

INSURANCE SETTLEMENTS: “REALITY SLICED AND DICED”

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Tort litigation over the last fifty years seems to have mirrored the statement Rod Tidwell (Cuba Gooding, Jr.) spoke in *Jerry McGuire*: “Show me the money!” “The money” motivating tort law principally resides in the insurance industry. Normally, access to the money comes from bringing the claim, and either collecting through settlement or judgment. However, in the never-ending search for *more* of the money, advocates push the bounds of reality by creatively altering the universe in which tort law is practiced.

One way to accomplish this is by the practitioner slicing and dicing the world in which insurance coverage applies to a tort case. Through a process of judicially accepted altered states, a good tort lawyer (whether plaintiff or defense) can transform a remote risk faced by an insurer into a viable and potentially large exposure. This is accomplished merely by creating a world where liabilities are divided, opponents are join together, and the laws of math are suspended. This is the world of insurance settlements in tort litigation.

The following materials provide an overview of four of the more creative insurance settlement vehicles which can be utilized by any party so long as they know how the agreements work. Two of these vehicles are available when more than one policy is potentially available to respond to the claim. Each of the agreements utilizes the insurer’s defense obligation either as a weapon to force an insurer into a settlement or obligation which quite often exceeds the carrier’s otherwise normal exposure, or a carrot to entice the insurer into the agreement. Recognizing how these insurance settlements work allows attorneys to obtain the best possible result for their client.

¹ The Presenter expresses his appreciation to the Co-Authors of these materials, Johnson & Condon law clerks Mr. Lee A. Hutton III and Mr. Jake M. Tomczik.

These materials are educational in that the content is intended to encourage discussion and interaction. The views expressed in the following pages are not necessarily those of the Authors, Johnson & Condon, P.A. or their clients. The Authors encourage questions or comments.

DRAKE-RYAN AGREEMENTS

INTRODUCTION

Under a “Drake-Ryan” Agreement, an insurer closest to the risk pays less than the full limits of its liability coverage to the plaintiff in exchange for a release of the insured to the extent of the primary insurer’s limits, as well as any uninsured amounts over the limits of any available excess coverage. The agreement is modeled closely on the agreements executed in *Loy v. Bunderson*, 107 Wis.2d 400, 320 N.W.2d 175 (1982), and subsequently in *Teigen v. Jelco of Wisconsin, Inc.*, 124 Wis.2d 1, 367 N.W.2d 806 (1985). The relevant language is set forth in detail in the case which gives the agreement its name in Minnesota, *Drake v. Ryan*, 514 N.W.2d 785, 786-87 (Minn. 1994).

THE CASE

In *Drake*, plaintiff Ione Drake was injured when she was rear-ended by a car driven by James Ryan and owned by his brother, Richard Ryan. *Id.* at 786. Richard carried \$30,000 of liability insurance coverage on the vehicle through Dairyland Mutual Insurance Co. *Id.* James was separately covered under his parents’ liability policy issued by State Farm Mutual Automobile Insurance Company in an additional amount totaling \$50,000. *Id.* It appears undisputed that the Dairyland policy was the primary coverage to respond to the loss, and therefore Dairyland hired counsel to defend the lawsuit. *Id.*

Before trial, the Plaintiff, the Ryans and Dairyland, after giving notice to State Farm, *Id.*, entered into the following agreement:

- 1) Dairyland would pay \$20,000 to satisfy the first \$30,000 of the plaintiff’s claim;
- 2) The payment would fully satisfy Dairyland’s obligations under its policy;
- 3) The payment would fully release the defendants except as to the portion of liability which would be insured by State Farm, if any (that is, the defendants were released to the extent of the

Dairyland coverage amount, as well as any liability which exceeded any applicable State Farm coverage);

- 4) The plaintiff specifically reserved her cause of action against the defendants up to the limit of the State Farm policy; and
- 5) The parties agreed that Dairyland could not seek reimbursement of the consideration if it was later found the defendants were not liable to the plaintiff.

Id. at 786-87.

James Ryan, allegedly at State Farm's urging (and likely on their nickel), moved the court to dismiss him from the action because he read the release as no longer subjecting him to personal liability, *Id.* at 787; further, he asserted the release was not enforceable because Dairyland had not exhausted its policy limits, and the release violated public policy considerations. *Id.* at 789. The trial court and court of appeals disagreed. *Id.* at 787. Thereafter, the supreme court accepted further review.

The supreme court held the agreement did not fully and finally release James Ryan from all liability. *Id.* at 788. Instead, the release "merely served 'to protect his personal assets by limiting satisfaction of any judgment against him to the insurance limits.'" *Id.* However, even though James Ryan no longer had a direct financial interest in the case, the court observed that he had a personal interest in the outcome because he still had his driving record and insurance rates to consider. *Id.* In the court's eyes, this was a sufficient tie to the lawsuit to overcome the distinction between how *Loy* read Wisconsin's "Direct Action" statute, and Minnesota's prohibition of a suit directly against the tortfeasor's carrier. Besides, the court commented a party could still have an interest in the litigation even when they have already been fully compensated *Id.* (citing *Jostens v. Mission Ins. Co.*, 387 N.W.2d 161 (Minn. 1986)).

The court recognized that Minnesota has a long history of dissecting a tortfeasor's liability in order to chip away portions of the claim from the lawsuit *Id.* (citing *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982) and *Naig v. Bloomington Sanitation*, 258 N.W.2d 891 (Minn. 1977)). Further, the

effect of the settlement was to remove one of the defendants and one of the insurers completely from the action, and limit the plaintiff's access to assets to merely insurance proceeds. *Id.* at 790. This supposedly streamlined the litigation.

The court next observed that State Farm was not prejudiced by the release. The agreement did not eliminate the liability defense. *Id.* Further, the agreement did not require the more remote insurer on the risk to respond at any point earlier than otherwise as the plaintiff "swallow[s] the gap." *Id.* at 789. Further, the supreme court agreed with the court of appeals that State Farm benefitted as the agreement eliminated its bad faith excess exposure.² *Id.* at 790.

State Farm also argued that it was prejudiced because the defense of the underlying action had effectively been shifted to it because of the settlement. However, as in *Loy*, the court rejected this contention by observing that State Farm's premium was likely calculated to afford a defense in a case just like this. *Id.* at 789. State Farm actually benefitted by the fortuity of having another carrier be closer to the risk, *Id.*, that is, until that carrier (Dairyland) recognized it could slip out from under that primary risk by settling with the underlying plaintiff for less than its limits and without paying all the defense costs.

DRAKE "EXTENDED:" CINCINNATI INS. CO. v. FRANCK

The court of appeals recently applied the *Drake* rationale to a more traditional primary policy/excess policy scenario in *Cincinnati Ins. Co. v. Franck*, 644 N.W.2d 471 (Minn. App. 2002), *review granted*, (Minn. August 6, 2002). In *Franck*, the plaintiffs, the insureds, and the primary insurer (a company other than the umbrella carrier) entered into a Drake-Ryan Agreement. *Id.* at 474. The substance of the release was the same in that the insured was personally released for any amounts underlying and in excess of

² How this could be when liability was apparently an issue is not discussed in either the court of appeals or the supreme court opinions. See *Northfield Ins. Co. v. St. Paul Surplus Lines Ins. Co.*, 545 N.W.2d 57 (Minn. 1996)(primary carrier cannot be in bad faith when there is a bona fide dispute as to the insured's liability).

the umbrella coverage, and the insured ate the gap between the settlement amount and the primary coverage limits. However, the parties consummated the settlement *before* the tort action began. *Id.* at 472. Thereafter, the plaintiffs sued; the primary carrier defended the action, but apparently only after the umbrella carrier tendered the claim to it. *Id.* The opinion does not state whether liability was an issue. However, the umbrella carrier later took over the defense, *Id.*, implying that liability was an issue.

The court of appeals held the true umbrella insurer's excess coverage was activated by the Drake-Ryan Agreement. *Id.* at 474. The court cited the same reasons as those cited in *Drake* and as articulated in the similar Wisconsin case applying *Loy* to primary/umbrella insurance arrangements, *Teigen v. Jelco of Wisconsin, Inc.*, 124 Wis.2d 1, 367 N.W.2d 806 (1985). The court did not seem bothered by the fact the umbrella insurer was paying for the defense as it had exercised its option to defend the suit. *Franck*, 644 N.W.2d at 474. However, the court did not go so far as to specifically rule that the primary carrier's defense obligation was actually extinguished in this factual scenario, despite the fact a typical *Drake-Ryan* Agreement would include a provision deeming the primary carrier's obligations to be exhausted.³

Judge Shumaker dissented from the majority, apparently for this very reason. He determined that the agreement rewrote the umbrella carrier's excess coverage provided in the policy by converting the protection into primary coverage. *Id.* at 477. He observed that cases such as *Schmidt v. Clothier*, 338 N.W.2d 256 (Minn. 1983) relied upon by the majority to justify the gap between the settlement amount and the primary limits may be justified

³ It may well be that, when directly presented with this issue, the appellate courts may will determine that the primary carrier's defense obligation is not exhausted when a true excess policy sits above the primary coverage. Unlike Wisconsin law which activates both the primary and excess policies' duty to defend at the suit's commencement, *see American Motorists Ins. Co. v. Trane Co.*, 544 F.Supp. 669 (W.D. Wis. 1982), *aff'd*, 718 F.2d 842 (7th Cir. 1983), Minnesota law looks to the actual policy language which generally would not activate the true excess carrier's defense obligation until the primary coverage is exhausted. *See generally, SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305 (Minn. 1995).

in statutory automobile law, but that “there might [not] be [] such public policy considerations in other insurance contexts.” *Id.* at 478. Instead, the majority’s reading of the agreement “shift[s] duties and costs to the excess carrier where the excess carrier had no obligation to assume the duties or pay the costs.” *Id.*⁴

PRACTICE

It appears the overriding factor weighing in favor of enforcing these agreements is the elimination of the insured’s personal liability. Only when the insured is fully protected through these risk-limiting agreements does the agreement make sense.

However, because the supreme court will not be addressing Judge Shumaker’s concerns, it remains an open question as to whether a primary carrier and the insured can compel the true excess insurer to defend when the primary carrier’s settlement does not exhaust the policy. Therefore, a primary carrier may not be interested in settling for a discount off of the policy limits if it thereafter is required to continue the defense. On the other hand, if the liability and damages realistically implicates the true excess carrier’s coverage, the excess carrier may be more than willing to assume the defense.

Because the *Drake* supreme court reproduced the substantive paragraphs of the agreement in its opinion, the practitioner is provided with a roadmap to follow on how to structure the agreement. This “approved” form will work well when two co-primary carriers are involved in a claim. The form may also be acceptable in a primary-true excess carrier situation so long as the effect of the agreement does not compel the excess carrier to obligations beyond those agreed to in the excess policy.

Finally, it is possible to fashion a “reverse” Drake-Ryan agreement between the excess insurer, the claimant and the insured if circumstances so warrant.

⁴ As noted above, the supreme court accepted review of the case on August 6, 2002. However, during the briefing process, the court was notified of a settlement. As of this time, the court awaits receipt of a Stipulation to Dismiss once a release is completed.

MEADOWBROOK AGREEMENTS

INTRODUCTION

A “Meadowbrook” agreement allows the insurer to bypass the insured and directly deal with the underlying plaintiff to resolve claims covered, and “arguably” covered, under the insurance policy. These agreements will typically be utilized in cases where some of the claims against the insured are covered, and some of the claims are not covered, by the applicable policy (such as where there are negligence and breach of contract counts). It allows the insurer to avoid massive defense costs when but one claim is covered in a multi-count Complaint. It also has the potential of eliminating any expertise which comes with the defense service provided by the duty to defend, and casting the insured adrift on the high seas of litigation.

THE CASE

The agreement takes its name from *Meadowbrook, Inc. v. Tower Ins. Co.*, 559 N.W.2d 411 (Minn. 1997). *Meadowbrook* had its roots in four Meadowbrook employees’ claims against their employer which asserted, among other theories, sexual harassment, defamation, and a hostile work environment. *Id.* at 413. The defamation claims were admittedly “arguably covered,” a condition which triggered the carrier’s defense obligation. *Id.* Because of this, the carrier undertook Meadowbrook’s defense of the entire action under a reservation of rights, but suggested that the insured retain counsel to help defend the uninsured claims. *Id.* The insured took the carrier’s advise, and retained private counsel.

A year into the suit, the court dismissed the defamation claims.⁵ 559 N.W.2d at 413. Thereafter, Tower withdrew its defense, claiming its defense obligations ceased when the Order was issued. *Id.* at 414. Meadowbrook’s private counsel continued on with the defense of the remainder of the action, and also commenced a declaratory judgment action against the carrier for breach of its defense duty. *Id.* The trial court agreed the insurer breached

⁵ The court of appeals notes the dismissal was pursuant to Meadowbrook’s Summary Judgment Motion, and that a number of additional claims were also dismissed. 543 N.W.2d 418, 421 (Minn. App. 1996).

the defense obligation, and entered a Partial Judgment against the carrier for the insured's defense costs incurred to date. *Id.*

Apparently realizing the underlying case was going to continue on for some time, the insurer negotiated a partial settlement with the underlying plaintiffs within a month of the Partial Judgment's entry. The plaintiffs agreed to release their defamation claims against the insured (arguably covered) and several others claims (which apparently were not covered). *Id.* Neither appellate opinion states whether the insurer gave notice to the insured of these negotiations, or the settlement, prior to its consummation.

Following the settlement, the insurer again moved for Summary Judgment in the coverage action, and now claimed the settlement made the dismissal of the defamation claim "final." *Id.* The trial court denied the Motion as it believed other counts remaining in the lawsuit were also "arguably covered;" these additional counts would also independently trigger the carrier's defense obligation. *Id.*

Ultimately, the defense fees and costs charged by private counsel for defending the underlying action and prosecuting the coverage action exceeded \$230,000. *Id.* at 414-15. The subsequent verdict in the underlying case, along with the underlying plaintiff's attorneys fees awarded, cost the insured over \$210,000. 543 N.W.2d at 421. The coverage action court determined that the carrier owed none of the damages awarded to the underlying plaintiffs, but held the carrier responsible for all defense fees and costs incurred through trial. 559 N.W.2d at 414-15.

On appeal, the insurer argued the settlement made the dismissal of the "arguably covered" (defamation) claims "final," and therefore the carrier's duties to the insured were fulfilled which would allow the carrier to withdraw its defense. *Id.* at 415. This was a case of first impression in Minnesota. However, past decisions never precluded a carrier from acting in this manner. *Id.* at 415-16. Therefore, the supreme court ruled that an insurer may withdraw its defense once all arguably covered claims had been extinguished. *Id.* at 416. The court noted this was consistent with Minnesota's public policy which only obligates parties to the responsibilities set forth in their contracts; the court also stated the rule also encourages insurers to defend

lawsuits instead of avoiding a defense obligation which would increase litigation in the form of more coverage actions. *Id.*⁶

PRACTICE

Meadowbrooks are sometimes attractive to a plaintiff. A Meadowbrook provides capital to finance the ongoing litigation against the defendant. The plaintiff may also want to eliminate a member of the defense's team by ousting the insurer from contact with the case. Finally, a plaintiff may be able to use the agreement as leverage to make a difficult defendant more reasonable in settlement discussions on the non-covered claims.

On the other hand, there appears to be little incentive for an insured to allow the insurer to eliminate the policyholder's pre-paid defense service. Therefore, the insurer should expect the insured to fight the agreement's effect. The penalty to the insurer for not crafting an airtight release is the payment of the insured's subsequent declaratory judgment action fees and costs, *American Standard Ins. Co. v. Le*, 551 N.W.2d 923 (Minn. 1996); *Lanoue v. Fireman's Fund Am. Ins. Cos.*, 278 N.W.2d 49 (Minn. 1979). *Morrison v. Swenson*, 274 Minn. 127, 142 N.W.2d 640 (1966), or even an adverse judgment entered pursuant to *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982).

It is interesting to note that the settlement agreement between the insurer and the underlying plaintiffs was not part of the appellate record. This may simply mean that, as long as the release is crafted in plain and unambiguous language, the intent of the parties will be honored. In order to implement this intent, it may be beneficial to attach a copy of the policy at issue to the release, and utilize language in the release which does not refer to specific counts in the Complaint, but instead refers to "any and all facts,

⁶ The remaining issue after this rule was announced was whether any of the remaining claims were "arguably covered" under the policy. The supreme court held they were not, thereby making the date of the settlement extinguishing the defamation claim the last date the carrier was obligated to defend. *Id.* at 714-720.

claims or causes of actions which a court may hereafter determine sufficient to trigger the Policy's duty to defend the insured."⁷

As noted above, the opinions do not state whether the insurer gave notice of the negotiations, or the imminent settlement, to the insured. However, the court did state:

“Had the insurer failed to notify the insured in a reservation of rights letter that it was undertaking the defense only upon the basis of the defamation claims, the insurer possibly would have an estoppel argument. But since the insurer sent such a letter and even suggested that the insured retain his [sic] own counsel to help defend those actions not arguably covered by the policy, the insured cannot now argue that the withdrawal harmed its defense.”

Id. at 417, n. 15. Therefore, it is prudent for the insurer to articulate in its reservation of rights letter which claims are, in its opinion, “arguably covered,” and that final resolution of those claims would allow the insurer to withdraw its coverage. Further, especially where the insured has not retained counsel to work with carrier-appointed counsel to defend the case, pre-withdrawal notice to the insured of the fact of the negotiations, as well as providing the insured with a “grace period” in which to retain its own counsel following a settlement to get up to speed in the case before the defense is withdrawn, are practices which will likely garner favor with the court if the insured attempts to object on prejudice grounds.

Finally, as with other insurance settlement agreements, it is helpful to cite to the originating case with language such as:

⁷ Keep in mind the policy at issue may not be interpreted under Minnesota law. Therefore, the determiner which triggers the duty to defend may be different than Minnesota's “arguably covered” standard. Because of this, language limited to Minnesota practice such as “any and all claims or causes of actions which a court may hereafter determine to be arguably covered pursuant to Minnesota law” may not be appropriate.

“It is the intent of the parties that this agreement be construed in accordance with the rulings in *Meadowbrook, Inc. v. Tower Ins. Co.*, 559 N.W.2d 411 (Minn. 1997).”

LOAN RECEIPT AGREEMENTS

INTRODUCTION

Loan Receipt agreements allow an insurer to avoid Minnesota’s *Iowa National Rule*⁸ which prohibits one insurer from seeking equitable contribution from another insurer providing overlapping coverage for the common insured’s defense costs. Under a Loan Receipt agreement, one insurer “loans” the insured the lawsuit’s defense in exchange for the insured’s agreement to pursue the second insurer’s concurrent defense obligation.⁹

THE CASE: *JOSTENS, INC. v. MISSION INS. CO.*

Loan Receipt agreements were popularized in modern insurance practice in *Jostens, Inc. v. Mission Ins. Co.*, 387 N.W.2d 161 (Minn.1986). Underlying the *Jostens* case was a lawsuit commenced against Jostens by one of its former employees. Larry Wepler sued for damages arising from Jostens’ allegedly improper termination him. *Id.* at 162. Jostens was insured under a comprehensive general liability (CGL) policy with one insurer, and an “umbrella” liability policy with another. *Id.* at 162. Jostens tendered the case’s defense to both carriers. *Id.* at 162. The CGL carrier denied coverage, as did the umbrella carrier. *Id.* at 163. However, the umbrella carrier offered to defend under a reservation of rights. *Id.* at 163. Jostens refused this arrangement, and instead defended the case on its own,

⁸ *Iowa Nat. Mut. Ins. Co. v. Universal Underwriters Ins. Co.*, 276 Minn. 362, 150 N.W.2d 233 (1967). The *Iowa National Rule* was subsequently followed in *St. Paul School District No. 625 v. Columbia Transit Corp.*, 321 N.W.2d 41, 48 (Minn. 1982), and *Nordby v. Atlantic Mut. Ins. Co.*, 329 N.W.2d 820, 824 (Minn. 1983).

⁹ The agreement utilized in *Jostens* is attached to these materials.

putting the umbrella carrier on notice that the insured would look to it for repayment of the defense costs. *Id.* at 163.

Jostens settled with the underlying plaintiff after giving notice of the settlement discussions to the umbrella carrier. *Id.* at 163. Thereafter, the insured sued both insurers, and sought reimbursement for its defense and settlement costs, as well as its costs to pursue the coverage action. *Id.* at 163. Shortly before cross-motions for Summary Judgment Motions were to be decided in the coverage action, the insured entered into a “Loan Receipt” agreement with the CGL carrier. In the agreement, Jostens agreed to dismiss its claims against the CGL carrier in exchange for payment of a sum certain (which did not equal the amount sought in the coverage action), and the CGL carrier funding the insured’s ongoing litigation against the umbrella carrier. *Id.* at 163-164. The agreement also contained the following provisions:

“Jostens hereby releases and discharge Wausau from any claim for interest claimed to be due on attorneys’ fees paid by Jostens in defense in defense of the Wepler case or in proceedings to establish coverage therefor or the amount paid in the Wepler action.

“That in the event Jostens is not successful in recovering the full amount sought in its action against Mission the following provisions shall apply:

“i. Jostens will pay Wausau whatever amount, if any, it recovered in said action.

“ii. Within 30 days after Jostens makes payment of the amounts set forth in (a) above to Wausau, Wausau agrees to pay Jostens \$35,000, less the amount, if any, received from Mission for the reimbursement of the settlement paid in the Wepler action.

“iii. The loan shall then be forgiven.”¹⁰

¹⁰ See attached agreement.

The trial court ruled that the umbrella carrier owed the insured's entire defense under its "broader than primary" portions of its policy, but only owed the insured one-half of its fees and costs incurred in pursuing coverage; the trial court also ruled the umbrella carrier was not obligated to pay for the settlement costs. *Id.* at 164. The court of appeals reversed the trial court, and determined that the insured was not a real party in interest given the agreement with the CGL insurer. *Jostens, Inc. v. Mission Ins. Co.*, 354 N.W.2d 575 (Minn. App. 1984).

Given these lower court rulings, Justice Simonett fashioned the issues as follows:

"(1) Did the court of appeals correctly rule Jostens was no longer a real party in interest in this lawsuit? (2) Did the trial court err in ordering Mission to pay Jostens all of its Wepler defense costs? and (3) Did the trial court err in ordering Mission to pay Jostens half of the reasonable attorney fees and costs incurred by Jostens in bringing this action?"

Jostens, 387 N.W.2d at 164.

The supreme court determined that the insured remained a real party in interest because the Loan Receipt agreement was merely a loan. *Id.* at 164 (citing *Blair v. Espeland*, 231 Minn. 444, 449, 43 N.W.2d 274, 277 (1950) and *Pacific Indemn. Co. v. Thompson-Yaeger, Inc.*, 260 N.W.2d 548, 556-57 (Minn. 1977)).¹¹

The court next addressed which carrier owed the defense costs. This was an issue given Minnesota's caselaw which bars an insurer which steps up to defend its insured from obtaining contribution, equitable or otherwise, from other insurers who also owe the insured a defense. *Iowa Nat. Mut. Ins. Co. v. Universal Underwriters Ins. Co.*, 276 Minn. 362, 150 N.W.2d 233 (1967). This rule results in a "brinkmanship" relationship between overlapping insurers who both owe the insured a defense instead of encouraging

¹¹ The supreme court also recognized that the insured had not been paid its interest on the defense expenses, which independently gave it "real party in interest" status. *Id.* at 165.

prospective cooperation between the insurers to protect their common insured.

The *Jostens* court ruled that each carrier is obligated to pay the insured's defense costs. 387 N.W.2d at 165. This ruling was an easy conclusion, and was based on the proposition that each of the two carriers arguably owed the insured a first dollar defense. *Id.* at 165. Because of this, the insured would normally be free to seek its defense costs from either of the carriers.

However, it seemed unfair to the supreme court to subject only one insurer to the insured's "whim" of pursuing one insured when, at the time of tender, both owed a defense obligation. *Id.* at 167. Therefore,

"If neither [carrier] undertakes the defense and the insured defends himself, then the insured, as *Jostens* has done here, may bring an action and recover his costs in defending the claim from either or both insurers. If it is established that both insurers arguably had coverage at the time of the rejected defense tender, the insurers, as between them, shall be equally liable for the insured's defense costs; provided, however, where an umbrella policy is involved, as between the underlying insurer and the umbrella insurer, the underlying insurer shall be liable for the entire defense costs except as to those costs that the underlying insurer can show were for defending claims covered only under the umbrella insurer's 'broader' or primary coverage.

"We believe this rule will encourage two insurers, when tendered a defense, to resolve promptly the duty to defend issue either by some cooperative arrangement between them, or by a declaratory judgment action, or by some other means. When an umbrella carrier is involved, our rule assigns more of the risk of liability for defense costs to the underlying carrier, which, because it bargained for the primary coverage, seems appropriate."

Id. at 167-168 (footnote omitted).

PRACTICE

“A loan-receipt agreement is a device used to achieve an equitable result. John E. McKay, *Loan Agreement: A Settlement Device That Deserves Close Scrutiny*, 10 Val. U. L. Rev. 231, 240 (1976). Loan receipts are essentially a subrogation tool. *Pacific Indem. Co. v. Thompson-Yaeger, Inc.*, 260 N.W.2d 548, 556-57 (Minn. 1977). The purpose of the loan-receipt agreement between an insurer and its insured is to allow a subsequent action to be brought in the name of the insured even when the insurer has in effect fully indemnified the insured for the loss. *Blair v. Espeland*, 231 Minn. 444, 448, 43 N.W.2d 274, 277 (1950); *see also Jostens, Inc. v. Mission Ins. Co.*, 387 N.W.2d 161, 164 (Minn. 1986) (loan-receipt agreements useful in disposing of insurance disputes when there has been payment); E. Michael Johnson, *The Real Party Under Rule 17(a): The Loan Receipt and Insurers' Subrogation Revisited*, 74 Minn. L. Rev. 1107, 1130 (1990).”

Jerry Mathison Constr., Inc., v. Binsfield, 615 N.W.2d 378, 381 (Minn. App. 2000).

Pursuant to these concepts, the Loan Receipt agreement provides various avenues to have one insurer fund an insured's defense, or a settlement, if the purpose is to ultimately offload some of the defense or all of the settlement on another insurer. Especially where the defense of a case will be expensive, Loan Receipt agreements allow an insurer, even apparently when the insurer has agreed to defend, with an opportunity to recoup some of the defense expenses from a recalcitrant insurer. *Redeemer Covenant Church of Brooklyn Park v. Church Mut. Ins. Co.*, 567 N.W.2d 71 (Minn. App. 1997) (retrospective Loan Receipt agreements allowed carriers defending an insured to recoup a portion of the defense costs from non-participating insurer; non-participating insurer liable for the insured's entire coverage action attorneys fees and costs).

MILLER-SHUGART AGREEMENTS

INTRODUCTION

These agreements derive their name from *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982). Miller-Shugart agreements are available to an insured who is a defendant in a lawsuit, but whose insurer has allegedly breached its obligation to that insured, typically by wrongfully denying coverage. The rationale for enforcing these types of settlements is stated by the court as follows:

“While the defendant insureds have a duty to cooperate with the insurer, they also have a right to protect themselves against plaintiff’s claim. * * * If . . . the insureds are offered a settlement when their insurance coverage is in doubt, surely it cannot be said that it is not in their best interest to accept the offer. Nor, do we think, can the insurer who is disputing coverage compel the insureds to forgo a settlement that is in their best interests.”

Id. at 733-34.

Miller-Shugart agreements benefit the insured by utilizing insurance proceeds to fund the settlement instead of the insured’s personal assets. This allows the insured to transfer the risk of loss back to the insurer. It also benefits the insured by saving the dollars the insured would have to pay to defend itself when the breach involves a denial of the carrier’s duty to defend.

These settlements also benefit the underlying plaintiff by eliminating the litigation against the insured-defendant. This may not be as advantageous as it sounds as there will still likely be litigation against the carrier to compel the insurer to pay pursuant to the settlement. However, where the insurer’s denial includes a denial of the duty to defend, the Miller-Shugart agreement potentially allows the injured plaintiff the opportunity to obtain more than just the two-thirds of their damages they would normally receive under a standard contingent retainer with their counsel. This is because, if the coverage claim against the insurer is successful, current Minnesota caselaw allows the party asserting the coverage claim to recover the attorneys fees and costs the

insured incurred in defending the underlying claim, as well as the attorneys fees and costs incurred in prosecuting the coverage claim.

THE CASE

Lynette Miller was a passenger in a vehicle owned by Barbara Locoshonas and driven by Mark Shugart when the car struck a tree. *Id.* at 731-732. The automobile was insured under a policy with Milbank Mutual Insurance Company in Locoshonas' name. *Id.* at 732. Following the accident, Miller brought a negligence claim against Shugart for injuries she sustained. *Id.* Shugart tendered the defense of the claim to Milbank. *Id.* Milbank claimed Shugart was not an agent of the owner, and therefore denied coverage. *Id.* Despite the denial, Milbank provided Shugart with counsel to defend the action while separately pursuing a declaratory judgment action to resolve the coverage issue. *Id.*

Ultimately, Milbank lost the coverage dispute. *Id.* While the coverage action was pending on appeal, Shugart's (and Locoshonas') counsel advised Milbank that negotiations were underway between Miller and the defendants, and invited Milbank to participate in negotiations. *Id.* Milbank declined to participate, claiming the coverage issue on appeal was unresolved. *Id.* Before the coverage issue was decided on appeal, Miller settled with Locoshonas and Shugart by confessing judgment to damages which exceeded the Milbank policy's \$50,000 limits, but which was only collectable from the Milbank insurance proceeds. *Id.* Milbank never consented to the settlement. *Id.*

Once the supreme court affirmed Milbank's coverage responsibility, Miller commenced garnishment proceedings against the insurer. *Id.* Despite the finality of the coverage action, Milbank denied liability on the grounds that it was not bound by the underlying judgment, and that Shugart had breached the contract by entering in to the confessed settlement. *Id.* The trial court held Milbank owed its limits. *Id.*

Relevant to this paper, the first issue the supreme court addressed was whether Shugart violated the policy's cooperation clause. *Id.* at 733. The insured opposed Milbank's claim by asserting the carrier first breached the contract by refusing to defend. This clearly not being the case, Justice

Simonett stated that “Milbank ha[d] never abandoned its insureds nor, by seeking a determination of its coverage, ha[d] it repudiated its policy obligations.” *Id.* However, the issue ultimately was whether an insured breaches “their duty to cooperate by not waiting to settle until after the policy coverage had been decided[.]” *Id.* The court held the insured is not so obligated. *Id.*

The court then addressed the substantive issues which involve every Miller-Shugart agreement:

“. . . [W]hether the judgment stipulated to by the plaintiff and the defendant insureds is the kind of liability the insurer has agreed under its policy to pay. This involves an inquiry into whether the judgment is the product of fraud or collusion perpetrated on the insurer and whether the judgment reflects a reasonable and prudent settlement.”

Id. at 732-733. The court agreed that a fraudulent or collusive settlement is not binding on a carrier. *Id.* at 733. However, Milbank never asserted, or proved, that the settlement was a product of fraud or collusion. *Id.* at 734. The mere fact the insurer is placed in somewhat of a “Catch-22” as to whether to participate in settlement discussions does not make a settlement fraudulent or collusive.

“Nevertheless, it seems to us, if a risk is to be borne, it is better to have the insurer who makes the decision to contest coverage bear the risk. Of course, the insurer escapes the risk if it should be successful on the coverage issue, and, in that event, it is plaintiff who loses.”

Id.

Finally, the court addressed whether the amount of the settlement was reasonable. *Id.* at 735. “This involves a consideration of the facts bearing on the liability and damage aspects of plaintiff’s claim, as well as the risks of going to trial.” *Id.* When applied to the fact of the case, it was clear Miller, the passenger, had no fault, and the driver, Shugart, could be the only party at fault. The undisputed damage evidence showed the plaintiff suffered

“severe and disfiguring personal injuries,’ that no-fault benefits in excess of \$20,000 were paid and that the no-fault benefits were likely to total \$35,000 or more.” *Id.* at 736. This uncontested evidence supported the trial court’s determination that the plaintiff had met her burden of proving that the value of the case exceeded the \$50,000 Milbank limits. *Id.*

PRACTICE

A prerequisite to a Miller-Shugart agreement is that the insurer somehow abandon the insured (whether named or otherwise insured under the contract) “on the high seas of litigation.” This puts the insured’s personal assets at risk, either by forcing the insured to pay for its own defense, or potentially paying a judgment or settlement. Once this occurs, the insured is free to negotiate with the injured plaintiff to settle for a sum certain which will only be satisfied out of the denying insurer’s policy proceeds. This is typically accomplished through a settlement agreement between the underlying plaintiff and the defendant-insured.¹² However, the insured’s negotiations must not violate its duty to cooperate with the carrier; if the insured breaches the policy’s cooperation clause, the entire coverage will be forfeited. *See Buysse v. Baumann-Furrie & Co.*, 481 N.W.2d 27, 28 (Minn. 1992).

The “abandonment” can come as a result of a complete denial of a duty to defend and indemnify, or even where the insurer defends in the face of a denial of the duty to indemnify. There is arguable support for the proposition that such an agreement can be consummated even where the insurer reserves rights pending litigating a coverage action with the insured. *See Alton M. Johnson Co. v. M.A.I. Co.*, 463 N.W.2d 277, 278 n. 1 (Minn.1990)(a settlement made before an insurer acknowledges coverage is not a violation of the duty to cooperate). However, the better rule is that there must be a complete denial of coverage before the insured can enter into

¹² The original agreement utilized in *Miller v. Shugart* is attached to these materials. The original settlement agreement was in the form of a Confession of Judgment. The court did not treat the agreement as a confession, however, as there was a question as to whether the rules involved with confessing or defaulting a judgment were followed. *Id.* at 735. Instead, the court merely treated the judgment a one based on a stipulation. *Id.*

an agreement with the plaintiff. See *Buyse v. Baumann-Furrie & Co.*, 448 N.W.2d 865, 874-875 (Minn. 1989)(a complete denial of coverage by the insurer is a prerequisite to an enforceable *Miller-Shugart* agreement); *Steen v. Underwriters at Lloyds, London*, 442 N.W.2d 158 (Minn. App. 1989), *review denied* (Minn. August 15, 1989)(when the insurer reserves the right to deny coverage on particular claims, but concedes coverage on others, the courts have also held the requisite denial of coverage is lacking).

Regardless of whether caselaw may or may not require the insured to give notice to the carrier, the best practice is to give notice to the insurer of the impending settlement in order avoid any possibility that the settlement would be unenforceable due to lack of notice. While *Miller* acknowledged that the insurer was kept apprised of settlement negotiations, *Miller* did not expressly impose such an express condition. However, subsequent cases recognize that springing an underlying settlement on an insurer without notice, especially where the insurer is defending the insured, likely voids the agreement:

“There was coverage for the acts in [the insured’s] insurance policy. However, failure to give [the insurer] notice of any negotiations leading up to the agreement precluded all coverage. Notice is a crucial element under *Miller v. Shugart*. Therefore, the settlement agreement was void.”

The Rivers v. Richard Schwartz/Neil Weber, Inc., 459 N.W.2d 166, 172 (Minn. App.1990), *review denied* (Minn. October 25, 1990). Under this analysis, it appears prejudice need not be shown.

The insured cannot use the *Miller-Shugart* agreement to transfer non-covered risks to the insurer. This occurs when the agreement attempts to convert liabilities which are not covered under the policy into covered losses. For example, in *Steen*, the insured attempted to characterize non-negligent conduct (excluded under the policy) as that which was covered under the policy. This conduct goes beyond merely settling with the plaintiff as it manipulates the procedure beyond merely placing the insurer in the “Catch-22” of whether to negotiate a settlement while the coverage issue remains in dispute. Such conduct is held to breach the policy’s cooperation clause, *Id.* at 162, and therefore voiding the coverage. However, this limitation does not

necessarily prevent the insured and the underlying plaintiff from negotiating a settlement when both covered and non-covered counts are alleged in the Complaint. *See e.g., St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698 (Minn.1990)(en banc)(intentional and negligent counts in Complaint did not preclude a Miller-Shugart settlement based on the covered counts).

The ultimate agreement reached between the insured-defendant and the injured plaintiff, must not be excessive in amount, or the result of collusion. In other words, the insured cannot be unfair to the insurer even if the insurer wrongfully denies coverage. If the agreement is either fraudulent or collusive on the one hand, or unreasonable in amount on the other, the agreement is unenforceable, and the underlying action is reinstated. *Alton M. Johnson Co., v. M.A.I. Co.*, 463 N.W.2d 277 (Minn. 1990). The court, and not the jury, acts as the fact-finder to determine whether the agreement is unenforceable for either of these reasons. *Alton M. Johnson*, 463 N.W.2d at 279.

First, the settlement must not be fraudulent or collusive. *Miller*, 316 N.W.2d at 734. Clearly, an agreement is collusive if it attempts to recover more than the policy limits from the insurer. *Id.*, n. 5. However, collusion is not established merely because the insured bargains for and receives personal benefits as part of the settlement. *See McNicholes v. Subotnik*, 12 F.3d 105, 109 (8th Cir. 1993)(apparent dismissal of non-covered claims). It is the insurer's burden to prove fraud or collusion. *Miller*, 316 N.W.2d at 734.

Especially because of the favorable treatment the courts have provided insurers in *Loy-Teigen*, *Loan Receipt*, and *Meadowbrook* agreements, the court has not allowed insurers to manipulate Miller-Shugart agreements to the detriment of another insurer. In *Burbach v. Armstrong Rigging and Erecting, Inc.*, 560 N.W.2d 107 (Minn. App. 1997), *review denied, appeal after remand* 1998 WL 747905 (Minn. App. 1998), the court rejected an insurer's attempt to settle with the underlying plaintiff and the common insured under a so-called Miller-Shugart agreement where the purpose of the agreement was to seek recovery from the second insurer. In *Burbach*, the underlying plaintiff was injured when allegedly improperly loaded equipment in his employer's trailer fell on him. *Id.* at 109. The equipment was loaded by another company. *Id.* This fact pattern caused both the loading company's coverage

to apply as well as the employer's policy as the loading company was allegedly a permissive user of the employer's truck. *Id.* at 109.

When the plaintiff sued the loading company, its carrier defended the case without reservation. Ultimately, the plaintiff, the loading company, and the loading company's insurer settled allegedly pursuant to a Miller-Shugart agreement. Under the agreement, the plaintiff accepted \$212,000, stipulated to a total settlement amount of \$825,000, and agreed the plaintiff would only seek the settlement amount from the truck's insurer. *Id.* at 109.

The court of appeals refused to enforce the agreement. The court recognized that the insured-defendant was not at risk of personal liability given its insurer's acceptance of coverage. *Id.* at 109. Therefore, because Miller-Shugart agreements were never intended to shift risks from one insurer to another, the agreement was found collusive as a matter of law. *Id.* at 110. *See also, Koehnen v. Herald Fire Ins. Co.*, 89 F.3d 525 (8th Cir. 1996).

Second, the settlement amount must be reasonable. The burden of proving reasonableness of the settlement amount, however, is on the underlying plaintiff or defendant-insured. *Miller*, 316 N.W.2d at 735. As noted above, this analysis weighs the evidence involving the liability of the parties, the damages, and the relative risks of proceeding to trial. *Id.* at 735. The test is whether the amount reflects what a reasonably prudent person in the defendant's position would have paid based on the merits of the underlying plaintiff's claim. *Id.* at 735. This may well include an assumption as to what the case would have settled for in the absence of insurance. It has been held that a settlement amount is unreasonable as a matter of law when the settlement amount was roughly double what was previously demanded. *Burbach*, 560 N.W.2d at 111.

Finally, the agreement does not compel the insurer to pay the underlying plaintiff unless the policy actually provides coverage for the liability and damages at issue. *Alton M. Johnson, Miller*.

Once the agreement is reached, the underlying plaintiff then proceeds to attempt to collect directly from the carrier. This can be accomplished either through a Garnishment Proceeding, or through a more traditional Declaratory Judgment action brought in the name of the insured. If coverage

exists, there is no breach of the Cooperation Clause, the agreement is not collusive or fraudulent, and the settlement amount is reasonable, the insurer is required to pay the settlement amount. Moreover, if the insurer completely denied coverage for both defense and indemnity, the insurer may also be responsible for the insured's defense costs as well as the insured's (or underlying plaintiff's) attorneys fees and costs incurred to prove the insurer's obligation. *American Standard Ins. Co. v. Le*, 551 N.W.2d 923 (Minn. 1996); *Lanoue v. Fireman's Fund Am. Ins. Cos.*, 278 N.W.2d 49 (Minn. 1979). *Morrison v. Swenson*, 274 Minn. 127, 142 N.W.2d 640 (1966). This additional relief, however, may not be available if the underlying plaintiff pursues recovery solely through a Garnishment Proceeding. See e.g., *Economy Fire & Cas. Co. v. Iverson*, 445 N.W.2d 824 (Minn. 1989).