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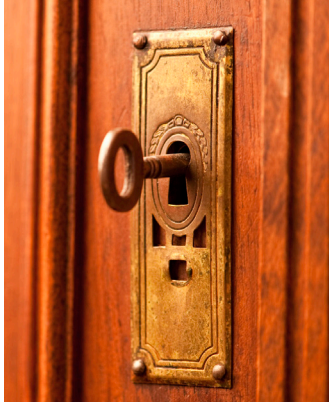

The 1st Party Report

A Property & Insurance Update

Spring 2017

Timeless Values. Progressive Solutions.

To Have and to *Holt* (Demand)

By: Kelly G. Chartash

In March 2017, the Georgia Supreme Court issued an opinion holding that O.C.G.A. § 9-11-67.1 does not prohibit a claimant from conditioning acceptance of a pre-suit offer upon the performance of some act. *Grange Mutual Casualty Company v. Woodward, et al.*, Case No. S16Q1875 (Ga. Mar. 6, 2017). What does this mean? O.C.G.A. § 9-11-67.1 sets forth certain terms which must be included in a pre-suit offer to settle. However, the party making the offer may now condition acceptance of a pre-suit *Holt* demand on additional terms, such as timely payment. This even means that a condition of the demand for timely payment is not met if a settlement check is timely issued, but accidentally sent to the wrong address.

To take a step back, a brief history of pre-suit time-limited demands in Georgia is helpful. 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. The seminal Georgia case shaping the area of bad faith failure to settle law is *Southern General Insurance Company v. Holt*. 262 Ga. 267, 416 S.E.2d 274 (1992). 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. 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." The Supreme Court, however, noted an insurer has a duty to respond to a settlement deadline within policy limits where the insurer has knowledge of clear liability, and special damages which will exceed the policy limits. The primary thrust of *Holt* is the Supreme 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*.

Since the Georgia Supreme Court's ruling in *Holt*, Georgia courts have continued to address time-limited demands. In 2013, the Georgia Legislature enacted O.C.G.A. § 9-11-67.1 to address the procedure to be followed with *pre-suit* time-limited policy limits settlement demands for *motor vehicle accident cases*.

In March 2017, the Georgia Supreme Court issued a decision in *Woodard*, the first appellate decision interpreting O.C.G.A. § 9-11-67.1. In *Woodward*, the claimants made a policy-limit demand. Under a boldface heading "***Note: The following items must be noted and fully and strictly complied with in order to accept this offer***," the claimants set forth a list of demands, including payment must be made . . . "within ten (10) days after your written acceptance of this offer to settle. Timely payment is an essential element of acceptance." The insurer accepted the offer in writing within 30 days and issued the checks. In a stroke of bad luck, the insurer mailed the checks to the wrong address. Upon learning of the error, the insurer apologized and offered to issue new checks and overnight them to the correct address. But the claimants refused because the insurer had not issued payment within the 10-day deadline and contended there was no settlement. The insurer nonetheless issued new settlement checks and mailed them to the correct address. The claimants rejected the checks as untimely and returned the checks indicating their intent to file suit. The insurer then filed a lawsuit for breach of settlement contract.

O.C.G.A. § 9-11-67.1 provides as follows: "Nothing in this Code section shall prohibit a party making an offer to settle from requiring payment within a specified period; provided that, such period shall be not less than ten days after

the written acceptance of the offer to settle." The Georgia Supreme Court in *Woodward* explained that while the statute does require the demand to contain certain terms, it does not prohibit additional settlement terms. The Supreme Court also looked to fundamental contract law providing that "an offeror is the master of his or her offer, and free to set the terms thereof." Here, the claimant had added a certain date by which the insurer had to issue the checks. The Supreme Court held that the claimant was permitted under O.C.G.A. § 9-11-67.1 to impose additional conditions on the acceptance of the offer, including setting a deadline for the issuance of the checks.

The Georgia Supreme Court declined to decide whether a settlement was reached. The United States District Court for the Northern District of Georgia posed certified questions to the Georgia Supreme Court regarding the interpretation of O.C.G.A. § 9-11-67.1. This means the U.S. District Court asked the Georgia Supreme Court to interpret new Georgia law. The Georgia Supreme Court answered questions about the interpretation of O.C.G.A. § 9-11-67.1, but declined to decide the ultimate issue in the case, whether an enforceable settlement was reached. Instead, the Georgia Supreme Court sent the case back to the Eleventh Circuit Court of Appeals for ruling on that issue.

So, what is the moral of the story? Take all reasonable efforts to comply with all conditions set forth in a pre-suit offer to settle, including conditions beyond those set forth in O.C.G.A. § 9-11-67.1.

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The Ongoing Implications of Hoover: Reservation of Rights Letters

By: Christy A. Maple

In June 2012, the Georgia Supreme Court decided *Hoover v. Maxum Indemnity Co.*, 291 Ga. 402. The *Hoover* decision established that an insurer waives any defense not explicitly set forth in its initial denial or reservation of rights letter. The implications of the Court's decision in *Hoover* were broad and sweeping, and the problems with this decision were immediately apparent.

The *Hoover* dissent identified a potential pitfall: an insurer who discovers during litigation that, but for the fraud of the insured, it could have raised another defense would be unable to raise the new defense simply because it was not explicitly asserted when the claim was denied. As such, an insurer seeking to deny coverage would be forced to blindly list any and all defenses in their initial denial letter, in the absence of necessary information and information obtained during the discovery later litigation might provide. In the face of a laundry list of defenses, some related and others not, the insured would be left with no clarity on where he or she stood. Moreover, the *Hoover* decision seemed to be a direct contradiction to the longstanding principle of Georgia insurance law that coverage that does not exist in the policy cannot be created by waiver or estoppel. *See, e.g.*, *Andrews v. Georgia Farm Bureau Mutual Insurance Co.*, 226 Ga. App. 316, 317, 487 S.E.2d 3, 4 (1997).

In recent years, courts grappling with the effects of *Hoover* appear to have reached a happy compromise. Courts have narrowed the scope of *Hoover* to apply only to "policy defenses" and not to "coverage defenses." *See, e.g.*, *Langdale Co. v. National Union Fire Ins. Co.*, 609 Fed. Appx. 578 (N.D. Ga. 2014). In *Langdale*, an insured sought insurance coverage from its director's and officer's ("D&O") insurance policy. Specifically, the insured sought advance payment of the costs to defend against a lawsuit. The insurer initially denied coverage on the basis of policy exclusion 4(g), which excluded coverage arising out of a director's acts or omissions other than those as a director. The insurer reserved all of its rights in the denial letter.

After exchanging several rounds of correspondence over the course of approximately one year, the insurer agreed to advance reasonable defense costs for covered portions of the underlying action. Another year later, after changing coverage counsel, the insurer issued another coverage denial letter to the insured, this time denying coverage based on policy exclusion (d) and Endorsement 8, which excluded coverage for claims arising out of certain enumerated events or that were previously tendered to an insurance carrier. According to National Union, the complaint and the counterclaim related to allegations raised in a 2008 state court suit and a 2008 federal court suit that other Langdale family members had filed against Johnny Langdale. The insured filed suit against the in-

An Important Change to Georgia's Valued Policy Act

By: Shannon L. Schlottmann

In 1971, the Georgia Legislature first enacted the Valued Policy Act, codified at O.C.G.A. § 33-32-5. The Act conclusively establishes the value of a residential structure in the event of a total loss by fire. It was designed to protect insureds against the difficult task of proving the pre-fire value of a residential structure after the structure has been completely destroyed. *Marchman v. Grange Mutual Insurance Co.*, 232 Ga. App. 481, 500 S.E.2d 659 (1998). Under the Act, the property's value is deemed to be the coverage limits contained within the insurance policy covering the property. For example, if a policy provides coverage limits of $250,000 for structural damage to a residential property [Note that this does not include any additional limit amounts such as where a policy provides up to an additional 25% in coverage where the cost to repair or replace the property exceeds the stated limits], then the property will be valued at $250,000 in the event of a total loss by fire regardless of the true market value of the property prior to the fire. However, there are certain requirements that must be satisfied to receive the protections of the Act. One of those requirements — that the policy be issued to a natural person(s) — has recently changed with Georgia's new Valued Policy Act, which became effective on July 1, 2016.

While most of the statute remained unchanged, 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 . . . ." O.C.G.A. § 33-32-5 (2016) (emphasis added). The prior version of the Act provided that it only applied to policies issued to "a natural person or persons." What does the change mean? In short, the change now makes it possible for corporations and other legal entities to make claims under the Act.

To date, no court in Georgia has addressed the new language of the Act. However, it is expected that this small change will have large implications. The revised statute suggests that if the insured is a corporation, limited liability company, partnership, or other legal entity (including an entity that is the mortagee), the insured may be able to make claims under the Act, so long as it is owned by a natural person. In fact, based on the plain language of the revised statute, the only "legal entity" insured which could not make claim under the revised act is a legal entity that is owned, either in whole or in part, by another entity.

In determining whether the revised act applies, insurers will have to ask a critical question: *who owns the insured entity?* Partnerships are owned by their partners, corporations by their shareholders, and limited liability companies by their members. Mortgagees are typically banks that are corporations, so their ownership will be determined by the status of their shareholders. While partners, shareholders, and members are often natural persons, nothing prevents them from being an entity. For instance, a typical bank/mortgagee, like other large corporations, will almost always have a non-natural person shareholder (and, therefore, would not be entitled to reap the benefit of the Valued Policy Act).

In Georgia, sole proprietorships, partnerships and joint ventures are not required to file any documentation with the State regarding their ownership. While corporations and limited liability companies, for instance, are required to file documentation with the Secretary of State, there is no requirement that the documentation identify the entity's owners. So how can an insurer determine whether an insured entity is wholly owned by a natural person (and thus entitled to make a claim under the Act)?

Insurers should actively seek ownership information during recorded statements, document requests,and examinations under oath. The insurer should ask the insured for the appropriate documentation in order to determine ownership. For instance, a corporation's shareholder list or stock register will reveal its owners. A partnership agreement (including all amendments) will identify the owners in a partnership. For a limited liability company, an insurer should request the operating agreement or membership agreement. Tax returns and schedules can also help to identify ownership. For instance, an insurer could request that an insured partnership produce a copy of its tax return and the Schedule K-1s issued that year.

Ownership can change over the lifetime of an entity. So which point in time should an insurer look to — when the policy was issued or when the loss occurred? The plain language of the statute points to the time the policy was issued. Is this when the policy was originally issued or when it was re-issued at the most recent renewal? It is unclear how a court would interpret the Act in this regard, but we suspect that the time of the issuance at the renewal before the date of loss would be most appropriate. Timing could pose an issue in a situation where, for instance, a policy is issued to a corporation with one natural person shareholder, but the loss occurs later when the corporation has grown to include entity shareholders.

Even when relevant documents are obtained, interpreting the ownership documents and issues such as timing can be a complicated task and may require the assistance of outside counsel. By expanding the reach of the Act to include entities wholly owned by natural persons, the Georgia Legislature has placed a burden on insurers when evaluating claims under the Act.

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surer, arguing that under *Hoover*, the insurer had waived its right to rely on exclusion (d) and Endorsement 8 because those provisions were not raised in the insurer's initial denial letter.

In reconciling the insured's waiver argument based on *Hoover* and the insurer's argument based on long-standing Georgia law that coverage cannot be created through waiver or estoppel, the *Langdale* court distinguished between "policy defenses" – in which an insurer denies coverage based on the insured's failure to fulfill a procedural condition of the insurance policy (*e.g.*, a notice condition) – and "coverage defenses" – in which the insurer argues the insurance policy does not cover the specific injury in question (*e.g.,* a policy exclusion). Although the *Hoover* opinion did not use these terms, instead referring to "policy defenses" and "claims of non-coverage," the *Langdale* court interpreted *Hoover* to be limited to applying only to "policy defenses." That is, the *Langdale* court interpreted *Hoover* to mean an insurer cannot both deny a claim outright and attempt to reserve the right to assert a different "policy defense" in the future. Under this reasoning, an insurer can reserve the right to assert a different "coverage defense" in the future. Thus, the *Langdale* court found the insurer had not waived its right to deny coverage based on exclusion (d) and Endorsement 8.

It is worth noting that on appeal, the Eleventh Circuit declined to address the waiver issue, instead affirming the district court's grant of summary judgment in favor of the insurer on the basis that exclusion (g) – the exclusion initially cited by the insurer in its first denial letter as the basis for the denial – precluded coverage. However, other more recent federal district court decisions have followed the lead of the *Langdale* court in holding that "coverage defenses," as opposed to "policy defenses," cannot be waived. *See, e.g.*, *Liberty Surplus Insurance Corp. v. Norfolk Southern Ry. Co.*, No. 7:14-CV-142 (HL), 2015 U.S. Dist. LEXIS 142509 (M.D. Ga. Aug. 17, 2015) (granting insurer's motion for leave to amend complaint, because the additional coverage defense the insurer sought to add to its complaint was not futile, and because the omission of that coverage defense from the reservation of rights letter did not result in waiver of that defense); *SavaSeniorCare, LLC v. Beazley Insurance Co.*, No. 1:14-CV-2738-RWS, 2015 U.S. Dist. LEXIS 111442 (N.D. Ga. Aug. 24, 2015) ("estoppel and waiver may not be asserted against 'coverage defenses,' because to do so would expand the scope of the contracted-for insurance coverage").

Although the *Hoover* decision has not been expressly overturned and therefore remains good law, the above-cited, recent federal court decisions indicate that things are not as dire as they once seemed for Georgia liability insurers immediately following *Hoover*. A liability insurer should nonetheless take care to be as precise as possible with respect to potential coverage defenses and policy defenses in any communications to an insured.

For more information on this topic, contact Christy Maple at christy.maple@swiftcurrie.com or 404.888.6142. ■

Events

Webinar: First Party Basic Training — Dealing with Damages
Thursday, June 8
1:00 - 2:00 pm EST

WC Webinar: Is That *Really* an Accident?
Tuesday, July 18
1:00 - 2:00 pm EST

Annual WC Client Seminar
Friday, September 29
Cobb Energy Performing Arts Centre

Annual Property, Coverage and Casualty Insurance Litigation Client Seminar
Friday, November 3
Cobb Energy Performing Arts Centre

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