BY WILLIAM SANDWEG III & JOHN AGER

A Primer on the Cooperation Clause

Damron v. Sledge and Its Progeny

Every insurance contract imposes upon the insured party an express or implied duty to cooperate with the insurer. This duty is commonly referred to as the cooperation clause.[1] The cooperation clause protects the insurer's right to a fair determination of a claim by prohibiting an insured from doing anything that might prejudice the insurer's defense of the claim.[2]

Three duties are imposed on the insurer in exchange for the benefits the cooperation clause provides. They are an *express duty to defend*, an *express duty to indemnify*, and an *implied duty to equally consider an insured's financial interests with its own*.[3] The actual or anticipatory breach of any of these duties can expose the insured to the risk of a judgment or other damage that may not be covered by the insurance policy or that may exceed the policy's limit of coverage.[4]

Insurance policies are governed by general principles of contract law.[5] Therefore, a breach of any of the duties an insurer owes to an insured excuses the insured from the obligations imposed by the cooperation clause.[6] When a breach occurs, the insured may enter into an agreement with an adverse party to protect against harm that may result from the insurer's breach.

Arizona courts have recognized four basic situations when this may happen. The nature of these situations and the types of agreements that can be entered into when they arise have been the source of some confusion among practitioners. The courts have added to the confusion by calling the agreements by different names or calling one type of agreement by the name of another.

The following article describes the four situations in which the insured is excused from the obligations of the cooperation clause, discusses the agreements into which an insured is permitted to enter, and offers practical considerations for responding to an insurer's breach.

Breach of the Duty to Defend *Damron* Agreements

When presented with a claim, an insurer must determine whether there is coverage that would trigger a duty to defend the insured against the claim. The Arizona Supreme Court examined the consequences of an insurer's refusal to defend an insured, which resulted in an arranged default judgment and the assignment of the insured's claims against the insurer, in *Damron v. Sledge*.[7] There, two insurance carriers refused to defend a driver involved in a motor vehicle accident on the grounds that there was no coverage because he was driving without the owner's permission. Before the case could be tried, the defendant driver agreed to withdraw his answer and allow a default judgment to be entered against him. He also agreed to assign to the plaintiff any claims he had against the insurance companies for failing to provide him with a defense. In exchange, the plaintiff agreed not to execute the resulting default judgment against the defendant driver's assets. The Supreme Court held that the agreement was an appropriate mechanism for the driver to protect himself from the risks associated with the insurers' refusal to provide a defense.

Damron agreements, as they are now known, usually involve either a stipulated judgment or a withdrawal of the answer followed by the entry of a default judgment, along with a covenant not to execute the judgment against the defendant's assets. In addition, the defendant usually assigns to the plaintiff any breach of contract and bad faith claims the defendant has against the insurer. When an insurer denies the existence of coverage and refuses to defend, it is not entitled to advance notice of the parties' intent to enter into a *Damron* agreement, nor is it entitled to intervene in a default hearing after the agreement has been finalized.

Damron agreements are valid so long as they are not fraudulent or collusive.[8] They are not tested for reasonableness. Fraud or collusion are extremely high bars for an insurer to overcome when trying to defeat such an agreement.[9] Examples of fraudulent or collusive conduct include an agreement by an insured to perjure herself in a subsequent bad faith claim[10] and conduct by a plaintiff and an insured acting in concert in the underlying action to obtain benefits to which the insured would not otherwise be entitled.[11]

Whether an insurer had a duty to defend and whether a *Damron* agreement is fraudulent or collusive are usually determined in a declaratory judgment action or a garnishment proceeding. If a *Damron* agreement is found to be valid and coverage exists, the insurer must pay the entire judgment up to the policy limits. As discussed later in this article, only when an insurer is found to have acted in bad faith can it be held liable to pay an amount in excess of its limit of coverage.

Before executing a *Damron* agreement, a plaintiff should carefully consider wheth-

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er to establish damages at a default hearing, or by stipulation. An insurer's breach of its duty to defend an insured deprives it of the right to participate in a default hearing.[12] Therefore, a default proceeding can be an attractive way to establish damages because there will be no challenge by the insurer to the plaintiff's evidence. The amount of damages established by an independent fact finder in a default proceeding is also less likely to be viewed as fraudulent or collusive in a subsequent action to determine the validity of the agreement than the amount of a stipulated judgment.

On the other hand, a plaintiff at a default hearing risks that the trier of fact will find the amount of damages to be lower than an amount that would have been stipulated to by the parties, but still found to be free of fraud or collusion in a later proceeding in which the insurer is involved. Generally speaking, a stipulated judgment gives the plaintiff far greater control over the outcome.

Anticipatory Breach of the Duty to Indemnify
Helme Agreements

The duty to indemnify normally does not arise until a judgment has been entered. However, it can be breached in advance of the entry of judgment. The Arizona Supreme Court examined the consequences of an anticipatory breach of the duty to indemnify in *Arizona Prop. & Cas. Ins. Guar. Fund v. Helme*.[13]

There, the plaintiff in an underlying wrongful death action sued a physician and his vicariously liable professional corporation alleging negligence. The State Guaranty Fund defended the claim because the defendants' professional liability insurance carrier was insolvent. The plaintiff offered to settle the claim against those defendants for the Fund's per-claim liability limit of $99,900. The Fund declined. As discovery progressed, the plaintiff identified another physician in the same professional corporation whom the plaintiff also believed was negligent. The plaintiff then made a demand for $199,800 for the separate acts of negligence of the two physicians. The Fund took the position that its liability was limited to $99,900. It reasoned, in part, that because there was only one "occurrence" under the insolvent insurer's policy, there was only one claim. The Fund told the defendants that it would pay only one limit of $99,990 regardless of the size of the judgment.

The defendants then entered into a settlement agreement with the plaintiff in which they stipulated to a judgment against themselves for $350,000. In exchange, the defendants received a covenant not to execute and assigned to the plaintiff any claims they had against the Fund. The Fund then paid the plaintiff $99,900 and filed a declaratory judgment action to determine whether the physicians' conduct constituted one occurrence or two and whether there had been a breach of the cooperation clause.

The Supreme Court held that there were two occurrences and that two limits applied. The Court also concluded that the Fund's coverage position constituted an anticipatory breach of its duty to indemnify, which excused the insureds from the constraints of the cooperation clause.

Helme agreements are treated in the same manner as *Damron* agreements. Once it is determined that there has been an anticipatory breach, they may be defeated only by proving that they are fraudulent or collusive. If a *Helme* agreement is found to be valid, the insurer must pay the entire judgment up to the policy limit, unless the insurer is found to have acted in bad faith, in which case a higher amount may be permitted.[14] Because an insurer may now "reserve" the right to challenge an insured's coverage position, as set forth in the next section, it makes little sense for an insurer to take a firm pre-judgment position of no or limited coverage.

Defense Under a "Reservation of Rights"
Morris Agreements

An insurer can set forth the reasons it may prospectively refuse to indemnify an insured while continuing to provide a defense to any claims against the insured without breaching its obligations under the policy.[15] This is known as a *reservation of rights*.[16] A reservation of rights preserves the right of the insurance carrier to later or simultaneously litigate the issue of coverage.[17] The Arizona Supreme Court examined the effects of a defense being provided under a reservation of rights in *United Services Auto. Ass'n v. Morris*.[18]

There, the plaintiff sued the defendants alleging gross negligence and recklessness in connection with a shooting. The insurer notified the defendants that it was providing a defense, but not waiving any coverage defenses. While a motion to amend the complaint to add an allegation of intentional conduct was pending, the defendants notified the insurer that they intended to settle the case by allowing a judgment to be taken against them. The insurer then specifically reserved its right to refuse to indemnify the defendants against any judgment that might be entered based on the defendants' intentional conduct. The next day, the defendants stipulated to a judgment for the policy limit with a covenant not to execute and assigned their claims against the insurer to the plaintiff.

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The trial court later granted the motion to amend.

The insurer took the position that the insureds had breached the cooperation clause and prejudiced its rights by entering into the settlement. The insureds argued that the insurer's position exposed them to the risks of a judgment in excess of the policy limits or a judgment within the limit that might not be covered.

The Supreme Court held that, despite the existence of the cooperation clause, when an insurer reserves it rights, insureds may act reasonably to protect themselves.[19] The Court reasoned that if a judgment were entered against the insured in the underlying action, the insurer would get a second chance to escape liability by challenging coverage in a subsequent declaratory judgment action or garnishment proceeding.[20] In addition, absent bad faith, the insurer would never be exposed to liability beyond its policy limits, while the insureds risked financial ruin.[21]

Unlike *Damron* and *Helme* agreements, *Morris* agreements require advance notice to the insurer before they can be executed.[22] The amount of advance notice required depends on the circumstances, but it must be sufficient to allow the insurer to assess the situation and decide how to proceed. The notice must not only inform the insurer of the date by which the insureds will enter into the agreement; it must also provide the insurer with notice of the terms of the proposed agreement. The most practical means of doing this is to negotiate the terms of the agreement and provide a copy of the final form of the agreement to the insurer. After receiving the required notice, the insurer may withdraw the reservation of rights, and, should it do so, the case then proceeds as if the insurer had defended unconditionally from the outset.[23] If the insurer stands by the reservation of rights, the insured may then enter into the *Morris* agreement without breaching the cooperation clause.[24]

While *Morris* agreements take the same form and are enforced in the same way as *Damron* and *Helme* agreements, they are tested for reasonableness in addition to fraud or collusion.[25] The reasoning is that, unlike an insurer in a *Damron* or *Helme* situation, an insurer in a *Morris* situation has not breached the obligations it owes to the insured.[26] For the same reason, the insured must notify the insurer once a *Morris* agreement has been signed, after which the insurer may intervene and participate in a reasonableness hearing as a matter of right.[27]

The test of reasonableness is the same one that an insurer must apply when evaluating a settlement proposal to determine whether it has complied with the implied covenant of good faith and fair dealing.[28] It is what a reasonably prudent person with unlimited funds would pay to settle the same claim with all of the information known to the parties at the time of the agreement.[29] The trier of fact may consider the facts bearing on liability and damages as well as the risks of going to trial.[30] The plaintiff bears the burden of proof on reasonableness.[31]

If a court determines there is no coverage, the insurer owes nothing on the judgment.[32] If there is coverage and the trier of fact concludes that the agreement was reasonable, the insurer must pay the judgment up to the amount of the policy limit.[33] If coverage is found, but the amount is determined to be unreasonable, then the insurer must pay whatever amount the trier of fact determines to be reasonable.[34]

The determination of what is reasonable usually involves a battle of experts, with the plaintiff calling someone to testify that the judgment was reasonable and the insurer calling someone to testify that it was not. This process usually favors the plaintiff for two reasons. One, the battle of experts over whether an established amount is reasonable is easier for the plaintiff to fight than proving damages in front of a jury. Two, if the

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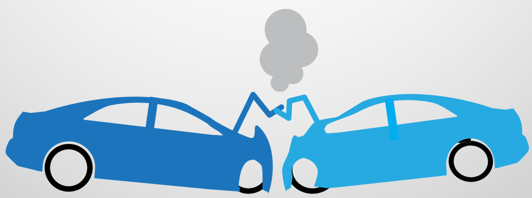

amount of the judgment is found to be unreasonable, the trier of fact starts with that amount and goes down until it reaches what it considers to be a reasonable amount. This amount is likely to be higher than what a jury might award starting at zero and going up.

At first blush, it may seem attractive in a *Morris* setting to attempt to set damages at a default hearing to defend against later claims that a judgment was not reasonable. However, the plaintiff is exposed to the risk that the insurer may intervene in the default hearing process, because an insurer must be notified when the parties' intend to enter into a *Morris* agreement and when the agreement has been executed. The insurer then has a right to trial by jury on the issue of damages in a default proceeding where the trier of fact will establish a reasonable amount starting from zero and going up.[35] An insurer, however, only gets one bite at the apple: If it intervenes, then it likely will not be permitted to challenge damages in a later action to determine coverage.

Morris agreements can be dangerous to the party taking an assignment of any claims because if the coverage defense upon which the reservation of rights was based is found to be valid, the party taking the assignment usually recovers nothing.[36] Therefore, the more uncertain the question of coverage, the more risky a *Morris* agreement becomes. Similarly, a *Morris* agreement becomes less appealing as the amount of assets an insured has against which a judgment may be executed increases.

Breach of the Duty to Give Equal Consideration to an Insured's Interests

Peaton Agreements

In *State Farm Mut. Auto. Ins. Co. v. Peaton*,[37] the Court of Appeals examined the cooperation clause in the context of an insurer's duty to equally consider the financial interests of its insured with its own when confronted with a settlement offer. There, the underlying case involved a significant personal injury. Before an answer to the complaint had been filed, the plaintiff demanded the policy limits plus interest until paid. Ten days later, the plaintiff made another policy limits demand that did not include interest. The insurer accepted the second demand and thought it had a settlement until the plaintiff suggested that payment of interest was still a part of the agree-

ment. The insurer then filed an answer and again offered to settle for the policy limits. Not long after that, the insurer offered to pay interest as well, but the plaintiff claimed that filing the answer was a rejection of his previous offer and refused to settle on those terms.

The plaintiff and the insured then entered into a "*Morris*-style" agreement (which the Court referred to as a *Damron* agreement).[38] Damages were addressed at a default hearing in which the insurer was not permitted to intervene. The insurer did not appeal the trial court's denial of its request for intervention.

In a subsequent declaratory judgment action to determine coverage, the Court of Appeals considered whether the insurer's failure to involve its insured in the settlement breached the duty to give equal consideration to the insured's interests. The court concluded that because the offer to settle had been withdrawn before the demand for interest was met, the insurer had no legal obligation to involve the insured in negotiations for amounts in excess of the limits. The court noted that there was nothing about the negotiations that suggested the insured's involvement was necessary to reach a settlement. Because the insurer breached no duty to the insured, the court held that the agreement was a breach of the insured's duty of cooperation from which he had not been excused.

An insurer's failure to give equal consideration to the financial interests of its insured excuses the insured from the duties imposed by the cooperation clause, after which the insured may enter into a *Peaton* agreement. Generally, there must have been an offer to settle within the policy limits to trigger the duty of an insurer to give equal consideration to the financial interests of its insured. The court in *Peaton,* however, noted that the duty to give equal consideration may require an insurer to initiate settlement attempts where an insured faces significant exposure to a judgment in excess of the policy limits.[39]

While there currently is no requirement that an insurer be given prior notice before an insured enters into a *Peaton* agreement, as a practical matter, it is usually provided when the plaintiff threatens to enter into such an agreement unless the insurer accepts the pending settlement demand. The insurer has the right to intervene and to participate in a default hearing once a *Peaton* agreement has been executed.[40] Like *Morris* agreements, *Peaton* agreements currently are enforceable only to the extent that they are reasonable.[41] This may change on further appellate consideration, however, because the insurer in a *Peaton* situation has breached the insurance agreement. For that reason, application of the test required for *Damron* or *Helme* agreements seems more consistent with the policy behind such agreements.

If the insurer was not in bad faith for refusing to settle within the policy limits, entering into a *Peaton* agreement is a breach of the cooperation clause, but the insurer must have been prejudiced by the insured's conduct before it will be excused from paying anything. That said, it is difficult to imagine a situation where a *Peaton* agreement would not be considered prejudicial to the insurer because it deprives an insurer of the opportunity to defend and subjects it to liability for a stipulated or default judgment over which it has little or no control.

From the plaintiff's perspective, *Peaton* agreements should only be entered into in very limited circumstances. There is significant risk that the trier of fact may conclude there was no bad faith in failing to accept a settlement offer within the policy limits where a final judicial determination of damages is not reached. Not much, if anything, is to be gained by entering into a *Peaton* agreement in a case with good liability, good damages and good coverage given the risk that the insurer might be excused from paying anything.

On the other hand, an insurer will probably still be obligated to pay the financial responsibility minimum in an auto case, even where an insured's breach of the cooperation clause is prejudicial.[42] Therefore, in an auto case with catastrophic injuries and minimum limits, entering into a *Peaton* agreement makes good sense where the insurer does not promptly agree to pay the policy limits because the minimum recovery will likely be the same, even if the insured breached the cooperation clause.

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Recovering More Than the Policy Limits

An insurer cannot be obligated to pay more than the policy limits solely as the result of a breach of contract, regardless of the amount of the judgment against the insured. There must be "something more" to require a payment in excess of the limits. The tort of bad faith refusal to settle is that "something more."[43] If a plaintiff has not given an insurer the opportunity to settle within policy limits before entering into one of the four agreements discussed here, the insurer's liability will almost certainly be capped at the policy limits.

While Arizona law recognizes there may be occasions when the liability and damages are so bad that the insurer has an obligation to make settlement offers without waiting for the plaintiff, the courts have been reluctant to find an insurer guilty of bad faith on this basis alone. A plaintiff who hopes to recover more than the policy limits should give the insurer an opportunity to settle the case within limits before entering into one of these agreements. A tort claim for bad faith gives rise to a claim for extra-contractual damages, which includes the difference between the policy limits and the amount of the final judgment, punitive damages, attorney's fees and, in the case of an individual insured, damages for emotional distress.[44]

Practical Considerations

An insurer should not do anything to impede or prevent an insured from taking advantage of the protections provided by these agreements, although it can negotiate with the insured to reach an agreement to provide protection that the insured finds acceptable. While the former is almost certainly bad faith, the latter has been held not to interfere with the contractual rights of a plaintiff, at least where a *Morris* agreement has been proposed.[45]

For the reasons previously mentioned, an insurer should attempt to intervene in any default hearing and request a jury trial on damages, because a contested hearing before a jury is likely to result in a lower amount than might be set at an uncontested default hearing before a judge or commissioner. Furthermore, allowing a default hearing to proceed without intervention and planning to claim later that the default award is unreasonable is a risky and probably unsuccessful strategy. For the same reasons, a plaintiff should avoid a default hearing in cases in which an insurer might have a right of intervention and use a stipulated judgment instead.

Where a default hearing is held following a successful motion to intervene by an insurer, the insurer may be permitted to participate in the name of the insured and to offer proof on comparative fault and damages, although this will be within the court's discretion. If an insurer participates in a default hearing, it will almost certainly be bound by the outcome in any future action. For example, if the default hearing is limited to damages only, the insurer may discuss liability and comparative fault in a reasonableness hearing to determine how much of the now-fixed damages a reasonable person would have paid to settle the case. The Court of Appeals, however, has encouraged trial courts to expand default hearings to include consideration of liability issues to avoid the necessity of a second reasonability hearing in a subsequent bad faith action.[46]

Many issues in this area of law remain unresolved and courts are considering them on a regular basis. Practitioners should take advantage of the significant opportunity for creative lawyering when these situations arise. AZ AT

endnotes

1. *Arizona Prop. & Cas. Ins. Guar. Fund v. Helme*, 735 P.2d 451, 458-59 (Ariz. 1987).
2. *Id.* at 458.
3. *Id.* at 458-59.
4. *Id.* at 459.
5. *Id.*
6. *Id.*
7. 460 P.2d 997 (Ariz. 1969).
8. *State Farm Mut. Auto Ins. Co. v. Paynter*, 593 P.2d 948, 950 (Ariz. Ct. App. 1979).
9. *Id.*
10. *Damron*, 460 P.2d at 1001.
11. *Paynter*, 593 P.2d at 951-52.
12. *Manny v. Anderson's Estate*, 574 P.2d 36, 38 (Ariz. Ct. App. 1977).
13. 153 Ariz. 129, 735 P.2d 451 (1987).
14. *Id.* at 460.
15. *Farmers Ins. Co. of Arizona v. Vagnozzi*, 675 P.2d 703, 708 (Ariz. 1983).
16. *Id.*
17. *Id.*
18. 741 P.2d 246 (Ariz. 1987).
19. *Id.* at 251.
20. *Id.*
21. *Id.*
22. *Parking Concepts, Inc. v. Tenney*, 83 P.3d 19, 22 (Ariz. 2004).
23. *Id.*
24. *Id.* at 24.
25. *H.B.H. v. State Farm Fire and Cas. Ins. Co.,* 823 P.2d 1332, 1339 (Ariz. Ct. App. 1991).
26. *Tenney,* 83 P.3d at 22.
27. *H.B.H.,* 823 P.2d at 1339.
28. *Tenney,* 83 P.3d at 24.
29. *Himes v. Safeway Ins. Co.,* 66 P.3d 74, 82 (Ariz. Ct. App. 2003).
30. *Tenney,* 83 P.3d at 24.
31. *Id.* at 26.
32. The only exception to this rule involves automobile liability policies, which are subject to the financial responsibility provisions of A.R.S. § 28-4009. Up to the financial responsibility limits, liability coverage under these policies becomes absolute at the time of the accident. § 28-4009(C)(5)(a).
33. *Id.*
34. *Id.*
35. *McGough v. Insurance Co. of North America*, 691 P.2d 738 (Ariz. Ct. App. 1984); ARIZ. CONST. art II, § 23.
36. *But see supra* note 32.
37. 812 P.2d 1002 (Ariz. Ct. App. 1991).
38. *Id.* at 1007.
39. *Id.* at 1013-14 (citing *Fulton v. Woodford*, 545 P.2d 979, 984 (Ariz. Ct. App. 1976)).
40. *Himes,* 66 P.3d at 84.
41. *Id.*
42. A.R.S. § 28-4009(C)(5)(a).
43. *Taylor v. State Farm Mut. Auto. Ins. Co.,* 913 P.2d 1092, 1094 (Ariz. 1996); *Rawlings v. Apodaca*, 726 P.2d 565 (Ariz. 1986).
44. *Farr v. Transamerica Occidental Life Ins. Co. of California,* 699 P.2d 376 (Ariz. Ct. App. 1984).
45. *Strojnick v. General Ins. Co. of America*, 36 P.3d 1200, 1207 (Ariz. Ct. App. 2001).
46. *Waddell v. Titan Ins. Co., Inc.*, 88 P.3d 1141, 1147 (Ariz. Ct. App. 2004).