The State of Bad Faith Litigation in Kansas (and Missouri)

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I. What is covered in this presentation?

We will discuss:

• The duties owed by an insurance company to its insured;

• The mechanics of filing and litigating against an insurance company that has breached its duties to its insured; and

• Some strategic considerations involved in such litigation, presented in the context of a case we recently resolved.

The emphasis of this presentation is on Kansas law, though many of the principles discussed would apply in other jurisdictions. We have also highlighted some specific distinctions under Missouri law. Of course, this area of law is complex and the case law is unusually robust, so what follows is merely a summary of some of the more important concepts.

II. What is this cause of action?

• In short: when an insurance carrier breaches a contractual duty owed to its insured, and when such breach leads to entry of a judgment against the insured, the insured may seek payment by the carrier of the entire judgment amount, even if the judgment is in excess of the coverage limits. This action is most commonly assigned to and brought by the injured party in exchange for the injured party’s promise not to execute the judgment against the insured’s personal assets.

• In Kansas: a contract action evaluated using tort standards.

“Under Kansas law, even though an insurer’s duties to its insured are contractually based, breach of such duties is determined by a tort standard of care . . . As a result, Kansas courts use negligence, due care, and other tort concepts to describe the substance of this contract duty.” Roberts v. Printup, 595 F.3d 1181, 1186 (10th Cir. 2010).

In Kansas, either a negligent breach of contract or a bad faith breach of contract is sufficient to render the insurance carrier liable. Negligence is generally regarded as a less rigorous burden for a plaintiff to carry, as proving an insurer’s mal-intent is not required.
Missouri distinction: bad faith refusal to settle is a tort action. Zumwalt v. Utilities Ins. Co., 228 S.W.2d 750, 756 (Mo. 1950).

“Whether an insurer acted in bad faith is a generally a fact question for the jury . . . Liability cannot be predicated upon negligence, but, rather, there must be a showing of a lack of good faith.” Allen v. Bryers, No. SC 95358, 2016 WL 7378560 (Mo. Dec. 20, 2016).

“Bad faith” has been defined by the Missouri Supreme Court as “the intentional disregard of the financial interest of [the] insured in the hope of escaping the responsibility imposed upon the [insurer] by its policy.” Scottsdale Ins. Co. v. Addison Ins. Co., 448 S.W.3d 818, 828 (Mo. 2014).

In Missouri, though bad faith refusal to settle is a tort action, failure to provide a defense to the insured is a contractual claim. Bonner v. Auto. Club Inter-Ins. Exch., 899 S.W.2d 925, 928 (Mo. Ct. App. 1995).

III. What are some of the duties of an insurance company in a third-party liability case?

- Duty to Provide a (Competent) Defense

An insurance carrier has a duty to provide a defense if there is any potential for coverage, meaning the duty to defend is broader than the duty to indemnify. MGM v. Liberty Mut. Ins. Co., 253 Kan. 198, 855 P.2d 77 (1993).

Obviously, the defense provided must be a competent one. “Inherent within the duty to exercise good faith in hiring independent counsel is the duty to hire counsel that is competent to defend the allegations against its insured and to provide such counsel with adequate resources to competently defend the suit.” Hackman v. W. Agr. Ins. Co., 275 P.3d 73 (Kan. Ct. App. 2012)

- Duty to Initiate Settlement Negotiations/Duty to Settle Within Policy Limits


When an insurance carrier knows or should know that liability is reasonably clear and the damages exceed available coverage, the insurance company has a duty to promptly initiate settlement. This is because a claim for damages in excess of the policy limits creates a conflict of interest between the insurer and the insured. Under such circumstances, the carrier must give equal consideration to the interests of the insured, meaning “the claim should be evaluated by the insurer without looking to the policy limits and as though it alone would be responsible for the payment of any judgment rendered on the claim.” Farmers Ins. Exchange v. Schropp, 222 Kan. 612, 567 P.2d 1359 (1977).
Importantly, there is no demand requirement—that is, the duty to settle exists without regard to whether the injured party makes a settlement offer. Coleman v. Holecek, 542 F.2d 532, 536 (10th Cir. 1976). Covill v. Phillips, 452 F. Supp. 224 (D. Kan. 1978). Put another way, the duty arises not out of actions taken by the injured party, but rather out of the insurer’s obligation to give equal consideration to the interests of its insureds as it gives to itself.

- **Missouri law on carrier’s duty:**

  “Examples of bad faith include: failing to investigate fully a third-party claimant's injuries or recognize their severity; ignoring that a verdict could exceed policy limits; refusing to consider a settlement offer; and not keeping an insured informed of settlement offers or the risks of an excess judgment.” Allen v. Bryers, No. SC 95358, 2016 WL 7378560 (Mo. Dec. 20, 2016) (citing Shobe v. Kelly, 279 S.W.3d 203 (Mo. App. W.D. 2009)).

- **Missouri law on demand requirement:**

  Early bad faith cases set forth the proposition that an insurer was not guilty of bad faith unless the insured made a demand of the carrier to settle. More recently, the Missouri Supreme Court dispelled that notion, finding that although the existence of a demand is relevant in determining whether the carrier acted in bad faith, the Court “has never required the insured to make a demand for settlement and declines [the] invitation to do so.” Scottsdale Insurance Company v. Addison Ins. Co., 448 S.W.3d 818 (Mo. 2014).

  “Accordingly, a bad faith refusal to settle action will lie when a liability insurer: (1) reserves the exclusive right to contest or settle any claim; (2) prohibits the insured from voluntarily assuming any liability or settling any claims without consent; and (3) is guilty of fraud or bad faith in refusing to settle a claim within the limits of the policy.” Id.
IV. Who can bring a bad faith case?

- Direct action:


- Assignment by Insured to Injured Party (“Glenn v. Fleming Agreements”)

  Because the insured’s action against the insurance carrier is a contract claim, it may be assigned. This assignment is typically given by the insured to the injured party in exchange for the injured party’s agreement not to pursue the insured’s personal assets to satisfy a judgment in excess of the coverage limit. Such arrangement was approved in Glenn v. Fleming, 247 Kan. 296, 799 P.2d 79 (1990). The mechanics of entering into a “Glenn v. Fleming agreement” are discussed later.

- Garnishment

  Where a plaintiff has obtained a judgment against the insured following negligence or bad faith by the insurance carrier, the plaintiff may—with or without obtaining an assignment—bring a garnishment action against the insurance carrier to collect the full judgment amount. Moses v. Halstead, 491 F.2d 177 (10th Cir. 1974). Unlike the direct or assigned breach of contract actions described above, garnishment actions are tried to a judge, not a jury.

- Missouri Law: RSMo. § 537.065:

  “Any person having an unliquidated claim for damages against a tort-feaso, on account of bodily injuries or death, may enter into a contract with such tort-feaso or any insurer in his behalf or both, whereby, in consideration of the payment of a specified amount, the person asserting the claim agrees that in the event of a judgment against the tort-feaso, neither he nor any person, firm or corporation claiming by or through him will levy execution, by garnishment or as otherwise provided by law, except against the specific assets listed in the contract and except against any insurer which insures the legal liability of the tort-feaso for such damage and which insurer is not excepted from execution, garnishment or other legal procedure by such contract . . .”
Assignability under Missouri law

“An insurer's duty to act in good faith in settling third-party claims arises from the insurer's reservation in the policy of the exclusive right to contest and settle third-party claims. An action for the breach of that duty, while a tort, arises from a contract of insurance, which is not of a purely personal nature. Therefore, a bad faith refusal to settle action falls within the category of assignable torts.” Scottsdale Ins. Co. v. Addison Ins. Co., 448 S.W.3d 818, 829-830 (Mo. 2014).

Garnishment under Missouri law

Following entry of an excess judgment, the plaintiff-assignee may commence a garnishment action against the carrier. Under Missouri law, there are two avenues of relevance: a “traditional/legal” garnishment under RSMo. 525.240/Rule 90 and an “equitable” garnishment under RSMo. 379.200.

Recent case law indicates that in a traditional/legal garnishment action, the judgment-creditor’s recovery may be limited to the available insurance coverage whereas success in an equitable garnishment entitles the plaintiff/assignee/judgment-creditor to recovery of all “extra-contractual” damages. See Allen v. Bryers, No. SC 95358, 2016 WL 7378560, at *7 (Mo. Dec. 20, 2016) (“[A]n equitable garnishment plaintiff may assert additional claims that go beyond the mere satisfaction of the underlying judgment for the contractual limits such as an insurer’s alleged bad faith in refusing to defend or settle the claim that, if proven, would permit recovery beyond the insurance policy limits.”

Traditional garnishment and equitable garnishment are not mutually exclusive remedies, so it is often useful or even necessary to bring both actions to ensure full recovery. See id. at *7 n. 8.
V. Case Study: Rudzik v. Star Insurance (Grant County, Kansas)

- Facts of the collision (*November 2012*)
  - Clear liability
    Evident from police report and witness statements.
  - Catastrophic injury
    Evident from pictures of the wreck, early medical records and diagnostic codes, and the insurance carrier’s on-the-ground investigation.
  - No potential for assigning fault to plaintiff
    Suspected from the beginning and confirmed by testing of the plaintiff’s turn signal light.
  - Limited coverage
    Carrier knew early on that the damages would likely exceed $1M policy limits.

- Underlying litigation
  - Repeated requests for coverage information before suit filed. Failure of carrier to provide necessary information and initiate settlement negotiations. (*January-May 2013*)
  - Suit commenced. (*July 2013*)
  - Failure of the carrier, even after receiving additional medical records, to initiate settlement negotiations. (*May-October 2013*)
  - Untimely policy limits offer. Irrelevant if the carrier has already breached its duty to the insured. (*October 2013*).

  “[A]ll the good faith and settlement offers in the world after suit is filed will not immunize a company from the consequences of an unjustified refusal to pay which made the suit necessary . . . If an insurer were permitted to ‘cure’ an earlier breach of a fiduciary duty, the policy of encouraging an insurer to exercise due care and attempt to settle claims in a fair and expeditious manner would be undermined.” Roberts v. Printup, 595 F.3d 1181 (10th Cir. 2010).
Assignment (September 2014)

- In light of the carrier’s breach of its contractual duties to its insureds, the plaintiff entered into a “Glenn v. Fleming” agreement with the insureds.

- Notably, the agreement left it to the judge to decide fault and damages after presentation of evidence at a contested bench trial (discussed below), rendering the resulting judgment immune from attack in ensuing breach of contract litigation.

Where an assignment agreement sets forth determinations of fault and the amount of damages, the Glenn court expressed concerns over enforcing resulting judgments against the insurance carrier. Under such circumstances, the Court set forth a two-step test for enforceability of the judgment against the insurance carrier. Initially, the plaintiff bears the burden of producing evidence that the settlement amount was reasonable and reached in good faith; once the plaintiff makes that showing, the burdens of proof and persuasion rest with the insurer to establish that the settlement was made in bad faith or that it was unreasonable.

Where an assignment agreement leaves it to the judge to assign fault and/or damages, the two-step Glenn test does not apply. Instead, the insurer is simply estopped from challenging the judgment in the ensuing breach of contract case. E.g. Dyer v. Holland, No. 95-1359, 1997 WL 807866 (D. Kan. Dec. 9, 1997).

- Missouri case law on enforceability of judgment.

“[A]n insurer who had notice of the litigation and the opportunity to control and manage it is bound by the result of the litigation, and the judgment rendered therein is conclusive in a later action on the indemnity contract as to those issues and questions necessarily determined in the underlying judgment.” Vill. at Deer Creek Homeowners Ass’n, Inc. v. Mid-Continent Cas. Co., 432 S.W.3d 231, 245 (Mo. Ct. App. 2014).

“Where the insurer had the opportunity to defend the insured but wrongfully refused to do so, the insurer is precluded from relitigating any facts that actually were determined in the underlying case and were necessary to the judgment. The facts decided in the underlying action most often will determine whether there is a duty to indemnify.” Allen v. Bryers, No. SC 95358, 2016 WL 7378560, at *10 (Mo. Dec. 20, 2016).
• Trial/Judgment (September 2014)
  - One day contested bench trial. Counsel for the insured cross-examined witnesses and contested the life care plan, arguing for damages in the $3-4M range.
  - Judge found insureds 100% at fault and entered judgment in the amount of $10,482,974.60.

• Litigation against the insurance carrier (December 2014-December 2016)
  - Following entry of judgment against the insureds, the plaintiffs filed an action for breach of contract against the insurance carrier. They did so as assignees pursuant to the Glenn v. Fleming agreement. The insureds were also plaintiffs, alleging tort claims against the independent investigator hired by the carrier.
  - When deposed, the carrier’s adjusters admitted that early on, they knew the case involved clear liability and exposure in excess of the available coverage. They further admitted that under such circumstances, the insurance carrier has a duty to initiate settlement negotiations. Simply put, that was the case against the insurance carrier. Notwithstanding knowledge within a month or two of the collision that triggered the duty to settle, the carrier waited approximately eleven months to make a policy limits offer.
  - The carrier’s defenses evolved somewhat during the course of the litigation. At times, the carrier argued that early initiation of settlement negotiations was unwarranted because it was unclear whether the plaintiff’s paralysis was permanent or whether the paralysis pre-dated the wreck. These apparent concerns were not contemporaneously documented in the claims file.
  - The carrier also claimed that until “complete” medical records were received, it was reasonable to delay initiation of settlement negotiations. The plaintiff countered that very early, the medical documentation in the carrier’s possession provided ample basis to conclude that the plaintiff was paralyzed as a result of the insured’s conduct—and regardless of what detail additional records would reveal, the case was worth well in excess of the available $1M in coverage. Further, the decision to finally make a policy limits offer came prior to receipt of the “complete” medical records, undercutting this rationalization for not paying earlier.
  - Included in the records the insurer had from nearly the very beginning was a set of medical bills and claims forms confirming the cause and extent of plaintiff’s paralysis and containing diagnostic (ICD9) codes that provided even more specificity. In addition to highlighting the significance of the bills and claims forms (which plainly described “paralysis”), the plaintiff developed evidence that ICD9 codes are a reliable source of both causation
and damages information. In this case, the plaintiff’s ICD9 codes echoed and expanded upon the plain language of the claims forms—lending further certainty that the plaintiff was paralyzed secondary to a motor vehicle collision.

- The final defense the carrier raised was based on a federal case, Wade v. EMCASCO, 483 F.3d 657 (10th Cir. 2007). This case is often used by defendant insurance carriers because, they argue, it establishes that a plaintiff’s attorney cannot “manufacture” or “set up” a bad faith/breach of contract claim. The applicability of Wade’s specific factual circumstances to subsequent cases (including this one) is routinely a source of disagreement. It is true that in Wade, the plaintiff’s attorney was found to have actively frustrated the insurance carrier’s efforts to comply with its duties to its insureds, but whether and to what extent Wade serves as a path to defeating subsequent breach of contract claims is hotly disputed by plaintiffs and defendants.

VI. Strategic considerations during Rudzik v. Star litigation

- Jurisdiction

The breach of contract case was filed in Grant County, Kansas. Although a local, non-diverse independent adjuster was named in the negligence action brought by the insureds, the defendants removed the case to federal court, alleging fraudulent joinder. The perceived danger to the defendants of litigating the breach of contract action in state court was that the judge who entered the sizeable judgment against the insureds would also be presiding over the breach of contract action.

Remanding the case back to state court, the United States District Court for the District of Kansas held that proof of fraudulent joinder is a “heavy burden” that the removing defendants had not carried. To prevail under a theory of fraudulent joinder, a defendant must “demonstrate that there is no possibility that [the plaintiffs] would be able to establish a cause of action against” the non-diverse party alleged to have been fraudulently joined. Rudzik v. Star Insurance Co., No. 14-1421-MLB, 2015 WL 1023892 (D. Kan. Apr. 28, 2015); see also Montano v. Allstate Indemnity, 2000 WL 525592 (10th Cir. April 14, 2000).

- The causation element

Plaintiffs in insurer breach of contract actions must prove that the carrier’s breach caused or contributed to cause damage to the insured (e.g. entry of an excess judgment against the insured). This causation element is often satisfied with evidence that a timely offer of settlement would have been accepted.
When a carrier rejects a policy limits demand, the causation element is easy to establish, because the existence of a demand makes clear the plaintiff’s willingness to accept a timely settlement offer.

But as discussed above, there is no requirement under Kansas law that the injured plaintiff make a settlement demand of the carrier during the underlying litigation—again, this is because the carrier’s obligation to initiate settlement arises out of its duty to the insured, not out of any action taken by the plaintiff.

Although the existence of a demand essentially obviates the causation argument, causation can still be established in the absence of a demand—whether through testimony of the plaintiff that a timely offer would have been accepted, through expert testimony along the same lines, or in myriad other ways. Where a plaintiff intends to rely upon these alternative methods of proving causation, consideration must be given to whether and to what extent privilege and/or work product will need to be waived in order to adduce sufficient evidence. This is discussed below.

- Discovery

The scope of permissible discovery is a key strategic battle in insurer breach of contract actions. As noted above, this battle often centers on applicability and waiver of privilege and/or work product.

- Plaintiff’s Attorney-Client Privilege and Work Product Protection

In many instances, plaintiff’s attorneys simply produce their entire file from the underlying litigation, assuming that this waiver is required when pursuing an insurer breach of contract action. Recent case law confirms, however, that such waiver is not automatically necessary. Where privileged information or work product is not placed at issue by the plaintiff, both the attorney-client privilege and work product doctrine still apply. See Cincinnati Ins. Co. v. M.S. ex rel. Serrano, No. 11-CV-2075-JAR/KGG, 2011 WL 6304086 (holding that the plaintiffs did not place privileged communications at issue “simply [by] asserting [a] bad faith claim.”).

Thus, plaintiffs must make a decision as to whether it is worth placing “at issue” privileged information or work product. The upside is that disclosing what went on internally during the underlying litigation may be helpful in establishing both breach of contract and causation. The downside is that disclosure of any privileged information risks “at issue” waiver of all privileged information, at least with regard to the topic the limited disclosure pertained to.
Discoverability of Carrier’s File

Several documents are of central importance in any insurer breach of contract action. Most notably, the claims file will (or at least should) contain the bases or explanations for every action taken by the insurance carrier in the underlying litigation. There is no meritorious basis upon which the carrier can refuse production of the claims file. In fact, even in regular personal injury actions, a plaintiff may discover the contents of an insurance claims file up through the point in which outside counsel was retained. Henry Enterprises, Inc. v. Smith, 225 Kan. 615, 592 P.2d 915 (1979).

In an insurer breach of contract case, there is an even broader justification for production of claims documents that might, at first glance, appear to be privileged. In Bollinger v. Nuss, 202 Kan. 326, 449 P.2d 502 (1969), the Kansas Supreme Court set forth eight factors that are always “at issue” in consideration of an insurance carrier’s alleged breach of contract:

1. the strength of the injured claimant’s case on the issues of liability and damages;
2. attempts by the insurer to induce the insured to contribute to a settlement;
3. failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured;
4. the insurer’s rejection of advice of its own attorney or agent;
5. failure of the insurer to inform the insured of a compromise offer;
6. the amount of financial risk to which each party is exposed in the event of a refusal to settle;
7. the fault of the insured in inducing the insurer’s rejection of the compromise offer by misleading it as to the facts; and
8. any other factors tending to establish or negate bad faith on the part of the insurer.

Emphasis is added here to factors three and four because they are most pertinent with regard to discoverability of the carrier’s file. Factor three confirms that all documents pertaining to the carrier’s investigation (or failure to investigate) the claim against its insured are plainly relevant. And factor four establishes that advice rendered to the carrier—even by its attorneys—is relevant and necessarily “at issue,” frustrating most attempts by defendant carriers to withhold claims documents on the basis of attorney-client privilege.

Other key documents to consider obtaining—using Bollinger where necessary—include those pertaining to reserves (evidences the carrier’s estimation of the risk to its insured), those setting forth policies or procedures for claims handling and settlement (evidences standards set by the carrier itself regarding proper handling of claims), and personnel files for the adjusters handling the underlying claim (evidences the training provided to the carrier’s employees and may contain relevant past instances of poor claims handling).