not covered. It also may be necessary to update the ROR letter as extrinsic evidence is developed. Be sure to keep this checklist close and refer to it often when drafting ROR letters, in order to avoid missteps. Also, be sure to seek legal advice if you encounter a situation that does not fit neatly into the general rules outlined above.

Rotten Potatoes: Mashed or Twice Baked — Potatometer Rating the Recent Releases by Our Courts

By Thomas D. Martin

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Partner

Thomas D. Martin practices civil litigation emphasizing first-party insurance defense. His practice includes arson and fraud insurance defense, where he has extensive experience defending carriers with claims involving homeowners, auto, life, disability and health insurance fraud. His practice also includes insurance coverage defense in the context of both first-party and third-party property losses. He joined Swift, Currie, McGhee & Hiers in 1987. A member of the American Bar Association and the State and Federal Bars of Georgia, Mr. Martin has participated as a guest speaker on topics relating to insurance fraud defense and insurance coverage issues. He has also acted as an instructor for insurance industry personnel in courses sponsored by Georgia State University, the American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America. He is also a member of the Metro and Georgia Associations of Fire Investigators.

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Rotten Potatoes: Mashed or Twice Baked — Potatometer Rating the Recent Releases by Our Court

RESCISSION

In *Georgia Casualty & Surety Co. v. Valley Wood, Inc.*,[1] insurer Georgia Casualty brought a declaratory judgment action to determine whether its crime policy for insured Valley Wood was void. After a jury trial with a verdict for Valley Wood, Georgia Casualty appealed and alleged that the trial court erred by denying its motion for a directed verdict, among other errors. Valley Wood applied for a policy with Georgia Casualty through Valley Wood's agent, J. Smith Lanier, but Lanier did not sign the application. Richard Ramey, the co-owner of Valley Wood, had never seen the application before, claimed that no one had ever asked him the questions contained in the application and claimed that he had not given his permission for the agent to answer any questions on the application. A Georgia Casualty underwriter received the application from Lanier, which did not mention that Valley Wood did not audit with a certified public accountant and did not require countersignatures on checks. At trial, Ramey admitted this was true, and it was undisputed that these facts were not revealed in the application for coverage. Georgia Casualty's underwriter testified that he would not have issued a policy if the application had contained this information.

Georgia Casualty sought a directed verdict based on O.C.G.A. § 33-24-7(b), which states in relevant part:

> Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:
> (1) Fraudulent;
> (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
> (3) The insurer in good faith would either not have issued the policy or contract . . . if the true facts had been known to the insurer as required either by the application for the policy or contract or otherwise.

The court found that a directed verdict for Georgia Casualty was proper where uncontested evidence proved the use of auditing and countersignatures were material to the decision to issue insurance. The court cited *Pope v. Mercury Indemnity Co.*,[2] for the proposition that an insurer can avoid coverage merely by showing that the misrepresentation was both false and material; that is, "one that would influence a prudent insurer in determining whether . . . to accept the risk." Moreover, although materiality is usually a question for the jury, it is possible that the evidence can "exclude[] every reasonable inference except" materiality, and thus the court may properly grant a motion for a directed verdict on the issue.

Next, the court found unavailing Valley Wood's argument that it could not be bound by the statements its agent made on an unsigned application. Citing *Assaf v. Cincinnati Ins. Co.*,[3] the court noted a "principal shall be bound by all representations made by his agent in the business of his agency," even though the principal is not aware the agent has willfully concealed any material facts in the course of the representation.

Finally, the court also rejected Valley Wood's argument that Georgia Casualty was required to rescind the policy and return the premium, as maintaining the policy gave Georgia Casualty the requisite uncertainty for filing a declaratory judgment action. Rather, the court cited a Florida case, *Transportation Casualty Ins. Co. v. Soil Tech Distributors*,[4] for the proposition that an insurer may use a declaratory judgment to determine whether a policy is voidable before seeking rescission, and thus it does not have to return the premiums merely to determine whether a policy is voidable. Ultimately, the Court of Appeals held that the trial court should not have denied Georgia Casualty's motion for a directed verdict finding the policy void for misrepresentation and reversed the trial court's decision.

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1 336 Ga. App. 795, 783 S.E.2d 441 (2016).
2 297 Ga. App. 535, 537-38, 677 S.E.2d 693 (2009).
3 327 Ga. App. 475, 479, 759 S.E.2d 557 (2014).
4 966 So.2d 8, 10 (Fla. 4th DCA 2007).

VANDALISM AND MALICIOUS MISCHIEF COVERAGE

In *R&G Investments & Holdings, LLC v. American Family Ins. Co.*,[5] R&G Investments owned an apartment complex which American Family Insurance Company insured. In February 2012, while the buildings were unoccupied for renovations, several buildings were vandalized. Subsequently, in November 2012, a water pipe burst in another building and flooded several units in it. Renovations had concluded, but only one of the eight units in that building were leased. R&G sought coverage from American Family for both the vandalism and water damage losses, but American Family refused to pay those claims, asserting the vacancy exclusion applied. R&G then sued American Family both for coverage and for bad faith penalty and attorney fees for this refusal. American Family countered with the vacancy defense as well as a defense based upon R&G's alleged failure to cooperate with American Family's investigation of the claims.

The vacancy exclusion applied to loss from vandalism or water damage for buildings "vacant" for more than 60 consecutive days before the loss but exempted buildings undergoing renovation. Under the policy definitions, a building was not "vacant" if 31 percent or more of the building's square footage was "(i) [r]ented . . . and used by the lessee or sub-lessee to conduct its customary operations; and/or (ii) [was] used by the building owner to conduct customary operations." "Operations" meant "business activities occurring at the described premises."

After the close of discovery, R&G moved for summary judgment on its vandalism claim and on American Family's vacancy defenses. The trial court denied these motions, finding genuine issues of material fact. R&G later moved for summary judgment on its water damage claims and American Family cross-moved for summary judgment on its vacancy defense. The trial court denied R&G's motion and granted American Family's motion. R&G appealed all the summary judgment rulings. As to the vacancy clause, R&G argued the vacancy exclusion ought not apply at all, reasoning that the tenants of a residential apartment complex did not conduct "business operations" on the premises. The Court of Appeals rejected this argument, finding that such an interpretation would render the entire vacancy clause meaningless. Rather, the court found the purpose of the vacancy clause was for the insurer to protect from the heightened risk of damage to an unoccupied building. The court ruled the vacancy exclusion would apply where the building was not undergoing renovations or at least 31 percent full with tenants.

Still, the Court of Appeals held the trial court should not have denied R&G's motion because the uncontested evidence showed renovations were ongoing. According to the Court of Appeals, the trial court erred when it found a genuinely disputed material fact based on an affidavit by one of American Family's adjusters that contained hearsay and an unauthenticated exhibit. The adjuster had not personally visited the site, but relied on the report of an independent investigator who claimed no renovations were occurring. By contrast, R&G's resident manager testified in an examination under oath that she regularly walked the property and that the renovations had begun, but not concluded, on the buildings in question. In light of the inadmissible evidence from American Family, R&G's evidence was undisputed and should have entitled R&G to summary judgment. The trial court wrongly relied on hearsay and unauthenticated evidence to find an issue of fact.[6]

Finally, American Family contended R&G failed to cooperate with American Family's investigation of the claim. The law requires the insured to provide the insurer any information it is entitled to receive under the policy, and that failing to do so without an excuse places the insured in breach. Although Georgia law imposes the compliance requirement, the question of whether an insured has sufficiently cooperated with the insurer's request is one for a jury. American Family claimed that R&G had not sufficiently cooperated because it had not produced records of the renovation, and had not provided a sufficiently knowledgeable employee to testify at an examination under oath.

R&G moved for summary judgment on the compliance question, making three arguments. First, it claimed American Family had not made a proper EUO request. The court found a factual question on this issue based on R&G's own affidavit. Next, R&G claimed American Family had waived and was estopped from asserting the cooperation provisions because it had not issued a reservation of rights. The court likewise dispatched this argument by noting that an insurer does not need to issue a reservation of rights when investigating a claim by its insured; rather, the reservation of rights is relevant where the insurer is defending its insured. Finally, R&G argued harmless error based on its earlier contention that the vacancy exclusion did not apply to it at all. The court rejected this by noting it had already found the vacancy exclusion did apply to R&G, and thus American Family was entitled to investigate the claim with R&G's full cooperation. Therefore, it found proper the trial court's denial of R&G's summary judgment on this issue.

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5 337 Ga. App. 588, 787 S.E.2d 765 (2016).

6 The Court of Appeals never addressed the trial court's ruling with respect to water damage. Presumably, however, the court likewise would have concluded that the insured's testimony was uncontested.

In *Auto-Owners Ins. Co. v. Neisler*,[7] Auto-Owners insured a rental home that Neisler owned. Before Neisler could find a tenant, burglars vandalized it.[8] Although Neisler did not dispute that the property policy did not cover stolen fixtures, he nevertheless submitted a claim for the labor to replace the fixtures and for lost rent.[9]

The policy excluded vandalism and malicious mischief, including loss by theft and burglary. A separate provision covered "damage by burglars to the dwelling or other structures . . . ." but excluded "any property taken by burglars."[10] Finding that these provisions were ambiguous and in conflict, the Court of Appeals held that Neisler could recover the damage caused by the burglars, including the cost of labor to replace the items that were removed.[11] Moreover, because Neisler gave notice of the alleged ambiguity in correspondence to the company before suit was filed, the Court of Appeals held that Auto-Owners' good faith was not vindicated as a matter of law. A jury would have to decide if the Auto-Owners acted in bad faith in denying the labor charges on the vandalism claim.[12]

On the issue of lost monthly rent, the policy covered "loss of normal rents" when the property was rendered unfit for habitation owing to a covered loss.[13] The court found this provision unambiguous: it only covered lost rent while a tenant rented the property at the time of loss, and so Neisler, who had been unable to rent the house, could not recover lost monthly rent.[14] Auto-Owners was entitled to summary judgment on bad faith for the lost monthly rent claim, as Auto-Owners had reason to contest that claim.[15]

DIMINUTION OF VALUE AND "PROPERTY DAMAGE"

In *Odell v. Pacific Indemnity Company*,[16] a seller did not disclose flooding on his Savannah property to the buyer who began to experience flooding and septic problems after closing. The buyer filed suit, seeking damages for diminution in value from flooding, among other damages. The Eleventh Circuit held that a claim for diminution in value of a residential property was not "property damage" caused by an occurrence; rather, it agreed with the district court in finding this a "purely economic loss" and thus not covered.[17] Since no property suffered physical injury or destruction, no property damage had occurred.[18]

COMMERCIAL GENERAL LIABILITY (CGL) COVERAGE

The United States Court of Appeals for the Eleventh Circuit and the Court of Appeals of Georgia both addressed when in a sequence of events coverage could be initially triggered. In a matter of first impression, the Georgia Court of Appeals examined when a CGL policy covered a malicious prosecution claim. In *Zook v. Arch Specialty Insurance Company*,[19] Zook filed the underlying lawsuit, alleging that a bouncer at the insured nightclub had assaulted him in May 2009. Zook himself had been arrested for simple battery related to that altercation, was formally charged 10 months later, and ultimately acquitted at trial.[20] Although the CGL policy was in effect at the time of the alleged assault and arrest in May 2009, it was no longer in effect when Zook was formally charged.[21] The policy did not specify when a malicious prosecution claim triggered coverage and the court noted that no Georgia appellate courts had ever considered this issue. Thus, it looked to other jurisdictions for guidance. The Court of Appeals ultimately held the malicious prosecution cause of action arose upon favorable termination of the underlying criminal case and that the policy covered this claim — even though it occurred after the policy was no longer in effect — because the offense leading to the criminal proceeding occurred during the policy period. When the bouncer called 911 and reported the incident to the police, the "legal machinery of the state was set into motion" and triggered coverage for a possible malicious prosecution claim.[22]

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7 334 Ga. App. 284, 779 S.E.2d 55 (2015).
8 *Id.* at 284.
9 *Id.* at 284-85.
10 *Id.* at 287.
11 *Id.* at 287-88.
12 *Id.* at 291.
13 *Id*. at 289.
14 *Id.*
15 *Id*. at 291.
16 619 Fed. Appx. 828 (2015).
17 *Id.* at 831.
18 *Id.*
19 336 Ga. App. 669, 784 S.E.2d 119 (2016).
20 *Id.* at 671.
21 *Id.* at 673.
22 *Id.* at 675 (*quoting Muller Fuel Oil Co. v. Ins. Co. of N. Am.*, 95 N. J. *Supra* 564, 232 A.2d 168 (Ct. App. Div. 1967) (finding that the "essence of the

The United States Court of Appeals for the Eleventh Circuit held that the policy definition of "occurrence" was ambiguous with respect to whether a negligent repair or the subsequent accident the repair caused — which was outside the policy — triggered coverage. In *Lee v. Universal Underwriters Ins. Co.*,[23] Universal Underwriters insured a Ford dealership that repaired a Ford Expedition in June 2005. In December 2008, the owner was involved in an accident, and further investigation revealed that the 2005 repair had caused damage to the cruise control cable. This damage, in turn, caused the throttle stick to open, and the driver lost control of the car, thereby causing the accident. [24] The Eleventh Circuit agreed with the district court that the policy's plain language about what "occurrence" triggered coverage was ambiguous.[25] The policy did not explicitly require that covered injures must occur during the policy period, and it did not specify the accidents or events within the policy period that triggered coverage.[26] Thus, the Eleventh Circuit determined it could "reasonably interpret [the policy] as requiring that either the accident — here the negligent repair — occurred during the policy period or that the injury resulting from the accident — here the car crash — occurred during the policy period."[27] Given this ambiguity, the Eleventh Circuit applied the interpretive canon of construing the policy against the drafter and found that the accident resulting from the negligent repair was a covered "occurrence" within the policy.[28]

The Southern District of Georgia also addressed whether a policy covered certain claims for damage, and resolved the case in favor of the insurer. In *Spivey v. American Casualty Company of Redding*,[29] the court found that allegedly intentional and malicious conversion of equipment did not constitute a covered "occurrence." Thus, it granted American Casualty's motion to dismiss. The plaintiff filed suit against Dixie, the insured, alleging that Dixie had engaged in "willful and malicious conversion of plaintiff's security interest or rights in the equipment."[30] Dixie sought a defense under its liability policy with American Casualty, but American Casualty refused to provide it.[31] The plaintiff in the underlying case obtained a consent judgment from Dixie, as well as an assignment of Dixie's rights under its policy with American Casualty. The plaintiff then sued American Casualty for bad faith and American Casualty immediately filed a motion to dismiss.[32]

The District Court granted the insurer's motion. The court contrasted prior decisions involving occurrences for deliberate acts with unintended damages and found those decisions were distinguishable because they applied to faulty workmanship incidents — cases where deliberate acts were negligently performed resulting in injury.[33] The District Court held that the present case was different because it did not involve faulty workmanship or "… the unintended legal consequences of an intentional act." Rather, the plaintiff alleged that Dixie "willfully and maliciously converted plaintiff's equipment."[34] The court therefore concluded the policy did not cover the alleged willful and malicious conversion since it did not constitute an "accident" under the policy, and the underlying complaint did not "seek a remedy for the unintended consequences of an intentional act, but rather for the willful and malicious conversion itself."[35] Thus, the policy did not cover the occurrence, and the plaintiff had no claim against American Casualty.

Special thanks to the following additional editors and contributors: Kate Hicks, Steve Schatz and Brad Wolff.

tort is the wrongful conduct in making the criminal charge" in a case where the criminal complaint, arrest, and indictment all occurred before insurance coverage began).

23 642 Fed. Appx. 969 (11th Cir. Feb. 11, 2016).

24 *Id.* The Universal policy was cancelled in June 2007 a year and a half before the accident.

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id.*

29 128 F.Supp.3d 1281 S.D. Ga. (2015).

30 *Id.* at 1283.

31 *Id.*

32 Pursuant to Fed. R. Civ. P. 12(b)(6).

33 *Cam. Empire Surface Lines Ins. Co. v. Hathaway*, 288 Ga. 749, 707 S.E.2d 369 (2011) and *Capital City Insurance Co. v. Forks Timber*, No. CV 511-039, 2012 WL 3757555, at *2 (S.D. Ga. Aug. 28, 2012).

34 *Id.* at 1285.

35 *Id.*

Walk the Line: How to Navigate the Tripartite Relationship

By Melissa A. Segel and Kelly G. Chartash

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Walk the Line: How to Navigate the Tripartite Relationship

How do you "tax Socrates?"[1] According to the Supreme Court of Mississippi, one merely has to look at the tripartite relationship and the ethical dilemma it imposes on the insurer-retained defense attorney.[2] In the insurance world, insurance counsel is often faced with the ethical dilemma of how to successfully navigate the tripartite relationship, which consists of the insurance company, the insured and retained counsel. In discussing the dilemma presented by the tripartite relationship, the Supreme Court of Mississippi stated that "no decision or authority we have studied furnishes a completely satisfactory answer."[3]

WHO IS THE CLIENT IN THE TRIPARTITE RELATIONSHIP?

A majority of states, including Georgia, hold that the defense attorney has two clients: the insurance company and the insured. This is commonly referred to as the "dual client" approach. Georgia courts have not officially adopted the dual client approach in case law, but the Georgia Supreme Court issued a Formal Advisory Opinion stating "the attorney for the insured is also the attorney for the insurer."[4] In other states, such as Texas, there is no attorney-client relationship between an insurance carrier and the attorney it hired to defend its insured.[5]

Insurance policies usually include provisions providing that the insurer has the right to control the defense. Ethics rules are generally silent on an insurer's contractual rights to retain defense counsel and direct and control counsel's activities.[6] Nonetheless, the duties of client loyalty and the exercise of independent judgment owed by defense counsel to the insured are paramount. The Georgia Rules of Professional Conduct requires a "lawyer shall provide competent representation to a client."[7] Further, a lawyer is required to reasonably consult and inform a client during the representation.[8]

The Restatement (Third) of The Law Governing Lawyers § 134 (2000) is often considered the accepted approach for handling the competing interests arising out of the tripartite relationship, particularly when the insurer is paying the defense fees and costs, but the insured is the client:

1. A lawyer may not represent a client if someone other than the client will wholly or partly compensate the lawyer for the representation, unless the client consents under the limitations and conditions provided in § 122 and knows of the circumstances and conditions of the payment.
2. A lawyer's professional conduct on behalf of a client may be directed by someone other than the client if:
    a. the direction does not interfere with the lawyer's independence of professional judgment;
    b. the direction is reasonable in scope and character, such as reflecting obligations borne by the person directing the lawyer; and
    c. the client consents to the direction under the limitations and conditions provided in § 122.[9]

As such, insurance defense counsel must uphold the interests of both the insurer and the insured at the same time. If the interests come into conflict, defense counsel cannot ethically continue to represent both the insurer and insured, and must withdraw, unless each affected client gives informed written consent.[10]

1 *Hartford Acc. & Indem. Co. v. Foster*, 528 So. 2d 255, 273 (Miss. 1988).
2 *Id.*
3 *Id.*
4 *See* Formal Advisory Opinion No. 86-4 (Dec. 17, 1987).
5 *See Safeway Managing Gen. Agency, Inc. v. Clark & Gamble*, 985 S.W.2d 166, 168 (Tex. App. 1998).
6 *See* ABA Model Rule of Prof'l Conduct 1.8(f) (1983).
7 State Bar of Georgia, Rules of Prof'l Conduct, Rule 1.1 (2001).
8 State Bar of Georgia, Rules of Prof'l Conduct, Rule 1.4 (2001).
9 Restatement (Third) of The Law Governing Lawyers § 134 (2000).
10 *See* State Bar of Georgia, Rules of Prof'l Conduct, Rule 1.7 (2001).

HOW DOES THE ATTORNEY-CLIENT PRIVILEGE WORK IN THE TRIPARTITE RELATIONSHIP?

Defense counsel's tripartite relationship includes the attorney-client privilege. The Supreme Court of the United States has described the attorney-client privilege as "the oldest of the privileges for confidential communications known to the common law."[11] In Georgia, the attorney-client privilege is codified in Georgia statute and protects against the admission of attorney-client communications on the grounds of public policy.[12] The Supreme Court of Georgia has explained the purpose of the privilege is "to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice."[13]

The attorney-client privilege belongs to the client and, importantly, can be waived only by the client.[14] Georgia recognizes an exception to the attorney-client privilege where the attorney jointly represents two or more clients whose interests subsequently became adverse.[15] It appears that no Georgia court has yet to expressly hold that the attorney-client privilege vanishes when the same attorney represents both the insurer and the insured under the joint-defense exception.[16]

REASONABLENESS OF DEFENSE COSTS AND BILLING GUIDELINES

Billing guidelines are often implemented by insurers to control costs. However, it is important that the use of litigation and billing guidelines do not restrict counsel's ethical duty to exercise independent professional judgment in the defense of the insured.[17]

RESERVATION OF RIGHTS

How is the tripartite relationship affected when the insurer issues a reservation of rights letter and coverage defenses are asserted? Few states have enacted statutes to specifically address conflict of interests between an insurer and its insured when coverage defenses are asserted. However, Florida has done so — its statute assumes there is an inherent conflict of interest between an insurer and its insured when a coverage defense is asserted by the insurer.[18] When a coverage defense is asserted, the insurer must either: (1) obtain the insured's non-wavier agreement following "full disclosure of the specific facts and policy provisions upon which the coverage defense is asserted and the duties, obligations, and liabilities of the insurer during and following the pendency of the subject litigation;" or (2) "retain independent counsel which is mutually agreeable to the parties."[19] In addition, a California statute provides that "when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist."[20] Similar to Florida, the California statute requires the insurer to provide independent counsel to the insured if a conflict exists, unless the insured is informed of the conflict and expressly waives the right to independent counsel in writing.[21]

Few states have statutes similar to Florida and California. In states without applicable statutes, it is prudent practice for defense counsel to stay out of coverage issues, and for such issues to remain solely between the insurer and the insured.

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11 *Upjohn Co. v. U.S.,* 449 U.S. 383, 389, 101 S.Ct. 677 (1981).

12 O.C.G.A. § 24–5–501(a)(2).

13 *St. Simons Waterfront, LLC v. Hunter, Maclean, Exley & Dunn, P.C.*, 293 Ga. 419, 422, 746 S.E.2d 98 (2013) (*quotingTenet Healthcare Corp. v. Louisiana Forum Corp.,* 273 Ga. 206(1), 538 S.E.2d 441 (2000)).

14 *See Waldrip v. Head*, 272 Ga. 572, 577, 532 S.E.2d 380 (2000).

15 *See Peterson v. Baumwell*, 202 Ga. App. 283, 284-85, 414 S.E.2d 278 (1991) ("Thus, '[i]f two or more persons jointly consult [or retain] an attorney the communications which either makes to the attorney are not privileged in the event of any subsequent litigation between the parties. In such situations it is considered that the attorney does not have an attorney-client relationship with either of the joint parties.'") (*quoting Gearhart v. Etheridge*, 232 Ga. 638, 640-41, 208 S.E.2d 460 (1974)).

16 *See Camacho v. Nationwide Mut. Ins. Co.*, 287 F.R.D. 688, 692 (N.D. Ga. 2012).

17 *See Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 61 Cal. App. 4th 999, 1009, 71 Cal. Rptr. 2d 882 (1998), *as modified* (Mar. 27, 1998) ("Under no circumstances can such [billing] guidelines be permitted to impede the attorney's own professional judgment about how best to competently represent the insureds. If the attorney's representation is to be limited in any way that unreasonably interferes with the defense, it is the *insured, not* the insurer, who should make that decision.") (emphasis in the original).

18 Fla. Stat. § 627.426.

19 Fla. Stat. § 627.426(2)(b).

20 Cal. Civ. Code § 2860.

21 *Id.*

THE DUTY TO SETTLE

The tightrope of the tripartite relationship can become tricky to navigate during the evaluation of settlement offers. Insurance policies generally provide that the insurer has the contractual right to control the settlement of claims and suits against the policyholder. Yet, ethics rules provide that "[a] lawyer shall abide by a client's decision whether to settle a matter."[22] Further, courts across the country have tried to protect an insured's interests by imposing obligations on an insurer. Some states impose a bad faith standard on the insurer. For example, California law provides that an insurer has an implied covenant of good faith and fair dealing in settling within policy limits.[23] In addition, Georgia statute provides for "not more than 50 percent of the liability of the insurer for the loss or $5,000, whichever is greater, and all reasonable attorney's fees for the prosecution of the action against the insurer" if an insurer refused to settle in bad faith.[24] Georgia courts have further ruled that when deciding whether to accept a settlement offer within policy limits, "the insurer must accord the interest of its insured the same faithful consideration it gives its own interest. It is for the jury to decide whether the insurer has or has not so acted."[25] Therefore, defense counsel must be cognizant that the insurer must give equal consideration to both the insured's financial interest and the insurer's own interest when deciding to settle a claim.

SO, WHAT'S THE ANSWER?

As the Supreme Court of Mississippi stated, "there is no completely satisfactory answer" to the tripartite relationship.[26] Instead, the best thing insurance defense counsel can do is to explain the tripartite relationship to the insured at the initial client meeting and be aware of potential conflicts of interest.

[22] State Bar of Georgia, Rules of Prof'l Conduct, Rule 1.2(a) (2001).
[23] *See PPG Indus., Inc. v. Transamerica Ins. Co.*, 20 Cal. 4th 310, 312–13, 975 P.2d 652 (1999).
[24] O.C.G.A. § 33-4-6(a).
[25] *Thomas v. Atlanta Cas. Co.*, 253 Ga. App. 199, 205 558 S.E.2d 432 (2001).
[26] *Hartford*, 528 So. 2d at 273.

Those Dirty Rotten Scoundrels — Dealing with Vendors Who Commit Fraud

By Frederick O. Ferrand and Kori E. Eskridge

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Frederick O. Ferrand specializes in complex litigation claims relating to commercial and insurance disputes, property damage claims, products liability actions and negligence causes of action, both from plaintiff and defense perspectives. Having gained his experience in trial and appellate courts throughout the United States, the Caribbean and Europe, Mr. Ferrand has successfully litigated and arbitrated cases around the world. Mr. Ferrand is fluent in French and Spanish. Mr. Ferrand is admitted to practice in state, territorial and federal courts in Georgia, Pennsylvania and the Virgin Islands. He is also admitted in the Supreme Court of the United States and in the United States Courts of Appeals for the Third and Eleventh Circuits. As a member of the Georgia, Pennsylvania and Virgin Islands Bar Associations, Mr. Ferrand participates in their insurance, litigation and products liability committees.

After receiving his undergraduate and law degrees from the University of Virginia in 1981, and University of Pittsburgh in 1984, respectively, Mr. Ferrand started his practice of law in the Virgin Islands. Within his first five years of practice, his appellate work there, which helped lower then-existing high jury awards, was published in the *American Bar Association Journal*. During that same period, Mr. Ferrand was included in the *Who's Who in American Law* listings as a result of his litigation experience, his position as Treasurer of the Virgin Islands Bar Association and his being the creator of their Attorney Referral Program. In 2004, Mr. Ferrand was named a Georgia Super Lawyer by *Atlanta Magazine*, a listing of the top attorneys in Georgia as voted by his peers. Additionally, Mr. Ferrand has spoken on litigation matters in many national forums.

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Those Dirty Rotten Scoundrels — Dealing with Vendors Who Commit Fraud

This paper deals with vendors who commit fraud in performing work in first and third party insurance claims. In determining whether a vendor falls into the above category, we must first determine what constitutes fraud. Do we allude to Supreme Court Justice Potter Stewart's concurring opinion in *Jacobellis v. Ohio*, where, in answering the question, "What is pornography?" Justice Stewart stated:

I know it when I see it.[1]

While sensing fraud intuitively may be a means to spot fraud, certain objective factors may be utilized to indicate potentially fraudulent acts by a vendor. To illustrate these factors, we present the following hypothetical scenario for your consideration.

HYPOTHETICAL ONE – THE WATER LOSS

Your insured, Developmental Properties, owns a five-story apartment complex in downtown Atlanta. On a Saturday evening, vandals break into two vacant apartments on the top floor of the structure and break off sprinkler heads in those units, causing significant water damage to the structure. In an effort to mitigate its damages, your insured obtains the name of a water remediation company, Acme Remediation, and contacts Acme for assistance in dealing with this water loss. Acme immediately sends several representatives to the scene to meet with the owners to discuss what needs to be done.

In these discussions with the owners, Acme assures the owners that it has successfully worked with numerous major insurance companies and has great expertise in handling water remediation losses. Acme then tells the building owners that failure to act immediately will lead to toxic mold growth in the building, which could potentially add millions of dollars in additional remediation costs. When asked by the building owners how much Acme believes the remediation will cost, Acme answers that it will not know until it actually performs the work, but gives the owners a price list for charges of the various pieces of equipment and manpower that could be utilized on the job. Scared about the potential for toxic mold, the building owners retain Acme to perform the water remediation work. Acme immediately starts its work in the subject building.

By the time the carrier learns of the loss and can send an adjuster to the loss site, several days have passed. The adjuster arrives and sees several Acme trucks in front of the building, along with 20 Acme employees with respirators and Tyvek suits entering and exiting the building. The adjuster then finds an Acme supervisor to discuss the extent of damage and proper scope of work needed to remediate this loss. The supervisor refuses to give the adjuster any specifics regarding the loss and continues with his work.

To protect the insurer's interest, the adjuster immediately sends a remediation expert to try and obtain the information Acme refused to give the adjuster. While the scene has been heavily changed through Acme's actions, the insurer's remediation expert determines, that, under a worst-case scenario, the remediation cost should not exceed $250,000. Several days later, the building owners present the adjuster with Acme's bill for $1.4 million.

The adjuster explains to the insured that the fees charged by Acme are grossly excessive and are over 400 percent more than the cost your expert determined to be reasonable in a worst-case scenario. The adjuster then cites to the loss payment provisions of the policy, specifically referencing the following language:

A. In the event of loss or damage covered by this coverage form, at our option we will either:
   1. Repair, rebuild or replace the property with other property of like kind and quality, or pay the reasonable cost of such repair, rebuilding or replacement.

The adjuster then tells the owners that Acme's charges are beyond the scope of reasonableness and must be rejected.

[1] 378 U.S. 184, 197, 84 S. Ct. 1676 (1964) (Stewart, J., concurring).

DO ACME'S CHARGES CONSTITUTE FRAUD?

In the above hypothetical loss, several red flags exist to indicate potential fraud by Acme. First, Acme failed to give the insured any estimate as to what the cost of the remediation could be. While Acme did state that it would not be able provide an estimate until it could see the full extent of the loss while performing its work, Acme could have given ranges for such work, utilizing best and worst-case scenarios.

Further, Acme did not provide a contract to the building owners. Accordingly, there are no delineations as to the scope of work, price or standards to be utilized in performing the remediation work. Without this information, the building owners would have no idea as to what work was being performed.

Acme also refused to provide the insurance carrier with specifics regarding the loss and its work in the remediation process. While Acme had told the insured that it frequently and successfully worked with major insurance carriers in other similar losses, its refusal to do so in this loss suggests that it was hiding something.

Lastly, the fact that Acme was charging over four times what your expert determined to be a worst-case scenario cost strongly indicates potential fraud by the vendor. While it is axiomatic that certain companies will charge more than their competitors, the gross difference between reasonable cost and what Acme charged suggests more than a difference of opinion as to the reasonable cost of the work performed.

As seen in the above-presented language, the carrier in our hypothetical is only contractually obligated to pay the reasonable cost for the remediation work. If a carrier faces a scenario like the one in our hypothetical, there is no question that it needs to immediately obtain counsel to assist it in preserving its rights, as found in the insurance contract. This is especially true should the insured, through the vendor's threats of a lawsuit or lien to collect its sums, challenge the carrier's position regarding the reasonableness of Acme's remediation fees.

HYPOTHETICAL TWO – DEDUCTIBLE KICKBACKS

In our next hypothetical, you learn Acme agreed to kickback the insured's deductible of $150,000 to the building owners should they retain Acme. While a deductible rebate of $100 could possibly be waved off, the instant hypothetical shows a massive kickback being offered by the vendor. How does the carrier deal with this scenario? It seems implausible that a deductible kickback this large could be offered unless the fees charged were grossly inflated.

Some states have anti-kickback laws dealing with the return of deductibles by a vendor to the insured.[2] Further, should the insured submit Acme's bill and fail to disclose that the actual cost of work performed by the vendor is, using this scenario, $150,000 less than was actually presented to the carrier, then the insured has also intentionally misstated the amount of its loss. This could potentially trigger exclusionary policy language barring coverage.

CONCLUSION

The two scenarios presented are just a small snapshot of the countless ways opportunistic vendors and insureds can attempt to perpetrate fraud over the course of an insurance claim. Therefore, it is important to recognize the red flags in dealing with vendor fraud so both the insured and the carrier are protected against the submission of fraudulent claims.

[2] *See, e.g.*, O.C.G.A. § 33-1-9(a)(1)(A).

Home Alone No More — Changes to Georgia's Valued Policy Act

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During law school, Alex gained valuable experience while working as a law clerk for an insurance defense firm and as an extern for Justice Harold D. Melton of the Supreme Court of Georgia. Mr. Mikhalevsky also worked with the Gwinnett County Solicitor's office, where he tried misdemeanor offenses under Georgia's Third Year Practice Act.

Home Alone No More — Changes to Georgia's Valued Policy Act

In the late 1800s, Georgia's legislature took up the issue of how to value total losses caused by fire.[1] That bill provided that "in case of total loss by fire the whole amount of insurance shall be paid."[2] In writing about the proposed bill, the *New York Times* noted "the insurance men of Georgia are all torn up" over the bill and that they "violently oppose the measure."[3]

Despite the supposedly violent opposition from insurers in Georgia, the bill passed, and today, Georgia is one of 20 states that have adopted some form of a valued policy law.[4] In 2016, the Georgia Legislature made minor revisions to Georgia's Valued Policy Act that significantly expanded its applicability. Now, individuals are no longer left "Home Alone" under the Act, as the recent revisions have opened the door to corporations and other entities making claims under the Act.

WHAT IS A VALUED POLICY ACT AND WHY DO WE HAVE ONE?

A "valued policy" is defined as an insurance policy "in which the value of property insured is agreed upon by the parties so that in the case of a total loss, it is not necessary to prove the actual value to recover under the policy."[5] Valued policy laws originally came about due to the "perception that insurers were profiting by selling insurance policies with inflated face values, and, then, after the building suffered a total loss, litigating the actual value of the insured structure."[6] This, in turn, resulted in a windfall for insurers, who could collect higher premiums on increased coverage limits and then refuse to provide the increased coverage purchased by the insured.

In explaining Georgia's Valued Policy Act, Georgia courts have stated its "purpose . . . is to protect property owners from the overwhelming burden of proving the value of property after it has been totally destroyed by fire by 'conclusively' establishing that the value of the property equals the face value of the policy."[7]

By setting a defined value of the property before a loss, insureds and insurers are relieved from the "difficult and perhaps impossible task of proving" the actual value of the property, which can be especially challenging in the face of a tumultuous real estate market, such as the markets property owners dealt with in the late 2000s and early 2010s. In addition, valued policy laws act as a type of "liquidated damages clause" that fix the amount owed under the policy without either party having to present proof of the actual damages.[8] In short, state legislatures implement valued policy laws to allow more efficient adjustment of total losses, prevent litigation over the value of damaged property and to protect insureds from improper adjustment practices by insurers.

GEORGIA'S PREVIOUS VALUED POLICY ACT

After passing the Valued Policy Act about a century ago, the language of Georgia's Valued Policy Act remained largely unchanged. For the last few decades the Act read, in relevant part, as follows:

> Whenever any policy of insurance is issued to <u>a natural person or persons</u> insuring a specifically described <u>one or two family residential building</u> or structure located in this state against loss by fire and the

1 *Valued Policy Law in Georgia*, N.Y. TIMES, September 24, 1885.
2 *Id.*
3 *Id.*
4 *Id.* These States include: Arkansas, A.C.A. § 23-88-101; California, Cal. Ins. Code § 2054, § 2056, § 2058; Florida, Fla. Stat. § 627.702; Georgia, O.C.G.A. § 33-32-5; Kansas, K.S.A. § 40-905; Louisiana, LSA-RS 22:1318; Minnesota, Minn. Stat. § 65A.01; Mississippi, Miss. Code Ann. § 83-13-5; Missouri, R.S.Mo. § 379.140; Montana, Mont. Code Ann. § 33-24-102; Nebraska, Neb. Rev. Stat. § 44-501.02; New Hampshire, RSA § 407:11; North Dakota, N.D. Cent. Code § 26.1-39-05; Ohio, ORC Ann. § 3929.25; South Carolina, S.C. Code Ann. § 38-75-20; South Dakota, S.D. Codified Laws § 58-10-10; Tennessee, Tenn. Code Ann. § 56-7-801; Texas, Tex. Ins. Code § 862.053; West Virginia, W. Va. Code § 33-17-9; Wisconsin, Wis. Stat. § 632.05(2).
5 44 Am. Jur. 2d Insurance § 1500 (2003).
6 John V. Garaffa, *The Uncertain Scope of "Hurricane Damage" Under State Valued Policy Laws*, 41 Tort Trial & Ins. Prac. L.J. 943, 952 (2006).
7 *Ussery v. Allstate Fire & Cas. Ins. Co.*, 150 F. Supp. 3d 1329, 1348 (M.D. Ga. 2015).
8 Robert Groelle, *Florida's Valued Policy Law: An Insurer's Obligation for Additional Coverages After Mierzwa v. FWUA*, 24 No. 1 Trial Advoc. Q. 19, 19 (Winter 2005).

> building or structure is wholly destroyed by fire without fraudulent or criminal fault on the part of the insured or one acting in his behalf, the amount of insurance set forth in the policy relative to the building or structure shall be taken conclusively to be the value of the property . . . . Nothing in this Code section shall be construed as . . . preventing the insurer from repairing or replacing damaged property at its own expense without contribution on the part of the insured.[9]

The Statute also included a number of limitations.[10] More specifically, the statute did not apply when:

- The loss occurs within 30 days of the original effective date of the policy;
- The building or structure is not wholly destroyed by fire;
- The insured fails to disclose the existence of other insurance policies covering the same property;
- The building is insured along with other buildings under a blanket policy for a single amount of insurance; or when
- The completed value of the building is insured under a builders' risk policy.[11]

In short, for Georgia's prior Valued Policy Act to apply, the following conditions must have been met:

- The insured must be a natural person and not some legal entity;
- The property must be wholly destroyed by fire;
- The insured property must be a one or two family residential building or structure;
- The insured must not have engaged in fraud or intentionally caused the loss;
- The loss must occur more than 30 days after the original effective date of the policy;
- The policy cannot be a builders' risk policy;
- The insured property must not be under a blanket form coverage insuring multiple properties; and
- There must not be multiple undisclosed policies covering the same property.[12]

Recent revisions to the statute changed the natural person requirement, but the rest of the requirements remained the same.

"Wholly Destroyed By Fire"

As a threshold matter, for the Act to apply, the insured property must have been "wholly destroyed by fire." Stated another way, if the damage to the insured property did not: (1) result from a fire; and (2) result in a total loss to the property, then the Valued Policy Act will not apply.

Whether the damage resulted from fire is typically an easy determination. However, where an excluded cause of loss contributes to the damage or results in a fire that destroys the property, insurers may be able to argue that the Act does not apply. While such a scenario has not been addressed by Georgia courts, other jurisdictions have addressed the issue and have held that an insurer does not have to issue payment for a total loss under a valued policy law where an excluded loss contributes to the damage.[13]

Georgia courts have determined that the issue of whether a property is "wholly destroyed" is a question of fact for the jury to decide.[14] When the parties contest the applicability of the Act, each party will have the burden of establishing evidence as to whether the Act applies or not.[15] In doing so, Georgia courts will consider repair estimates, appraisals, photographs and other documentation relative to the cost of repairs, value of the property and the damage that resulted from the loss.[16]

To support a conclusion that the property was not "wholly destroyed," an insurer will have to come forward with evidence that the property can be rebuilt or repaired using the remaining structure. Estimates showing the repair cost will

9 O.C.G.A. § 33-32-5 (2005) (emphasis added).
10 *Id.*
11 *Id.*
12 *Id.*
13 *See Fl. Farm Bur. Cas. Ins. Co. v. Cox*, 967 So. 2d 815, 820 (Fla. 2007).
14 *Allstate Ins. Co. v. Baugh*, 173 Ga. App. 615, 327 S.E.2d 576 (1985).
15 *Id.; see also Ga. Farm Bur. Mut. Ins. Co. v. Brown*, 192 Ga. App. 504, 507, 385 S.E.2d 87 (1989), *aff'd*, 260 Ga. 160, 390 S.E.2d 586 (1990).
16 *Id.*

be less than the value of the property will not be sufficient. To that end, engineer reports, detailed estimates from outside contractors and testimony from public officials, such as building inspectors, that portions of the damaged structure do not require repairs may provide sufficient evidence for a jury to conclude that the property was not "wholly destroyed." Where there is a question as to whether a property has been "wholly destroyed" by fire, insurers should be proactive in obtaining evidence to establish that repairs to the remaining structure are a viable option.

One- or Two-Family Residence

For the Act to apply, the loss must occur at a one- or two-family residential building. This requirement prevents the application of the Act where the loss occurs to an apartment building or commercial structure.

Notably, Georgia Courts have held that a house under construction qualifies as a residence.[17] However, while a house under construction may qualify as a residence for purposes of the Act, it is unlikely that loss would otherwise be covered, as a typical homeowners' policy precludes coverage if the insured is not residing at the "residence premises." Similarly, if the property is under construction, the property may be covered by a builder's risk policy, which is expressly excluded by the Act. Importantly, the Georgia Court of Appeals in *Georgia Farm Bureau Mutual Co. v. Garzone* held that a policy that mirrored the language of the standard fire policy actually qualified as "builder's risk coverage" based on the fact the property was under construction during the loss.[18] As such, the court held the Valued Policy Act did not apply based on the builder's risk exception.[19]

Insured's Fraud or Intentional Acts

An insured's intentional act in procuring the loss will negate the applicability of the Act. Apart from the applicability of the Act, the insurance policy at issue will also likely exclude coverage for any intentional loss caused by or at the direction of the insured.

While the intentional loss requirement does not have any significant impact on coverage for the insured, it does have an impact on a mortgagee's claim. When an insured intentionally burns the insured property, the mortgagee still has an independent right to recover under the policy. However, the mortgagee cannot use the Valued Policy Act as a means to prove the value of the property at the time of the loss. Rather, the mortgagee will still have to provide evidence that the value of the insured property at the time of the loss exceeded the balance of the insured's debt. To that end, an insurer will be able to challenge the mortgagee's valuation of the property and potentially reduce its exposure. Notably, however, the recent changes to the Act, which are discussed in further detail below, may open the door for mortgagees to use the Act to prove the value of the property in the event an insured intentionally causes the loss.

The Option to Repair or Replace

While the Act fixes the value of the property after a loss, it expressly provides that the insurer may still exercise the option, if expressly reserved in its policy, to repair or replace the damaged property rather than issuing payment to the insured.

In *Love v. Safeco Ins. Co. of Indiana*, the United States District Court for the Middle District of Georgia analyzed the interplay between the Valued Policy Act and a provision in the insurance policy allowing the insurer to repair or replace the damaged structure.[20] In *Love*, the insureds' home was destroyed during a fire.[21] The insureds then claimed they were entitled to recover the stated value of the structure listed in the policy – $267,100.[22] In opposition, the insurer, Safeco, argued it was entitled to rebuild the property at its own cost rather than issue payment for a total loss under the Valued Policy Act.[23]

In addressing the issue, the court noted that an insurer could only exercise the right to repair or replace instead of issue payment if the right is reserved in the policy and if the insurer completes all necessary conditions precedent to exercising the right to repair.[24] In *Love*, the insureds' policy required that Safeco give notice to the insured that it was electing to repair

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17 *Ga. Farm Bur. Mut. Ins. Co. v. Garzone*, 240 Ga. App. 304, 305, 523 S.E.2d 386 (1999).
18 *Id.*
19 *Id.*
20 3:12-CV-87 CAR, 2013 WL 5442208 (M.D. Ga. Sept 27, 2013).
21 *Id.* at *2.
22 *Id* at *9.
23 *Id.* at *8.
24 *Id.* at *9.

or replace the damaged property within 30 days of receiving the insureds' sworn proof of loss. Safeco failed to do so and the court determined Safeco waived its right to repair or replace the property.[25]

Based on the language of the Act and the court's analysis in *Love*, insurance companies may have the right to elect to repair or replace the damaged property if it is provided in the policy and the insurer satisfies any conditions set forth in the policy. This provision provides insurers with an alternative to issuing payment for the total value of the property in accordance with the Act.

An insurer may want to invoke its right to repair or replace when a property is grossly over-insured, the loss satisfies the requirements of the Act and the property could be repaired for far less than the amount it would have to pay under the Act. Importantly, however, insurers should not accept this option without careful consideration. By invoking its right to repair or replace the property rather than issuing payment, the insurer transforms itself into a general contractor for the repair of the property. As such, the insurer opens itself to additional liability, including liability for improper or defective work and potential bad faith penalties if it later changes its mind and tries to issue payment to the insured rather than perform repairs.[26]

In short, while the Act allows an insurer to exercise its right to repair the damaged property, an insurer should carefully weigh its decision to do so. Even when the cost of repair is less than the total insured value of the structure, choosing to repair the property may not be worth the additional risk associated with doing so.

2016 REVISIONS: EXPANSION OF THE "NATURAL PERSON" REQUIREMENT

On July 1, 2016, Georgia's new Valued Policy Act became effective. The vast majority of the statute remained unchanged. However, the legislature modified the first sentence of the statute to provide as follows: "Whenever any policy of insurance is issued to a natural person or persons or to any legal entity wholly owned by a natural person or persons . . . ."[27] The prior version of the Act provided that it only applied to policies issued to "a natural person or persons." In short, through its revisions to the Act, the Georgia legislature has opened the door for corporations and other entities to make claims under the Act.

This small change has drastic implications. No Georgia court has addressed the new language of the Act so its new reach is not entirely clear. However, the revised statute suggests that an insured corporation, limited liability company (LLC), partnership, mortgagee or trust may be able to make claims under the Act so long as they are owned by a natural person. In fact, based on the plain language of the statute, the only insured that would be excluded from making a claim under the revised act is an entity that is owned, in whole or part, by another entity.

In evaluating the applicability of the revised Act, the critical question to ask is who owns the insured entity? As for partnerships, they are owned by their partners. Corporations are owned by their shareholders. Limited liability companies are owned by their members. Mortgagees are typically banks, which are corporations, so their ownership will be determined by the status of their shareholders. While partners, shareholders and members are typically natural persons, nothing prevents them from being an entity. In fact, with respect to large corporations, including mortgagees, there will almost always be a non-natural person shareholder.

As for trusts, which are also considered legal entities under Georgia law, they are not "owned" by anyone. Rather, trusts are legal entities that hold property for the benefit of another. The technical ownership of trust property is vested with the trustee,[28] but the beneficiary of a trust maintains equitable ownership of trust property.[29] It is unclear how a Georgia court would treat an insured trust where the trustee is not a person and the beneficiary is (and vice versa), but, presumably, where both the trustee and beneficiaries are individuals, the trust could make a claim under the Act.

Less formal entities, such as sole proprietorships, partnerships and joint ventures, are not required to file any documentation with Georgia regarding their ownership so determining whether they are owned by a person can prove challenging. On the other hand, federal regulations require corporations to maintain a list of all shareholders. However, shareholder lists are not typically publicly available and can only be obtained by the public in certain enumerated circumstances.

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25 *Id.*

26 *S. Ins. Underwriters, Inc. v. Ray*, 188 Ga. App. 469, 471, 373 S.E.2d 236 (1988).

27 O.C.G.A. § 33-32-5 (2016) (emphasis added).

28 O.C.G.A. § 53-12-2(15).

29 O.C.G.A. § 53-12-2(2).

As the ownership structure of entities and trusts is not always clear, insurers will have to rely on their insureds to produce documentation to show their ownership structure. In addition, insurers will have to actively seek this information during recorded statements and examinations under oath. Insurer document requests should be aimed at obtaining all ownership related documentation including: corporate formation documents, such as articles of incorporation, partnership agreements and membership agreements; shareholder lists; tax returns and tax documents, including schedule K-1s, which list income received by partners in a partnership, shareholders in a corporations and beneficiaries to a trust; and trust agreements. Even once relevant documents are obtained, interpreting the documentation to evaluate ownership can be a complicated task and may require the assistance of outside counsel. By expanding the reach of the Act, the legislature has placed another burden on insurers when evaluating claims under the Act.

CONCLUSION

The seemingly minor revisions to Georgia's Valued Policy Act have significantly expanded its reach. With the recent changes to Georgia's Valued Policy Act, natural person insureds are no longer left "home alone" as the only claimant that can seek the benefit of Georgia's Valued Policy Act. Now the list of claimants has greatly expanded and allows almost any category of insured to assert a claim under the Act.

With the significant expansion in reach of the Act comes a significant expansion of the duties facing insurers in evaluating the applicability of the Act. In addition to evaluating the lengthy list of conditions required for the prior version of the act to apply, including whether the property was "wholly destroyed by fire" and whether the insured intentionally caused the loss, insurers are now faced with the onerous task of determining the ownership structure of the entity that insured the property. This will likely prove difficult in most cases, as ownership information is not typically publicly available. As such, insurers will have to seek their insureds' cooperation and develop this information through recorded statements, examinations under oath and formal document requests. Even then, determining whether a "natural person" owns the entity that insured the property may prove challenging. In short, while the changes to the Act are small, the implications on insurers are large.

A World of Pure Imagination: Navigating the Tricks and Treats of Magistrate Court Trials

By Jessica M. Phillips

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Ms. Phillips evaluates coverage issues under a variety of policies including traditional home owners policies, inland marine policies, builders risk policies, renters policies and valuable articles policies. She has taken numerous examinations under oath and depositions and she defends her clients in litigation relating to a variety of policy provisions, including appraisal provisions and "suit against us" provisions. In conjunction with her defense of these matters, Ms. Phillips has prepared and successfully defended dispositive motions, including motions to dismiss and motions for summary judgment. She also assists her clients in evaluating the value of losses including replacement cost value, actual cash value and additional living expenses. Ms. Phillips also defends numerous third party claims including auto-accidents, dog bite claims and first amendment claims.

Ms. Phillips graduated, *cum laude,* from Mercer University Walter F. George School of Law. While in law school, Ms. Phillips was an active member of the *Mercer Law Review* where she was published on two separate occasions. She was also an active member of the Mercer Advocacy Board and was inducted into the Order of the Barristers. Ms. Phillips graduated, *cum laude,* from the College of Charleston in 2004 with a degree in psychology and a minor in biology.

A World of Pure Imagination: Navigating the Tricks and Treats of Magistrate Court Trials

"Come with me and you'll be in a world of pure imagination. Take a look and you'll see into your imagination. We'll begin with a spin traveling in the world of my creation. What we'll see will defy explanation . . . . "[1] Imagine . . . you are sitting at your desk checking the boxes off your ever-growing "To Do" list when a notification pops up on your system advising you that you have received a new lawsuit. You click on the notification and an image of the complaint appears. This is not any ordinary lawsuit. The complaint is hand written and barely legible. There are no enumerated paragraphs. It does not specifically state any causes of action. It is signed with hearts and smiley faces dotting the "I"s. Congratulations. You have just been served with a complaint for a lawsuit in magistrate court.

The term "magistrate" is defined as "a civil officer charged with the administration of the law" or alternatively, "a local judiciary official having limited original jurisdiction especially in criminal cases."[2] The Georgia General Assembly created a magistrate court system with a single magistrate court for each county.[3] Magistrate courts were created to be "courts of the people" and the rules and procedures of the courts were crafted so that individuals could present their cases *pro se* without having to retain an attorney. Therefore, the formality of these courts is often reduced, and the procedure for these courts is often simplified. As a result, often times "anything goes" in magistrate court. Magistrate courts, however, have significantly limited jurisdiction.[4] Specifically, the courts may only hear cases involving specific issues and/or meeting specific requirements, including:

> (1) The hearing of applications for and the issuance of arrest and search warrants;
> . . .
> (4) The trial of charges of violations of county ordinances and penal ordinances of state authorities;
> (5) The trial of civil claims including garnishment and attachment in which exclusive jurisdiction is not vested in the superior court and the amount demanded or the value of the property claimed does not exceed $15,000.00, provided that no prejudgment attachment may be granted;
> (6) The issuance of summons, trial of issues, and issuance of writs and judgments in dispossessory proceedings and distress warrant proceedings as provided in Articles 3 and 4 of Chapter 7 of Title 44;
> . . .
> (10) The issuing of subpoenas to compel attendance of witnesses in the magistrate court and subpoenas for the production of documentary evidence before the magistrate court;
> . . .
> (14) The trial and sentencing of misdemeanor violations of other Code sections as provided by Article 13 of this chapter; and
> (15) The foreclosure of liens on animals as established in Title 4.[5]

Of the issues identified above, item number (5) (and to a lesser extent, item (6)) will be the primary issues relevant to insurers with claims before the magistrate court, and, therefore, will be the focus of this article. Notably, a plaintiff in a civil action will be limited to recovering at most $15,000 in a civil lawsuit before the magistrate court. The court does not have the authority or subject matter jurisdiction to issue any judgment that exceeds $15,000 even if the party has alleged punitive awards such as bad faith damages and attorney's fees. Therefore, any civil action before the magistrate court will be capped at $15,000, even if the party had previously sought a higher amount.[6]

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1 *Pure Imagination*, written by Leslie Bricusse and Anthony Newley for *Willy Wonka & the Chocolate Factory*, performed by Gene Wilder (1971).

2 "Magistrate" Merriam-Webster's Online Dictionary. 2016. [http://www.merriam-webster.com/dictionary/magistrate].

3 O.C.G.A. § 15-10-1 (stating "[t]here shall be one magistrate court in each county of the state which shall be known as the Magistrate Court of _____ County.").

4 O.C.G.A.§ 15-10-2.

5 *Id.*

6 *See WPD Center, LLC v. Watershed, Inc.* 330 Ga. App. 289, 765 S.E.2d 531 (2014). Notably, the magistrate court does not have authority to hear claims

Magistrate court judges are both elected and appointed. The chief magistrate is elected by the voters of the county during the general election preceding the expiration of the term of the incumbent chief magistrate court judge.[7] The chief magistrate court judge then appoints, with the approval of the superior court, additional magistrate court judges.[8] The term of a magistrate court judge is generally four years, though it may be shorter if the judge is replacing an incumbent who has stepped down or otherwise prematurely terminated his or her term of service.[9] Magistrate court judges are not required to have legal training prior to their service on the bench. Instead, magistrate court judges are only required to: (1) be a resident of the county in which he or she would serve for one year prior to beginning his or her term of office; (2) be at least 25 years of age before assuming office; and (3) have at least a high school diploma or its equivalent.[10] In more urban counties, such as the Metro Atlanta Area, Savannah, Macon, Columbus, Augusta and Brunswick, the magistrate court judges often have extensive legal training and, in fact, many are former practicing attorneys or retired judges. However, in more rural counties, magistrate court judges may not have any legal training and may be local business owners, teachers, politicians or anyone who volunteered for the job! Knowing your audience is important for effective presentation of your case. It is best to avoid, or at least, simplify, complex legal arguments or strategies when trying your case before a magistrate court judge who may have no legal training. Instead, in these circumstances, it is best to focus the presentation of your case on the facts established by the evidence and the "common sense" reasons why the facts support your claims or defenses.

The goal of magistrate court is to adjudicate cases as pragmatically and cost efficiently as possible. Thus, there are no jury trials in magistrate court.[11] Instead, all matters are resolved through a bench trial governed by the magistrate court judge assigned to the case. The magistrate court judge acts as the finder of fact, the gatekeeper for evidence and as the arbiter of the law. Importantly, the Georgia Civil Practice Act does not apply to civil cases in magistrate court.[12] Therefore, there are very few pretrial motions filed in magistrate court. In fact, if a party files a motion in magistrate court, the other party is not required to respond to the motion until the date of the scheduled hearing or trial.[13] The motion will not be heard and adjudicated until the date of the scheduled hearing or trial.[14] Moreover, "use of O.C.G.A. § 9-11-26 through O.C.G.A. § 9-11-37 for purposes of pre-trial discovery is not favored."[15] Therefore, there is no discovery in magistrate court, and consequently, neither side will be aware of the other side's evidence until the date of the hearing or trial.

An action in magistrate court is initiated by the filing of a statement of claim which is signed and verified by the plaintiff or his attorney. The statement of the claim should include a brief statement of the plaintiff's claim in sufficient detail to give the defendant some idea as to why he is being sued.[16] A copy of the complaint must be personally served on the defendant by an official or person authorized by law.[17] Once served, the defendant must submit an answer, either admitting or denying the allegations in the claim, within 30 days. This claim may be written or "orally presented to the judge or clerk of the court within 30 days after service."[18] In the event the defendant fails to serve or otherwise provide an answer to the plaintiff's complaint within 30 days, he will be in default and the plaintiff may be able to immediately recover the amount sought in the lawsuit without adjudication of the claim on the merits.[19] A short period of time after the answer is filed, the clerk of the court will schedule a hearing or a magistrate court "trial." The trial is typically scheduled for approximately one month after the answer was filed, though this will vary depending on the county in which the case is filed. Generally, once a hearing is scheduled, it is very difficult to reschedule or continue the hearing in advance. Often, in order to continue a hearing, both parties will have to agree and file a joint request with the court. Even then, the request may not be granted until the day of the hearing.

for injunctive relief as the superior court has exclusive equitable jurisdiction. *Adams v. Madison County Planning and Zoning,* 271 Ga. App. 333, 609 S.E.2d 681 (2005).

7 O.C.G.A. § 15-10-20.

8 *Id.*

9 *Id.*

10 O.C.G.A. § 15-10-22.

11 O.C.G.A. § 15-10-41.

12 O.C.G.A. § 15-10-42.

13 Unif. Mag. Ct. Rul. 38.

14 *Id.*

15 Unif. Mag. Ct. Rul 40.

16 O.C.G.A. § 15-10-43.

17 *Id.*

18 O.C.G.A. § 15-10-43(c).

19 O.C.G.A. § 15-10-43 (d).

The magistrate judge will conduct the trial in such a manner as to do "substantial justice" between the parties.[20] Thus, the judge will liberally construe all rules governing the pleading, practice and procedure so as to administer what he or she considers to be justice in the case at issue.[21] This means the judge may relax evidentiary standards, rule of law or procedural standards, particularly in cases involving *pro se* plaintiffs. The judge may even decide not to follow court established precedent in the event he or she believes that so doing would not serve justice based on the evidence of the particular case. As a result, it is extremely difficult to predict the manner in which the proceeding will be governed, what evidence will be sought to be admitted by the opposing party, what evidence the court will admit and how the court will rule on either party's substantive arguments.

Immediately prior to the trial of any case, the judge will counsel the parties to make an earnest effort to reach a mutually agreeable settlement agreement.[22] In the event the parties cannot reach a settlement agreement, the judge will proceed with the trial. While the Georgia Civil Practice Act does not apply to govern magistrate court proceedings, the Georgia Rules of Evidence do apply. Parties must comply with the rules and procedures for admitting the evidence they believe necessary to prove their case. Addressed below are some of the most common evidentiary rules which can cause challenges for the uninformed litigant.

Any evidence sought to be admitted must be relevant.[23] All relevant evidence will be admissible, unless limited by constitutional requirement or otherwise provided by law or rules.[24] Evidence is "relevant" if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."[25] Relevancy is a threshold requirement for evidence to be admitted. However, relevant evidence will be excluded in the event the value of the evidence is "substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence."[26] The magistrate court judge will be the gatekeeper to determine whether the evidence is sufficiently relevant to be admitted and considered during the adjudication of the underlying issues. However, since the magistrate court judge is also the finder of facts, in practicality, the court will likely consider the proffered evidence when deciding the matter, even if it only has the slightest tendency to make the fact more or less probable, provided that it is not unduly scandalous or prejudicial. Notably, certain facts, such as offers of compromise, certain types of guilty pleas, collateral sources and the financial condition of the parties, have been deemed not relevant and inadmissible as matter of law. Even so, the magistrate judge cannot "unhear" such evidence and may be swayed accordingly.

In addition, any litigant seeking to introduce documentary or other tangible evidence must be prepared to "lay the foundation" or "authenticate" the evidence.[27] In short, the party proffering the evidence must provide information sufficient to support a finding that the proffered evidence is what the proponent claims it to be.[28] The most general way of authenticating evidence is "testimony of a witness with knowledge that a matter is what it is claimed to be."[29] This method requires a witness with firsthand knowledge of the proffered evidence. However, authentication may also be based on non-expert opinion as to the genuineness of handwriting, evidence of the appearance or other distinctive characteristics of the item given the circumstances, evidence that the proffered document is recorded or filled in a public office or on public record in the public office where items of this nature are kept and evidence describing a process or system used to produce a result and showing that the process or system produces an accurate result, amongst others.[30] In these circumstances, a witness is not required to have firsthand knowledge, but must provide information to the judge that the proffered evidence is what is purports to be.

A common trap for parties before the magistrate court is seeking to admit "hearsay" evidence to support their claims or defenses. Hearsay is defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."[31] For example, if Willy Wonka seeks to offer testimony that Veruca Salt told him Charlie (who is not a party) admitted he stole the piece of candy, this testimony would be hearsay if it

[20] O.C.G.A. § 15-10-44.
[21] *Id.*
[22] O.C.G.A. § 15-10-44 (a).
[23] O.C.G.A. § 24-4-402.
[24] *Id.*
[25] O.C.G.A. § 24-4-401.
[26] O.C.G.A. § 24-4-403.
[27] O.C.G.A. § 24-9-901.
[28] O.C.G.A. § 24-9-201(a).
[29] O.C.G.A. § 24-9-901(b)(1).
[30] O.C.G.A. § 24-9-201(b)(2)(4)(7)(10).
[31] O.C.G.A. § 24-8-801(c).

was sought to be admitted to prove that Charlie actually stole the piece of candy. Generally, "hearsay shall not be admissible" unless it falls within one of the established exceptions to the hearsay rule.[32] Notably, some statements have been expressly excluded from the hearsay rule, even though they would otherwise be considered an out of court statement and, thus, inadmissible. For example, admissions by a party opponent are admissible, even though the purported admission constitutes an "out-of-court statement" which would classically be considered hearsay.[33] Notably, in order to constitute an "admission," the statement of the party must be sought to be admitted by the opposing party. Therefore, using the example discussed above, if Charlie is a party to the lawsuit, and Willy Wonka seeks to offer testimony from Veruca Salt that Charlie admitted to her he stole the candy, then this statement would not be considered hearsay and would be admissible.

Hearsay evidence can be admissible if it falls within the exceptions to the hearsay rule set forth in the Official Code of Georgia Annotated Section 24-8-801, *et seq*. A common exception to the hearsay rule is the "business records exception" also referred to as "records of regularly conducted activity."[34] This exception provides that, "unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness," certain documents may be admitted if they were: (1) made at or near the time of the events; (2) made by or from information transmitted by a person with knowledge and a business duty to report; (3) kept in the regular course of business; and (4) it was the regular practice of the activity to make the report.[35] The factors to satisfy the exception must be shown through witness testimony, whether through affidavit, certification or live testimony. Importantly, this exception only allows documents in as evidence for the truth of what the documents contain, not for the truth of any inferences which may be sought to be made from the documents. For example, if a party seeks to introduce an invoice documenting the amount charged for work at a property, then the party may have the invoice admitted provided the provisions of the business records exception are satisfied. However, the invoice cannot be used to prove that the work charged therein was actually necessary to repair the property. A live witness must be present to testify as to the necessity of the tasks listed on the invoice to repair the property.

Another evidentiary issue which parties to a lawsuit in magistrate court must consider is the use of expert witnesses. Expert witnesses may be used if "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue."[36] The witness may be considered an "expert" based on knowledge, skill, experience, training or education.[37] Thus, a claim representative may be considered an "expert" sufficient to offer testimony as to his or her estimate, the damages to a property and other issues related to the claims adjustment. In contrast, the insured/plaintiff is likely not considered an expert as to any of these issues and will have to present testimony from their public adjuster, subcontractor or other individual with specialized knowledge related to their basis for suit. Failure of a plaintiff to present witnesses with the necessary expertise will likely result in a dismissal of their action or in a defense verdict.

Importantly, any ruling from a magistrate court after a civil trial is subject to appeal to the state or superior court in the presiding county.[38] All appeals to the state or superior court are considered "*de novo*" which means the litigation will start over as if brand new. The parties will have a second opportunity to develop their evidence, present their evidence and seek new adjudication of the issues. The appealed litigation will proceed as a traditionally filed lawsuit and will be subject to the Civil Practice Act. Therefore, the parties will participate in the discovery process and will be permitted to file dispositive and other pretrial motions. However, the defendant may not appeal from a default judgment entered because it failed to timely file its answer.[39] Therefore, a defendant served with a magistrate court lawsuit would benefit strategically by answering the lawsuit and trying the case at the magistrate court hearing. It is possible the defendant could prevail at the hearing, and the plaintiff could lose motivation to appeal. However, even if the defendant does not prevail, it would have obtained a "sneak peek" at the plaintiff's evidence and arguments and can plan to combat the plaintiff's position in the event the defendant decides to appeal the magistrate court's ruling.

[32] O.C.G.A. § 24-8-802.
[33] O.C.G.A. § 24-8-801(b)(2).
[34] O.C.G.A. § 24-8-803 (6).
[35] *Id.*
[36] O.C.G.A. § 24-7-702(b).
[37] *Id.*
[38] O.C.G.A. § 15-10-41.
[39] O.C.G.A. § 15-10-41(b)(2).

Honoring Aunt Edna: How to Conduct Yourself, and Your Claim, When the Named Insured Has Passed

By Audrey S. Eshman

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Honoring Aunt Edna: How to Conduct Yourself, and Your Claim, When the Named Insured Has Passed

Navigating a property insurance claim is no small feat. Handling a claim where the named insured has passed away, either before or after the loss, is even more challenging. In addition to ensuring you are sensitive to the grieving family members, there are special considerations that need to be taken into account when handling a claim where the named insured has passed away.

WHO QUALIFIES AS AN "INSURED" AFTER THE DEATH OF A NAMED INSURED?

Naturally, one of the first questions that comes to mind when a named insured passes away is whether there is anyone else who qualifies as an insured under the policy and can therefore submit a claim after a loss occurs. Typically the policy will define an "Insured" as the named insured, the named insured's relatives and any other person residing with the named insured who is in the named insured's care or the care of a relative. Policies also typically define a relative as a person residing with the named insured and related to the named insured by blood, marriage or adoption. Therefore, even if the named insured has passed away, there can be others who also qualify as an insured under the policy.

Insurance policies also typically have a "death" provision, which provides that the policy will cover the named insured's legal representative while acting in that capacity upon the death of the named insured. In layman's terms, this means that the person appointed to represent the estate of the deceased named insured is considered the insured with regard to the decedent's property. This person may be a different person entirely than others who may qualify as insureds as discussed above. The legal representative of the estate is therefore entitled to any insurance proceeds under the named insured's policy that are due, subject to any applicable exclusions or limitations.

DOES THE SUIT LIMITATION PERIOD APPLY WHEN THE NAMED INSURED HAS DIED?

Setting up an estate and appointing a legal representative can take some time, especially if any heirs or relatives of the insured reside in a different state. Importantly though, the policy's suit limitation is not triggered until a legal representative is appointed. Under Georgia law, when an estate is unrepresented, all statutes of limitations are tolled. O.C.G.A. § 9-3-92 provides:

> The time between the death of a person and the commencement of representation upon his estate or between the termination of one administration and the commencement of another shall not be counted against his estate in calculating any limitation applicable to the bringing of an action, provided that such time shall not exceed five years. At the expiration of the five years, the limitation shall commence, even if the cause of action accrued after the person's death.

The use of the word "shall" in this statute means the tolling occurs by operation of law, for a maximum time period of five years.[1] In other words, once a person dies, the statute of limitations for bringing an action on behalf of the person's estate is tolled (up to five years) until a legal representative is appointed to represent the estate. After a legal representative is appointed, the tolling ends. From that point on, even if the estate has not been fully administered, the estate is charged with knowledge of the applicable limitation period.[2]

It is therefore important to monitor the status of the estate and to pinpoint as best as possible the date a legal representative has been appointed to the estate, as this date triggers the policy's suit limitation period. Once a legal representative has been appointed, the insurer can then hold that person responsible for cooperating with the investigation of the claim.

1 *Legum v. Crouch*, 208 Ga. App. 185, 188, 430 S.E.2d 360 (1993).
2 *See Harrison v. Holsenbeck,* 208 Ga. 410, 413, 67 S.E.2d 311 (1951).

WHAT IF THE NAMED INSURED DIES AFTER THE LOSS?

The death of an insured during a pending claim adds another layer of complexity. As discussed above, most policies contain an assignment clause that provides guidance upon the passing of the named insured. Such clauses generally include language such as the following: "[i]f **you** die, the policy will cover . . . any surviving member of **your** household who was covered under this policy at the time of **your** death, but only while a resident of the **insured premises**[,] **your** legal representative while acting in that capacity [and] any person having proper custody of covered property until a legal representative is appointed."

Unfortunately, there are no Georgia decisions that directly construe the death provisions in policies where the named insured has died while a claim is pending. Other jurisdictions have addressed this issue and provide some guidance. For example, the Alabama Supreme Court held that an insurance policy on a building is personal property which passes to the personal representatives of the insured.[3] The Kentucky Supreme Court reached the same conclusion, holding that the personal representative is the proper person to sue for proceeds regardless of who may be entitled to the property after collection.[4] Therefore, it would appear that insurance rights remain with the estate as long as someone takes proper, temporary custody or a legal representative is appointed. Importantly, under Georgia law, a party's rights with respect to insurance proceeds are determined at the time of the occurrence or loss.[5]

Accordingly, we think the named insured's death, after the date of loss, would not affect the interests of any individuals who qualified as insureds on the date of loss. However, the named insured's post-loss death may affect how payment is made, to whom payment should be made and whose interests may have to be protected on any payment. For instance, the insurer must determine whether the named insured had a will or died intestate so that the insurer can identify any potential heirs, as these heirs may have an interest in the deceased's property. In addition, it must be determined whether a legal representative has been appointed for the estate and, if not, whether anyone has temporary custody of the deceased's property, as those individuals can assert a claim as well. Oftentimes, this requires checking with the local probate court to determine the status of the estate and/or obtaining a copy of the deceased's death certificate to see if it identifies a spouse or next of kin.

First Steps to Honoring Aunt Edna:

1. Determine if anyone was living with the named insured at the time of the loss and the relationship of any identified individuals to the deceased.
2. Determine whether the named insured had a will or died intestate.
3. Determine whether anyone is currently in temporary custody of the deceased's property.
4. Determine whether the named insured had any heirs. Potential heirs may be listed on the death certificate. A death certificate can be requested from the Department of Public Health as long as an explanation that the insurance company has a tangible interest in obtaining the death certificate is provided to the Department.
5. Determine whether someone has been appointed as the deceased's legal representative. This can be done by reviewing the county probate court's records.
6. Determine whether there was a mortgagee or lienholder and if so, what the payoff on the loan was on the date of the loss.
7. Request a Proof of Loss and inventory from the estate and any other individuals who qualify as named insureds or heirs to determine who is making a claim and what is being claimed.

[3] *Gray v. Holyoke Mut. Fire Ins. Co.*, 293 Ala, 291, 295, 302 So.2d 104 (Ala. 1974).
[4] *Oldham's Trustee v. Boston Ins. Co.*, 189 Ky. 844, 846-47, 226 S.W.106 (Ky. Ct. App. 1920).
[5] *See Republic Ins. Co. v. Chapman*, 146 Ga. App. 719, 247 S.E.2d 156 (1978).

Mission Impossible: Diminution Protocol

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Mission Impossible: Diminution Protocol

GOOD MORNING MR. HUNT . . .

Since the Georgia Supreme Court's 2001 ruling in *State Farm Mutual Automobile Insurance Company v. Mabry*, Georgia has been in the minority of states requiring insurance companies to pay insureds for the post-repair diminished value of their vehicles. While diminution in value (DIV) claims increased following that ruling, we have recently seen an uptick in such claims. It is no coincidence that this uptick in DIV claims has coincided with an increase in the number of diminished value appraisal "experts" for hire promising to get insureds more money from insurance companies for DIV claims. Given this trend, insurers must be prepared to defend against suspect DIV claims.

A little context may be helpful in explaining how diminished value claims regarding vehicles came about in Georgia. In *Mabry*, the Georgia Supreme Court affirmed the trial court's ruling that even when a motor vehicle is repaired to its pre-loss condition, the insurer is obligated to pay the insured the difference in value between the repaired vehicle and pre-loss vehicle.[1] In that case, Plaintiffs sought to require State Farm to notify its insureds of coverage for diminution in value claims, establish a procedure for handling such claims and force State Farm to honor its contractual obligations to pay diminution in value for first-party claims.[2] In response, State Farm argued that such questions of diminished value arise only when "the vehicle is assessed as a total loss of when repairs cannot return the vehicle to its pre-loss condition."[3] The trial court found for the plaintiffs, noting that there exists "a common perception that a wrecked vehicle is worth less simply because it has been wrecked" and that "the public perceives a loss of value in any wrecked vehicle."[4]

In affirming the trial court's ruling that Georgia law required State Farm to pay first-party claimants for diminution of value and that the company had to evaluate diminution of value in every vehicle claim, the court noted that Georgia case law over the past 75 years has been consistent in establishing value, rather than condition, as the baseline for the measure of damages under the physical damage coverage of an auto policy.[5] Thus, an insurer is obligated to pay for diminution of value because "what is lost when physical damage occurs is both utility and value," and that "[r]ecognition of diminution in value as an element of loss to be recovered on the same basis as other elements of loss merely reflects economic reality."[6] Later in 2012, the Supreme Court of Georgia extended its ruling to real property losses concluding that an insured could potentially recover for the loss in value of a building, even after repairs, based upon the stigma of loss.[7]

Defining the amount of loss associated with a vehicle DIV claim is an inherently subjective process. However, the recent emergence of an entire industry of appraisal "experts" for hire has further complicated the claim adjustment and dispute resolution process. Like public adjusters, such appraisal experts increasingly peddle their services to insureds via the internet, offering insureds assistance in disputing diminution in value estimates from their insurer in order "to get the money they are entitled to."[8] Once hired, those appraisers generate questionable estimates based upon their assessment of vehicle damage, quality of repairs and a vehicle's market value pre- and post-loss. Such an estimate is typically much higher than the insurer's DIV and is used to demand additional payment from the insurer. If an insurer rejects that additional demand for payment, the insured can file suit against the insurer, alleging breach of the insurance contract and pursue additional costly bad faith damages pursuant to O.C.G.A. § 33-4-6, even if the DIV dispute is over a difference of a few hundred dollars. Pursuant to that statute, an insured can recover the following damages if bad faith is found:

> In the event of a loss which is covered by a policy of insurance and the refusal of the insurer to pay the same within 60 days after a demand has been made by the holder of the policy and a finding has been made that such refusal was in bad faith, the insurer shall be liable to pay such holder, <u>in addition</u>

1 274 Ga. 498, 556 S.E.2d 114 (2001).
2 *Id.* at 499.
3 *Id.* at 502.
4 *Id.* at 503.
5 *Id.* at 508.
6 *Id.*
7 *Royal Capital Dev. LLC v. Maryland Cas. Co.*, 291 Ga. 262, 728 S.E.2d 234 (2012).
8 *See* www.diminishedvalueofgeorgia.com and www.collisionclaims.com for examples.

to the loss, not more than 50 percent of the liability of the insurer for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action against the insurer.[9]

However, O.C.G.A. § 33-4-6 only allows for recovery of bad faith penalties when the following circumstances are met:

(1) The holder of the policy makes a demand for a loss covered by a policy of insurance;
(2) The insurer refuses to pay the demand within 60 days; and
(3) The insurer's conduct was in bad faith.[10]

YOUR MISSION, SHOULD YOU CHOOSE TO ACCEPT IT . . .

Employing an accepted method of calculation can assist in resolving a dispute over diminished value by lending both accuracy and credibility to an insurer's appraisal. Use of an accepted valuation method may also aid in defending an insurer from a claim of bad faith under O.C.G.A. § 33-4-6. Many insurers utilize what is referred to as the "17(c)" formula to determine a vehicle's diminished value. As a caution however, Georgia's Commissioner of Insurance has expressly stated that its office "has never indicated that the diminished value result obtained by a carrier's use of a particular formula or method constitutes the definitive determination of the carrier's liability to its insured."[11]

The 17(c) formula was discussed by and approved for use by the trial court in the previously discussed *Mabry* case. In the trial court, State Farm was directed to employ "a methodology for assessment of non-repair related diminished value based on criteria and standards that the Court [could] approve as being acceptable."[12] The *Mabry* trial court provided three methodologies that State Farm could use to make the required assessments, including "the formula distributed by the Georgia Insurance Commissioner's office and used by Safeco, Progressive, Nationwide and Crawford & Co.," identified in paragraph 17(c) of the court's Order.[13] State Farm chose to use the 17(c) formula and the *Mabry* trial court held in its Order and Final Judgment that State Farm could not "be found to have acted in bad faith by virtue of applying the 17(c) formula to assess diminished value claims."[14]

Other cases further recognize the general acceptance of the 17(c) formula, as well as the absence of bad faith on the part of an insurer in using that formula to calculate a vehicle's diminished value. In an unreported Georgia Court of Appeals case, the court discussed the history of the *Mabry* case and noted that the 17(c) formula has court approval that has never been withdrawn.[15] More recently, in *Amica Mutual Insurance Company v. Sanders, et al.*, the court determined that the 17(c) formula to adjust a claim as part of the insurer's subjective determination of the lost value of a vehicle was not in bad faith.[16] In *Amica*, plaintiffs brought suit for bad faith against automobile insurer Amica in connection with its offer of $716.25 to settle the diminished value of their vehicle after it was struck by insured's vehicle in an accident.[17] Plaintiffs' appraiser calculated the vehicle's diminished value to be approximately $3,000.[18] The court noted that in order to recover bad faith penalties, it must be shown that an insurer had no reasonable ground to contest a claim.[19] The court further noted that determining the amount of loss associated with diminution in value was a subjective process and that the 17(c) formula accounted for the subjective nature of that process in its calculations.[20] As such, the court determined that Amica's use of the 17(c) formula in calculating diminished value was reasonable and provided it with good cause as a matter of law for its refusal to pay the amount demanded by plaintiffs.[21] As *Amica* demonstrates, an insurer can defend against potential bad faith claims by utilizing the 17(c) formula for calculating diminished value.

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9 O.C.G.A. § 33-4-6 (emphasis added).
10 *Id.*
11 December 1, 2008 Directive issued by the Georgia Insurance Commissioner regarding "Dimunition of Value – Property & Physical Damage Claims" available at https://www.oci.ga.gov/ExternalResources/Announcements/Directive-1222008-1058.pdf.
12 June 12, 2001 Order on Compliance and Injunction Granting Further Relief, *Mabry v. State Farm Mutual Automobile Insurance Company*, in the Superior Court of Muscogee County, SU-99-CV-4915.
13 *Id.*
14 Mar. 5, 2002 Final Order and Judgment, *Mabry v. State Farm Mut. Auto. Ins. Co.*, in the Superior Court of Muscogee County, SU-99-CV-4915.
15 *Miles v. State Farm Fire and Cas. Co.*, No. A1ZA1166, at *9 (Ga. Ct. App. July 27, 2012).
16 335 Ga. App. 245, 779 S.E.2d 459 (2015).
17 *Id*. at 245.
18 *Id*. at 248.
19 *Id*. at 250.
20 *Id*. at 251.
21 *Id.*

Another means to defend against a lawsuit premised upon diminished value is to attack the appraisal on which the dispute is based. Many of the purported diminished value experts are demonstrably biased, lack the qualifications to prepare an estimate or employ unproven methods in coming to their valuations. Like any other expert, a diminished value appraiser's opinions must meet the standard of admissibility set forth by O.C.G.A. § 24-7-702(b):

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise, if:
>
> (1) The testimony is based upon sufficient facts or data;
> (2) The testimony is the product of reliable principles and methods; and
> (3) The witness has applied the principles and methods reliably to the facts of the case which have been or will be admitted into evidence before the trier of fact.

Section 24-7-702(f) expresses the intent of the Georgia legislature that applicable federal case law be considered in evaluating the admissibility of expert testimony. In *Daubert v. Merrell Dow Pharmaceuticals, Incorporated*, the United States Supreme Court determined that any scientific testimony or evidence to be admitted must be both relevant and reliable.[22]

The need for reliable methodology in valuing a vehicle was discussed in *Moran v. Kia Motors America, Incorporated*.[23] Although not a diminution in value case, the issue in *Moran* was the exclusion of a plaintiff's expert testimony regarding the value of a vehicle that was allegedly defective at the time of sale.[24] In approving the trial court's exclusion of the witness, the Georgia Appeals Court noted that the plaintiff's expert relied on his own formula, developed in conjunction with two other individuals who worked in the automotive industry, in determining the value of the vehicle.[25] Although the witness had testified several times in other cases as to values derived using his methodology, the witness' methodology involved adjusting values found in wholesale guides such as *Kelly's Blue Book* according to "his own formula."[26] The *Moran* Court determined that methodology was unreliable and affirmed the trial court's exclusion of the expert witness because his methodology was not widely accepted by others in the field, the error rate of that methodology was not known and there was no indication that methodology had been reviewed by other qualified experts.[27]

Based on the *Moran* decision, any appraisal expert offered by the insured should not only be questioned as to his or her qualifications, but the reliability of their valuation methods as well. Appraisers should be questioned regarding whether their methodology is used or accepted by other DIV appraisers in the field. DIV appraisers must also show that their methodology has been reviewed by other appraisers. Such appraisers should also be questioned as to whether the error rate of their methodology is known, through comparison of their work against market surveys or retail sales figures for similar vehicles, for example.

. . . THIS MESSAGE WILL SELF-DESTRUCT IN TEN SECONDS. GOOD LUCK.

22 509 U.S. at 589.
23 276 Ga. App. 96, 622 S.E.2d 439 (2005).
24 *Id.* at 96.
25 *Id.* at 97-98.
26 *Id.* at 98.
27 *Id.*

Austin Powers — The Truck That Shagged Me

By Mike O. Crawford, IV

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Partner

Mike O. Crawford, IV, litigates commercial general liability, premises liability, trucking/transportation, excess coverage, automobile, fire, explosion, contract, toxic tort and construction defect claims, as well as a variety of subrogation claims. Throughout his career, Mr. Crawford has represented insurance carriers and their insureds including trucking companies, transportation companies, hotels and restaurants as well as various other corporations and individuals. He has extensive experience in the resolution of claims through negotiations, mediations, jury trials and bench trials. Mr. Crawford has personally appeared as lead counsel in 139 of the 159 counties within the State of Georgia. Mr. Crawford attended Georgia State University, College of Law. While there, he served as an intern for the Honorable Marion Pope at the Georgia Court of Appeals. Mike graduated with Honors in 2000.

Austin Powers — The Truck That Shagged Me

Trucking cases share some similarities with standard auto liability claims (i.e. traffic rules, driver negligence, comparative negligence, etc.), but there are some fundamental differences as well. In Georgia, a plaintiff may bring a direct action against the trucking carrier *and* the insurance carrier in addition to the ordinary claim against the tortfeasor. The practical result is that, if the case ultimately goes to trial, a jury will know (or at least believe) that there are deep pockets that can pay a judgment, which can cause a jury to loosen the purse strings. Gathering the necessary information at the outset of a trucking claim can go a long way toward mitigating a potentially inflated award.

This worksheet is intended to guide an adjuster with a new trucking claim. While the steps taken at the outset of any claim often impact the outcome of the claim, that is never more true than in a trucking case. When possible, it is best to obtain the information below as soon as possible since some of the records and potential evidence are not generally kept forever by trucking carriers or drivers.[1]

First, some definitions . . .

DOES THE INSURED QUALIFY AS A "MOTOR CARRIER"?

Under Georgia law, a "motor carrier" is "any entity subject to the terms of the Unified Carrier Registration (UCR) Agreement" (the federal system which regulates **interstate** motor carriers) or "any entity who operates or controls **commercial motor vehicles**" *regardless* of "whether operated in **interstate or intrastate** commerce, or both."[2] Most tractor-trailers, for-profit bus companies or large dump trucks will qualify as "motor carriers."

WHAT IS A COMMERCIAL MOTOR VEHICLE (CMV)?

There are two basic definitions of a CMV which are identical under Georgia and federal law. First, a CMV is defined as a vehicle:[3]

- with a manufacturer's gross vehicle weight rating (GVWR) or gross combination weight rating (GCWR) of 10,001 or more pounds, OR
- which is designed or used to transport more than 8 passengers (including the driver) if for compensation, OR
- which is designed or used to transport more than 15 passengers (including the driver) if not for compensation, OR
- used to transport hazardous materials in a quantity requiring placards.

If your insured vehicle qualifies as a CMV (above), then all Federal Motor Carrier Safety Regulations (FMCSR) rules apply to the company, its drivers and the vehicles except for Commercial Driver's Licensing (CDL) and Alcohol & Controlled Substance Testing.[4] This means a so-called "light" CMV (10,001 to 26,001 pounds GVWR, *including* any trailer capacity) is required to keep a logbook, maintain a Driver Qualification file and comply with inspection rules.[5]

The second definition of a CMV is meant to capture **larger vehicles**. A vehicle is a CMV where it:[6]

- has a GCWR or gross combination weight of 26,001 or more pounds, whichever is greater, inclusive of a towed unit with a GVWR of 10,001 pounds or more, OR
- has a GVWR or gross vehicle weight of 26,001 or more pounds, whichever is greater, OR
- is designed to transport more than 16 passengers (including the driver), OR
- is transporting hazardous materials in a quantity requiring placards.

1 Obviously, if the claimant's counsel has sent a preservation letter, obtaining these records could also help avoid potential spoliation problems later.
2 O.C.G.A. § 40-2-1(6).
3 49 C.F.R. § 390.5.
4 49 C.F.R. §§ 40, 382, 383 and 390.5.
5 49 C.F.R. § 391.
6 49 C.F.R. § 383.5.

Drivers of CMVs falling under the larger vehicle category are required to hold a CDL and must comply with all the regulations of the FMCSR, including post-accident drug and alcohol testing.[7]

WHAT IS NOT A COMMERCIAL MOTOR VEHICLE OR A MOTOR CARRIER?

Under Georgia law, "no agricultural vehicle, commercial vehicle operated by military personnel for military purposes, recreational vehicle, or fire-fighting or emergency equipment vehicle shall be considered a commercial motor vehicle."[8] Additionally, school buses, taxicabs, limousines, hotel shuttles, government vehicles and ambulances are specifically exempted from the term "motor carrier."[9]

DIRECT ACTIONS DETAILED

Georgia is one of a very small minority of states which **allow the insurer to be sued directly**, specifically in cases involving "motor carriers."[10] As a general rule, direct actions INCREASE EXPOSURE, typically by at least one third.

Exceptions to direct action:

- No direct action allowed against excess carriers.[11]
- No direct action allowed in situations where driver was not operating as CMV.[12]

IF YOUR ACCIDENT MAY RESULT IN A DIRECT ACTION, USE THE FOLLOWING CHECKLIST:

Immediately post-accident, secure the following information:

- Did the accident involve a fatality?
- Any bodily injury which required immediate treatment away from the scene?
- Did any vehicle require towing from the scene?
- Was a citation issued to the truck driver?
- Was the truck driver given a drug and alcohol test?[13]
  - **a. If test NOT given, were there good reasons why not (i.e. injury to driver)?**
  - **b. DO NOT take the driver's recorded statement!**

Consider engaging liability counsel at the outset to protect the investigation via Attorney-Client Privilege/Anticipation of Litigation/Work Product Doctrines.

To avoid a spoliation battle (and some negligence arguments against the motor carrier), secure the following from the motor carrier as soon as possible:

Driver Qualification File

- Driver's application for employment;[14]
- Driver's traffic violations certificates provided by each State in which Driver has a driving record;[15]
- Certificate of Driver's road test;[16]
- Response of each State agency (where Driver has a record) to annual Motor Vehicle Record inquiry;[17]
- Certificate of your review of Driver's Motor Vehicle Record;[18]

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7 49 C.F.R. § § 40, 382.
8 O.C.G.A. § 40-5-142.
9 O.C.G.A. § 40-1-100.
10 O.C.G.A. § 40-1-112.
11 *Jackson v. Sluder*, 256 Ga. App. 812, 569 S.E.2d 893 (2002).
12 *Mornay v. Nat'l Union Fire Ins. Co.*, 331 Ga. App. 112, 769 S.E.2d 807 (2015).
13 49 C.F.R. § 382.303.
14 49 C.F.R. § 391.51(b)(1).
15 49 C.F.R. § 391.51(b)(2).
16 49 C.F.R. § 391.51(b)(3).
17 49 C.F.R. § 391.51(b)(4).
18 49 C.F.R. § 391.51(b)(5).

- A record of all driving citations or violations received by Driver in the preceding 12 months (this should be filled out by Driver);[19] and
- Driver's medical examiner's certificate (or waiver if applicable).[20]

Safety Performance Records

- Driver's written authorization to seek drug and alcohol records;[21] and
- Documents received in response to safety inquiry from previous employers (or documentation of good faith efforts to contact them).[22]

Logs and Pre-Accident Records

- Driver's daily records of duty status (if any) for the 16 days prior to the accident;
- Driver's fuel receipts for the 16 days prior to the accident;
- Driver's weight tickets for the 16 days prior to the accident;
- Driver's trip invoices, manifests or bills of lading for the 16 days prior to the accident;
- Driver's meal receipts (if any) for the 16 days prior to the accident; and
- Driver's post-trip inspection reports for the 16 days prior to the accident.

Post-Accident Records

- Driver's drug and alcohol test results.[23]

Inspection and Maintenance Records

- All maintenance records for the 12 months immediately preceding the accident on the tractor *and* trailer (if any) involved in the accident.[24]

To Avoid Physical Spoliation of the Evidence, Confirm the Following:

- Is insured in possession of the commercial motor vehicle?
- Is the motor vehicle stored in a secure location?
- Was the engine of the motor vehicle *started* after the accident?
- If so, how many times?
- Keep to less than three starts to avoid deleting data.
- Has any party performed an Electronic Control Module (ECM) download?

Personnel Management Considerations

- Has the motor vehicle driver been terminated or disciplined because of the incident?
  a. If yes, driver could become an adverse party entitled to his own defense counsel!
- Have any personnel recorded their statements via an affidavit?
  a. If any employee is likely to be disciplined or fired, consider recording their sworn statement while they remain cooperative with defense.
- If driver was ticketed, do you know the disposition of the ticket?
  a. Paying the fine works a "bond forfeiture" and generally amounts to an admission of fault. If the ticket is erroneous, consider appointing *criminal* defense counsel to prevent admissions in the criminal case.
- Do you have all pertinent parties' present addresses and cell phone numbers?
  a. Remind any insureds to remain in contact to avoid cooperation issues.

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19 49 C.F.R. § 391.51(b)(6).
20 49 C.F.R. § 391.51(b)(7).
21 49 C.F.R. § 391.53(b)(1).
22 49 C.F.R. § 391.53(b)(2).
23 49 C.F.R. § 382.303(a) - (b).
24 49 C.F.R. § 396.3(c), *et seq.*

Other Considerations

The following are potentially useful actions depending on case circumstances:

- Consider securing 911 audio tapes and logs via Open Records Act Request.
    - Consider visiting the scene of incident to note locations of surveillance cameras and secure copies of any footage of the incident.
    - Perform social media searches of any potential plaintiffs as soon as practicable, avoiding "friending" or "contacting" plaintiffs, but saving and documenting all posts before they can be deleted.
    - Remind insured drivers and other likely defendants to avoid social media comment on the incident.
    - Secure all scene photography or video which may have been recorded by the motor vehicle driver or motor carrier personnel.
    - Identify the county of the motor carrier's registered agent for determining likely venue.

While this worksheet should not be considered exhaustive, it should ensure that you acquire most of the pertinent evidence before it can be destroyed or lost. Whether or not you are able to settle the claim pre-suit, the information obtained by following this checklist will allow you and your counsel to properly evaluate the liability issues and will go a long way toward analyzing the value of the claim.

"Those Aren't Pillows!" — Planes, Trains and Uninsured Automobiles

By Steven J. DeFrank

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"Those Aren't Pillows!" — Planes, Trains, and Uninsured Automobiles

WHAT IS UNINSURED MOTORIST COVERAGE?

Uninsured motorist (UM) coverage is "insurance against lack of insurance."[1] UM coverage is a hybrid coverage. It is a form of first-party coverage in favor of the insured which is predicated on principles of fault: benefits are recoverable only where the owner or operator of an uninsured motor vehicle is found to be legally responsible for the insured's damages.

The purpose of the uninsured motorist statute, found under O.C.G.A. § 33-7-11 (UM Statute), is to provide some provision for first-party insurance coverage to facilitate indemnification for injuries to a person who is legally entitled to recover damages from an uninsured motorist, and thereby protect innocent victims from the negligence of irresponsible drivers.[2] The UM Statute is remedial in nature and must be broadly construed to accomplish its legislative purpose.[3]

UM coverage in Georgia also encompasses those situations where the tortfeasor is operating an "underinsured" (UIM) motor vehicle. A tortfeasor's motor vehicle is underinsured to the extent that both the insured's proven damages and the uninsured motorist coverage exceed the tortfeasor's available liability coverage. In order to recover under UM coverage, a judgment against the uninsured motorist must be obtained.[4] Georgia's UM statute contemplates damages for bodily injury, death and injury to or destruction of property of the insured.[5]

WHO IS AN INSURED?

The UM statute's definition of who is "insured" contains two classes of persons. The first class consists of the named insured, resident spouse of the named insured and the resident relatives of the named insured, regardless of their location or whether they are occupants of an insured motor vehicle.[6] They are covered under the statute "while in a motor vehicle or otherwise." The second class consists of those who use the insured motor vehicle with the implied or express consent of the named insured, including guests. Unlike the first class, coverage of the second class hinges on the involvement of the insured motor vehicle.[7]

For those in the second class of insureds, "use" of a vehicle is determined by whether the subject injury "originated from, had its origin in, grew out of or flowed from the use of the vehicle."[8] Determining UM coverage for users of an insured vehicle requires analyzing the facts surrounding the vehicle's use. For example, in *State Farm Mutual Auto Insurance Company v. Vaughn*,[9] the insurer sought to deny UM coverage to a child struck by a truck as she crossed a highway to board a school bus because she did not occupy the insured vehicle. The Georgia Court of Appeals found that the "use" of the school bus in that situation involved crossing the road. The school bus stopped for children to board, its flashing lights were engaged and its stop arm was extended. As such, the parties to the insurance contract, State Farm and the school district, must have contemplated the use of the school bus in that manner.

REJECTION OF COVERAGE

The coverage required under the Georgia's UM statute is not applicable "where any insured named in the policy shall reject the coverage in writing."[10] Once the insured makes a rejection of UM coverage, the coverage need not be provided in or

1 Joseph Laufer, *Insurance Against Lack of Insurance? A Dissent from the Uninsured Motorist Endorsement*, 1969 Duke L.J. 227 (1969).
2 *Smith v. Commercial Union Assur. Co.*, 246 Ga. 50, 268 S.E.2d 632 (1980); *Atlanta Cas. Co. v. Gordon*, 266 Ga. App. 666, 598 S.E.2d 70 (2004), *cert. granted*, (Sept. 8, 2004); *Hambrick v. State Farm Fire & Cas. Co.*, 260 Ga. App. 266, 581 S.E.2d 299 (2003), *cert. denied*, (June 9, 2003).
3 *See St. Paul Fire & Marine Ins. Co. v. Goza*, 137 Ga. App. 581, 584, 224 S.E.2d 429 (1976) ("The statute is designed to protect the insured as to his actual loss, within the limits of the policy or policies of which he is the beneficiary.")
4 *Cook v. State Farm Mut. Auto. Ins. Co.*, 237 Ga. App. 400, 514 S.E.2d 48 (1999).
5 O.C.G.A. § 33-7-11(a)(1).
6 *Dunn-Craft v. State Farm Mut. Auto. Ins. Co.*, 314 Ga. App. 620, 621, 724 S.E.2d 903 (2012).
7 *Beard v. Nunes*, 269 Ga. App. 214, 215, 603 S.E.2d 735 (2004).
8 *State Farm Mut. Auto. Ins. Co. v. Vaughn*, 253 Ga. App. 217, 218, 558 S.E.2d 769 (2002).
9 *Id.*
10 *Soufi v. Haygood*, 282 Ga. App. 593, 639 S.E.2d 395 (2006).

supplemental to a renewal policy issued to the insured by the same insurer.[11] Furthermore, there are no requirements as to the form of the rejection, merely that it be in writing.[12] While the statute expressly provides that UM coverage may be rejected or waived in writing by the insured, this provision may not be used as a vehicle to modify the minimum UM coverage.[13] The minimum coverage is fixed by statute; thus, substitution of a lesser coverage is not allowed.[14]

WHETHER THE UM CARRIER SHOULD ANSWER THE COMPLAINT

Although a UM carrier does not have to file an answer to a lawsuit, if the UM carrier decides to answer it must do so in a timely fashion and comply with the Georgia Civil Practice Act.[15] After being served with a complaint against an uninsured or underinsured motorist, a UM carrier has the option to join that action by filing an answer, but it is not required to do so.[16] If the UM carrier does not join the action, it can still litigate any contract dispute it may have separately in any action allowable by law.[17]

STACKING UNINSURED MOTORIST COVERAGE

Under Georgia law, when more than one source of UM motorist coverage is available, claimants may stack the policies, but the priority of the multiple UM carriers must first be determined.[18] The purpose of UM stacking is to create a rule for layers of coverage by examining the language of the policies to provide injured motorists with all available UM coverage and simplify UM cases.[19] To assist in this task, Georgia courts have developed tests that, if applicable, can assist in resolving the priority issue.[20]

Under the "receipt of premium" test, the UM insurer that receives a premium from the injured insured is deemed to be primarily responsible for providing coverage.[21] The UM carrier that received a premium from the injured insured is the carrier that provides primary UM coverage.[22] Where the receipt of a premium from the injured insured is shown to exist, it is controlling to the exclusion of consideration of any other factors which might be otherwise present.[23]

If the "receipt of premium" test does not resolve the issue of priority, the court then applies the "more closely identified with" test.[24] The "more closely identified with" test does not focus on the relationship between the circumstances of the collision and a particular policy of insurance; it looks instead to the relationship of the injured party to the policy.[25] For example, if the injured person is a family member of the premium payer, that relationship is considered closer for UM priority purposes than if the individual was covered merely because he was an occupant in the car.[26] The family relationship is also considered closer than UM coverage that is provided through an employment relationship.

Where neither the "receipt of premium" nor the "more closely identified with" tests resolve the issue of priority of UM coverage, courts look to the circumstances of the injury to determine which policy assumes priority of coverage.[27] Under this circumstance, the vehicle involved in the accident will trump UM coverage over vehicles that are identified under UM coverages, but not directly involved in the "circumstances of the injury" incurred by the injured insured.[28]

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11 *Nat'l Union Fire Ins. Co. v. Johnson*, 183 Ga. App. 38, 357 S.E.2d 859 (1987).
12 *Doe v. Rampley*, 256 Ga. 575, 351 S.E.2d 205 (1987).
13 *Id.*
14 *Adams v. State Farm Mut. Auto. Ins. Co.*, 288 Ga. 315, 702 S.E.2d 898 (2010).
15 *Kelly v. Harris*, 329 Ga. App. 752, 766 S.E.2d 146 (2014).
16 *Id.*
17 *Id.*
18 *Great Divide Ins. Co. v. Safeco Ins. Co.*, 260 Ga. App. 531, 532 580 S.E.2d 313 (2003) (*quoting Canal Ins. Co. v. Merchant*, 225 Ga. App. 61, 62, 483 S.E.2d 311 (1997)).
19 *Ga. Farm Bur. Mut. Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 255 Ga. 166, 336 S.E.2d 237 (1985) (resolving the priority of two stackable UM policies and determining the secondary policy liable for damages only to the extent they exceeded the limits of the primary carrier).
20 *Id.*
21 *Progressive Classic Ins. Co. v. Nationwide Mut. Fire Ins. Co.,* 294 Ga. App. 787, 788, 670 S.E.2d 497 (2008).
22 *Ga. Farm Bur. Mut. Ins. Co.,* 255 Ga. at 166.
23 *Nat'l Gen. Ins. Co. v. United Services Auto. Ass'n,* 224 Ga. App 821, 482 S.E.2d 727 (1997).
24 *Id.*
25 *Canal Ins. Co.*, 225 Ga. App at 62.
26 *Nationwide Mut. Fire Ins. Co. v. Progressive Bayside Ins. Co.*, 278 Ga. App . 73, 628 S.E.2d 177 (2006) (*citing Travelers Indem. Co. v. Maryland Cas. Co.*, 190 Ga. App . 455, 379 S.E.2d (1989)).
27 *Dairyland Ins. Co. v. State Farm Automobile Ins. Co.*, 289 Ga. App. 216, 656 S.E.2d 560 (2008).
28 *Clarendon Nat'l Ins. Co. v. Sledge*, 261 Ga. App. 661, 583 S.E.2d 514 (2003) (*citing Great Divide Ins. Co. v. Safeco Ins. Co.,* 260 Ga. App. 531, 580 S.E.2d 313 (2003)).

When none of the tests resolves the issue of UM coverage priority, the court can determine the priority issue from the plain language of the policies.[29] This is the most sensible solution where the priority of coverage is made clear from the language of the insurance policies, and where such priorities of coverage mandate threshold damages needed to trigger such coverage.[30]

Where there are multiple UM policies, the policy offering "reduced by" UM coverage is entitled to the liability coverage offset regardless of priority of coverage.[31] In *Allstate Fire & Casualty Ins. Co. v. Rothman*, the plaintiff was injured in an auto accident and was paid $100,000 under the named defendant's liability policy pursuant to a limited liability release. The plaintiff then sought to recover UM benefits from his personal Allstate UM policy as well as his employer's UM policy. The Allstate policy afforded a traditional "reduced by" UM coverage of $100,000. The employer's UM policy provided "add on" UM coverage of $500,000. The parties agreed that Allstate's UM coverage was primary.

Allstate took the position that it was entitled to the set off and, as a result, it had no UM exposure. The employer's UM carrier argued that Allstate was not entitled to a set off and that it did not have UM exposure until the plaintiff recovered more than $200,000. The Court of Appeals agreed with Allstate because of the "reduced by" language contained in the Allstate policy, holding that "where multiple UM carriers provide coverage but only one of those carriers provides 'reduced by' coverage, then the carrier providing the 'reduced by' coverage is entitled to the set off, regardless of whether that carrier is primary, secondary, or excess under the stacking rules."[32]

THE LAW APPLICABLE TO A UM POLICY MAY BE DETERMINED BY WHERE THE INSURED VEHICLE IS USED AND REGISTERED

In *St. Paul Fire & Marine Insurance Co. v. Hughes*, the Court of Appeals held that Georgia law applied to a UM policy issued in Indiana even though the insured vehicle was registered and located in Georgia.[33] The UM policy in this case was issued and delivered to the insured in Indiana, and the policy specifically excluded UM coverage. The insurance carrier, St. Paul, was licensed in Georgia at the time and there was no written rejection of UM benefits for the Policy. The plaintiff who was injured in an automobile accident in Georgia was driving a vehicle that was registered in Indiana, but was used and garaged in Georgia.

Suit was filed and the UM carrier contended there was no UM coverage, arguing that Indiana law applied and that Indiana law did not require UM coverage at the time the policy was issued. The Court of Appeals held that because the undisputed evidence showed the insured vehicle was principally used and garaged in Georgia at the time of the accident, it was reasonable for the parties to assume that Georgia was the principal location of the risk and to expect that Georgia law, rather than Indiana law, would be determinative on the issue of whether the policy provided UM coverage.

The *Hughes* Court also found that because St. Paul was licensed in Georgia, the injured victim was driving an insured vehicle principally used and garaged in Georgia, and there was no written rejection of UM benefits. The policy's UM exclusion conflicted with the plain terms of O.C.G.A. § 33-7-11 and was therefore void. Thus, UM coverage was grafted onto the policy equal to the limits of liability coverage.

TRENDING DECISIONS AS TO INSURANCE CONTRACT PROVISIONS IN THE UM CONTEXT

Georgia court decisions have shown an increasing reluctance to enforce certain contractual provisions in automobile liability policies as they apply to the UM context. In recognizing the remedial purpose of the UM statute, and that the statute is to be liberally construed to afford benefits to victims of uninsured or underinsured tortfeasors, courts have been finding certain

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29 *Progressive Classic Ins. Co.,* 294 Ga. App. at 788.

30 *See Merchant v. Canal Ins. Co.*, 238 Ga. App. 727, 520 S.E.2d 57 (1999) (in apportioning coverage among the insurer of the tortfeasor and two uninsured motorist insurers, the trial court must first determine the coverages available to each plaintiff under the tortfeasor's policy, as defined in subdivision (b)(1)(D)(ii), and then calculate the difference between that amount and the limits of the uninsured motorist coverage provided by the latter insurers, stacking them in the established order.).

31 *Allstate Fire & Cas. Ins. Co. v. Rothman*, 332 Ga. App. 670, 774 S.E.2d 735 (2015).

32 *Rothman,* 332 Ga. App. at 673 (*citing Donovan v. State Farm Mut. Auto Ins. Co.*, 329 Ga. App. 609, 765 S.E.2d 755 (2014)).

33 321 Ga. App. 738, 742 S.E.2d 762 (2013).

coverage provisions unenforceable, or in contravention of the UM statute, if such provisions can be interpreted to limit the potential UM recovery of the victim of an automobile accident.

In *St. Paul Fire & Marine Ins. Co. v. Goza*, the Court of Appeals reiterated the proposition that provisions of a liability policy in a UM context that serve to restrict coverage for a victim's actual losses are given little effect.[34] Thus, where terms of UM policies are in conflict with the public policy considerations of the UM statute, such as "other insurance" provisions, these "illegal" provisions of the policy are rendered void, and the provisions of the statute are grafted onto the policy itself.[35] Where "other insurance" provisions are struck from the policy, and where none of the three priority tests applied, Georgia courts may consider prorating a judgment between excess insurers as a viable means of resolving conflicts of priority.

Other provisions and conditions to coverage have likewise been wrestled with by the courts. In *Progressive Mountain Insurance Co. v. Bishop*, at issue was whether the automobile insurer was within the insurance contract in claiming there was no coverage for UIM benefits because the insured failed to promptly report the automobile accident in violation of the "Notice" condition to coverage.[36] In this case, while the condition provision was recognized as a condition precedent to coverage, the fact the insured believed the expenses for his medical treatment would be covered by the tortfeasor's liability carrier, and would not pierce his UM coverage, presented a question of fact as to whether he notified his UM carrier "promptly" of the accident.

This year, in C*oker v. American Guarantee and Liability Insurance Company,*[37] three excess liability insurers — Great American Insurance Company (Great American), American Guarantee & Liability Insurance Company (American Guarantee) and Endurance American Specialty Insurance Company (Endurance) (collectively "insurers") — appealed the district court's order granting summary judgment in favor of the insureds with respect to their contention that vertically tiered excess policies were to be treated as primary insurers when none had obtained an express rejection of UM coverage, and that the excess insurers' failure to tender payment amounted to a breach of contract.[38]

The insurers argued these policies were vertically structured so that each policy required exhaustion of the excess policy below it before coverage triggered. However, the insureds entered into settlement agreements with excess insurers underlying these defendants for substantially less than the policy limits. Despite the money recovered in the settlements, a substantial portion of the $5.5 million consent judgment remained unsatisfied. The insureds then made separate written demands against each of the defendants for payment of the remainder of the $5.5 million consent judgment. The three excess insurer defendants here did not tender payment in response to the insureds' demands.

On appeal, the Eleventh Circuit held that a vertical exhaustion requirement contained in the defendant excess insurers' Policies did not undermine the remedial purpose of the UM/UIM statute. The only way an insured might not recover for the full amount of his injuries — and therefore realize the harm the statute was designed to prevent — is if, as is the case here, he settles with an underlying insurer for less than the policy limits. In that case, the insured voluntarily settled for less than the policy limits and, therefore, is undercompensated of his own volition. In such a situation, it is not the exhaustion requirement that directly contravenes the legislative intent of the statute, but the insured's own settlement negotiations.

CONCLUSION

Years after the 2009 amendments to O.C.G.A. § 33-7-11 became effective, courts continue to struggle with the task of balancing the public policy intentions of UM coverage to fully compensate injured victims of automobile accidents, while attempting to recognize the principles of insurance contract law and interpretation. UM carriers must recognize that this balancing of interests is ongoing and that long-held contract provisions and conditions, in the UM context, may continue to evolve in the courts.

[34] 137 Ga. App. 581, 583-84, 224 S.E.2d 429 (1976) ("[W]here an 'other insurance' policy provision attempts to limit coverage to sums which are in excess of other insured motorist protection, it conflicts with the plain terms of the statute [O.C.G.A. § 33-7-11], and is of no effect."); *St. Paul Fire and Marine Ins. Co. v. Hughes*, 321 Ga. App. 738, 741, 742 S.E.2d 762 (2013) ("Georgia courts have consistently struck down UM exclusions where they conflict with the remedial purpose of UM coverage.").

[35] *See* O.C.G.A. § 33-24-12(a); *see also Flewellen v. Atlanta Cas. Co.*, 250 Ga. 709, 714, 300 S.E.2d 673 (1983).

[36] 338 Ga. App. 115, 790 S.E.2d 91 (2016).

[37] 825 F. 3d 1287 (11th Cir. 2016).

[38] The accident in which the insured was injured occurred before the 2009 amendment to the UM statute. The amendment no longer required excess and umbrella carriers to obtain a written rejection of UM coverage. In the version of the pre-2009 statute, excess and umbrella liability insurers were not expressly excused from the written rejection requirement, and thus if they did not obtain the waiver, were exposed to UM limits equal to the excess liability limits.

Welcome to the Party Pal: Making the Other Guy Die Harder Through Additional Insured Clauses and Indemnification Clauses in Construction Contracts

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Welcome to the Party Pal: Making the Other Guy Die Harder Through Additional Insured Clauses and Indemnification Clauses in Construction Contracts

Your insured just filed a construction defect claim and coverage has been confirmed, now what? One of your first inquiries should be "is there anyone else we can invite to this party?" By identifying all those involved on the project and analyzing relevant insurance documents and contractual agreements, an insurer may be able to shift the ultimate liability for the claim, or at least some of it, to other parties and carriers. This paper will explore two particular risk shifting tools: (1) additional insured clauses; and (2) indemnification clauses, and how Georgia and Alabama courts enforce them.

Your insured may be an additional insured on another entity's policy or may avail itself of an indemnification clause contained in a contractual agreement with another entity. Applicable insurance policy language often extends coverage to an additional insured for claims "arising out of" acts or omissions of the named insured. This language may extend additional insured coverage to any and all claims that have any relationship to the business transaction between the named insured and the additional insured, and such business transaction alone may suffice to satisfy the requirement between the alleged injury and the alleged negligence of the named insured.

With respect to indemnification clauses, some contracts purport to indemnify one party for "any and all" acts or omissions of another party to the contract. These clauses, though they may appear to encompass the indemnification one seeks, may be void as a matter of public policy within the construction context. However, this determination depends largely on the applicable law and contractual language.

WHO IS AN ADDITIONAL INSURED

The general contractor's commercial general liability (CGL) policy is one of the most common commercial risk shifting policies used for construction projects. Generally speaking, most insurers use the ISO CGL forms for primary layers of coverage, including either CG 00 01 (occurrence) form or CG 00 02 (claims made) form.[1] Many CGL policies, in either the "Who Is An Insured" section or in a specific additional insured endorsement, contain language which provides that any person for whom the named insured agrees in a "work contract" or written agreement that such person or organization be made an insured or named as an additional insured on the policy does in fact qualify as an additional insured.[2] Most contractors require verification from subcontractors through certificates of insurance indicating the additional insured endorsement. Those same provisions typically contain a limitation, which restricts additional insured coverage to liability "arising out of" or "resulting from" the named insured's (often a subcontractor's) work or operations performed for that additional insured (typically a general contractor, developer or owner).

Many insurers have taken the position that if the named insured was not liable or responsible for the bodily injury or property damage alleged by the claimant against the additional insured, then the additional insured is not entitled to coverage under the policy. However, decisions over the last 10 years have continued to underscore the fact that insurers should not take that position absent more specific policy language.

Alabama

Alabama courts interpret the "arising out of" language very broadly and comprehensively to mean "origination from," "having its origin in," "growing out," or "flowing from."[3] In other words, this broad interpretation "simply requires that the

1 Fred P. Wilshusen et. al, *Construction Checklists: A Guide to Frequently Encountered Construction Issues* 161 (2008).

2 The ISO form CG 20 10 Additional Insured-Owners, Lessees or Contractors-Scheduled Person or Organization is an additional insured endorsement that covers the primary named insured's acts or omissions or the acts or omissions of those acting on its behalf "in performance of its ongoing operations for the additional insured." If the contract requires both operations exposure and completed operations coverage to the additional insured, both forms 20 33 and 20 37 must be issued. Form CG 20 33 is entitled Additional Insured-Owners, Lessees or Contractors-Automatic Status When Required in Construction Agreement with You and CG 20 37 is entitled Additional Insured-Owners, Lessees or Contractors-Completed Operations (scheduled entity).

3 *See, e.g., Taliaferro v. Progressive Specialty Inc. Co.,* 821 So. 2d 976 (Ala. 2001); *State Farm Fire & Cas. Co. v. Erwin,* 393 So. 2d 996 (Ala. 1981) ("arising

additional insured's negligent acts are connected to the named insured's operations performed for the additional insured."[4] However, even with a liberal construction of an additional insured endorsement covering "liability arising out of the named insured's operations," an additional insured (general contractor), for example, has no coverage where the damages did not arise out of the named insured's (subcontractor) work if the additional insured endorsement states:

> Who Is An Insured is amended to include . . . the person or organization shown in the SCHEDULE as an insured but only with respects to liability arising out of the Named Insured's operations . . . . The insurance afforded by this endorsement . . . shall not apply to damages arising out of the negligence of the person(s) or organization(s) added by this endorsement.[5]

In *Regency Club*, the insurer filed a declaratory judgment action arising from a lawsuit brought by a homeowners' association against the developer, general contractor and subcontractors. The facts were undisputed that the subcontractor did not perform any work for the general contractor, the putative additional insured, on the subcontractor's policy on the development. The federal district court held the additional insured provision (cited above) clearly limited additional insured coverage to "liability arising out of the Named Insured's operations . . . ." The court held that the general contractor's vicarious liability did not arise out the work actually performed by the named insured. Therefore, the general contractor was not entitled to coverage under the express language of the policy.

Alabama appellate courts have not interpreted an additional insured endorsement similar to CGL 088 (07 10). Thus, we do not know how broadly or narrowly the Alabama courts will interpret the provision limiting the additional insured coverage to "'bodily injury' . . . which is caused, in whole or in part, by 'your work' . . ." or similar provisions. This very question is currently on appeal in the Supreme Court of Alabama.[6] There, the trial court granted summary judgment in favor of the putative additional insured, granting that status for claims apparently based on its sole negligence.

There are a wide variety of additional insured endorsements, so the specific language must be taken into account. For example, where the additional insured endorsement states it applies to "liability arising out of the named insured's operations," Alabama courts liberally construe the endorsement.

Furthermore, endorsements such as CGL026 (11 08) (providing additional insured coverage "with respect to your negligent actions, which cause liability to be imposed on such person . . . without fault on the part of said person . . . , caused by 'your work' performed for that insured") and CGL055 (12 05) (providing additional insured coverage "with respect to (1) your negligent actions . . . which cause liability to be imposed on such person . . . without fault on the part of said person . . . and (2) the partial negligence of the additional insured which combines with your partial negligence . . . in causing the accident . . . . This insurance does not cover the sole negligence of the additional insured . . . .") may be interpreted differently.

Georgia

Interpretation of Georgia courts' application of additional insured language suggests that so long as there is a "business transaction" between the putative additional insured and named insured, which can be formed via contract, then the injuries necessarily "arose out of" the named insured's work.

In *BBL-McCarthy, LLC v. Baldwin Paving Co.,*[7] the general contractor subcontracted with Baldwin Paving and Magnum Development (the subcontractors), separately, to construct a traffic "deceleration lane" leading from the project. Magnum performed the grading work and Baldwin completed the paving. Both subcontracts contained an indemnification clause and insurance clause. The indemnification clause required the subcontractors to defend, indemnify and hold the general contractor harmless for all claims arising out of the performance of the subcontractors' work. The insurance clause required the subcontractors to obtain liability insurance to cover claims arising out of the subcontractors' work, and for which the general

out of the ownership, maintenance, or use of the owned automobile" is about as general and broad as could be written); *Pacific Indem. Co. v. Run-A-Ford Co.*, 161 So. 2d 789 (Ala. 1964) (the words "arising out of" are broad, general and comprehensive, effecting broad coverage); *see also Twin City Fire Ins. Co., Inc. et al, v. Ohio Cas. Ins. Co., Inc.*, 480 F.3d 1254 (11th Cir. 2007) (*citing Davis Constructors & Eng'rs, Inc. v. Hartford Acc. & Indem. Co.*, 308 F. Supp. 792, 795 (M.D. Ala. 1968) (where indemnity provision applied to claims "arising out of work," the subcontractor is obligated to indemnify contractor even though the subcontractor's employees "were injured only because their work for [the subcontractor] happened to put them in the path of an accident that was him solely by [the contractor's] negligence")).

4 *Int'l Paper Co., Inc. v. QBE Ins. Corp.*, No. 3:09-CV-347-WKW, 2010 WL 1856193, *4-5 (M.D. Ala. May 5, 2010).

5 *Canal Indem. Co. v. Regency Club Owners Ass'n*, 924 F. Supp. 2d 1304 (M.D. Ala. 2013).

6 *See Am. Res. Ins. Co. v. Int'l Paper Co.*, Appeal Nos. 1140230, 1140272, 1140359.

7 285 Ga. App. 494, 646 S.E.2d 682 (2007).

contractor may be liable. The subcontractors obtained CGL policies which named the general contractor as an additional insured, but the policies contained language limiting coverage to the general contractor for liability "arising out of" the subcontractors' work or operations.[8] Following an auto collision near the construction project, claimants brought lawsuits alleging their injuries resulted from the general contractor's negligent management of the project and the general contractor's and the subcontractors' negligent construction of the road.

The trial court held the general contractor qualified as an additional insured under the subcontractors' policies, regardless whether the injuries were attributable to the general contractor or subcontractors.[9] The court broadly construed the phrase "arising out of" the subcontractors' work or operations as meaning arising out of a business transaction with or work performed for the general contractor.[10] Because the alleged injuries were related to the subcontractors' work, the general contractor qualified as an additional insured, regardless of whether actual liability for the injuries was attributable to the general contractor or the subcontractors.[11]

Similarly, in *Ryder Integrated Logistics v. Bellsouth Telecommunications, Inc.,*[12] the putative additional insured, did not dispute that it was *solely* negligent for the injuries to the named insured's employee, and did not contend that the named insured did anything to contribute to the injuries in a premises liability claim.[13] The named insured, Ryder, agreed in its contract with Bellsouth to provide additional insured coverage to Bellsouth.[14] Ryder's CGL policy provided that Bellsouth would be an additional insured, "but only with respect to liability arising out of [Ryder's] operations."[15] The court held that because the claimant was a Ryder employee performing work at the Bellsouth facility pursuant to Ryder's "business transaction" – that is, pursuant to the contract with Bellsouth – Bellsouth qualified as an additional insured under the policy, even though it was solely liable for the injuries.[16] "The fact that the defect [that caused the injury] was attributable to [the additional insured's] negligence is irrelevant, since the policy language does not purport to allocate coverage according to fault."[17]

The decisions in *BBL* and *Ryder* initially shocked a lot of insurers in Georgia, because the rulings all but eliminate the requirement of any causal connection between the plaintiff's injury and the work performed by the named insured. In fact, the courts suggest that as long as there is a "business transaction" between the named insured and purported additional insured, which can be evidenced by a contract between them, then the injuries necessarily "arose out of" the named insured's work. In *Ryder*, the fact that the injured person was a Ryder employee and the fact that a contract existed between Bellsouth and Ryder was sufficient for the court to find a connection, even though Ryder's operations did not contribute to the alleged injury – other than the employee's mere presence in doing his job at the project site pursuant to the contract.

Insurers whose additional insured provision uses the language "liability resulting from" the named insured's work, may be tempted to argue that such language requires a much more direct, causal connection between the named insured's work and the claimant's alleged injuries or damages than is required by an additional insured provision containing the phrase "liability arising out of" the named insured's operations. However, Georgia law has found no material distinction between the phrases "arose out of" and "caused by."[18]

While Georgia courts have shown a propensity to interpret additional insured provisions in CGL policies very broadly to find that an entity qualifies as an additional insured, courts are beginning to narrowly interpret the extent of coverage

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8 *BBL-McCarthy, LLC*, 285 Ga. App. at 495-96.

9 *Id.* at 499.

10 *Id.* at 498 (The court noted that it had similarly construed "arising out of" as meaning "had its origins in," "grew out of," or "flowed from," and, therefore, "almost any causal connection or relationship will do" in satisfying the "arising out of" requirement.).

11 *See also Video Warehouse Inc. v. So. Trust Ins. Co*., 297 Ga. App. 788, 678 S.E.2d 484 (2009) (noting the Georgia Supreme Court has interpreted same "arising out of" language as excluding all claims for injuries caused by the excluded acts, regardless of the theory of tort liability).

12 277 Ga. App. 679, 627 S.E.2d 358 (2006), reversed *on other grounds,* 281 Ga. 736, 242 S.E.2d 695 (2007).

13 *Ryder Integrated Logistics*, 627 S.E.2d at 360-61.

14 *Id.*

15 *Id*. at 363.

16 *Id*. at 364-65.

17 *Id*. at 364 (*citing Acceptance Ins. Co. v. Syufy Enter.*, 69 Cal. App. 4th 321, 81 Cal. Rptr. 2d 557 (1999)).

18 *See Jefferson Ins. Co. of N.Y. v. Adrian*, 269 Ga. 213, 496 S.E.2d 696 (1998) (Both phrases required the same causal connection between the alleged injuries and the insured's conduct). An additional insured's coverage may be limited to instances where the additional insured is vicariously liable for the wrongs of the named insured. *BP Chemicals, Inc. v. First State Ins. Co*., 226 F. 3d 420, 423 (6th Cir. 2000) (Finding that additional insured under CGL policy was not provided with coverage for its own negligence. Neither an indemnity agreement nor the additional insured endorsements expressly stated an intention to indemnify the additional insured against its own negligence). However, such language must be specifically and unambiguously stated in the policy.

provided to the additional insured. In *Auto-Owners Inurance Co. v. Gay Construction Co.,*[19] the general contractor, Gay Construction, qualified as an additional insured under a CGL policy issued by Auto-Owners to named insured Dai-Cole Waterproofing Company, Inc., the waterproofing subcontractor on the project. After completion of the project, the owner complained that water was leaking into the space below the terrace when it rained. Gay Construction investigated the complaint and determined the waterproofing membrane and drainage mat were improperly installed. Dai-Cole either failed and/or refused to properly repair the work and, as a result, Gay Construction was forced make the repairs and replace damaged materials and fixtures.

As a prerequisite to performing work on the project, the contract documents required Dai-Cole to obtain a CGL policy, which it obtained from Auto-Owners. The policy provided, in part, that:

> A person or organization is an Additional Insured only with respect to liability arising out of "your work" for that Additional Insured by or for you (1) [i]f required in a written contract or agreement; or (2) [i]f required by an oral contract or agreement only if a Certificate of Insurance was issued prior to the loss indicating that the person or organization was an Additional Insured.

And that Auto-Owners would:

> Pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies . . . . This insurance applies to "bodily injury" and "property damage" only if . . . [such] is caused by an "occurrence" that takes place in the "coverage territory."[20]

Following Gay Construction's completion of the repairs and replacement work, Gay Construction sought coverage under the Auto-Owners Policy as an additional insured.[21] Auto-Owners denied the claim and Gay Construction sued.[22] Auto-Owners filed a motion for summary judgment arguing Gay Construction's claim did not seek damages resulting from property damage as defined by the policy and that the damages sought were barred by the policy's business risk exclusion.[23] The trial court denied Auto-Owner's motion and permitted an interlocutory appeal.[24]

On appeal, the Georgia Court of Appeals confirmed that Gay Construction did qualify as an additional insured and determined that the policy's business risk exclusion applied to Dai-Cole's faulty workmanship.[25] Meaning, had Dai-Cole made a request for coverage under the CGL policy, Auto-Owners would have denied the request because of the business risk exclusion. This left the court with a question of first impression as to "which party's scope of work should be considered when determining whether a business risk exclusion applies to a general contractor's claim for first-party coverage as an additional insured under its subcontractor's CGL policy."[26]

The court reasoned that Auto-Owners did not contract to guarantee Dai-Cole's scope of work and the business risk exclusion removed Dai-Cole's defective workmanship that caused damage to the project from coverage under the policy.[27] Gay Construction was responsible for all work performed within the scope of its contract with the owner.[28] If the business risk exclusion were interpreted so narrowly as to only apply to work performed by Dai-Cole, then it would permit the additional insured, Gay Construction, to enjoy broader coverage than was granted to Dai-Cole, the policy holder. In essence, requiring Auto-Owners to guarantee Dai-Cole's work.[29]

19 332 Ga. App. 757, 774 S.E.2d 798 (2015).
20 *Id.* at 799.
21 *Id.* 799-800.
22 *Id.* at 800.
23 *Id.*
24 *Id.*
25 *Id.* at 800-01.
26 *Gay Constr. Co.*, 332 Ga. App. at 761.
27 *Id.*
28 *Id.*
29 *Id.* at 801-02.

INDEMNIFICATION CLAUSES

Indemnification clauses present another opportunity to shift risk in the construction context. Many construction contracts contain an indemnification clause which requires one of the parties, typically the subcontractor, to defend, hold harmless and indemnify the other party for claims, injuries and damage that arise out of the work on the project.

While the breadth of indemnification clauses vary, there are certain restrictions at play based on the applicable law. In Georgia, it is against public policy to contract away liability to an indemnitor for damages arising from the sole negligence of an indemnitee in construction contracts.[30] Alabama has no such statutory limitation. Alabama law allows parties to enter into "indemnity agreements that allow an indemnitee to recover from the indemnitor even for claims resulting solely from the negligence of the indemnitee" so long as the indemnity contract clearly and unequivocally indicates an intention to indemnify for the indemnitee's own negligence.[31]

Georgia

Generally, Georgia law allows a party to contract away liability to another party for consequences of his own negligence without contravening public policy, except when such an agreement is prohibited by statute.[32] However, in the construction context, such an agreement is specifically prohibited by statute, namely O.C.G.A. § 13-8-2, which provides, in part:

> (b) A covenant, promise, agreement, or understanding in or in connection with or collateral to a contract or agreement relative to the construction, alteration, repair, or maintenance of a building structure, appurtenances, and appliances, including moving, demolition, and excavating connected therewith, purporting to require that one party to such contract or agreement shall indemnify, hold harmless, insure, or defend the other party to the contract or other named indemnitee, including its, his, or her officers, agents, or employees, against liability or claims for damages, losses, or expenses, including attorney fees, arising out of bodily injury to persons, death, or damage to property caused by or resulting from the sole negligence of the indemnitee, or its, his, or her officers, agents, or employees, is against public policy and void and unenforceable. This subsection shall not affect any obligation under workers' compensation or coverage or insurance specifically relating to workers' compensation, nor shall this subsection apply to any requirement that one party to the contract purchase a project specific insurance policy, including an owner's or contractor's protective insurance, builder's risk insurance, installation coverage, project management protective liability insurance, an owner controlled insurance policy, or a contractor controlled insurance policy.[33]

Courts have explained O.C.G.A. § 13-8-2(b) as follows:

> The apparent purpose of O.C.G.A. § 13-8-2(b) is to prevent a building contractor, subcontractor, or owner from contracting away liability for accidents caused solely by his negligence, whether during the construction of the building or after the structure is completed and occupied . . . [I]t would seem that construction contracts were singled out because of the possibility of hidden, or latent, defects of an extremely dangerous nature and not ordinarily detectable by a lay person.[34]

The Supreme Court of Georgia has imposed even stricter requirements for indemnification/limitation of liability clauses in design and construction contracts. In *Lanier at McEver, L.P. v. Planners and Engineers Collaborative, Inc.*[35] Lanier, the construction developer hired Planners, a civil engineering firm, to design the storm-water drainage system for an apartment complex. In the contract, the parties agreed:

> In recognition of the relative risks and benefits of the project both to [Lanier] and [Planners], the risks have been allocated such that [Lanier] agrees, to the fullest extent permitted by law,

[30] O.C.G.A. § 13-8-2 (b).

[31] *Holcim (US), Inc. v. Ohio Cas. Ins. Co.*, 38 So. 3d 722, 728 (Ala. 2009); *Indus. Tile, Inc. v. Stewart*, 388 So. 2d 171, 175 (Ala. 1980).

[32] *See, e.g., Smith v. Seaboard Coast Line R. Co.*, 639 F.2d 1235, 1239 (5th Cir. 1981).

[33] O.C.G.A. § 13-8-2 (emphasis added).

[34] *Federated Dep't Stores, et al. v. Superior Drywall & Acoustical, Inc.*, 264 Ga. App. 857, 862, 592 S.E.2d 485 (2003) *(citing Borg-Warner Ins. Fin. Corp. v. Exec. Park Ventures*, 198 Ga. App. 70, 74, 400 S.E.2d 340 (1990)).

[35] 284 Ga. App. 204, 663 S.E.2d 240 (2008).

> to limit the liability of [Planners] and its sub-consultants to [Lanier] and to all construction contractors and subcontractors on the project or any third parties for any and all claims, losses, costs, damages of any nature whatsoever[,] or claims expenses from any cause or causes, including attorneys' fees and costs and expert witness fees and costs, so that the total aggregate liability of [Planners] and its subconsultants to all those named shall not exceed [Planners]'s total fee for services rendered on this project. It is intended that this limitation apply to any and all liability or cause of action however alleged or arising, unless otherwise prohibited by law.[36]

Following completion of the apartment complex and drainage system, Lanier discovered erosion which an expert attributed to the negligent design of the drainage system.[37] Lanier repaired the system and then sued Planners for negligent construction, breach of contractual warranty and litigation expenses.[38] During litigation, Planners filed a partial motion for summary judgment arguing that the parties' agreement applied and limited Planners' liability to its total fee for services.[39] The trial court granted Planners' motion and the court of appeals affirmed. Lanier filed a petition for certiorari to determine whether the construction contract violated Georgia's public policy, under O.C.G.A. § 13-8-2(b).

The Georgia Supreme Court reversed the lower courts' decision because the clause violated public policy. The court reasoned that the contract violated public policy, as prohibited by O.C.G.A. § 13-8-2(b), particularly regarding claims for which Planners may be solely negligent for injuries to a third party. For instance, the clause applies to "any and all claims" by third parties and, in essence, shifts all liability above Planners' fees for services to the developer, Lanier, no matter who was at fault.[40] In other words, while the clause does not prevent a third party from suing Planners, the clause permits all liability above its fees for services to be shifted to Lanier, even for damages arising from Planners' sole negligence.[41]

The *Lanier* Court indicated that the limitation of liability clause might have been valid had it restricted damages to only those between the contracting parties, opining that removal of third party language may remove the problem altogether.[42] Moreover, parties may avoid violating O.C.G.A. § 13-8-2 if the agreement includes an insurance clause which shifts the risk of loss to an insurer, no matter who is at fault.[43]

In *Federated Department Stores v. Superior Drywall and Acoustical, Inc.*, the Georgia Court of Appeals held that, absent an insurance clause showing the parties' mutual intent for the subcontractor's insurance to supply coverage for loss or damages incurred by both parties, the indemnity clause at issue in that case was void and unenforceable pursuant to O.C.G.A. § 13-8-2(b).[44] In *Federated Department Stores*, the indemnity clause provided that the subcontractor must indemnify the contractor and owner for "'all damage or injury of any kind . . . resulting from' or 'arising out of' the Work. Injuries or damages that may arise out of the sole negligence of the contractor or owner that were included in the definition of the 'Work' would be included in the blanket and general indemnity clause in the Contract."[45]

The requirement that insurance be purchased was not automatically a cure-all for the dangers proscribed by the enactment of O.C.G.A. § 13-8-2.[46] The subcontractor purchased CGL insurance to cover only its own negligence and the insurance satisfied the owner before the work began.[47] Thus, the owner could not credibly assert the intent of the parties was for the insurance to cover the negligent acts of the owner or contractor. An indemnity clause within the terms of a contract must "unequivocally express the intent of the parties to shift the risk of loss and look solely to an insurance policy obtained in order to cover loss or damages incurred by both parties . . . the type of insurance and the intent of the parties in mandating the purchase of insurance must play a part in the analysis."[48]

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36 *Id.* at 241-42 (emphasis added).
37 *Id.*
38 *Id.*
39 Lanier spent approximately $250,000 in repairs to the system and expected to spend $500,000 in total. Planner's total fee for services was approximately $80,000.
40 *Id.* at 243.
41 *Id.*
42 *See Id.* at 243-44 (*citing 1800 Ocotillo, LLC v. WLB Group, Inc.*, 217 Ariz. 465, 176 P.3d 33 (2008) (limitation of liability clause did not reference third party claims or allow for reimbursement by developer for third party negligence claims for which the subcontractor was solely liable)).
43 *Lanier at McEver, LP v. Planners & Eng'rs Collaborative, Inc.*, 284 Ga. 204, 663 S.E.2d 240 (2008) (*citing ESI, Inc. of Tennessee v. Westpoint Stevens, Inc.*, 254 Ga. App. 332, 562 S.E.2d 198 (2002)).
44 *Federated Dep't Stores*, 264 Ga. App. 857, 592 S.E.2d 485 (2003).
45 *Id.* at 860-61.
46 *Id.*
47 *Id.*
48 *Id.* at 861-62.

Moreover, simply naming one party to an insurance policy as an additional insured does not create an independent basis that would require the named insured to defend and indemnify the additional insured for the additional insured's *own* negligence or gross negligence.[49] The court will look to the policy itself along with the applicable endorsements to determine the obligation of the insurer (by virtue of its contract with the insured).

Thus, it appears the only way an indemnification clause may be upheld in a construction defect claim is if the clause is specific in its application only to claims between the contracting parties or shifts liability only as a result of partial fault of the contracting party (and not its sole liability) or shifts the responsibility to an insurance carrier or carriers (waiver of subrogation clause). Therefore, upon receipt of a construction defect claim, the insurer should obtain a copy of all contracts between its insured and other parties. If the contracts contain an indemnification clause, the insurer should analyze its validity. If the clause does not attempt to shift the insured's sole negligence or liability to the other party, then the carrier should tender a defense and indemnification to the other party. As long as the indemnification clause is valid, and as long as the other party is at least 1 percent negligent (*i.e.*, the insured is not solely negligent), then many indemnification clauses will require the other party to provide the insured with 100 percent of the defense and indemnification.

Once the indemnification clause is found to be valid and enforceable, the Court of Appeals has shown a similar propensity to uphold the language as it has done with respect to additional insured language. For example, in *JNJ Foundation Specialists, Inc. v. D.R. Horton, Inc.,*[50] the indemnification clause in the contract between D.R. Horton and JNJ provided that JNJ had a duty to defend and indemnify D.R. Horton for any claims "in any way occurring, incident to, arising out of, or in connection with . . . the work performed or to be performed by contractor [JNJ] or contractor's personnel, agents, suppliers or permitted subcontractors." In upholding and enforcing this language, the Court of Appeals undertook the same analysis as it did in finding additional insured coverage under *BBL-McCarthy*:

> Under Georgia law pertaining to indemnity provisions, "arising out of [means] 'had its origins in,' 'grew out of,' or 'followed from.'" Importantly, "the term 'arising out of' does not mean proximate cause in the strict legal sense, nor [does it] require a finding that the injury was directly and proximately caused by the insured's actions. Almost any causal connection or relationship will do."[51]

Alabama

Generally, Alabama law prohibits contribution or indemnity between joint tortfeasors.[52] Broad indemnification agreements are not looked upon favorably in Alabama. Agreements that purport to indemnify another for the other's intentional conduct are void as a matter of strong public policy.[53]

Alabama law allows parties to enter into "indemnity agreements that allow an indemnitee to recover from the indemnitor even for claims resulting solely from the negligence of the indemnitee."[54] Strict construction against the indemnitee is appropriate where it seeks indemnification for its own negligence.[55] Furthermore, the burden of proof is on the indemnitee to establish its right to indemnification under such an agreement.[56]

Whether an indemnity agreement applies depends on the contract language and the facts surrounding the claim. That the injured party did not sue the indemnitor is not controlling. A duty to indemnify may be triggered even when the plaintiff in the underlying action avoided directly naming the indemnitor as a party. Alabama courts have recognized, "the fact that a complaint names one possible tortfeasor alone does not resolve whether any resulting damages in that case relate solely to the named tortfeasor's own fault or conduct, because that tortfeasor may be held liable for the entire loss, which may be also attributable to other joint tortfeasors."[57] Thus, "under Alabama law, when determining liability under an indemnity

[49] *See Serv. Merch. Co. v. Hunter Fan Co.*, 274 Ga. App. 290, 297, 617 S.E.2d 235 (2005).
[50] 311 Ga. App. 269, 717 S.E.2d 219 (2011).
[51] *Id.* at 270.
[52] *See, e.g., Humana Med. Corp. v. Bagby Elevator Co.*, 653 So. 2d 972, 974 (Ala. 1995).
[53] *City of Montgomery v. JYD Int'l, Inc.*, 534 So. 2d 592, 594 (Ala. 1988).
[54] *Holcim (US), Inc. v. Ohio Cas. Ins. Co.*, 38 So. 3d 722, 728 (Ala. 2009); *Industrial Tile, Inc. v. Stewart*, 388 So. 2d 171, 175 (Ala. 1980) (indemnity contract must "clearly indicate" an intention to indemnify for the indemnitee's own negligence; that intent must be expressed in "clear and unequivocal language").
[55] *Craig Constr. Co. v. Hendrix*, 568 So. 2d 752, 757 (Ala. 1990).
[56] *Royal Ins. Co. v. Whitaker Contracting Corp*., 824 So. 2d 747, 752 (Ala. 2002).
[57] *Holcim (US), Inc. v. Ohio Cas. Ins. Co*., 38 So. 3d 722, 729-30 (Ala. 2009) (*citing FabArc Steel Supply, Inc. v. Composite Constr. Sys., Inc.,* 914 So. 2d 344, 361 (Ala. 2005)).

provision, a court may look beyond the complaint in the underlying action to the underlying facts shown by admissible evidence."[58]

The controlling question is usually what is "clear and unequivocal" language? The following indemnity agreements did not provide for indemnity as to the Owner's negligence (i.e., the indemnitee):

> [Indemnify/defend claims] . . . arising out of the work undertaken by the Subcontractor . . . and arising out of any other operation no matter by whom performed for and on behalf of the Subcontractor, whether or not due in whole or in part to conditions, acts or omissions done or permitted by the Contractor or Owner.[59]

> Owner agrees to save agent harmless from all damage suits and claims arising in connection with said property and from all liability for injuries to persons or property while in, on, or about the premises. *Nationwide Mut. Ins. Co. v. Hall*, 643 So. 2d 551, 555 (Ala. 1994) (indemnity for the consequences of indemnitee's own negligence is enforceable only when contract language specifically refers to the negligence of the indemnitee).

> [Indemnify/defend claims] . . . arising out of or occasioned by [indemnitor], or anyone for whose acts [indemnitor] is or may be liable, provided that such claim . . . is attributable to bodily injury . . . to the extent caused or alleged to be caused in whole or in any part by any act . . . by [indemnitor] . . . .[60]

> [Indemnify/defend claims] . . . arising out of or in any manner connected with the performance of this Agreement, whether such injury, loss or damage shall be caused by the negligence of the Contractor, his subcontractor, or any other party for whom the Contractor is responsible . . . .[61]

Whereas these indemnity clauses did require indemnification even for the Owner's own negligence:

> [Indemnify/defend claims] . . . attributable to bodily injury . . . alleged to be caused in whole or in any part by any negligent act or omission of the Subcontractor . . . regardless of whether it is caused in part by a party indemnified hereunder.[62]

> [Indemnify/defend claims] . . . arising out of or in any way related to the performance of the Work by [West] . . . in whatever manner the same may be caused, and whether or not the same may be caused, occasioned or contributed to by the negligence, sole or concurrent, of ARP . . . .[63]

> To the fullest extent permitted by law, [Marathon] shall defend and indemnify . . . 'Indemnitees'[] against . . . all liabilities, [etc.] . . . that arise in any way, directly or indirectly, out of a failure by [Marathon] . . . to . . . : (a) carry out the Work in a safe manner; (b) strictly comply with any applicable laws, regulations, building codes, rules, or industry standards; (c) exercise reasonable care in the performance of the Work or to execute the Work in a non-negligent manner; or (d) strictly comply with the requirements of this Subcontract. [Marathon's] obligation to defend and indemnify the Indemnitees shall not be diminished or excused merely because the negligence or other breach of a legal duty on the part of any Indemnitee also contributed to the Indemnified Loss . . . .[64]

> [Indemnify/defend claims] . . . arising out of or resulting from the performance of the work, provided that any such claim . . . (1) is attributable to bodily injury . . . , and (2) is caused in whole or in part by any negligent act . . . of the contractor, any subcontractor, anyone directly or indi-

[58] *Holcim*, 38 So. 3d at 730.

[59] *Craig Constr. Co. v. Hendrix*, 568 So. 2d 752, 754 (Ala. 1990); *see also Brown Mech. Contractors, Inc. v. Centennial Ins. Co.*, 431 So. 2d 932, 946 (Ala. 1983) ("[T]his provision was insufficient as a matter of law for [the Contractor] to be indemnified for its own negligence . . . ."); *U.S. Fid. & Guar. Co. v. Mason & Dulion Co.*, 274 Ala. 202, 145 So. 2d 711 (1962).

[60] *McInnis Corp. v. Nichols Concrete Constr., Inc.*, 733 So. 2d 418 (Ala. Civ. App. 1998).

[61] *Amerisure Mut. Ins. Co. v. QBE Ins. Corp.*, No. CV-11-J-1751-NE, 2012 WL 3854402 (N.D. Ala. Sept. 5, 2012).

[62] *FabArc Steel Supply, Inc. v. Composite Constr. Syss., Inc.*, 914 So.2d 344 (Ala. 2005) (emphasis added).

[63] *Twin City Fire Ins. Co. v. Ohio Cas. Ins. Co.*, 480 F.3d 1254 (11th Cir. 2007) (emphasis added).

[64] *Doster Const. Co. v. Marathon Elec. Contractors, Inc.*, 32 So. 3d 1277, 1283 (Ala. 2009) (emphasis added).

rectly employed by any of them or anyone for whose acts any of them may be liable, regardless of whether or not it is caused in part by a party indemnified hereunder.[65]

POINTERS AND TAKEAWAYS

Alabama and Georgia courts continue to broadly interpret the "arising out of" or "resulting from" language in additional insured clauses, which should provide a caveat to insurers who refuse to defend a purported additional insured entity without first examining the contractual relationship between that entity and the named insured. The expansive application of these terms may broaden the policy coverage applicable to the insured on another contracting party's policy, or vice versa, may broaden the availability of coverage to an additional insured under the insured's policy. Based on recent case law, no more than a slight causal connection between the injuries alleged and the contractual scope of work is required to find additional insured coverage. Only where no relationship whatsoever exists between the scope of the work and the alleged injuries can an insurer have any confidence that no additional insured coverage exists. As a result of this application, many insurers now include special additional insured endorsements intended to restrict the circumstances under which additional insured coverage will be triggered. Those endorsement specifically state that an entity qualifies as an additional insured only for damages or injury in which the named insured is found at fault or negligent.

Whether an indemnity agreement applies, depends on the contract language, the facts surrounding the claim and the applicable law. Refusing to defend and/or indemnify an insured based on contractual liability shifting provisions is a risky proposition if the contract is drafted incorrectly. Determining whether other entities may owe indemnification at an early stage is critical to ensure timely notice may be provided to those parties' insurers. Moreover, in construction defect claims involving latent defects, all policies in effect from the date of the alleged improper construction and the date of discovery of the defects may be triggered.

So what should you do? Taking the application of the law to these clauses and policy language, an insurer's main questions when looking to applicable contracts, an insurer's own policy and those of others, are as follows: (1) does the contract specify insurance to be procured; (2) how expansive is the language in the insured's own policy; (3) how expansive is the language in the endorsements purporting to include the insured as an additional insured on other contracting parties' policies; (4) what is the damage asserted; (5) who does the complaint assert caused the damage; and (6) what is the date of construction and the date of discovery of a latent defect? If another policy is arguably applicable to the loss, whether through contract or insurance policy language, the insured should give notice of the claim or suit as soon as practicable, and tender its defense for same. The same applies to any tender of a defense and indemnification to the indemnitee under a construction contract.

[65] *McBro, Inc. v. M & M Glass Co.*, 611 So. 2d 283, 284 (Ala. 1992).

The Wolves of Litigation Street: Funding Companies' Investment Stake in Litigation

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The Wolves of Litigation Street: Funding Companies' Investment Stake in Litigation

Litigation is expensive for both plaintiffs and defendants. According to the Wall Street Journal, "[c]ommercial litigation funding took hold in the U.S. less than a decade ago, touted as a way for little-guy plaintiffs to fund lawsuits against deep-pocketed defendants."[1]

AN OVERVIEW OF LITIGATION FUNDING COMPANIES

Lawsuit funding provides funding to a plaintiff (or group of plaintiffs) for litigation expenses and possibly other expenses, such as living expenses or medical expenses, during litigation. Often, the lawsuit funding is not in the form of a traditional loan. Rather, the plaintiff is only obligated to repay the funding out of any settlement or judgment, and the funding company agrees not to seek money from the plaintiff if the settlement or judgment does not satisfy the loan.[2] In non-recourse financing, the lender can only recover from the collateral. Therefore, the most common types of lawsuit funding are a type of non-recourse financing. Generally, non-recourse financing is not subject to the regulations that apply to loans.[3]

Litigation funding can be divided into two broad categories: (1) consumer funding to individual plaintiffs; and (2) investment financing in large-scale tort and commercial cases.[4] In consumer litigation funding, the plaintiffs who seek funding are often out of work and may not have access to more traditional sources of capital, such as bank loans and credit cards. Litigation funding helps them cover litigation expenses, medical expenses and living expenses.[5] In some consumer funding cases, the plaintiffs would simply rather have money now, even if it is subject to interest and repayment, than wait for a settlement or judgment.[6]

Medical lien funding is a specific type of litigation funding in which "medical funders profit by purchasing bills for the medical treatment of injured plaintiffs at a deep discount from health care providers, then claim the full amount of the bill as a lien against the patient's legal recovery through a settlement or verdict."[7] The medical lien funding company's profit is equal to the difference between the amount it paid to purchase the bill and the amount it recovers.[8] The plaintiffs who seek medical lien funding tend to be uninsured, underinsured or lack the means to pay deductibles and co-payments.[9] In addition to offering to pay for the medical care, medical lien funding companies sometimes provide additional services such as transportation to and from appointments or funding for other expenses. The medical lien funding company includes the costs of those services in the loan, for repayment later.[10]

BALANCING THE INTERESTS OF LITIGATION FUNDING COMPANIES AND PLAINTIFFS

Litigation funding companies provide capital to plaintiffs for legal, medical and living expenses, a benefit for their plaintiff-customers. However, litigation funding companies are created to make a profit. Therefore, their motives are not exclusively altruistic.

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1 Sara Randazzo. *Litigation Financing Attracts New Set of Investors*. WALL STREET JOURNAL, May 15, 2016, available at http://www.wsj.com/articles/litigation-financing-attracts-new-set-of-investors-1463348262.

2 U.S. Chamber of Commerce Institute for Legal Reform. *Lawsuit Lending*, available at http://www.instituteforlegalreform.com/issues/lawsuit-lending.

3 *Id.*

4 U.S. Chamber of Commerce Institute for Legal Reform. *Stopping the Sale on Lawsuits: A Proposal to Regulate Third-Party Investments in Litigation*. Oct. 24, 2012, available at http://www.instituteforlegalreform.com/uploads/sites/1/TPLF_Solutions.pdf (hereinafter "Stopping the Sale").

5 Am. Bar Ass'n Comm'n on Ethics 20/20. *Informational Report to the House of Delegates*, White Paper on Alternative Litigation Finance. Feb. 2012, available at http://www.americanbar.org/content/dam/aba/administrative/ethics_2020/20111212_ethics_20_20_alf_white_paper_final_hod_informational_report.authcheckdam.pdf (hereinafter "ABA Informational Report").

6 *Id.*

7 Allison Frankel and Jessica Dye. *U.S. business groups call for probe of medical funding industry.* REUTERS. Aug. 26, 2015, available at http://www.reuters.com/article/us-usa-litigation-mesh-idUSKCN0QV2BU20150826 (hereinafter "Call for probe of medical funding industry").

8 Allison Frankel and Jessic Dye, *Special Report: Investors profit by funding surgery for desperate women patients*, REUTERS. Aug. 18, 2015, available at http://www.reuters.com/article/usa-litigation-mesh-idUSL3N10S54U20150818. (hereinafter "Investors profit").

9 *Id.*

10 *Id.*

Whose Financial Interests Are Being Served?

At the most basic level, litigation funding companies provide capital to plaintiffs who could not otherwise pursue their claims.[11] They do so by spreading the risk of litigation among many plaintiffs.[12] Lee Drucker, the founder of a litigation finance company, writes that "[l]itigation finance redistributes this risk to the party that is most willing and able to bear and manage it. The social benefit of this risk distribution is the allocation of capital resources to their highest and best use; allowing companies to invest in projects that optimize returns and promote general economic growth."[13] In other words, no single plaintiff bears all the risk or the reward of a lawsuit.

Critics believe that litigation funding companies hurt plaintiffs financially. The funding companies' profits diminish the plaintiffs' recovery. In at least one instance, a Pennsylvania slip and fall plaintiff and her lawyer borrowed money. At trial, she won a $169,000 verdict, but she owed the litigation funding company $221,000.[14] In another instance, the effective interest rate on a loan of $1,250 was approximately 50 percent per year.[15] Even in less egregious cases, the interest rate on litigation funding often exceeds 15 percent per year.[16] Yet, the litigation funding companies contend that the high rates of return are justified by the risk that they bear.[17]

What is the Impact on the Medical Care Provided to Plaintiffs?

Litigation funding companies contend that they provide the plaintiff-patients access to medical care they could not otherwise afford.[18] However, that access to care comes at a cost, both monetarily and in the medical care itself. Medicare has a set fee schedule of what it will reimburse for various procedures.[19] Health insurers negotiate reimbursement rates and increasingly tie those rates to the amount Medicare is willing to reimburse.[20] Neither Medicare nor private insurance rates apply when a medical lien funding company purchases the bill. As a result, medical lien funding companies often demand to enforce medical bills that are more than the amount that Medicare or a health insurer would pay for a given medical procedure.[21] Thus, the cost of the procedures may be significantly higher. The litigation funding companies contend that plaintiffs are aware the cost of the care may be more expensive.[22]

Moreover, the funding companies may encourage unnecessary tests and procedures, which artificially and unnecessarily increase the cost of medical care.[23] The medical lien funding companies profit off the medical procedures by purchasing medical bills at a discount. Further, increased special damages often result in higher overall verdicts, which provides an incentive to the funding company to fund additional procedures to inflate the damages.

What is the Impact on the Judicial System?

Advocates of litigation funding companies argue they benefit the justice system. They open the door to the justice system for under-capitalized plaintiffs.[24] The litigation funding company reviews the merits of the case before accepting it and may provide meaningful feedback to the plaintiff on the merits of the case.[25] Therefore, they argue, the entire civil justice system benefits because the cases that are funded are more meritorious. Litigation funding companies also contend they shorten litigation. Deep-pocketed defendants are accused of engaging in a war of attrition to outlast plaintiffs with insufficient capital

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11 Mark Spiteri. *Third-party funders come to the aid of finance directors seeking to reduce the risk of litigation and control the costs*. CHARTERED INSTITUTE OF MANAGEMENT ACCOUNTANTS. November 12, 2012, available at http://www.fm-magazine.com/feature/depth/litigation-funding#.

12 ABA Informational Report, *supra* note 5.

13 Lee Drucker. *A Financial Perspective on Commercial Litigation Finance*.

14 Binyamin Appelbaum. *Investors Put Money on Lawsuits to Get Payouts*. THE NEW YORK TIMES. Nov. 14, 2010, available at http://www.nytimes.com/2010/11/15/business/15lawsuit.html?pagewanted=all.

15 *Id.*

16 *Id.*

17 Investors profit, *supra* note 8.

18 *Id.*

19 *See* https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html.

20 Julie Appleby. *Out-of-network costs up as insurers tie payment to Medicare*. USA TODAY. February 9, 2012, available at http://usatoday30.usatoday.com/money/industries/health/story/2012-01-27/medical-bills-out-of-network-surprises/53013494/1.

21 Investors profit, *supra* note 8.

22 *Id.*

23 *Id.*

24 David Lat. *6 Virtues of Litigation Finance*. ABOVE THE LAW. Nov. 24, 2015, available at http://abovethelaw.com/2015/11/6-virtues-of-litigation-fnance/.

25 Third-party funders come to the aid of finance directors seeking to reduce the risk of litigation and control the costs, *supra* note 11.

to sustain litigation. By providing equal funding to plaintiffs, litigation funding companies argue that neither side will try to outlast the other and that the duration of litigation will generally decrease.[26]

Critics disagree that litigation funding companies are the white hats of the litigation system. In fact, critics contend that litigation funding companies increase meritless litigation. As investors, the funding companies depend on a diversified portfolio, which they achieve by taking on more cases, regardless of the merit.[27] Further, litigation funding companies may prolong litigation because they are less likely to engage in reasonable settlement negotiations. A plaintiff with a lawsuit loan needs to recover more in order to cover the financing costs and may reject reasonable settlement offers.[28] The plaintiff also has the financial wherewithal to let the case proceed to trial in an attempt to secure a higher verdict.

What is the Impact on the Attorney-Client Relationship?

Litigation funding companies contend that their interests are tied to the plaintiff's recovery, so the interests of the plaintiff, his lawyer and the litigation funding company are aligned.[29] However, litigation funding companies have a vested interest in the outcome of litigation. Therefore, in some instances, they attempt to exert control over strategic litigation decisions. If the funding company's interest diverges from the plaintiff, a conflict of interest arises.[30] In addition, the funding company may intrude on the attorney-client relationship in other ways. The American Bar Association has expressed concern that some funding agreements "may purport to restrict the client's right to terminate a lawyer or to retain substitute counsel."[31]

THE STATUS OF REGULATION

As discussed above, by structuring the financing as non-recourse, litigation funding companies have generally avoided regulation, such as usury laws (which cap interest rates). In 2014 and 2015, more than a dozen states considered legislation to regulate lawsuit lending,[32] and seven states (Arkansas, Vermont, Oklahoma, Tennessee, Maine, Nebraska and Ohio) have enacted legislation.[33] In some instances, the new regulations classify litigation funding as loans. In other instances, the regulations limit the fees involved, effective interest rate or duration of fee assessment.[34] Nevertheless, much of the litigation funding industry remains unregulated. The industry resists legislation, arguing that the government should not interfere with the plaintiff's right to contract.[35]

In 2014, Georgia considered H.B. 801, which would have provided for limitations on the finance charges for consumer lawsuit lending transactions. However, that bill was not passed.[36]

RECENT CASE LAW DEVELOPMENTS IN GEORGIA

Unique issues arise during litigation when litigation funding companies are involved.

- Are the amounts of the medical bills, as presented from the medical funding company, reasonable and necessary?
- Is the agreement between the funding company and the plaintiff admissible under the collateral source rule, which excludes from trial any evidence that the plaintiff has received compensation for his damages from sources other than the defendants?[37]
- Were the physicians who treated the plaintiff influenced by the medical funding company? Do any credibility issues arise?

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26 Lat, *supra* note 24.

27 Lisa A. Rickard, *The Real and Ugly Facts of Litigation Funding.* U.S. CHAMBER OF COMMERCE INSTITUTE FOR LITIGATION REFORM. Mar. 26, 2014, available at http://www.instituteforlegalreform.com/resource/the-real-and-ugly-facts-of-litigation-funding.

28 Stopping the Sale, *supra* note 4.

29 Spiteri, *supra* note 11.

30 Stopping the Sale, *supra* note 4.

31 ABA Informational Report, *supra* note 5.

32 Andrew Strickler. *Ind. Litigation Funding Law May Serve As National Model.* LAW360. May 3, 2016, available at http://www.law360.com/articles/791464/ind-litigation-funding-law-may-serve-as-national-model.

33 Heather Morton, *Is Financial Assistance During a Court Case a Lawsuit Loan*?, National Conference of State Legislatures Legisbrief, Mar. 2014; Heather Morton, *Litigation or Lawsuit Funding Transactions 2015 Legislation*, Jan. 8, 2016; Heather Morton, *Litigation or Lawsuit Funding Transactions 2014 Legislation,* Jan. 13, 2015.

34 *Id.*

35 Call for probe of medical funding industry, *supra* note 7.

36 http://www.legis.ga.gov/Legislation/en-US/display/20132014/HB/801.

37 *Wardlaw v. Ivey*, 297 Ga. App. 240, 244 676 S.E.2d 858 (2009).

Recent cases in Georgia suggest that courts are beginning to address these issues. In 2015, the Supreme Court of Georgia decided in *Bowden v. The Medical Center, Inc.* that when evaluating the reasonableness of charges secured by a hospital lien, the amounts charged to insured patients and uninsured patients is discoverable because a juror may reasonably consider the differences between the two bills.[38]

In July 2015, less than one month after *Bowden* was decided, the U.S. District Court for the Northern District of Georgia visited the issue in *Houston v. Publix Supermarkets, Inc.*[39] In *Houston*, the plaintiff alleged injury from a slip and fall. A medical lien funding company financed some of the plaintiff's medical bills. The defendant sought to admit evidence of the payments to attack the credibility of witnesses and to dispute the reasonableness of the charges, not to mitigate its damages. The plaintiff argued the evidence was barred by the collateral source rule. Two of the doctors who treated the plaintiff were anticipated to testify that the fall caused her injury. However, the doctors routinely received referrals from the medical lien funding company. The defendant argued the referrals created bias. The court observed that the medical lien funding company was "not in the nature of a traditional collateral source. Unlike an insurance company, to which the Plaintiff would pay premiums, [a funding company] serves as an investor in the lawsuit and receives no payment from the Plaintiff until after the lawsuit."[40] The court then ruled that the evidence of the funding arrangements was "admissible for the purpose of attacking the credibility of their opinions."[41] The court, relying on *Bowden*, also found evidence of the relationship between the funding company and the physicians was relevant and admissible to determine the reasonable value of medical services provided.[42]

In August 2016, Judge Baker of the United States District Court for the Southern District of Georgia reached a similar conclusion in *Rangel v. Anderson*.[43] In *Rangel*, the plaintiff alleged injuries arising from a motor vehicle accident. The plaintiff sought treatment with multiple doctors, including a pain management specialist, and her treatment was funded by a medical funding company. The plaintiff sought to rely on the pain management specialist as an expert to establish causation. Ultimately, the plaintiff was not permitted to do so because she failed to disclose the pain management specialist as an expert, as opposed to a treating physician, and because the pain management specialist did not survive a *Daubert* challenge. In response, the plaintiff filed a motion in limine to "prohibit Defendant from offering evidence referencing . . . a medical lien funding company which has paid for Plaintiffs medical treatment."[44] The court reiterated the holding in *Houston* that "a medical lien funding company . . . is not a traditional collateral source."[45] The medical lien funding company "essentially fronted Plaintiff the money for her treatment" and intended to recover that money from the plaintiff. Therefore, unlike an insurance company, the medical funding did not reduce the plaintiff's obligations, the defendant was not attempting to offset any liability and the plaintiff intended to tender bills from the funding company as evidence of some of her alleged damages.[46] For these reasons, the court concluded that excluding evidence regarding the funding company "would not serve the underlying rationale of the collateral source rule."[47]

Recent case law suggests a trend that courts are beginning to distinguish funding companies from traditional collateral sources. Moreover, courts are increasingly willing to admit evidence of the funding company's involvement for purposes of impeaching the doctors whose bills were paid by the funding companies.

[38] *Bowden v. The Med. Ctr., Inc.*, 297 Ga. 285, 292, 773 S.E.2d 692, (2015).
[39] *Houston v. Publix Supermarkets, Inc.*, No. 1:13-CV-206-TWT, 2015 WL 4581541, at *1 (N.D. Ga. July 29, 2015).
[40] *Id.* at *2.
[41] *Id.* at *1.
[42] *Id.*
[43] *Rangel v. Anderson*, No. 2:15-CV-81, 2016 WL 4468558 (S.D. Ga. Aug. 23, 2016).
[44] *Id.* at *8.
[45] *Id*. at *9.
[46] *Id.*
[47] *Id.*

Don't Get Slimed: Time-Limited Demands in Georgia

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Don't Get Slimed: Time-Limited Demands in Georgia

In Georgia, a liability insurer who unreasonably fails to settle a covered claim against its policyholder may be found liable for an amount in excess of its policy limits. With the stakes for insurers so high, plaintiffs' attorneys are setting complicated traps in order to reap outrageous awards from seemingly innocent conduct by claims professionals. These traps may include, for example, unreasonably short time frames or specific instructions regarding how the payment is to be made. When the insurer fails to accept the demand pursuant to the exact specifications in the demand letter, the claimant cries "gotcha" and demands that the insurer then pay all claimed damages, including those in excess of policy limits.

As if the sneaky scenarios devised by claimants' attorneys were not enough, some insurers unfortunately create their own obstacles or fall prey to these set-ups by failing to respond at all or by providing a limited or incomplete response. With diligence and care, however, along with an understanding of the consequences of unreasonably failing to accept a settlement offer with a sensitive time constraint, an insurer can better avoid breaching its duty to settle or finding itself liable for an excess judgment. Insurers subjected to "set-up" or "gotcha" demands may also have legal support to challenge liability arising from such a set-up.

In response to the insurance industry's cries for a fairer legal process when faced with a time limited demand for policy limits, the Georgia General Assembly enacted a statute in 2013, O.C.G.A. § 9-11-67.1, which outlines procedures for how such pre-suit settlement demands must be made and, if appropriate, how they are to be accepted. The statute applies only to claims arising from the use of a motor vehicle though. While the statute has helped limit the "traps" set by plaintiffs somewhat, the statute does not fix all of the problems, and plaintiffs are still finding ways to trap insurers with time-limited demands both in motor vehicle accident claims and non-vehicle claims made under S*outhern General Insurance Company v. Holt*.[1] The prudent insurer should be aware of the limitations of the protections of O.C.G.A. § 9-11-67.1 as well as the potential pitfalls faced in non-vehicle claims under *Holt*.

THE INSURER'S DUTY TO SETTLE

The insurer's obligation of good faith requires the insurer to conduct a reasonably thorough and adequate investigation of all claims against its insured.[2] The insurer must also give equal consideration to the interests of its insured when making decisions regarding the litigation or potential settlement of third-party claims.[3] However, the insurer is not required to give greater consideration to the interests of the insured over its own interests.[4]

The insurance company acts in bad faith if it capriciously refuses to entertain an offer or fails to consider the risk to the insured should the case proceed to trial and a judgment in excess of the policy limits be rendered.[5] Put another way, if liability is reasonably clear and if the damages are high, the insurer "may not gamble" with the funds of its insured by refusing to settle within the policy limits in the hopes of striking a better deal later, knowing its liability is capped by policy limits if hard ball tactics fail.[6]

Two preeminent Georgia cases have shaped the contours of the law on bad faith failure to settle. The first case is *Southern General Insurance Company v. Holt*.[7] In *Holt*, the attorney for the injured party offered to settle the case with the defendant's insurer for an amount within policy limits. This offer, however, stated it was only good for 10 days. The insurer failed to reply within the short deadline, but eventually responded by agreeing to the offer. By that time, the injured party considered the offer revoked and proceeded to trial. At trial, an excess verdict was reached. The insured then assigned her bad faith claim against her insurer to the injured party, who sued the insurer for bad faith and won.

1 262 Ga. 267, 416 S.E.2d 274 (1992).
2 *Cotton States Mut. Ins. Co. v. Phillips*, 110 Ga. App. 581, 139 S.E.2d 412 (1964).
3 *See Nat'l Svcs. Inds., Inc. v. Hartford Accident & Indemnity Co.*, 661 F.2d 458 (5th Cir. 1981) (applying Georgia law); *Great Am. Ins. Co. v. Exum*, 123 Ga. App. 515, 181 S.E.2d 704 (1971); *U.S. Fidelity & Guaranty Co. v. Evans*, 116 Ga. App. 93, 156 S.E.2d 809 (1967).
4 *Id.*
5 *Cotton States Mut. Ins. Co. v. Fields*, 106 Ga. App. 740, 128 S.E.2d 358 (1962); *Govn't Employees Ins. Co. v. Gingold*, 249 Ga. 156, 288 S.E.2d 557 (1982).
6 *McCall v. Allstate Ins. Co.*, 251 Ga. 869, 310 S.E.2d 513 (1984).
7 *Holt*, 262 Ga. at 267.

The case was appealed to the Georgia Supreme Court, which held "an insurance company does not act in bad faith solely because it fails to accept a settlement offer within the deadline set by the injured person's attorney."[8] The court, however, noted an insurer does have a duty to respond to a settlement deadline within policy limits where the insurer has knowledge of clear liability, and special damages will exceed the policy limits. The primary thrust of *Holt* is the court's recognition and recitation of the general rule that an insurer's bad faith depends on whether the company acted reasonably in responding to a settlement offer.

Another important case is *Cotton States Mutual Insurance Company v. Brightman*.[9] Brightman, who was seriously injured in the accident, offered in writing on several occasions (including after a non-binding arbitration panel found in Brightman's favor and awarded him $2 million) to settle his claims for payment by Cotton States and State Farm Mutual Automobile Insurance Company of their policy limits. The demand required that both insurers tender their policy limits.

In response to the demand made by Brightman, neither Cotton States nor State Farm tendered their policy limits before the expiration of the 10-day period outlined in the offer. A trial ensued where the jury awarded Brightman damages for personal injury far in excess of the coverage amounts. The driver who was liable for this excess amount then signed over his bad faith claim to Brightman, who brought suit against Cotton States and won the claim for bad faith penalties. This decision was then appealed to the Georgia Supreme Court.

On appeal, Cotton States argued it never had the opportunity to settle because the plaintiff's demand contained a condition beyond its control (the demand that State Farm also tender its policy limits). In response to this argument, the court stated, "an insurance company faced with a demand involving multiple insurers can create a safe harbor from liability for an insured's bad faith claim under *Holt* by meeting the portion of the demand over which it has control, thus doing what it can to effectuate the settlement of the claims against its insured."[10] Essentially, the court found an insurer could be liable for bad faith in not settling even when the settlement demanded required conditions beyond an insurers control.

Brightman does not serve as a mandate that an insurance company must tender its limits. The potential bad faith penalties at issue in *Holt* and *Brightman* were applied because the insurer had "knowledge of clear liability and special damages exceeding the policy limits." The rule is an insurer is negligent in failing to settle if the ordinary prudent insurer would believe choosing to try the case instead of settling it created an unreasonable risk to the insured that would not adequately take into account the best interests of the insured. An insurer must act unreasonably by not tendering its limits in order to be held liable for bad faith.

HOW TO SPOT ISSUES AND TRAPS WITH THE *HOLT* DEMAND

An insurer can only be liable for rejecting a reasonable settlement demand. Under Georgia law, a settlement demand is reasonable if the insurer knew or should have known at the time the settlement demand was rejected that liability was clear and the potential judgment was likely to exceed the policy limits based on the claimant's injuries or loss. It is also possible a settlement demand can be reasonable even if liability is questionable, if the damages are significant. In other words, it might be reasonable to demand the policy limits when damages are clearly several multiples in excess of the policy limits, and the likely allocation of liability against the insured will be a percentage that when applied to the verdict will likely exceed the policy limits (even if not 100 percent liable). Whether an offer or settlement demand is reasonable depends upon the information that was available to the insurer when the demand was made. The insurer's conduct is evaluated under the totality of circumstances in which the claim and the settlement demand were presented.

Plaintiffs' lawyers have learned that their primary tool to craft a claim for bad faith is the demand letter. As discussed below, these letters can often be one-sided, ambiguous and unreasonable. Many of these letters seem obvious as attempts to "set up" the insurance company for bad faith. Such demands place the insurance company in a dilemma. It can try to meet the terms of the demand and risk failing to meet one of the letter's ambiguous terms. Alternatively, it can try to contact plaintiff's counsel for clarification and risk its conversation being deemed a counter-offer, which then can be rejected. Although these demand letters take a myriad of forms, some of the commonly encountered issues are set forth below.

8 *Id.* (*citing Home Ins. Co. v. North River Ins. Co*., 192 Ga. App. 551, 385 S.E.2d 736 (1989)).
9 276 Ga. 683, 580 S.E.2d 519 (2003).
10 *Id.* at 686.

Arbitrarily Short Time Limits

The hallmark feature of a set-up demand letter is an arbitrary yet inflexible time period for responding. Offers to settle for policy limits may include short deadlines that pass before there has been adequate time for investigation or discovery and may be revoked on technicalities. Time limit demands are also often made without important documents in support of the claim, most notably medical records. This lack of documents prevents the insurer from adequately assessing its liability to make a settlement decision before the time limit offer expires. If the insurer fails to accept the settlement demand before it expires, then the insurer may find itself defending against a bad faith failure to settle claim. The more unscrupulous plaintiffs' attorneys may send the demand to the wrong department in the insurance company or send the letter when the primary adjuster is scheduled to be out of office.

Although courts have not provided bright-line rules regarding what time limits are acceptable, the Tenth Circuit Court of Appeals provided instructive guidance in *Wade v. Emasco Insurance Company.*[11] In *Wade*, the court held it was not bad faith for an insurer to reject a settlement limits demand because the time limit set by the plaintiff's attorney was unreasonable.

Indeed, the court found it was reasonable and acceptable for the insurance company to wait to review the relevant medical records before responding to a policy limits demand. The Tenth Circuit reasoned that permitting an injured plaintiff's chosen timetable for settlement to govern the bad-faith inquiry would promote the customary manufacturing of bad-faith claims, especially in cases where an insured of meager means is covered by a policy of insurance which could finance only a fraction of the damages in a serious personal injury case. Indeed, insurers would be bombarded with settlement offers imposing arbitrary deadlines and would be encouraged to prematurely settle their insureds' claims at the earliest possible opportunity in contravention of their contractual right and obligation to thoroughly investigate.

In sum, a demand should give the insurer a reasonable time to evaluate both the demand and the claim to determine whether it will accept the demand. If an insurer is not given a fair opportunity to evaluate the demand, its failure to accept the demand may be justified and excusable, even if a subsequent verdict exceeds both the demand and the policy limit. That is not to say the deadline should be blithely ignored. The insurance company should respond in writing within the arbitrary deadline to explain why the deadline is unreasonable and what investigation is necessary before the settlement demand can be considered. The response should be drafted with the expectation that, should a bad faith claim result, the letter will be used as an exhibit in the adjuster's deposition and shown to the jury at trial. On the other hand, if the insurer has sufficient information to evaluate a demand, then courts have held that deadlines as short as 10 days are reasonable, as demonstrated in the *Holt* decision. Moreover, now that O.C.G.A. § 9-11-67.1 has been enacted, an insurer has at least 30 days to accept a pre-suit demand for policy limits where the claimed injuries arise out of the use of a motor vehicle.

Vague Terms

The settlement demand letter will sometimes contain vague settlement terms requiring clarification. Plaintiff's counsel will argue any request to clarify terms or seek information, a counter-offer, and therefore a rejection of the settlement demand within the deadline. They try to place the carrier in a "heads-I-win, tails-you-lose" type situation. As a result, the claims representative, wary of this type of set-up, is reluctant to call, even to ask for clarification of intentionally ambiguous demand terms. When they do call, they may be put through to voicemail or given the run-around in an attempt to stall for time — as the days run out on the time demand. When the inevitable bad faith action is brought, such attempts at communication become a mere footnote in the "totality of circumstances" of considerations for the jury to apply their 20/20 hindsight to. Written communication is preferred, with great care given to ensure it is clear the letter seeks only to clarify terms of the demand so that the demand can be considered.

Conditions Precedent

Offers to settle for policy limits may require an insurer to fulfill various conditions precedent to valid acceptance. Although some conditions are acceptable, certain conditions may render a settlement offer unreasonable and thus preclude insurer bad-faith liability. For example, in California, a settlement demand is not "a settlement demand within policy limits" if it contains conditions beyond simply paying the policy limit.[12] Such conditions include requiring the insured to participate as parties at trial or requiring the insurer to provide a defense for the insured. A settlement offer that includes these conditions may

[11] 483 F.3d 657 (10th Cir. 2007).

[12] *Heredia v. Farmers Ins. Exch.*, 279 Cal. Rptr. 511, 516 (Ct. App. 1991).

not provide a basis for a bad faith claim. Some claimants' attorneys place as a condition precedent on their demands that the insurer not only accept the policy limits demand within the deadline, but also tender the payment within the deadline. Georgia courts have not had an opportunity to address whether such condition precedent is appropriate, but the legislature has given the insurer a minimum of 10 days to pay after the written acceptance of the offer to settle in O.C.G.A. § 9-11-67.1.

Absence of a Release

The absence of a release may render a settlement demand unreasonable and invalid as a basis for bad faith. When a settlement demand does not promise a release of all claims against the insured, the insurer should not be obligated to accept the demand. An insurer may also be justified in rejecting a settlement demand that leaves its insured vulnerable against claims by other parties.[13]

For example, in *Coe v. State Farm Mutual Automobile Insurance Company*, the plaintiff made a policy limits demand with an 11-day deadline for the insurer to respond. State Farm inquired whether the settlement would include a release of a workers' compensation lien and assured the plaintiff "upon receipt of the very basic information requested, we shall promptly advise you of our position regarding settlement." The plaintiff's attorney did not reply to this inquiry, took the case to trial and obtained a large verdict in excess of the policy limits. The appellate court reversed and ruled State Farm was not responsible for any damages over the policy limits because the demand did not provide the company with a reasonable opportunity to settle all claims, including liens.

That being said, several cases have been decided in Georgia which held an insurer liable for an excess verdict when the insurer's response to a time limit demand was along the lines that, "we will accept the demand for policy limits, but plaintiff must agree to satisfy any medical and/or workers' compensation liens." These cases have found that such a response is a counter offer and a rejection of the demand. In *Herring v. Dunning*, the defendant's insurer issued an acceptance letter including language requesting a confirmation that no liens existed relevant to the case.[14] The court characterized this language as a mere recommendation — not a "mandatory direction" — especially in light of the acceptance letter's grant of a full and final release; thus, the letter was "an unequivocal and unconditional acceptance of plaintiff's written offer to settle."

In contrast, in *Frickey v. Jones*,[15] the insurer responded to a policy limit offer with a letter stating its willingness to pay the policy limit, but only upon receipt of a full release and a resolution of hospital liens and medical insurance liens. The court found this response constituted a counteroffer and thus a rejection of the original offer to settle. The Georgia Supreme Court distinguished this case from *Herring* on the grounds the insurer's acceptance letter did not accept the offer "unequivocally and without variance of any sort" and the requirement to resolve liens rose above the request in *Herring* to confirm the nonexistence of any outstanding liens. The tenuous distinction drawn by the Georgia Supreme Court serves as a warning to insurers to be careful when accepting settlement demands with conditions. This has proven to be very frustrating to insurers, especially in light of the federal government's more aggressive stance recently in enforcing Medicare liens.

Recent decisions, though, should give insurers more comfort. For example, in *Southern General Ins. Co. v. Wellstar Health System*,[16] the court created a "safe harbor" for insurers from liability for bad faith if the sole reason for the parties' failure to reach a settlement within policy limits is the plaintiff's unreasonable refusal to assure that outstanding medical liens will be satisfied. Moreover, the court gave insurers the option, when faced with an unreasonable plaintiff, to pay the outstanding liens directly to the creditor and pay the remainder of the limits to the plaintiff.

Again, the overriding concern is for the insurer to demonstrate reasonableness and show the insured's interests are being protected and given at least equal weight to its own interests.

Demands in Excess of Policy Limits

A demand in excess of policy limits is not a reasonable demand that can be accepted by an insurer, and thus "an insurer's settlement duty is not activated until a settlement demand within policy limits is made, and the terms of the demand are such that an ordinarily prudent insurer would accept it."[17] However, keep in mind in other jurisdictions, the fact that a settlement demand exceeds the policy limits may not absolve the insurer from a duty to settle. In these jurisdictions, the insurer has a duty to make a counteroffer for an amount within the policy limit in an effort to resolve the claim against its insured.[18]

13 *See Coe v. State Farm Mut. Auto Ins. Co.*, 136 Cal. Rptr. 331, 337–38 (Ct. App. 2006).
14 *Herring v. Dunning*, 213 Ga. App. 695, 446 S.E.2d 199, 203 (1994).
15 *Frickey v. Jones*, 630 S.E.2d 374, 376–77 (Ga. 2006).
16 *So. Gen. Ins. Co. v. Wellstar Health System*, 315 Ga. App. 26, 726 S.E.2d 488 (2012).
17 *See, e.g., Rocor Int'l v. Nat'l Union Fire Ins. Co.*, 77 S.W.3d 253, 262 (Tex. 2002).
18 *See, e.g., Rova Farms Resort, Inc. v. Investors Ins. Co.*, 323 A.2d. 495, 506 – 07 (N.J. 1974).

Demand Includes Uncovered or Inflated Claims

Sometimes the demand letter will contain unreasonable terms relating to uncovered items or to inflated claims under other coverages. As an example, a plaintiff may reasonably seek policy limits on a bodily injury claim. With that demand, the plaintiff may also seek an overly inflated amount for property damage. The insurance company risks bad faith by contesting the property damage claim, and thereby losing the opportunity to settle the bodily injury claim.

Lack of Information

Some settlement demands arrive unsupported by necessary evidence and information. A claimant's failure or refusal to provide key information (e.g., medical records) may significantly affect whether an insurer's rejection of a settlement demand was "reasonable."[19] Other jurisdictions have embraced this reasoning. For example, in *Robins v. Allstate Insurance Company*, the insurer unsuccessfully attempted to obtain medical records and information from the claimant for two years. The insurer subsequently received a settlement offer for policy limits that included only some past medical bills, but very little documentation of medical evaluation and diagnosis to explain the medical bills and their relevance to the claim. The court found the insurer's refusal to settle without ascertaining the medical status of the insured was not unreasonable and did not give rise to a bad faith claim.

As a corollary to this principle, an insurer has a right and a duty to conduct a reasonable investigation.[20] Hence, an insurer who was not permitted to conduct a sufficient investigation to determine the likelihood of an excess judgment should not be held liable for bad faith.[21] Although plaintiffs or claimants will continue to try setting arbitrary and unreasonable time frames for insurers to respond to policy limit settlement demands, some courts have held such deadlines are not dispositive and insurers have the right to investigate and evaluate the plaintiff's claims.[22]

In *Baker v. Huff*,[23] liability was clear, but Liberty Mutual received medical bills at the time of the policy limit demand which were far less than policy limits and which contained notations that plaintiff's injuries had substantially improved. Plaintiff was not immediately forthcoming with any further medical records showing further treatment and the current status of plaintiff's injuries. Liberty Mutual refused to accept the demand within the deadline, but later received additional medical records which caused it to accept the demand, but the plaintiff rejected the acceptance. The Court of Appeals denied the argument that the fact that special damages were less than the limits automatically entitled Liberty Mutual to summary judgment for the bad faith claim, but granted the insurer summary judgment on the grounds that its failure to accept the demand within the deadline was not unreasonable as a matter of law because it did not have the information necessary to properly evaluate the demand.

It is important to note an insurer's lack of information is not an absolute shield to liability for bad faith. If an insurer's lack of sufficient information is due to the insurer's own negligence or lack of diligence, this lack of information will not provide a defense against a bad faith claim. California courts have held insurers liable for bad faith for failing to thoroughly investigate a claim or for unreasonably delaying the commencement of an investigation or coverage decision.[24] Therefore, insurers should document all steps necessary to determine whether a claim is likely to exceed policy limits, inform the insured of the settlement offer, involve the insured when prudent and request specific additional information or additional time to evaluate the claim.

Offer to Settle Only Part of a Bodily Injury Claim

In *Baker v. Huff*,[25] discussed above, the Court of Appeals of Georgia found that a time-limited demand for the policy limits that was an offer for a partial settlement of pain and suffering damages was not an offer to fully settle a claim within the policy limits within *Holt*.[26] Therefore, the insurer had no duty to engage in negotiations concerning a settlement demand that is in excess of the policy limits.[27]

19 *Robin v. Allstate Ins. Co.*, 870 So. 2d 402, 412-13 (La. Ct. App. 2004).

20 *See, e.g., Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 146 (Cal. 1979); *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 995 (9th Cir. 2001).

21 *Globe Indem. Co. v. Superior Court*, 8 Cal. Rptr. 2d 251, 255 (Al. Ct. App. 1992); *see also, e.g., State Farm Mut. Auto. Ins. Co. v. Hollis*, 554 So. 2d 387, 389–90 (Ala. 1989); *Gilderman v. State Farm Ins. Co.*, 649 A.2d 941, 946 (Pa. Super. Ct. 1994).

22 *Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 24, 28–29 (N.Y. 1993).

23 *Baker v. Huff,* 323 Ga. App. 357, 747 S.E.2d 1 (2013).

24 *See, e.g., Egan*, 620 P.2d at 146; *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 252 (Al. Ct. App. 1990).

25 323 Ga. App. at 357.

26 *Id.* at 365.

27 *Id.*

Defense Counsel's Valuation of the Claim

In some jurisdictions, the insurance company can rely on the advice of counsel in showing its response to a time limited demand was reasonable. Under California law, for example, an insurer may offer proof it acted in good faith reliance on advice of competent counsel to negate allegations it acted in "bad faith" toward its insured and to negate claims it acted with the requisite "oppression, fraud or malice" for an award of punitive damages. Along with other relevant evidence, a showing of good faith reliance on advice of counsel may tend to show the insurer was acting "reasonably" in its handling of the claim. Reliance on counsel's advice tends to show the insurer had "proper cause" for its actions and thus tends to negate "bad faith."[28]

Applicability of Coverage Defenses

The states are split on whether an insurance company has a duty to settle in the face of a good faith question about coverage under the policy. The California Supreme Court found where: (1) there is a settlement demand within policy limits; and (2) there is a great risk of a judgment in excess of policy limits, an insurer that refuses to accept the settlement demand does so at its own risk.

Importantly, the court clearly stated such risk includes liability for the entire excess judgment, and even a reasonable but erroneous belief in non-coverage is no defense.[29] However, in many jurisdictions the insurer has no duty to settle when there is a "fairly debatable" coverage question.[30]

In Georgia, it appears liability can exist for not settling a case even though coverage questions exist. In *Alexander Underwriters General Agency v. Lovett,* the insurer believed the insurance policy had been cancelled and therefore it did not defend a liability suit brought against the insured.[31] The lawsuit went into default. Before the trial on damages, the plaintiff wrote to the insurer offering to settle for the $10,000 policy limits. The insurer chose to rely on its position the policy was cancelled and declined to settle. This final demand was one of 35 items of correspondence directed at the insurer during the case. After an excess judgment was entered, the insured filed a bad faith action against its insurer. The bad faith action went to trial, and the insured was awarded the entire amount of the underlying judgment, plus attorney's fees and punitive damages. The insurer appealed, arguing such damages are not proper for the insurer's breach of the duty to defend. The Court of Appeals, however, held the insurer's liability was predicated not on violating the duty to defend, but instead arose from the fact "there was a timely offer of settlement within the limits of coverage and that the insurer negligently or in bad faith refused to adjust the account or to defend the insured (after the offer of settlement) when the amount of damages . . . was being established."

By holding the insurer liable for failing to settle in *Alexander*, an insurer is effectively required to reexamine its coverage position when confronted with an opportunity to settle and act reasonably in light of all new information. Even if the insurer continues to decline coverage wrongly, but in good faith, it may still be liable for failing to settle.

In *Davis v. Cincinnati Insurance Company*, the insurer was absolved by the jury of any bad faith in breaching its duty to defend the insured.[32] Nonetheless, the jury found the insurer acted negligently in failing to settle the claim on behalf of the insured. Implicitly then, an insurer can act negligently and be held liable in failing to settle a claim, even though it denied coverage. Further, the question of whether the insurer acted negligently in failing to settle is not necessarily tied to considerations of the insurer's good faith in denying coverage.

Based on these decisions, it is questionable whether an insurer can rely on its coverage defenses to determine the reasonableness of a settlement demand. Policyholders can argue an insurer's "good faith" belief in non-coverage will afford no defense to liability flowing from its refusal to accept a reasonable settlement offer. When coverage is dubious, an insurer can protect itself by accepting a settlement demand under a reservation of rights to seek reimbursement of payments for non-covered claims. Indeed, the insurer can make settlement payments over the objections of the insured and later seek reimbursement when it is determined the underlying claim was not covered under the policy.

[28] *State Farm Mut. Auto. Ins. Co. v. Superior Court (Johnson Kinsey, Inc.),* 279 Cal. Rptr. 116, 117–18 (Cal Ct. App.1991) (citations omitted).

[29] *Comunale v. Traders & General Ins. Co.*, 328 P.2d 198 (Cal. 1958).

[30] *See, e.g., Lasma Corp. v. Monarch Ins. Co.*, 764 P.2d 1118, 1122–23 (Ariz. 1988); *Mowry v. Badger States Mut. Cas. Co.*, 385 N.W.2d 171, 180 (Wis. 1986); *Snodgrass v. State Farm Mut. Auto. Ins. Co.*, 804 P.2d 1012, 1022–23 (Kan. Ct. App. 1991); *Pham v. State Farm Mut. Ins. Co.*, 70 P.3d 567, 572 (Colo. App. 2003); *Farmland Mut. Ins. Co. v. Johnson*, 36 S.W.3d 368, 375 (Ky. 2000); *Harman v. Estate of Miller*, 656 N.W.2d 676, 681 (N.D. 2003).

[31] *Alexander Underwriters Gen. Agency v. Lovett*, 182 Ga. App. 769, 357 S.E.2d 258 (1987).

[32] 160 Ga. App. 813, 288 S.E.2d 233 (1982).

Withdrawn Settlement Demands

It is important to remember an insurer cannot necessarily reverse the consequences of an unreasonable settlement demand by subsequently offering to settle for policy limits. When a settlement offer for policy limits is later withdrawn by the claimant and subsequent offers by the insurer to settle for the same amount are rejected, an insurer may still be found to have acted in bad faith.[33] Therefore, it is prudent to assume the insurer will not be given a "redo" after missing a chance to settle, so it is important to respond properly the first time within the deadline.

Compliance with the Terms of the Offer

A settlement offer may stipulate that acceptance may only be made in a specific manner (e.g. "mailing the lawyer a check for the amount of the policy limits;" providing the policy limits in cash in denominations of $20 and $50 to the lawyer). If such a requirement is present and the insurer accepts in a form that does not comply with the demand, the claimant may have an excuse to reject the acceptance and pursue a bad faith claim. However, courts are trending toward more a reasonable, common-sense approach when looking at whether compliance with a requirement amounts to bad faith.

In *Partain v. Pitts,*[34] the Court of Appeals of Georgia reversed an order denying a claimant's motion to enforce a settlement agreement where the insurer made a minor mistake. The insurer's settlement draft was made jointly payable to the claimant, claimant's husband and the claimant's attorney rather than only to the wife and attorney as instructed in the settlement demand. The insurer inadvertently sent the draft, along with a letter to its own attorney, to the claimant's attorney rather than to its own attorney who was handling the settlement. The insurer corrected its mistake and re-issued the payment to the correct parties. The claimant's attorney argued that the demand was rejected and a counter-offer was made. The Court of Appeals rejected the claimant's argument, finding that no counter-offer had been made and noted that the check, along with a letter from the insurer, was a privileged communication meant for the insurer's attorney and not the claimant.

GEORGIA'S MOTOR VEHICLE SETTLEMENT DEMAND STATUTE

O.C.G.A. § 9-11-67.1 addresses the procedure to be followed in connection with time-limited policy limits settlement demands for motor vehicle accident cases. Before diving into the outlined procedure, though, it is important to first discuss what the statute does not address:

(1) The statute only discusses the procedure for offering and accepting time limit demands. It does not address the merits of such demands. Therefore, the same legal standards discussed above apply in determining whether an insurer has acted in bad faith by rejecting a demand (i.e., whether such rejection was arbitrary or capricious and failed to give equal consideration to the insured's interests).

(2) The statute only applies to offers to settle tort claims for injuries "arising from the use of a motor vehicle." This language was part of the compromise. Auto liability insurers who issue minimum required limits in their policies were the most susceptible to getting abused by *Holt* demands. To get the bill to pass, a compromise was reached to limit the law solely to auto claims. Therefore, for tort claims not involving the use of a motor vehicle, the "old" case law addressing the procedure for time demands will apply. Insurers will need to be very careful not to assume that the protections set forth in O.C.G.A. § 9-11-67.1 apply to non-auto claims.

(3) The statute only applies to demand letters written by attorneys. Therefore, *pro se* claimants in auto claims who make *Holt* demands fall under the "old" procedure.

(4) The statute only applies to causes of action arising on or after July 1, 2013.

(5) The statute only applies to pre-suit demands.

The following is the new procedure for a time limit demand in auto cases:

(1) The deadline for acceptance of the demand cannot be less than 30 days from receipt of the demand.

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[33] *See, e.g., Berges v. Infinity Ins. Co*. 896 So. 2d 665, 669 (Fla. 2004).

[34] 787 S.E.2d 354 (2016).

(2) The demand must be in writing, sent by certified mail or overnight delivery, specifically referencing the statute, and set forth the following terms:
  a. Amount of monetary payment.
  b. Who will be released if the demand is accepted.
  c. The type of release the claimants will provide to each releasee.
  d. The claims to be released.

(3) The demand can require a deadline for payment of the settlement amount (limits), but that deadline cannot be less than 10 days after written acceptance of the demand.

(4) If the insurer decides to accept the terms of the demand, such acceptance must be in writing.

(5) The insurer has the right to seek clarification of "terms, subrogation claims, standing to release claims, medical bills, medical records, and other relevant facts," and such request for reasonable clarification will not be deemed a counter-offer.

(6) If the insurer decides to accept the demand, it can elect a variety of payment methods, including cash, money order, wire transfer, cashier's check, insurance company check or draft and electronic payment.

RECENT NOTABLE CASES

Grange Mutual Casualty Co. v. Boris & Susan Woodard, 826 F.3d 1289 (11th Cir. 2016).

On June 23, 2016, the United States Court of Appeals for the Eleventh Circuit in *Grange Mutual Casualty Co. v. Boris & Susan Woodard*,[35] certified questions to the Georgia Supreme Court regarding interpretation of Georgia's Motor Vehicle Settlement Demand Statute, O.C.G.A. § 9-11-67.1. The Georgia Supreme Court's findings could impact how settlement demands are handled in Georgia under the statute.

Woodard involves a dispute over a settlement agreement purportedly made pursuant to O.C.G.A. § 9-11-67.1, which is discussed above. Since this statute was enacted, there have been no published state or federal cases interpreting its provisions. In *Woodard*, a driver insured by Grange Mutual Casualty Company, Thomas Dempsey, was at fault in a serious auto collision with Boris Woodward and his daughter, Anna Woodard. Both Boris and Anna sustained injuries as a result of the accident, and Anna subsequently died as a result of her injuries. The at-fault driver, Thomas Dempsey, carried auto insurance with Grange with limits of $50,000 per person/$100,000 per accident for liability for bodily injury.

Shortly after the collision, the Woodards' attorney mailed a settlement demand containing 11 requirements, including one providing that payment, if not made in cash, must be made within 10 days of acceptance of the settlement demand. On the first day, Grange's adjuster mailed a letter accepting the settlement demand. On the seventh day, the adjuster ordered settlement checks to be mailed to the Woodards' attorney and emailed the attorney to say the checks were being issued that day. However, the attorney did not receive the checks due to a processing glitch in the automated claims payment system. The Woodards' attorney subsequently notified the Grange adjuster that he had not received the checks and took the position that the parties never reached a binding settlement agreement. Although the adjuster offered to reissue new checks for overnight delivery, the Woodards' attorney refused to accept them.

Grange then filed the underlying suit alleging breach of the settlement contract. The Woodards moved for summary judgment on the grounds that no settlement contract was formed because Grange did not send payment within the required time limits. Grange cross-moved for summary judgment, arguing that its written acceptance of the offer was sufficient to form a contract under O.C.G.A. § 9-11-67.1. The district court granted the Woodards' motion for summary judgment, concluding that the parties never formed a contract.

The Eleventh Circuit analyzed O.C.G.A. § 9-11-67.1 and noted the statute was ambiguous as to its requirements. Grange argued that the terms of the statute prohibits unilateral contracts that require acceptance in the form of performance (i.e., payment). Grange argued that the written acceptance of the terms bound the parties. The Woodards, on the other hand, argued that the statute allows parties to contract as they see fit, and that no agreement could be reached until payment was made. The Woodwards relied on section (c) of O.C.G.A. § 9-11-67.1, which states that "[n]othing in this Code section is intended to prohibit parties from reaching a settlement agreement in a manner and under terms otherwise agreeable to the parties." O.C.G.A. § 9-11-67.1(c).

[35] No. 15-3295, 2016 WL 2332242 (11th Cir. 2016).

Because of this ambiguity, the Eleventh Circuit certified questions of interpretation of O.C.G.A. § 9-11-67.1 to the Georgia Supreme Court. The Georgia Supreme Court's response to these questions could substantially affect how insurance companies may protect themselves from allegations of bad faith. These questions are as follows:

(1) Under Georgia law and the facts of this case, did the parties enter into a binding settlement agreement when the Insurer Grange accepted the Woodards' offer in writing?
(2) Under Georgia law, does O.C.G.A. § 9-11-67.1 permit unilateral contracts whereby offerors may demand acceptance in the form of performance before there is a binding, enforceable settlement contract?
(3) Under Georgia law and the facts of this case, did O.C.G.A. § 9-11-67.1 permit the Woodards to demand timely payment as a condition of accepting their offer?
(4) Under Georgia law and the facts of this case, if there was a binding settlement agreement, did the Insurer Grange breach that agreement as to payment, and what is the remedy under Georgia law?

Camacho v. Nationwide

In *Camacho v. Nationwide Mutual Ins. Co.*,[36] the District Court for the Northern District of Georgia found that insurer Nationwide acted in bad faith in failing to respond to the estate's settlement demand.[37] The facts and aggressive decision in *Camacho* should be very concerning to insurers.

In *Camacho*, Nationwide was ordered to pay over $8 million in damages for bad faith and negligence after a jury verdict. The jury determined that Nationwide acted negligently and in bad faith after denying a claim arising out of a 2005 automobile accident. Nationwide's insured, Seung Park, ran a red light, striking a car driven by Stacey Camacho and causing her death.

Nationwide was provided with a time-limited settlement demand (a 10-day deadline) for Park's $100,000 policy limit in exchange for a limited liability release that would have released Park from all personal liability for any and all claims arising out of the accident, except to the extent other insurance coverage was available from which the Camacho family could seek additional funds. Nationwide rejected the settlement offer after 13 days, insisting on a general release with an indemnification provision related to medical liens. When no settlement was reached, the claimants filed a wrongful death suit in state court. The state court jury awarded them $5.83 million.

Following the jury's verdict, Park assigned his right to his bad faith claim against Nationwide to plaintiffs, who filed suit against Nationwide. In the bad faith case, the jury returned a verdict in favor of the plaintiffs finding that Nationwide acted in bad faith in failing to settle. Nationwide argued that no reasonably prudent insurer would have accepted the demand because it did not clearly offer to resolve the estate claim and the new attorney who made the demand did not have the apparent authority to make it. The court rejected these arguments, finding the evidence was sufficient to support the jury's finding that by failing to respond to Camacho's settlement demand within the 10-day time limit, Nationwide gave no consideration to Mr. Park's financial interests. The court found that an insurer may be liable for failing to settle for the policy limits if an ordinarily prudent insurer would consider that choosing to try the case — rather than accepting a reasonable settlement offer to settle within the policy limits on the terms by which the claim could be settled — would be taking an unreasonable risk that the insured would be subjected to a judgment in excess of the policy's limits. The court rejected Nationwide's argument that the failure to settle was not the proximate cause of the excess verdict. Rather, the court found the evidence at trial sufficient for a jury to determine that Nationwide's failure to settle exposed its insured to a $5.83 million excess verdict. The court awarded interest, and found that the plaintiffs were entitled to an award of reasonable attorneys' fees and expenses.

Camacho has been appealed to the United States Court of Appeals for the Eleventh Circuit by Nationwide. Swift Currie McGhee & Hiers will continue to monitor these cases.

CONCLUSION

The policy limit demand is a tool employed by plaintiffs to transform low-limit insurance policies into open-ended policies of indemnity. Given the increasingly frequent occurrence of insurer "set ups," insurers are wise to be attentive to any policy limits demand and to proactively respond to such demand. By carefully reviewing and investigating claims and being re-

[36] No. 1:11-CV-0311-AT, 2016 WL 3059833 (N.D. Ga. May 25, 2016).
[37] Note the case involved a motor vehicle accident before O.C.G.A. § 9-11-67.1 applied. However, the case law is still applicable to non-vehicle cases and to any issues not addressed by the statute.

sponsive to claimants, insurers can avoid liability and the negative consequences these "set ups" can bring. The tide is slowly starting to shift toward decreasing the "gamesmanship" of time-limited demands, by both the courts and the legislature, and focusing on what should be the key issue: whether the insurer acted in bad faith in rejecting the demand. However, claimants' attorneys will continue to push the envelope to explore ways to expose insurers' policy limits. The Eleventh Circuit's recent certification of questions to the Supreme Court of Georgia could provide some answers to insurers on this issue.

Attorney Bios

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For more than 30 years, Michael H. Schroder has maintained a broad defense litigation practice, handling numerous trials and appeals. He advises insurance clients on a wide range of insurance coverage issues, including both first- and third-party coverage matters, the defense of premises and transportation cases, professional liability and intellectual property matters. Mr. Schroder is a member of the Federation of Defense and Corporate Counsel, the Atlanta Bar Association and the Defense Research Institute. He participates as a speaker, a discussion leader and a panelist for litigation seminars on numerous subjects. He serves as one of the Deans of the Litigation Management College presented each year at Emory University. In 2014, Mr. Schroder was again named a Georgia Super Lawyer by *Atlanta Magazine*.

As a 1972 graduate of Princeton University, *magna cum laude*, with a degree in History, Mr. Schroder obtained his Juris Doctor in 1976 from the University of Georgia, graduating with honors. He is a past chairman of the Aviation Section of the State Bar of Georgia.

Mark T. Dietrichs

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Mark T. Dietrichs, a partner with the law firm of Swift, Currie, McGhee & Hiers, LLP, in Atlanta, Georgia, specializes in property insurance law and the representation of insurance companies in first- and third-party coverage litigation, extra-contractual claims, and property subrogation cases. He has more than 30 years' experience investigating and trying coverage, bad faith, arson, fraud and property damage cases in State and Federal Courts throughout Georgia and the Southeast.

Mr. Dietrichs serves on the Litigation and the Tort and Insurance Practice Sections of the American Bar Association. He is also a member of the State Bar of Georgia, the Defense Research Institute, the Georgia Defense Lawyers Association and the Atlanta Bar Association. He is a member of the International Association of Arson Investigators, the Georgia Fire Investigators Association, the Metro Fire Investigators Association and the Southern Loss Association. He has served as the Chairman of the Ethics and Grievance Committee for the Georgia Fire Investigators Association for more than a decade.

Mr. Dietrichs has presented numerous seminars on property insurance issues to the Georgia Bar Association, the Atlanta Bar Association, the International Association of Arson Investigators, the Georgia Fire Investigators Association, the Southeastern Claims Executive Association, the Atlanta Claims Association, the Southern Loss Association, the Women's Insurance Association and other professional organizations. He is also a frequent speaker and contributor to the annual Southeastern Arson Seminar sponsored by the Georgia State Fire Marshal's Office and various seminars sponsored by the local and statewide Chapters of the G.F.I.A.

Mr. Dietrichs is admitted to practice before the United States Supreme Court, the Eleventh Circuit Court of Appeals, the Northern, Middle and Southern District Courts of Georgia and all Georgia Appellate Courts.

Mr. Dietrichs received a B.A. degree with distinction at the University of Virginia in 1978 and graduated, *cum laude*, in 198l, from the University of Georgia with a law degree. He was an Oralist and Brief Writer for the Jessup International Law Moot Court Team and served on the staff of the Georgia Journal of International and Comparative Law as Articles Editor. He has worked with Swift, Currie, McGhee & Hiers since 1981.

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Stephen M. Schatz practices in a wide variety of litigation cases, especially areas related to insurance, construction and general liability. Throughout his career, he has handled a multitude of complex coverage issues under commercial general liability, excess, reinsurance, auto, specialty lines, D&O, disability, pollution, professional liability and first-party insurance policies. He has litigated numerous bad faith, insurance coverage, arson, fraud, theft, damage disputes, agency liability, subrogation and construction defects cases. He has also litigated and tried cases involving general liability, products liability, class actions, multi-district litigation (MDL), environmental liability, employer liability, professional liability and business/contract disputes. Mr. Schatz is a member of the State Bar of Georgia and practices in all state and federal courts in Georgia. In addition to Georgia, he has litigated matters in jurisdictions pro hac vice, including Alabama, Florida, Mississippi, Missouri, New Jersey, North Carolina, South Carolina, Tennessee and Virginia. Mr. Schatz is a member of the Defense Research Institute, the Council on Litigation Management, the Georgia Fire Investigators Association and the Southern Loss Association. He has published an article every year in the *Mercer Law Review* (the "Annual Insurance Survey") since 2002 and the *National Fire and Arson Report*. He is also a frequent speaker on insurance coverage, bad faith and construction litigation issues. Mr. Schatz graduated with distinction from the University of Virginia in 1985, and earned his J.D. degree from the University of North Carolina School of Law in 1988. He has been a partner with Swift Currie since 1997.

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Melissa K. Kahren joined Swift, Currie, McGhee & Hiers, LLP, in 1999. Her practice is focused in the areas of property, first-party coverage and construction litigation.

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Ms. Kahren graduated, *summa cum laude,* with a degree in English literature from Vanderbilt University in 1992 where she was a member of Phi Beta Kappa. Ms. Kahren received her J.D. from Emory University School of Law in 1995, where she was a managing editor of the *Emory International Law Review*.

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Bright Kinnett Wright originally joined Swift, Currie, McGhee & Hiers, LLP, in 1981, practicing in the area of first-party insurance litigation, property law, bad faith, insurance coverage, arson and fraudulent insurance claims. She has worked for Swift Currie for 14 years, returning in May 2007. She also practiced for six years at other Atlanta law firms in the area of asbestos litigation and pharmaceutical defense. Ms. Wright currently practices in the area of property insurance law. She has significant experience in handling jury trials in both state and federal courts, as well as experience with worker's compensation hearings.

Ms. Wright has been a member of the State Bar of Georgia since 1980 and is a member of the Litigation Section. She is admitted to practice in the U.S. Courts of Appeal for the Eleventh Circuit and the United States District Courts for the Northern, Southern, and Middle Districts of Georgia. Ms. Wright formerly served on the Law Council of the Emory University School of Law and she is a Fellow of the State Bar of Georgia Lawyers Foundation. She has participated as a judge on several occasions for the Emory University Law School Trial Techniques program and as a judge for law school trial team competitions. She is also a member of the International Association of Arson Investigators and the Georgia Fire Investigators Association.

Ms. Wright obtained her B.A. in Psychology from the University of North Carolina at Chapel Hill in 1974 and received her Paralegal Certificate in Civil Litigation from the National Center for Paralegal Training in 1980. In 1980, Ms. Wright obtained her J.D. degree from the Emory University School of Law, where she was a teaching assistant for two years in Research, Writing and Advocacy.

Marcus L. Dean

Associate

Marcus L. Dean joined Swift, Currie, McGhee & Hiers, LLP, in 2013. He practices primarily in the area of coverage and commercial litigation.

Mr. Dean graduated from the University of North Carolina at Chapel Hill in 2010 with a bachelor's degree in Management and Society. He graduated, *magna cum laude,* from the Charlotte School of Law in 2013, where he was an editor of the *Charlotte Law Review*, a member of the Moot Court Board, a member of the Order of the Crown Honor Society, a member of the Phi Delta Phi Honor Society and a Property Law teaching assistant. While in law school, Mr. Dean was a summer associate with Swift, Currie, McGhee & Hiers, LLP, a summer intern for the Lord Corporation in Cary, North Carolina and a judicial intern for the Honorable Kimberly Best-Staton of the Mecklenburg County District Court in Charlotte, NC.

Jared K. Hodges

Associate

Jared K. Hodges received a B.A. in History and Political Science, *cum laude*, from the University of California, Los Angeles in 2005. He received his J.D., *magna cum laude*, from Georgia State University College of Law in 2012. While at Georgia State University College of Law, he served as Articles Associate Editor for the *Georgia State Law Review* and as President of the Asian American Law Students Association.

While attending law school, Mr. Hodges interned for Justice P. Harris Hines, Supreme Court of Georgia, and Judge John J. Goger, Fulton County Superior Court.

Prior to joining the firm, Mr. Hodges worked as a corporate, real estate and government litigator for a prominent Cobb County law firm.

David C. Williams, Jr.

Associate

David Williams (Dave) joined the firm in May 2016 as a senior attorney in the firm's general litigation practice group in Birmingham, Alabama. His practice focuses primarily on trucking litigation, general civil litigation, insurance coverage defense and premises liability. Mr. Williams has successfully litigated, mediated and arbitrated cases in federal court and throughout the state courts of Alabama. Mr. Williams serves his clients' needs from pre-lawsuit consultation to discovery and through trial. He has several reported cases affirming summary judgments he received for his clients. Also, he has been involved in several jury trial defense verdicts.

Mr. Williams received his B.S. in Health Care Administration from the University of Alabama in 2002 and was inducted into the Anderson Society which is awarded to the top 25 seniors. He also served as a member of Capstone Men & Women, the official ambassadors for the university. Mr. Williams then attended Cumberland School of Law at Samford University receiving his J.D. in 2005. After law school, Mr. Williams spent a year clerking for the Honorable Bruce E. Williams, Presiding Judge of Madison County, Alabama.

Prior to joining the firm, Mr. Williams practiced for another Birmingham defense firm for nine years where his primary focus was general civil defense litigation and premises liability.

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