

# **Recent Developments in Third-Party Bad Faith: The American Law Institute Principles of the Law of Liability Insurance<sup>1</sup>**

**By William T. Baker<sup>2</sup>**

A relatively little-noticed project of the American Law Institute ("ALI") has recently endorsed rules that, if adopted by courts, may significantly expand insurer liability for third-party bad faith and significantly expand the ability of insureds to settle without insurer consent. Insurers need to be prepared to argue against adoption of those rules.

The American Law Institute ("ALI"), best known for its production of highly influential "Restatements" of various bodies of law, is now engaged in a project to produce a set of "Principles of the Law of Liability Insurance." The ALI Council and Annual Meeting have now approved Tentative Drafts Nos. 1 and 2, which therefore represent the policy of the ALI and its recommendation to courts, legislators, and regulators to adopt rules of insurance law as set forth in the Principles. To date, the Principles has received limited attention from the insurance bar.<sup>3</sup> This paper describes the proposed rules most important to claims for third-party bad faith and

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<sup>1</sup> Much of the material in this paper is adapted with permission from WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION* and from William T. Barker & John G. Buchannan, III, *The American Law Institute Principles of the Law of Liability Insurance: Part I--What Rules Does It State?*, forthcoming in *CURRENT CRITICAL ISSUES IN INSURANCE LAW*. Copyright 2014 Matthew Bender & Company, Inc., a LexisNexis company. All rights reserved.

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<sup>3</sup> A notable exception, reviewing Tentative Draft No. 1, is Michael F. Aylward & Lorelei S. Masters, *A "Principled" Approach to Coverage?: The American Law Institute and its "Principles of the Law of Liability Insurance"*, 81 DEF. COUN. J. 117 (2014).

offers arguments why they ought not to be adopted.. Before doing so, it describes the process which the ALI follows in its projects and the status of this project.

## **I. The Principles**

### **A. Background**

The ALI undertakes four different types of projects, two of which are Restatements and Principles. Restatements are intended to be "clear formulations of common law and its statutory elements or variation and reflect the law as it presently stands or might plausibly be stated by a court."<sup>4</sup> Even so, Restatements need not reflect the majority rule:

A Restatement ... assumes the perspective of a common-law court, attentive to and respectful of precedent, but not bound by precedent that is inappropriate or inconsistent with the law as a whole. Faced with such precedent, an Institute Reporter is not bound to adhere to ... "a preponderating balance of authority" but is instead expected to choose the better rule and provide the rationale for choosing it. A significant contribution of the Restatements has also been anticipation of the direction in which the law is tending and expression of that development in a manner consistent with previously established principles.<sup>5</sup>

Principles, on the other hand, "may be addressed to courts, legislatures, or governmental agencies. They assume the task of expressing the law as it should be, which may or may not reflect the law as it is."<sup>6</sup>

The Reporters for the current project, Professors Tom Baker and Kyle D. Logue, have commented on this distinction as it affects the project:

Although this is Principles project rather than a Restatement, we support many existing rules. We have attempted to provide clear articulations of and to set forth the primary justifications for those rules. In a few Sections, our statement of a

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<sup>4</sup> AMERICAN LAW INSTITUTE, CAPTURING THE VOICE OF THE AMERICAN LAW INSTITUTE, at 4 (2005).

<sup>5</sup> AMERICAN LAW INSTITUTE, CAPTURING THE VOICE OF THE AMERICAN LAW INSTITUTE, at 5 (2005).

<sup>6</sup> AMERICAN LAW INSTITUTE, CAPTURING THE VOICE OF THE AMERICAN LAW INSTITUTE, at 4 (2005).

rule is a bit more direct than that of the courts in at least some jurisdictions, but in each of those instances we believe that the rule we propose describes what courts actually do in a substantial number of jurisdictions. In a number of instances, however, we propose adjustments to existing rules that we believe are superior. That, of course, is the point of a Principles project.<sup>7</sup>

The ALI Council has appointed Profs. Baker and Logue as Reporters and has also appointed 43 Advisers to the project. Any member of the ALI who wishes to do so may join the project's Members Consultative Group ("MCG"), and 135 had done so as of the publication of Tentative Draft No. 2. The Advisers and the MCG each include insurer lawyers, policyholder lawyers, law professors, and judges, as well as others who fit none of those descriptions.

In accordance with the ALI's normal process, each portion of the Principles begins as a Preliminary Draft, prepared by the Reporters and circulated to the Advisers and the MCG. The Advisers and the MCG meet with the Reporters to comment on the Preliminary Draft and may submit written comments. (In fact, anyone who learns what a draft says can submit written comments.) The Reporters consider the comments. Sometimes they produce and circulate a new Preliminary Draft, but they usually revise the Preliminary Draft to produce a Council Draft for submission to the ALI Council. Nothing becomes the policy of the ALI unless approved by the Council, so the Council may amend what the Reporters submit or direct them to revise it in a particular way. The Council may submit to the Annual Meeting of the ALI members either a Discussion Draft or a Tentative Draft. Nothing becomes the policy of the ALI unless approved by the Annual Meeting, so a Tentative Draft is subject to amendment by the Annual Meeting. If a section is amended by the Annual Meeting, that section must be referred back to the Council. Unless an amendment is adopted, the Annual Meeting typically approves whatever it has

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<sup>7</sup> PRINCIPLES OF THE LAW OF LIABILITY INSURANCE, at xv (Tent. Dr. No. 1 (revised) Jan. 6, 2014) (hereinafter, "PRINCIPLES TD#1").

discussed, subject to customary privileges of the Reporters to perfect the draft in light of the discussion.

Each section of a draft is composed of a "black letter" statement of a governing rule, followed by "comments" explaining the rule and the reasoning supporting it and elaborating on its application. Both the black letter and the comments speak for the ALI. Each section is accompanied by a Reporters' Note, discussing the authority supporting and (where it exists) opposing the rules stated in the black letter and comments; the Reporters' Note speaks only for the Reporters.

The Reporters have noted one novel feature of the Principles:

One important, cross-cutting innovation in Chapters 1 and 2 is to specify when a rule is a mandatory rule (meaning that the rule cannot be changed by contract) and when a rule is a default rule (meaning that the rule applies only if the liability insurance policy does not specify a different rule). A substantial number of the rules stated in Tentative Draft No. 1 are default rules for large commercial liability insurance policies. Most of those rules are mandatory for other liability insurance policies, however. In many cases, this innovation provides greater protection to consumers and small commercial policyholders than the prevailing common law of liability insurance, which generally grants insurers broad latitude in the drafting of insurance policies.<sup>8</sup>

The drafts so far approved include Chapters 1 and 2 of what are planned to be four chapters. Chapter 1 addresses basic liability insurance contract principles, including principles of contract interpretation, applicable doctrines of waiver and estoppel, and the effect of application misrepresentations by policyholders. Chapter 2 focuses on management of potentially insured liability insurance claims, including the insurer's duties to defend and to make reasonable settlement decisions, and the insured's duty to cooperate. Chapter 3 will address issues relating to the scope of the risks insured, including such issues as trigger and allocation, as

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<sup>8</sup> PRINCIPLES TD#1, at xvii.

well as certain exclusions and conditions. Chapter 4 will address advanced insurance contract issues, including choice of law, remedies, bad faith, and enforceability.

## **B. Settlement Duties**

### **1. The Duty To Make Reasonable Settlement Decisions**

Unless otherwise provided in a policy issued to a large commercial insured, an insurer that has the right to settle or whose consent to a settlement is required, "has a duty to the insured to make reasonable settlement decisions," but "only with respect to claims that expose the insured to liability in excess of the policy limits."<sup>9</sup> Also, the insurer need not offer or agree to pay more than the policy limit.<sup>10</sup> No direct duty is owed to excess insurers and no duty is owed to claimants.<sup>11</sup> Excess insurers do have a right of equitable subrogation for any payments resulting from a breach of this duty.<sup>12</sup>

"A reasonable settlement decision is one that would be made by a reasonable person that bears sole responsibility for the full amount of the potential judgment."<sup>13</sup> But the more detailed methodology described in the comments significantly modifies that rule as it has hitherto been explained and applied.

That exposition begins very conventionally:

In determining whether a settlement decision was reasonable, the factfinder should view the settlement decision from the perspective of the insurer and the insured-defendant at the time the settlement decision was made. A reasonable liability insurer is expected, at the time of the settlement negotiations, to take into account the realistically possible outcomes of a trial and, to the extent possible, to weigh those outcomes according to their

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<sup>9</sup> PRINCIPLES OF THE LAW OF LIABILITY INSURANCE, § 27(1) (Tent. Dr. No. 2 (revised) July 14, 2014) (hereinafter, "PRINCIPLES, TD#2").

<sup>10</sup> PRINCIPLES, TD#2, § 27(3).

<sup>11</sup> PRINCIPLES, TD#2, § 27, cmts. *n & o*.

<sup>12</sup> PRINCIPLES, TD#2, § 31.

<sup>13</sup> PRINCIPLES, TD#2, § 27(2). That rule assumes that the entire liability is clearly covered, but for the policy limits; the effect of coverage disputes and partial coverage is deferred to § 28. PRINCIPLES, TD#2, § 27, cmt. *a*.

likelihood. In a complex case, these evaluations are difficult, both for the insurer making the settlement decision and for the trier of fact in a subsequent suit challenging the reasonableness of the insurer's settlement decision. This difficulty, however, cannot be avoided. If a reasonableness standard is to be applied, such qualitative evaluations are inevitable. . . . In evaluating the reasonableness of an insurer's settlement decisions, the trier of fact may consider, among other evidence, expert testimony as well as testimony from the lawyers and others involved in the underlying insured liability claim.<sup>14</sup>

The exposition then takes an arguably novel tack:

The reasonableness standard set forth in this Section is a flexible one that permits the factfinder to take into account the whole range of reasonable settlement values. In the real world of civil litigation too many contingencies can affect trial outcomes for there to be only one reasonable settlement value. To the contrary, there generally is a range of reasonable settlement values. Because of the many contingencies that can affect trial outcomes and the corresponding difficulty of arriving at objective valuations there is no formula that can provide a definitive guide to what constitutes a reasonable settlement value, or even a reasonable settlement range, in many cases. The illustrations are provided here to suggest how a court might use the computation of expected values as a factor in evaluating the reasonableness of a settlement offer or demand, recognizing that any such computation will be imperfect. The liability insurer will be liable for any excess judgment against the insured in the underlying litigation if the trier of fact finds that the insurer rejected a settlement demand, or failed to consent to a settlement, that was within the range of reasonableness. *The effect of this rule is that, once a claimant has made a settlement demand in the underlying litigation that is within the range of reasonableness, a liability insurer that rejects that demand thereafter bears the risk of any excess judgment against the claimant at trial.* In the majority of jurisdictions, a liability insurer's decision to reject a settlement demand that is within the range of reasonableness makes the insurer liable for any excess judgment in the underlying litigation. This is true even if the rejected settlement demand was at the high end of the reasonableness range.<sup>15</sup>

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<sup>14</sup> PRINCIPLES, TD#2, § 27, cmt. c.

<sup>15</sup> PRINCIPLES, TD#2, § 27, cmt. d (emphasis added).

While the comment says that this is the majority rule, that assertion is contested insofar as it relates to a demand at the high end of the range of reasonableness.<sup>16</sup>

The rule stated by the Principles allows a jury to consider other, procedural factors:

The reasonableness standard ... requires the trier of fact in the breach-of-settlement-duty suit to evaluate the expected value of underlying litigation at the time of the failed settlement negotiations. That inquiry may be complex and difficult in some cases. Because of the difficulty of determining, in hindsight, whether a settlement demand or offer was reasonable, it is appropriate for the trier of fact to consider procedural factors that affected the quality of the insurer's decisionmaking or that deprived the insured of evidence that would have been available if the insurer had behaved reasonably. Factors that may affect the quality of the insurer's decisionmaking include a failure to conduct a reasonable investigation or to follow the recommendation of its chosen defense lawyer (including not seeking the defense lawyer's recommendation). Factors that may deprive the insured of evidence include a failure to conduct a reasonable investigation, a failure to keep the insured informed of within-limits offers or the risk of excess judgment, and the provision of misleading information to the insured.

Such factors are not enough to transform a plainly unreasonable settlement demand into a reasonable demand, but they can make the difference in a close case by allowing the jury to draw a negative inference from the lack of information that reasonably should have been available or from the low quality of the insurer's decisionmaking and fact-gathering processes. Just as reasonable investigation and settlement procedures cannot guarantee that an insurer will make a decision that is substantively reasonable, however, the failure to employ reasonable procedures does not necessarily mean that the insurer's decision was substantively unreasonable. In breach-of-settlement-duty cases in which the facts do not make clear that the insurer's settlement decision was substantively reasonable, the factfinder may decide on the basis of these procedural factors that the settlement decision was unreasonable. In an extreme case, the insurer may be subject to liability for bad-faith breach. The reasonableness of settlement demands and offers may also take into account other facts, such as the amount of time that is given to evaluate an offer and the jurisdiction in which the case would be tried.<sup>17</sup>

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<sup>16</sup> See text at notes 59-63, *infra*..

<sup>17</sup> PRINCIPLES, TD#2, § 27, cmt. *i*.

"An insurer's duty to make reasonable settlement decisions includes a duty to contribute its policy limits to a reasonable settlement of a covered claim if that settlement exceeds those policy limits."<sup>18</sup>

The rule stated by the Principles allows a jury to find that an insurer's failure to make a settlement offer or counteroffer was unreasonable.<sup>19</sup> The treatment of this issue is described and justified as follows:

This Section treats a liability insurer's decision to reject a reasonable settlement demand made by a claimant differently than an insurer's decision not to make its own reasonable settlement offer. A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer's decision not to make a reasonable offer, or counteroffer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

The reason for the difference in the two treatments relates to differences in the proof of causation. When an insurer fails to accept a reasonable settlement demand proffered by the claimant and the case goes to trial, resulting in an excess judgment against the insured, it is simple enough to identify the causal connection: had the insurer accepted the settlement demand, there would have been no trial and no possibility of an excess judgment. By contrast, when the insurer fails to make its own settlement offer, in the absence of a reasonable settlement demand from the claimant, and the case goes to trial and an excess judgment ensues, causation is not as clear-cut. The insurer's failure to make a reasonable offer caused the excess judgment only if the claimant would have accepted a reasonable offer from the insurer. Proving causation is difficult. Before the trial, the claimant would have been in the best position to answer the question whether they would have accepted the settlement offer, but after the trial the claimant's interests will often be too closely aligned with those of the insured defendant's to be objective. Other good sources of objective evidence on the matter will be scarce. Nevertheless, a trier of fact may conclude that an insurer's decision not to make a settlement offer or counteroffer constitutes an unreasonable settlement decision. Likewise, assuming the insurer has not rejected a settlement demand that is within the range of reasonableness, the trier of fact

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<sup>18</sup> PRINCIPLES, TD#2, § 27(4).

<sup>19</sup> PRINCIPLES, TD#2, § 27, cmt. *e*.



may conclude that an insurers' decision to make a settlement offer within that range, even if at the low end of the range, constitutes a reasonable settlement decision in satisfaction of the insurer's settlement duty.<sup>20</sup>

When confronting the vexing problem of multiple claims against a single (possibly inadequate) policy limit, "the insurer has a duty to the insured to make a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure."<sup>21</sup> The insurer may satisfy this duty by interpleading the policy limits and, if there is a duty to defend or pay defense costs on an ongoing basis, continuing to defend.<sup>22</sup>

## 2. Effect of Coverage Issue

Even if an insurer has reasonable grounds to contest coverage, it will be liable (if coverage is later found to exist) for any failure to make reasonable settlement decisions.<sup>23</sup> The rationale is that

[t]his rule ... allocates to the insurer a portion of the risk associated with reasonable but mistaken beliefs on the part of the insurer regarding coverage and discourages insurers from delaying settlement negotiations in the underlying lawsuit while potential coverage disputes with the insured are resolved.... The alternative approach places the risk of the insurer's mistaken coverage decisions on the insured, increasing the likelihood of substantial excess judgments.... The majority rule is superior because it places the risk of mistaken coverage decisions upon the party best able to reduce and spread that risk.<sup>24</sup>

A reservation of rights frees an insured to settle, under certain conditions:

Unless otherwise stated in a policy issued to a large commercial policyholder, when an insurer has reserved the right to contest coverage for a claim, the insured may settle the claim without the consent of the insurer and without violating the duty to cooperate or other restrictions on the insured's settlement rights

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<sup>20</sup> PRINCIPLES, TD#2, § 27, cmt. *f*.

<sup>21</sup> PRINCIPLES, TD#2, § 29(1).

<sup>22</sup> PRINCIPLES, TD#2, § 29(2).

<sup>23</sup> PRINCIPLES, TD#2, § 28(1).

<sup>24</sup> PRINCIPLES, TD#2, § 28, cmt. *a*.

contained in the policy, provided the following requirements are met:

- (a) The insurer is given the opportunity to participate in the settlement process;
- (b) The insurer declines to withdraw its reservation of rights after receiving prior notice of the proposed settlement;
- (c) A reasonable person that bore the sole financial responsibility for the full amount of the potential judgment and the costs of defending the claim would have accepted the settlement; and
- (d) If the settlement includes payments for damages that are not covered by the liability insurance policy, the portion of the settlement allocated to the insured component of the claim is reasonable.<sup>25</sup>

Under the Principles, reasonableness review has more teeth than in some jurisdictions that allow insureds to settle claims for which coverage is disputed:

If a court determines that the settlement between the insured and the claimant is not reasonable or that the portion allocated to the insurer is not consistent with the terms of the policy, the insurer is excused from its defense, settlement, and indemnity obligations to the insured. This rule more strongly discourages collusive or otherwise unreasonable settlements than the rule that applies to settlements in cases in which the insurer has breached the duty to defend. In such cases, the insurer is obligated to pay the reasonable portion of an unreasonable settlement. By contrast, an insurer that is fulfilling the duty to defend by defending under a reservation of rights has no obligation to pay any portion of an unreasonable settlement entered into without its consent.<sup>26</sup>

### **3. Liability for Breach**

"An insurer that breaches the duty to make settlement decisions is subject to liability to the insured for the difference between the amount of damages assessed against the insured in the underlying suit and the limits of coverage in the policy."<sup>27</sup> "If, and only if, an insured is entitled

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<sup>25</sup> PRINCIPLES, TD#2, § 28(3).

<sup>26</sup> PRINCIPLES, TD#2, § 28, cmt. *e*.

<sup>27</sup> PRINCIPLES, TD#2, § 30(1).

to recover for an excess judgment from an insurer . . . , the insured is also entitled to recover for actually foreseen and highly foreseeable harms caused to the insurer by the insurer's breach of the duty to make reasonable settlement decisions."<sup>28</sup>

This rule has two components: a requirement of an excess judgment for which the insurer is liable and a standard of the types of damages recoverable beyond the amount of that judgment.

As to the first point, the rationale is

one of practicality. It is often the case that an insurer's decision not to settle a suit against the insured will cause an insured aggravation and inconvenience, and perhaps even uninsured out-of-pocket expenditures, even when there is no excess judgment that must be paid by the insured. Such costs are typically relatively minor. To include them in the measure of damages in settlement-duty cases would create unnecessary uncertainty for insurers, which would be translated into premium increases for policyholders. This rule does not preclude insureds from being able to recover for such costs should the insurer's actions rise to the level of bad faith, nor does it preclude statutory or administrative remedies. However, when the claim is merely that the insurer's decision was unreasonable in an individual case, no such common law damages will be available in the absence of an excess judgment.<sup>29</sup>

An alternate rationale would be that the duty is one to protect the insured from an excess judgment if that can be accomplished by reasonable settlement decisions. On that view, there would be no breach unless and until an excess judgment resulted. That rationale appears consistent with the conceptualization of the duty in the Principles.<sup>30</sup>

As to the types of damages recoverable, these include

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<sup>28</sup> PRINCIPLES, TD#2, § 30(2).

<sup>29</sup> PRINCIPLES, TD#2, § 30, cmt. *b*. That comment says that this rule is "consistent with the prevailing rule in most jurisdictions." Note that bad faith is treated as something different from breach of the duty to make reasonable settlement decisions. What constitutes bad faith and what consequences flow from that remain to be addressed in Chapter 4 of the Principles.

<sup>30</sup> See PRINCIPLES, TD#2, § 27, cmt. *e* ("As with any liability standard, the reasonableness standard stated in [the Principles] does not, as a technical matter, require the insurer to do anything. Rather, the standard simply assigns to the insurer legal responsibility for excess judgments that result from a breach of the standard.").

reasonably foreseeable nonfinancial losses, such as emotional distress damages, if these can be proven. In cases involving individual insureds, some amount of nonfinancial harm is likely to be reasonably foreseeable. In cases involving commercial insureds, nonfinancial harm is less likely to be reasonably foreseeable.<sup>31</sup>

## **II. The Rules Stated by the Principles Regarding an Insurer's Duty To Make Reasonable Settlement Decisions Improperly Increase Insurer Obligations and Inflate Insurance Costs**

### **A. Courts Struggled To Define the Standards**

It appears now to be universally agreed that a liability insurer has some duty to make within-limits settlements to protect its insureds from the risk of excess judgments. Courts struggled to define this duty more precisely.

In the majority of American jurisdictions liability is predicated on bad faith.<sup>32</sup> But this does not necessarily require subjective culpability. Rather “bad faith” simply means “being unfaithful to the duty owed” to the insured.<sup>33</sup> One of the most common formulations of the duty is as one to give equal consideration to the insured’s interests with the insurer’s own interests.<sup>34</sup> Under that standard,

If an opportunity appears to settle within the policy limits, thereby protecting the insured from excess liability, the insurer must faithfully consider it, giving the insured’s interest at least as much respect as its own. The insurer need not submit to extortion; it may reject a bad deal without waiving the protection the policy limit gives it against the vagaries of lawsuits. But if the honest and prudent course is to settle, the insurer must follow that route. If it

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<sup>31</sup> PRINCIPLES, § 30, cmt. *b*.

<sup>32</sup> *See, e.g.* *Comunale v. Traders & Gen. Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958); *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255 (Miss. 1988); *Northfield Ins. Co. v. St. Paul Surplus Lines Ins. Co.*, 545 N.W.2d 57 (Minn. Ct. App. 1996).

<sup>33</sup> *Cernocky v. Indem. Ins. Co. of N. Am.*, 69 Ill. App. 2d 196, 205–206 (1966); *California Union Ins. Co. v. Liberty Mut. Ins. Co.*, 920 F. Supp. 908, 919 n.5 (N.D. Ill. 1996).

<sup>34</sup> *E.g.*, *City of Glendale v. Farmers Ins. Exch.*, 126 Ariz. 118, 120 (1980) *Commercial Union Assur. Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 913, 917 (1980); *Truck Ins. Exchange v. Bishara*, 128 Idaho 550, 554 (1996); *Long v. McAllister*, 319 N.W.2d 256, 262 (Iowa 1982); *Rider v. State Farm Mut. Auto. Ins. Co.*, 514 F.2d 780, 785 (10th Cir. 1975); *Short v. Dairyland Ins. Co.*, 334 N.W.2d 384, 387 (Minn. 1983); *Hartford Acc. & Indem. Co. v. Foster*, 528 So. 2d 255 (Miss. 1988).

deviates from that course, it will be liable for the whole judgment, so as to give the insured the protection that the policy was intended to provide.<sup>35</sup>

The California Supreme Court explicitly rejected any requirement for subjective culpability under the bad faith standard:

liability based on an implied covenant exists whenever the insurer refuses to settle in an appropriate case and that liability may exist when the insurer unwarrantedly refuses an offered settlement where the most reasonable manner of disposing of the claim is by accepting the settlement. Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing. Moreover, ... recovery may be based on unwarranted rejection of a reasonable settlement offer and ... the absence of evidence, circumstantial or direct, showing actual dishonesty, fraud, or concealment is not fatal to the cause of action.<sup>36</sup>

While the “equal consideration” standard sounds like it strikes a fair balance, it has been criticized as providing no guidance at all, because a decision to settle necessarily prefers the insured’s interest and a decision not to settle necessarily prefers the insurer’s interest.<sup>37</sup>

There is a solution to this difficulty.<sup>38</sup> But however that may be, juries are regularly instructed with the “equal consideration” formula and left to puzzle out its meaning for themselves.

A minority of jurisdictions<sup>39</sup> apply the negligence test, which imposes on the insurer a standard of care at least equal to what a reasonable person would exercise in the management of

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<sup>35</sup> [La Rotunda v. Royal Globe Ins. Co.](#), 87 Ill. App. 3d 446, 453–54 (1980) (international citations omitted).

<sup>36</sup> [See Crisci v. Security Ins. Co.](#), 66 Cal. 2d 425, 430 (1967). *See also* [The Birth Ctr. v. The St. Paul Cos.](#), 1999 PA Super 49, ¶ 24 (“An insurer does not satisfy the good faith standard merely by showing that it acted with sincerity.”).

<sup>37</sup> [Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.](#), 65 N.J. 474, 498 (1974).

<sup>38</sup> *See* text at notes 45-58, *infra*.

<sup>39</sup> *See* [Aetna Cas. & Sur. Co. v. Kornbluth](#), 28 Colo. App. 194, 197–98 (1970); [Knudsen v. Hartford Accident & Indem. Co.](#), 26 Conn. Supp. 325, 326 (1966); [Bennett v. Slater](#), 154 Ind. App. 67, 69 (1972); [Rector v. Husted](#), 214 Kan. 230, 230 (1974); [Dumas v. State Farm Mut.](#)

his own affairs.<sup>40</sup> Some of those states also subscribe to the “equal consideration” formula, and sometimes both standards are used in the same case.<sup>41</sup>

Authorities generally agree that the significance of any distinction between the two tests is minimal in most jurisdictions, with similar evidence being relied upon under both tests.<sup>42</sup> As one court stated:

In practice, however, these formulations of the test of the insurer’s conduct tend to coalesce; courts claiming to hold an insurer liable only for bad faith have held insurers liable for failure to settle in an appropriate case, even though the failure was attributable solely to negligence.<sup>43</sup>

Thus, many courts that purport to follow a bad-faith standard apply a negligence standard in practice. So long as the bad faith standard applied by a particular court does not require subjective culpability (which most states do not), the distinction between the two standards is, at most, very slight. Under either standard, most courts will agree that “[t]he insurer, as a professional defender of law suits, is held to a standard higher than that of an unskilled practitioner.”<sup>44</sup>

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Auto. Ins. Co., 111 N.H. 43, 46 (1971); *Maine Bonding & Cas. Co. v. Centennial Ins. Co.*, 298 Or. 514, 518–19 (1985); *Hamilton v. State Farm Ins. Co.*, 83 Wash. 2d 787, 523 P.2d 193 (1974).

<sup>40</sup> See *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544, 547–48 (Tex. Comm’n App. 1929, holding approved).

<sup>41</sup> See, e.g., *Waters v. American Cas. Co.*, 261 Ala. 252, 258 (1953); *Members Mut. Ins. Co. v. Blissett*, 254 Ark. 211, 215 (1973); *Rector v. Husted*, 214 Kan. 230, 239 (1974); *Hamilton v. State Farm Ins. Co.*, 83 Wash. 2d 787, 792 (1974).

<sup>42</sup> See *Ambassador Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 753 F.2d 824, 826 (10th Cir. 1985); *Clark v. Interstate Nat’l Corp.*, 486 F. Supp. 145, 147 (E.D. Pa. 1980); *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 429 (1967); *Campbell v. Gov’t Employees Ins. Co.*, 306 So. 2d 525, 528 (Fla. 1974); *Edwins v. General Cas. Co.*, 78 Ill. App. 3d 965, 968 (1979); *Kooyman v. Farm Bureau Mut. Ins. Co.*, 315 N.W.2d 30, 34–35 (Iowa 1982).

<sup>43</sup> See *Campbell v. State Farm Mut. Auto. Ins. Co.*, 840 P.2d 130, 139 (Utah Ct. App.), *cert. denied*, 853 P.2d 897 (1992); *State Farm Mut. Auto. Ins. Co. v. White*, 248 Md. 324, 329–32 (1967).

<sup>44</sup> See *State Farm Mut. Auto. Ins. Co. v. Marcum*, 420 S.W.2d 113, 120 (Ky. 1967) (overruled on other grounds); *Utica Mut. Ins. Co. v. Coastal Marine, Inc.*, 578 F. Supp. 1376, 1378 (E.D. La. 1984).

## B. Now Dominant Standard: Disregard the Limits

The prior discussion has noted that the “equal consideration” standard provides little guidance whether an insurer must settle in any particular case. That problem was also noted by Professor (later Judge) Robert B. Keeton in a seminal law review article.<sup>45</sup> He proposed a simple solution, pointing out that it corresponded closely with the negligence standard employed in some jurisdictions:

With respect to the decision whether to settle or try the case, the insurer, acting through its representatives, must use such care as would have been used by an ordinarily prudent insurer *with no policy limit applicable to the claim*. The insurer is negligent in failing to settle if, but only if, such ordinarily prudent insurer would consider that choosing to try the case (rather than to settle on the terms by which the claim could be settled) would be taking an unreasonable risk—that is, trial would involve chances of unfavorable results out of reasonable proportion to the chances of favorable results.<sup>46</sup>

This standard has now been widely adopted, whether the jurisdiction follows the “equal consideration” or the negligence test (or both).<sup>47</sup> It is now the dominant standard. It is also the one that best balances the relevant interests.

The sort of analysis this standard requires of an insurer (and the contrast with the analysis it would apply in the absence of a duty to settle) are illustrated in *Transport Insurance Co. v. Post Express Co.*<sup>48</sup> Post Express had a \$1 million policy and suffered a judgment of just over \$2 million. The jury found Transport liable for bad faith. (The Seventh Circuit commented that,

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<sup>45</sup> Robert B. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 *Harv. L. Rev.* 1136, 1146 (1954).

<sup>46</sup> 67 *Harv. L. Rev.* at 1147 (emphasis added).

<sup>47</sup> *E.g.*, *Clearwater v. State Farm Mut. Auto. Ins. Co.*, 164 *Ariz.* 256, 259 (Sup. Ct. 1990); *but see Miel v. State Farm Mut. Auto. Ins. Co.*, 185 *Ariz.* 104, 110 (Ct. App. 1995) (act or omission causing failure to settle must be intentional, not the result of mere negligence or inadvertence, and insurer must have known or recklessly disregarded the fact that it was acting unreasonably); *Kooyman v. Farm Bureau Mut. Ins. Co.*, 315 *N.W.2d* 30, 34 (Iowa 1982); *Badillo v. Mid-Century Ins. Co.*, 2005 *OK* 48, ¶ 26; *Goddard v. Farmers Ins. Co.*, 173 *Or. App.* 633, 642, *rev. denied*, 332 *Ore.* 631 (2001); *Cowden v. Aetna Cas. & Sur. Co.*, 389 *Pa.* 459, 470 (1957).

<sup>48</sup> *Transport Ins. Co. v. Post Express Co.*, 138 *F.3d* 1189 (7th Cir. 1998) (IL law).

“[d]espite the use of the opprobrious ‘bad faith’ language, this is a contractual claim informed by principles of negligence.”<sup>49</sup>) In the course of finding that Transport had adopted an unreasonably risky defense strategy, the court explained the analysis applicable to its duty to settle:

Insurers operate under a conflict of interest; the policy limit drives a wedge between what is good for insurers and what is good for clients. Suppose the plaintiff seeks an award of \$2 million, the policy limit is \$1 million, and the probability of a verdict in the plaintiff’s favor is 50%. An insurer concerned only about its own interests would offer only \$500,000 to settle the case, because that is the expected value of the exposure it faces ( $\$1,000,000 \times 0.5$ ). But if the insured is solvent (and thus good for the full verdict), the plaintiff will not accept less than \$1 million in settlement ( $\$2,000,000 \times 0.5$ ). Trial exposes the insured to an anticipated loss of \$500,000 (the \$1 million excess of the verdict over the policy limits, times the probability of a victory for the plaintiff). By settling the case at or within the policy limit, the insurer could insulate the client from this exposure. Most states, of which Illinois is one, require insurers to devise a litigation strategy (and make settlement offers within the policy limits) as if the insurer bore the full exposure.<sup>50</sup>

On the facts assumed in the quotation, the insurer would incur responsibility for any resulting excess judgment if it rejected any demand within the \$1 million limit, because the expected judgment at trial would be \$1 million.<sup>51</sup>

Without mentioning the “disregard the limits” rule, the California Supreme Court appeared to illustrate its operation in *Isaacson v. California Insurance Guarantee Ass’n*.<sup>52</sup> Oulette sued Dr. Isaacson for malpractice. Imperial Insurance Co. provided a defense until it became insolvent, with CIGA assuming the defense at that point. Oulette had demanded Imperial’s \$1 million limit, but CIGA had a \$500,000 per claim limit and Oulette dropped his

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<sup>49</sup> 138 F.3d at 1192.

<sup>50</sup> 138 F.3d. at 1192.

<sup>51</sup> See *Radcliffe v. Franklin Nat’l Ins. Co.*, 208 Ore. 1, 48 (1956) (under “disregard the limits” standard, insurer could properly have rejected within-limits demand exceeding its settlement evaluation had that evaluation been properly informed). *Miller v. Elite Ins. Co.*, 100 Cal. App. 3d 739, 756 (1980) (bad faith as a matter of law to reject \$5000 demand when insurer’s own evaluation was a 50% risk of an \$11,000 judgment).

<sup>52</sup> *Isaacson v. Calif. Ins. Guar. Ass’n*, 44 Cal. 3d 775 (1988).



demand to that amount when CIGA entered the case. Both before and after CIGA took over, Dr. Isaacson's counsel estimated liability at 50% and estimated that if liability were found and Oulette were found totally disabled, the expected damages would be about \$750,000. He therefore demanded that CIGA pay \$500,000 to settle the case. CIGA concurred in counsel's estimates, but refused to offer more than \$400,000. Fearing an excess verdict, Dr. Isaacson then contributed \$100,000 to settle the case and sued CIGA to recover his contribution. The trial court sustained a demurrer and the supreme court affirmed.

The court agreed that, in appropriate circumstances, CIGA could be liable for failure to settle, and that its statutory duties included a duty, in appropriate cases to accept a reasonable settlement offer.<sup>53</sup> In describing CIGA's duties, the court used "cf" cites to cases defining insurers' duties to settle,<sup>54</sup> and it appears to have regarded the standards applicable to CIGA as parallel. CIGA was not obliged to pay its limits "in every case in which there is some *possibility* that the damages could exceed" that limit.<sup>55</sup> "Rather, its duty is to pay and defend 'covered claims' (which necessarily includes paying a *reasonable* amount in settlement), based on a fair appraisal of potential exposure and the strength of each case."<sup>56</sup> Given the agreed estimates of the prospects at trial, Dr. Isaacson's "evidence does not indicate that CIGA failed to accept a reasonable settlement offer when it rejected Ouellette's \$500,000 settlement demand, and instead paid \$400,000."<sup>57</sup>

As the California court has succinctly summarized, " '[the] only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light

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<sup>53</sup> 44 Cal. 3d at 792.

<sup>54</sup> 44 Cal. 3d at 792 nn.11–12.

<sup>55</sup> 44 Cal. 3d at 792–93 (emphasis original).

<sup>56</sup> 44 Cal. 3d at 793 (emphasis original).

<sup>57</sup> 44 Cal. 3d at 794.

of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer."<sup>58</sup>

In short, the insurer is supposed to assign each potential verdict amount a probability and then compute an expected verdict amount by multiplying each verdict amount by its probability and summing the products, thereby arriving at an expected verdict value, which can then be compared with any potential settlement amount to determine whether that amount is reasonable.

### **C. The Principles**

The rule stated by the Principles is a novel approach. The black letter appears to embrace the disregard-the-limits rule: "[a] reasonable settlement decision is one that would be made by a reasonable person that bears sole responsibility for the full amount of the potential judgment."<sup>59</sup> But the more detailed methodology described in the comments significantly modifies that rule as it has hitherto been explained and applied.

Specifically, a comment states that:

The reasonableness standard set forth in this Section is a flexible one that permits the factfinder to take into account the whole range of reasonable settlement values. In the real world of civil litigation too many contingencies can affect trial outcomes for there to be only one reasonable settlement value. To the contrary, there generally is a range of reasonable settlement values. Because of the many contingencies that can affect trial outcomes and the corresponding difficulty of arriving at objective valuations there is no formula that can provide a definitive guide to what constitutes a reasonable settlement value, or even a reasonable settlement range, in many cases. The illustrations are provided here to suggest how a court might use the computation of expected values as a factor in

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<sup>58</sup> *Samson v. Transamerica Ins. Co.*, 30 Cal. 3d 220, 243 (1981), quoting *Johansen v. California State Auto. Ass'n Inter-Ins. Bur.*, 15 Cal. 3d 9, 16 (1975). Both *Samson* and *Johansen* were addressing the question of considering doubts as to coverage, which California law does not permit. (See WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION, § 3.02[4][b][iii]) But the statement appears to describe the analysis to be conducted after putting coverage doubts aside.

<sup>59</sup> PRINCIPLES, TD#2 § 27(2). That rule assumes that the entire liability is clearly covered, but for the policy limits, the effect of coverage disputes and partial coverage being deferred to § 28. PRINCIPLES, TD#2 § 27, cmt. *a*.

evaluating the reasonableness of a settlement offer or demand, recognizing that any such computation will be imperfect. The liability insurer will be liable for any excess judgment against the insured in the underlying litigation if the trier of fact finds that the insurer rejected a settlement demand, or failed to consent to a settlement, that was within the range of reasonableness. *The effect of this rule is that, once a claimant has made a settlement demand in the underlying litigation that is within the range of reasonableness, a liability insurer that rejects that demand thereafter bears the risk of any excess judgment against the claimant at trial.* In the majority of jurisdictions, a liability insurer's decision to reject a settlement demand that is within the range of reasonableness makes the insurer liable for any excess judgment in the underlying litigation. This is true even if the rejected settlement demand was at the high end of the reasonableness range.<sup>60</sup>

By subjecting the insurer to liability for failure to accept a demand at the high end of the range of reasonableness, this requires the insurer to behave in a risk averse fashion. A risk neutral insurer, with a diversified portfolio of risks, would recognize that, while there is a range of reasonableness for any claim, their average settlement value will be near the middle of that range, with low verdicts balancing out high ones. To always settle at the high end of the range of reasonableness would inflate insurance costs and, therefore, premiums. Thus, a risk neutral insurer would treat reasonableness as a point, in the middle of the reasonable range and would decline settlement demands in excess of that value.

That is the result called for by Professor Keeton when he formulated the test:

With respect to the decision whether to settle or try the case, the insurer, acting through its representatives, must use such care as would have been used *by an ordinarily prudent insurer* with no policy limit applicable to the claim. The insurer is negligent in failing to settle if, but only if, such *ordinarily prudent insurer* would consider that choosing to try the case (rather than to settle on the terms by which the claim could be settled) would be taking an unreasonable risk—that is, trial would involve chances of

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<sup>60</sup> PRINCIPLES, TD#2 § 27, cmt. *d* (emphasis added) (see text at notes 13-17, *supra*).

unfavorable results out of reasonable proportion to the chances of favorable results.<sup>61</sup>

While insureds are risk averse, ordinarily prudent insurers are not, nor should they be. Insureds should exercise their risk aversion by purchasing insurance adequate for the risks they face, not by expecting insurers to become risk averse when faced with particular claims. The rule stated by the Principles would inflate insurance costs and effectively force those who do purchase adequate insurance to bear part of the risk faced because others have not done so.

Not only does the rule stated by the Principles deviate from the rule proposed by Prof. Keeton and adopted by courts, but it is contrary to the leading cases which have explained the application of the disregard-the-limits rule. Those cases have treated reasonable settlement value as a point, not a range.<sup>62</sup> The only cases cited in support of requiring settlement at the upper end of a range of reasonableness are unreported trial court cases.<sup>63</sup>

As the comments note, the rule stated by the Principles has the practical effect of giving "claimants an incentive during the pretrial phase of the case to make settlement demands at the high end of the reasonableness range, since the insurer's rejection of such a demand creates the conditions for a subsequent settlement-duty lawsuit in the event of a ... verdict that produces an excess judgment." The incentive which the law ought to be providing is to make an offer at the projected verdict value, which would be in the center of the range of reasonableness, not at the high end.

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<sup>61</sup> Robert B. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 *Harv. L. Rev.* 1136, 1147 (1954).

<sup>62</sup> See text at notes 48-58, *supra*.

<sup>63</sup> PRINCIPLES, TD#2 § 27, Reporters' Note *d*, *citing* First Fid. Bancorporation v. Nat'l Union Fire Ins. Co., 1994 WL 111363, at \*6 (E.D. Pa. Mar. 30, 1994); Rhodes v. AIG Domestic Claims, Inc., 24 Mass. L. Rptr. 142, 2008 WL 2357015, at \*24 (Mass. Super. Ct. 2008).

### **III. The Rules Stated by the Principles Improperly Permit Juries To Rely on Procedural Factors Without any Showing That any Procedural Deficiencies Injured the Insured.**

According to the Principles, "[b]ecause of the difficulty of determining, in hindsight, whether a settlement demand or offer was reasonable, it is appropriate for the trier of fact to consider procedural factors that affected the quality of the insurer's decisionmaking or that deprived the insured of evidence that would have been available if the insurer had behaved reasonably."<sup>64</sup> In particular, inadequate investigation and inadequate or misleading communications with the insured are noted as significant considerations.<sup>65</sup>

It is certainly true that failure to investigate may cause an insurer to miss information that would have led a reasonable insurer to a different settlement decision. But for that to be a proper basis to impose liability, there would need to be more than a finding that the insurer's investigation was inadequate. There would need to be a basis for an inference that something significant was likely missed, in which case the insurer would be charged with knowledge of the information it would have discovered.<sup>66</sup> With the benefit of hindsight after an excess judgment, the nature of what was missed and how it should have been found ought to be ascertainable. That would allow the settlement decision to be assessed in light of all of the information that should have been considered. At that point, the inadequate investigation would cease to have independent significance.

Similarly, if an insured was not informed or was misinformed about a settlement offer, the insured should be able to explain (if it is true) how the correct information would have led the insured to offer a settlement contribution or to inform the insurer of something that would have affected the settlement calculus of a reasonable insurer. Again, the failure to inform or the

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<sup>64</sup> PRINCIPLES, TD#2, § 27, cmt. *i* (see text at note 17, *supra*).

<sup>65</sup> PRINCIPLES, TD#2, § 27, cmt. *i*.

<sup>66</sup> See WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION, § 5.04[3][a] (addressing failure to investigate in the context of first-party claims).

misinformation would lose independent significance, and the focus would be on whether correct information would have prevented the excess judgment.

Instead of requiring a focused inquiry on the effect of any procedural deficiency, the rule stated by the Principles " allow[] the jury [in close cases] to draw a negative inference from the lack of information that reasonably should have been available or from the low quality of the insurer's decisionmaking and fact-gathering processes."<sup>67</sup>

Hindsight evaluations by juries of insurer settlement decisions that led to excess judgments are already likely to lean heavily in favor of insureds who have suffered such judgments. Juries ought not to be distracted from the correct inquiry by being invited to focus on procedural deficiencies, in the absence of evidence that those deficiencies contributed to an unreasonable settlement decision. In particular, speculation that, if informed, the insured might have persuaded the insurer to settle, is not sufficient to support a claim for bad faith.<sup>68</sup>

#### **IV. The Rules Stated by the Principles Improperly Require Insurers To Make Settlement Offers, Rather Than Merely Responding To Settlement Demands**

##### **A. Overview**

Some jurisdictions hold that the duty to settle arises only when the claimant makes an offer that should have been accepted and would have shielded the insured.<sup>69</sup> As the Third Circuit has put it:

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<sup>67</sup> PRINCIPLES, TD#2, § 27, cmt. *i*.

<sup>68</sup> *Schubert v. Am. Ind. Ins. Co.*, 2003 U.S. Dist. LEXIS 10769, at \*9-10 (E.D. Pa. June 24, 2003)

<sup>69</sup> *E.g.*, *Puritan Ins. Co. v. Canadian Univ. Ins. Co.*, 775 F.2d 76, 82 (3rd Cir. 1985) (insurer usually has no obligation to initiate offers); *Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 875 (1973) (no conflict triggering duty absent demand within limits or above limits but within insured's ability to contribute excess); *Haddick v. Valor Ins. Co.*, 198 Ill. 2d 409, 417 (2001) (insurer usually has no duty to make offers); *Wierck v. Grinnell Mut. Reins. Co.*, 456 N.W.2d 191, 195 (Iowa 1990); *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 41 (1998) (duty to settle is triggered by receipt of an offer the insurer should have accepted).

Traditionally and logically, the impetus for settlement comes from the plaintiff. He is the one seeking recovery and therefore has the burden of stating just what it is that he wants. A feigned lack of interest in settlement by a defendant is a widely recognized negotiating ploy. We see no reason why use of this technique should excuse the plaintiff from stating his demand. The utter uselessness of ad damnum clauses in personal injury cases requires that at some stage in the litigation the real amount of the claim be disclosed. Only the plaintiff can supply it.<sup>70</sup>

But even where a demand is normally required, that requirement may be excused where insurer misconduct at least may have prevented the demand.<sup>71</sup>

Other jurisdictions do require insurers to initiate settlement negotiations if that is an appropriate method of resolving the case.<sup>72</sup> The Tenth Circuit best states the reasoning of courts imposing this requirement:

The duty to consider the interests of the insured arises not because there has been a settlement offer from the plaintiff but because there has been a claim for damages in excess of the policy limits. This claim creates a conflict of interest between the insured and the carrier which requires the carrier to give equal consideration to the interests of the insured. This means that “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.” When the carrier’s duty is measured against this standard, it becomes apparent that the duty to settle does not hinge on the existence of a settlement offer from

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ROBERT H. JERRY, II, & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW, § 112[d], at 840 (5th ed. 2012) (“In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless plaintiff makes a settlement offer within policy limits”).

<sup>70</sup> *Puritan*, 775 F.2d at 82 (citations omitted).

<sup>71</sup> *Davis v. Nationwide Mut. Fire Ins. Co.*, 370 So. 2d 1162, 1163 (Fla. Dist. Ct. App. 1979).

<sup>72</sup> *Hartford Ins. Co. v. Methodist Hosp.*, 785 F. Supp. 38, 41 (E.D.N.Y. 1992) (collecting authorities supporting this rule and predicting that New York would agree); *Powell v. Prudential Prop. & Cas. Ins. Co.*, 584 So. 2d 12, 14 (Fla. Dist. Ct. App. 1991) (“Where liability is clear, and injuries so serious that a judgment in excess of policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations.”); *Guar. Abstract & Title Co. v. Interstate Fire & Cas. Co.*, 228 Kan. 532, 537 (1980) *superseded by statute on other points in S. Am. Ins. v. Gabert-Jones, Inc.*, 13 Kan. App. 2d 324 (1989) and *Hartford Acc. & Indem. Co., v. Am. Red Ball Transit Co.*, 262 Kan. 570 (1997); *Goddard v. Farmers Ins. Co.*, 173 Or. App. 633, 638 (2001); *Alt v. Am. Family Mut. Ins. Co.*, 71 Wis. 2d 340, 351 (1976). *See: Delancy v. St. Paul Fire & Marine Ins. Co.*, 947 F.2d 1536, 1550 n.31 (11th Cir. 1991) (finding Georgia law unclear on issue but collecting authority supporting duty to make offer).

the plaintiff. Rather, the duty to settle arises if the carrier would initiate settlement negotiations on its own behalf were its potential liability equal to that of its insured.<sup>73</sup>

Even where the jurisdiction at least might find liability in the absence of a demand, the jurisdiction may trigger the requirement to make an offer only when the facts put the insurer on notice that there is an opportunity to settle. Recognizing that Georgia law was uncertain on whether a demand was necessary, *Kingsley v. State Farm Mutual Insurance Co.*,<sup>74</sup> concluded that:

an insurer will be exposed to a judgment in excess of its policy limits only where there is some certainty regarding the settlement posture of the parties in the underlying lawsuit -- i.e., where the insured's liability is clear, the damages are great and the insurer is on notice that it has an opportunity to settle the case, usually because a settlement demand in the amount of the policy limits or greater is received from the plaintiff. There must be a triggering event -- something that puts the insurer on notice that it must respond or risk liability for an excess judgment. Put another way, to find liability for tortious refusal to settle there must be something the insurer was required to "refuse."<sup>75</sup>

Even where an insurer is subject to a duty to initiate settlement negotiations, it has been held that no such duty arises until a claim has been asserted, even though the insurer was aware of the potential for a claim. In *Roberts v. Printup*,<sup>76</sup> Roberts was injured as a passenger in a family car driven by her son, Printup. She reported the loss to her insurer and gave a recorded statement in which she said that the brakes had failed and she didn't think that her son was at

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<sup>73</sup> *Coleman v. Holacek*, 542 F.2d 532, 537 (10th Cir. 1976) (Kansas law), *quoted with approval*, *Guar. Abstract & Title Co. v. Interstate Fire & Cas. Co.*, 228 Kan. 532, 537 (1980) (internal citations omitted). *See also*: *Badillo v. Mid-Century Ins. Co.*, 2005 OK 48, ¶¶ 33-34; *Goddard v. Farmers Ins. Co.*, 173 Or. App. 633, 638 (2001) (“ ‘In most circumstances the insurer, having reserved to itself the right to control the defense and the decision whether to agree to a settlement, should be obligated to explore the possibility of a settlement even in the absence of actions by the third-party or an express request by the insured,’ ” *quoting* ROBERT KEETON & ALAN I. WIDISS, *INSURANCE LAW*, § 7.8(c), at 889–90 (1988).

<sup>74</sup> *Kingsley v. State Farm Mut. Ins. Co.*, 353 F. Supp. 2d 1242 (N.D. Ga. 2005),

<sup>75</sup> 353 F. Supp. 2d at 1252.

<sup>76</sup> *Roberts v. Printup*, 422 F.3d 1211 (10th Cir. 2005) (KS law).



fault. The insurer paid PIP benefits for her injuries and \$250 on a property damage claim by a third party. It was aware of the potential for a bodily injury liability claim but took no action on account of that potential. Eventually, Roberts submitted a ten-day time limit demand, which was not acted on within the ten-day period. She sued her son, rejected a belated policy-limits offer, recovered a large judgment, and sued on an assigned claim for bad faith.<sup>77</sup> Among her theories was that the insurer should have initiated settlement negotiations even before she made a claim.

The Tenth Circuit disagreed:

"it seems odd to think that an insurer [(as part of its duty to the insured)] should beat the bushes to advise potential claimants to sue or make claims against their insured, especially if there is a possibility of an excess claim." The district court properly determined that an insurance company does not have a duty to the insured to initiate negotiations prior to a claim being made.<sup>78</sup>

## **B. Public Policy Analysis**

Professor Syverud suggests that some courts may think requiring the insurer to negotiate may be desirable, lest the insurer be able to manipulate the negotiations so the claimant never makes a demand.<sup>79</sup> But he points that such a requirement places insurers at the mercy of jury interpretations of the settlement strategies:

The problem with these rules, as with duty-to-settle standards generally, is their ambiguity when applied to particular settlement negotiations. It is not easy to predict whether a jury will regard a particular settlement demand, or a particular negotiating strategy, as reasonable or unreasonable. Juries and judges may err, with the result that appropriate conduct is punished and inappropriate conduct excused. Insurers may respond to the

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<sup>77</sup> 422 F.3d at 1212-14.

<sup>78</sup> 422 F.3d at 1216. *But see* Snowden v. Lumbermen's Mut. Cas. Co., 358 F. Supp. 2d 1125 (N.D. Fla 2003) (insurer verified liability and severity of injuries and sent insured an excess letter, but made no offer to injured party until after she had retained counsel--thereby incurring liability for fees; bad faith verdict upheld).

Roberts was permitted to proceed on other theories. 422 F.3d at 1220. She ultimately recovered. Roberts v. Printup, 595 F.3d 1181 (10th Cir. 2010).

<sup>79</sup> Kent D. Syverud, *The Duty to Settle*, 76 Va. L. Rev. 1113, 1166-67 (1990).

ambiguity by altering their behavior in every case, and not just in cases where duty-to-settle liability should attach. They may change bargaining strategy in every case, or marginally increase their assessment of the value of every case, rather than altering their behavior only in the cases where duty-to-settle liability is appropriate. As a result, insurers will accept some unreasonable, inefficient settlements, and they will sometimes avoid bargaining strategies that are in the interests of insureds. The resulting overpayment on such claims is a cost to all insureds.<sup>80</sup>

Looked at purely based on the rule that the insurer should act as it would if it alone were liable for the entire judgment, it would seem reasonable to require the insurer to initiate negotiations if that is what any reasonable insurer would do if it alone were liable. But that fails to take account of the distortion of the claimant's incentives resulting from the very existence of the duty to settle. While the law of bad faith is designed to provide insurers with incentives to address settlement in an appropriate manner, existence of that law alters the incentives of claimants in a way that can be harmful to insureds.

While creation of the settlement duty might not greatly affect the claimant if the policyholder could pay any excess judgment, it has a dramatic effect if the policyholder cannot do so. A greater amount would become recoverable if the insurer breached its duty than if the case were simply taken to a favorable judgment. The claimant thus acquires an incentive to exploit the existence of the duty.

If the expected value of the claim (without regard to collectibility) does not exceed limits by much, the claimant is most likely to use the duty to pressure the insurer to agree to pay the limit (or some smaller amount). If the insurer refuses, any judgment will become fully collectible. Still, the claimant is likely to be chiefly interested in settlement, just as would be the case with a sufficiently solvent tortfeasor.

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<sup>80</sup> 76 Va. L. Rev. at 1166.

But if the claim's expected value is far greater than the policy limit, the injured party may instead seek to provide occasions for the insurer to bypass an arguable settlement opportunity. If the insurer breaches its settlement duty, the entire judgment will become collectible (though at the cost of a second lawsuit), and this may permit settlement for the full value of the case. Even a colorable argument that the duty has been breached will permit bargaining for some payment above the policy limit.

The first of these situations involves a claimant primarily seeking performance of the settlement duty, while the second primarily involves an effort to find a breach. After all, performance of the settlement duty involves no more than payment of policy limits, and those limits are assumed to be far below the value of the second claim.

The opportunity for injured parties to seek increased payment by inducing an insurer misstep (or arguable misstep) has created a new danger for impecunious policyholders. If there were no settlement duty, claimants would recognize that the policy limits would be all that they could hope for. They would have no incentive to pursue litigation against a judgment-proof (or nearly so) tortfeasor, once the policy limits had been offered. This incentive would subject impecunious insureds to large judgments *only* because the claimants were pursuing a bad faith recovery, instead of simply taking the policy limits.

Pointing this out is not a criticism of injured parties or their counsel. They respond as best they could to a situation involving inadequate resources to fully compensate the injuries at issue. One court has strongly rejected criticism of counsel who allegedly made unreasonable demands in a situation where there were multiple claimants and inadequate limits:

Safeco's rhetorical complaint that the bad faith litigation was a setup engineered by Brindley was not successful with the jury, and as a legal argument it is equally unsuccessful. Pressing for a policy limits settlement for a badly injured client is a professional responsibility, not a sinister plot. Keeping bad faith litigation in mind as plan B if the insurer balks is a fair practice.

Safeco could have protected itself by putting the limits on the table for all three passengers.<sup>81</sup>

But the issue for a common-law court is whether it is desirable to hold out the incentives which produce such behavior. Those incentives harm impecunious policyholders, some of the very policyholders the settlement duty is designed to protect. They also harm the judicial system by generating litigation which would otherwise never be necessary.

For example, *Gutierrez v. Yochim*,<sup>82</sup> arose from an August 12, 2003 accident in which Gutierrez's car struck Yochim's motorcycle. Dairyland Insurance, Gutierrez's insurer, immediately concluded that she was at fault, and advised her that her policy had a \$10,000 bodily injury limit. On August 20, Dairyland obtained the police report, which described Yochim as having suffered "incapacitating" injuries. On August 18, a lawyer for Yochim contacted Dairyland, but ten days later said that Yochim had hired someone else, though asserting a lien for his own services. Having appraised the motorcycle, Dairyland paid its property damage limit in late August and notified Gutierrez that he might have liability for an excess judgment on either the property damage claim or for the potentially serious injuries to Gutierrez. On October 9, the new lawyer's paralegal told Dairyland that Yochim might have sustained a significant spinal cord injury, and it requested medical records or an authorization to obtain them, stating that it wished to settle the claim as soon as possible.<sup>83</sup> The lawyer apparently had the medical records, but sent only an authorization.<sup>84</sup>

On February 1, 2004, shortly after obtaining the hospital records, Dairyland sent a letter offering its policy limits, subject to placing the name of the first lawyer on the check or obtaining an agreement regarding the lien. Having received no response, it sent a similar letter a week

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<sup>81</sup> *Miller v. Kenny*, 2014 Wash. App. LEXIS 1030, ¶ 85 (April 28, 2014).

<sup>82</sup> *Gutierrez v. Yochim*, 23 So. 3d 1221 (Fla. Ct. App. 2009).

<sup>83</sup> 23 So. 3d at 1222-23.

<sup>84</sup> 23 So. 3d at 1225.

later. The new lawyer responded a week later that he would be responsible for any lien and that he would discuss the matter with his client when and if the limits were "tendered." The adjuster inquired what more he wanted in the form of a "tender" and that a check would be sent only if he indicated that it would be accepted in settlement; the lawyer responded that the adjuster should seek advice from his own counsel if he wanted it. On April 1, 2004, the adjuster hand delivered a check, which the lawyer refused. In his deposition, he claimed that he would have settled in February had the limits been tendered then.<sup>85</sup>

After a stipulated judgment in the suit against Gutierrez, she sued Dairyland for bad faith, and Dairyland obtained a summary judgment. The court of appeals reversed, saying that Dairyland knew enough about the severity of the injuries that it could not be said, as a matter of law that it did not have a duty to offer the policy limits earlier. Delay by Yochim's lawyer did not matter, because Dairyland's "fiduciary duty to timely and properly investigate the claim against the insured was not relieved simply because it was waiting to receive information from the claimant's attorney."<sup>86</sup>

In that situation, a policy limits offer would likely have been of little use to Yochim, as it would all have been consumed by a hospital lien. Yochim's lawyer was obviously doing everything he could to delay any offer from Dairyland, so that he could argue that it came too late and permitted a bad faith claim that would open the policy limit. Had that possibility not been present, he would instead have been encouraged to promptly provide Dairyland the information necessary to obtain payment of the limits, and neither the stipulated judgment nor the bad faith action would have been necessary.

The law should not hold out incentives to create unnecessary litigation and subject insureds to unnecessary risk of excess judgments. The settlement duty can and should be shaped

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<sup>85</sup> 23 So. 3d at 1223-24.

<sup>86</sup> 23 So. 3d at 1225.

to protect policyholders and the judicial system, while providing more appropriate incentives to claimants.

One who hopes more for a breach of the settlement duty than for performance would prefer not to make demands, for a demand might be accepted and eliminate any possible recovery above limits. Such a party would prefer to wait for an offer, perhaps “signaling” supposed receptiveness. If the offer never comes, it can later be argued that a reasonable insurer would have made one and the injured party can then testify that it would have been accepted. If an offer below limits is rejected, there is still an ability to claim that a higher offer, still within limits, would have been accepted. Yet the claimant (who may not have decided what would be acceptable), retains the ability to reject any offer that is made.

The Texas Supreme Court has noted that there are good reasons why insurers are reluctant to make offers, especially in cases where the value is significantly arguable. Once the insurer makes an offer, it establishes a “floor” for negotiations and must stand by its offer or later risk excess liability for unreasonably withdrawing its offer.<sup>87</sup> “Because the claimant bears little risk of losing the opportunity to settle ... [for the amount offered], the claimant has no incentive to settle” when the offer is made; the claimant can look for assets of the tortfeasor or hope that some other development will improve the prospects of an above-limits recovery.<sup>88</sup> And if the insurer’s offer is below limits, the injured party can reasonably expect it to rise.<sup>89</sup>

Precisely to provide proper incentives to both parties, Texas holds that the settlement duty is triggered only by a demand from the claimant that the insurer ought to have accepted.<sup>90</sup> For the reasons just stated, that rule is better than the one requiring the insurer to initiate offers.

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<sup>87</sup> *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 851 n.18 (1994).

<sup>88</sup> 876 S.W.2d at 851 n.18.

<sup>89</sup> 876 S.W.2d at 851 n.18.

<sup>90</sup> 876 S.W.2d at 851.

If a demand is required, it must be a firm demand: counsel's opinion about what the claimant would or might accept is not enough.<sup>91</sup> A demand subject to conditions that could not be satisfied cannot be the basis for bad faith liability, because acceptance of that demand could not have created a valid settlement.<sup>92</sup> But a claimant's informal statements that the claimant was only seeking the policy limits can constitute a demand.<sup>93</sup>

Even if an insurer is not required to initiate settlement negotiations, it may be obliged to respond to a demand with at least a counter offer.<sup>300</sup>

## **V. The Rules Stated by the Principles Improperly Free Insureds from Settlement Restrictions Whenever There Is a Coverage Issue, Thereby Inflating Insurance Costs by Transferring Noncovered Risks to the Insurance Pool**

### **A. Settlement Restrictions and the Structure of a Liability Insurance Policy**

#### **1. Insuring Agreement**

All provisions of a liability insurance policy must be read in conjunction with the basic insuring provision, which typically reads roughly like this:

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of [specified types of injuries] to which this insurance applies ... and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such injury, even if the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient.

These are promises *to the insured* that the insurer will: (1) indemnify the insured up to the policy limits for liabilities within the policy's coverage and (2) defend the insured against claims asserting liabilities which would be subject to indemnification if established. Negotiating to

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<sup>91</sup> [Commercial Union Ins. Co. v. Mission Ins. Co.](#), 835 F.2d 587, 588 (5th Cir. 1988) (LA law); *see* [Cotton States Mut. Ins. Co. v. Phillips](#), 110 Ga. App. 581, 583 (1964) (insured's letter expressing opinion that case could be settled within limits not enough).

<sup>92</sup> *See* [Ins. Corp. of Am. v. Webster](#), 906 S.W.2d 77, 80–81 (Tex. Ct. App. 1995) (demands conditioned on lack of other insurance when an excess policy existed).

<sup>93</sup> [Gibbs v. State Farm Mut. Auto. Ins. Co.](#), 544 F.2d 423, 427 (9th Cir. 1976) (CA law).

<sup>300</sup> [Baton v. Transamer. Ins. Co.](#), 584 F.2d 907, 913–14 (9th Cir. 1978) (OR law).

reach a settlement can be seen as part of the duty of defense. But paying (or agreeing to pay) the claimant an amount agreed to in settlement of the asserted claims is a clear aspect of the duty to indemnify, rather than, as sometimes suggested, of the duty to defend.

The actual indemnity coverage of the policy is defined by the scope of coverage specified in the insuring agreement, subject to the exclusions, definitions, and conditions stated in the policy. While those are central to any insurance case, our focus here is on the structural provisions common to policies with differing indemnity coverages.

The insurer also undertakes the duty and reserves the right to defend all potentially covered claims. Providing a defense is not merely the insurer's duty; it is one of the insurer's most fundamental rights. By defending cases, the insurer can defeat unmeritorious claims and can limit the judgment on meritorious ones, thereby minimizing amounts it must pay to indemnify. The insured is required to assist in this effort by language imposing a duty of cooperation.

## **2. Voluntary Payments Clause**

The right to defend might be worthless if the insured could unilaterally settle or admit liability. Settlement would moot any defenses to the original claim and would render the insured "legally obligated to pay" the agreed amount. Admission of liability would also limit the legal issues to the amount of damages. Accordingly, liability policies uniformly limit the insured's power to prejudice the insurer's ability to defend with language like this (known as the "Voluntary Payments Clause"):

The insured shall not, except at his own cost and expense, voluntarily make any payment, assume any obligation, or incur any expense other than for first aid to others at the time of any accident.



### 3. Claimant Rights and the No-Action Clause

While the duty to defend inures solely to the insured's benefit, the duty of indemnification also benefits the claimant, who is thereby guaranteed at least one payment source if the insured's liability can be established. Because the duty to indemnify relates only to amounts the insured is "legally obligated to pay," any indemnification duty could be eliminated or drastically reduced if the insured's debts were discharged in bankruptcy. Discharging *the insurer* under such circumstances, however, would confer a windfall on the insurer without benefiting either the bankrupt insured or the insured's other creditors (who cannot realize any value from insurance for past periods, the premium for which is no longer subject to refund).

Accordingly, policies commonly confer (and are often required by statute to confer)<sup>94</sup> certain rights on the claimant which preserve the obligation to indemnify even if the insured becomes bankrupt.<sup>95</sup> Such policy language (the "No Action Clause") may read like this:

No action shall lie against the company unless as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy nor until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the company.

Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy. No person or organization shall have any right under this policy to join the company as a party to any action against the insured to determine the insured's liability nor shall the company be impleaded by the insured or his legal representative. Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the company of any of its obligations hereunder.

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<sup>94</sup> See, e.g., 215 ILL. COMP. STAT. 5/388; IND. CODE § 27-L-L3-7; NEB. REV. STAT. § 44-508; S.D. CODIFIED LAWS ANN. § 58-23-2; UTAH CODE ANN. § 31A-22-201; VA. CODE ANN. § 38.2-2200; WIS. STAT. § 632.22.

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Such language grants the claimant certain rights against the insurer regarding indemnification while limiting how those rights (and the rights of the insured) can be enforced. The insurer cannot be joined in the action against the insured and cannot be sued until the claim against the insured has been resolved by a litigated judgment or a settlement the insurer agreed to.<sup>96</sup> “And as an obvious elaboration ... the clause eliminates out-of-court settlements made between the assured and the damage claimant without the consent of the insurer.”<sup>97</sup>

The Voluntary Payments Clause and the No-Action Clause will be referred to collectively as the "Settlement Restrictions."

#### **4. Effect of and Justification for Restrictions on Insured's Right To Settle**

In considering the effect of the Settlement Restrictions, we begin by assuming that no coverage question exists for the claim against the insured, that the claim clearly lies within policy limits, that the insurer is providing (or offering) an adequate defense, and that the insurer is not breaching any duties to the insured related to settlement of the case.

An insured usually cannot recover under his contract if he violates the terms of his policy by failing to preserve an opportunity for his insurer to defend or to compromise a claim.<sup>98</sup> This result is appropriate because such policy provisions “give the insurer the opportunity to contest liability, to participate in settlement negotiations and to have input as to the value of the claim.”<sup>99</sup> The restrictions also protect the insurer against collusion between an insured and a claimant:<sup>100</sup>

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<sup>96</sup> *Simon v. Md. Cas. Co.*, 353 F.2d 608, 612 (5th Cir. 1965).

<sup>97</sup> 353 F.2d at 612.

<sup>98</sup> *Central Bank v. St. Paul Fire & Marine Ins. Co.*, 929 F.2d 431, 433-34 (8th Cir. 1991); *Diversified Mortg. Investors v. U.S. Life Title Ins. Co.* 544 F.2d 571, 575 (2d Cir. 1976) (restrictions valid and improperly nullified by preliminary relief). *See, e.g.*, *Jones v. Southern Mar. & Aviation Underwriters, Inc.*, 888 F.2d 358, 361-62 (5th Cir. 1989); *Harville v. Twin City Fire Ins. Co.*, 885 F.2d 276, 279 (5th Cir. 1989).

<sup>99</sup> *Alyas v. Gillard*, 180 Mich. App. 154, 160 (1989).

<sup>100</sup> *E.g.*, *Giffels v. Home Ins. Co.*, 19 Mich. App. 146, 151-153 (1969); *American Auto. Ins. Co. v. Fidelity & Cas. Co.*, 152 A. 523, 527 (Md. 1930); *Kindervater v. Motorists Cas. Ins. Co.*, 120 N.J.L. 373, 376-78 (1938).

“It is pretty evident that if the insurer entrusted the matter of making settlements to its numerous policy holders, its existence would be precarious. We are all apt to be generous when it comes to spending the money of others. So long as the law countenances and to some extent encourages insurance of this character, the right of making voluntary settlements must, almost as a matter of necessity, rest with the insurer rather than with the insured. An insurance company could hardly be expected to do business on any other basis, because it furnishes the only safeguard available against the payment of excessive damages.”<sup>101</sup>

Apart from unconcern for the insurer’s pocketbook, there are other reasons insurers fear allowing insureds to settle. First, because insurance companies are in the business of handling liability claims, they may be better qualified than insureds to evaluate and to settle claims. Second, insureds may be motivated to overpay by considerations extrinsic to the legal obligation insured against: contrition for their involvement in the injury, desire to compensate an injured friend or relative, or the hope of promoting some other relationship with the claimant.

An example of the latter problem arose in *Coil Anodizers, Inc. v. Wolverine Insurance Co.*<sup>102</sup> There the insured, Coil Anodizers, was in the business of anodizing aluminum, a method of treating sheet metal to apply a finish. Its customer, Prime Metals, sold the treated metal to Avion Coach Corporation for incorporation into trailers and motor coaches. Due to a defect in a chemical used in the treatment process, some Avion vehicles yellowed upon exposure to sunlight. Avion demanded replacement metal and Prime notified the insured that Prime would hold it responsible. When notified of the claim, the insurer, Wolverine, denied any duty to indemnify and, no suit having been filed, had no occasion to consider defending. Coil Anodizers then settled with Prime and sought reimbursement from the insurer. The court held Wolverine not liable.

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<sup>101</sup> *Piper v. State Farm Mut. Auto. Ins. Co.*, 1 Ill. App. 2d 1, 2-6 (1953), *quoting*, *Wis. Zinc Co. v. Fid. & Dep. Co.*, 162 Wis. 39, 47-50 (Sup. Ct. 1916).

<sup>102</sup> *Coil Anodizers, Inc. v. Wolverine Ins. Co.*, 120 Mich. App. 118 (1982).

Because the duty of defense had not yet arisen, the court found no breach by Wolverine that excused Coil Anodizers obligation to adhere to the settlement restrictions.<sup>103</sup> Finding that violation of those restraints precluded any obligation of the insurer to pay, the court reasoned:

[D]efendant has bargained for the contractual right to contest the liability of its insured instead of having its money given away by an agreement to which it was not a party . . . . In this case, plaintiff's interest in retaining the goodwill of its customers may have led it to settle, believing the claim to be insured, for a larger amount than defendant may have been able to obtain had defendant conducted the negotiations.<sup>104</sup>

The insurance policy had agreed to indemnify against certain liabilities. While the parties disputed whether this was one of those liabilities, no question existed that the insurer did *not* agree to indemnify for *loss of goodwill* resulting from either liability-causing events or from normal delays in adjusting claims for such liabilities.<sup>105</sup> Preservation of insurer control was essential to preserve contractual limits on the insured risk.<sup>106</sup> (That is not to say that the insured might not have a claim for loss of goodwill resulting from *improper* delays in adjustment.)

The same conclusion was reached in *Charter Oak Fire Insurance Co. v. Color Converting Industries Co.*<sup>107</sup> Color Converting Industries, the insured had settled for \$200,000 a product liability claim by its customer, American National Can Company. Travelers Insurance Company (and/or its affiliate Charter Oak) had declined to approve the settlement without cost

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<sup>103</sup> 120 Mich. App. at 419.

<sup>104</sup> 120 Mich. App. at 418-19.

<sup>105</sup> See *Eureka Investment Corp. v. Chicago Title Ins. Co.*, 530 F. Supp. 1110, 1116-17 (D.D.C. 1982), *aff'd in part and rev'd in part*, 743 F.2d 932 (D.C. Cir. 1984); *Bodenhamer v. Super. Court*, 238 Cal. App. 3d 177 (1987).

<sup>106</sup> Similar problems were presented in: *Clark v. Bellefonte Ins. Co.*, 169 Cal. App. 3d 832 (1980); *Giffels v. Home Ins. Co.*, 19 Mich. App. 146 (1969); and *Charter Roofing Co., Inc. v. Tri-State Ins. Co.*, 841 S.W.2d 903 (Tex. Ct. App. 1992), all involving insureds who settled partially to protect business relationships. In *Finkelstein v. 20th Century Ins. Co.*, 11 Cal. App. 4th 926 (1992), the insured's decision to supplement the insurer's settlement offer was based in part on remorse.

<sup>107</sup> *Charter Oak Fire Ins. Co. v. Color Converting Indus. Co.*, 45 F.3d 1170 (7th Cir. 1995) (IA law).

information American declined to provide (on the ground that it was proprietary). American demanded that the claim be settled or it would stop doing business with Color Converting, which paid the settlement and sued Travelers. In an opinion by Chief Judge Posner, the Seventh Circuit held that the voluntary payments clause barred any duty to pay. While there is a duty to protect the insured from the risk of excess judgments, that risk was not implicated here.<sup>108</sup> “The only risk Travelers was creating was the risk that Color Converting might lose a customer. That is not a risk which Travelers agreed to insure.”<sup>109</sup> And there was good reason not to construe the insurance to cover such a risk:

Such insurance would be foolhardy to write, at least without an enormous premium. Products liability is (with the rare exception of a product that injures a bystander) liability for harm to a customer. Sellers of products do not want to harm their customers. If they do so by accident, as happened here, they are eager to make amends, especially if they can do so at no cost to themselves, or at least at no cost greater than the possible increase in insurance premiums that impends whenever an insurer has to pay a claim. They do not want to anger valued customers—and American Can appears to have been Color Converting’s *most* valued customer—by questioning the accuracy or honesty of the claim, or by trying to shift fault to the customer, or by failing to pay the claim promptly. If the insurance company has an implied duty to cooperate with its insured to the extent necessary to avoid offending powerful customers, the opening for collusive and exaggerated claims of products liability will be immense.<sup>110</sup>

For all the reasons stated in this section, insurance policy settlement restrictions should be enforced strictly, absent clear grounds for excusing compliance:

[T]he assured has no just cause for complaint if he be held to the substantial performance of duties thus freely undertaken. They are of the very essence of the contract . . . . Without these protective provisions, the insurer would be at the mercy of dishonest and culpably indifferent policy holders, for thereby it would run the risk of impoverishment to the detriment of honest

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<sup>108</sup> 45 F.3d at 1173.

<sup>109</sup> 45 F.3d at 1173.

<sup>110</sup> 45 F.3d at 1173-74. (emphasis original).

claimants. Neither the public nor private interest is served by laxity in this regard.<sup>111</sup>

### **5. Effect of Coverage Issue on Settlement Restrictions**

Under the rule stated by the Principles, an insurer's reservation of the right to deny indemnity coverage (even though it is providing a defense) essentially frees the insured to settle with the claimant, so long as the insurer is given the opportunity to participate in the settlement process, an opportunity to prevent the settlement by withdrawing its reservation, and an opportunity to contest the reasonableness of the settlement in subsequent coverage litigation.<sup>112</sup>

In that last regard,

[i]f a court determines that the settlement between the insured and the claimant is not reasonable or that the portion allocated to the insurer is not consistent with the terms of the policy, the insurer is excused from its defense, settlement, and indemnity obligations to the insured. This rule more strongly discourages collusive or otherwise unreasonable settlements than the rule that applies to settlements in cases in which the insurer has breached the duty to defend. In such cases, the insurer is obligated to pay the reasonable portion of an unreasonable settlement. By contrast, an insurer that is fulfilling the duty to defend by defending under a reservation of rights has no obligation to pay any portion of an unreasonable settlement entered into without its consent.<sup>113</sup>

But the settlement restrictions do not call for a mere post-settlement opportunity to contest reasonableness of the settlement. They require, in the absence of any breach or of the insurer's written consent to settle, that the insurer be allowed to try the claim to verdict. The insurer thereby reserves unto itself the right, pre-verdict, to determine the reasonableness of any settlement proposal, subject to the need to defend that determination if failure to settle produces an excess judgment.<sup>114</sup>

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<sup>111</sup> Kindervater, 120 N.J.L. at 376–80 (no showing of prejudice required to avoid coverage for insured's settlement).

<sup>112</sup> PRINCIPLES, TD#2, § 28(3) (see text at notes 23-26, *supra*).

<sup>113</sup> PRINCIPLES § 28, cmt. *e*.

<sup>114</sup> See text at notes 98-111, *supra*.

The rationale for the rule stated by the Principles is that:

This rule allows insureds to manage the risk of personal liability from the trial of a claim. The reasonableness and allocation requirements protect the insurer from fraud or collusion between the insured and the claimant.

The effect of the rule is to give an insurer that is disputing coverage for a claim the choice between (a) accepting the coverage obligation and retaining control of the defense and settlement of the claim or (b) preserving the right to contest coverage and conceding some control of the case to the insured. The rule encourages insurers to drop weak coverage defenses in order to maintain control of the underlying claim, because it is primarily the insurer's money at stake in the underlying litigation when a coverage defense is weak. The rule encourages insurers with strong coverage defenses to grant control over settlement to the insured. Insured control over settlement in such cases is appropriate: because of the strong coverage defense, it is primarily the insured's money at stake.<sup>115</sup>

But this ignores the fact that control of settlement is divisible, in a way which respects the nature of an insurance policy. A number of such risks are accepted, some of which inevitably involve losses. However, such losses are spread over all the risks assumed so as to enable the insurer to accept each risk at a slight fraction of its possible liability. The insurance policy defines the risks transferred from the insured to the insurer in return for payment by the insured of a specified premium.<sup>116</sup>

Risks outside the coverage of the policy remain with the insured, as do the portions of covered risks that exceed policy limits. Thus, any suit partially within coverage and partially without involves risks to each party. But unlike conduct of the defense, where the fates of insurer and insured are inextricably intertwined, each party can act independently to settle its own portion of the risk. The policy does not forbid the insured to settle, but only requires that any

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<sup>115</sup> PRINCIPLES, TD#2, § 28, cmt. *e*.

<sup>116</sup> William T. Barker, Paul E.B. Glad & Steven M. Levy, *Is an Insurer a Fiduciary to Its Insureds?*, 25 TORT & INS. L.J. 1, 7 (1989) (footnote omitted), citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979); CALIF. INS. CODE §§ 22, 250 (1972).

settlement be made at the insured's own expense. Insofar as the risk being settled is one which remained with the insured, the insured is the appropriate one to pay for its elimination.

To settle the uninsured portion of the claim, the insured need only pay the plaintiff a negotiated amount for a covenant not to execute on any assets other than the insurance policy. This leaves the plaintiff free to prosecute, and the insurer to defend, the action, with any resulting judgment collectible from the insurance proceeds. If both the coverage dispute and the tort claim are evaluated properly, the amount paid by the insured to settle his own exposure and the value of the remaining claim against the insurer will equal the tort claim's settlement value, with insurer and insured each bearing the portion of the risk appropriate to its prospects of success in the coverage dispute.

Thus, without disturbing insurer control over covered settlements, the insured is always free to "manage the risk of personal liability." Proceeding based on divisible control results in each party paying for the portion of the liability risk that the policy allocated to it, while the rule stated by the Principles is likely to shift some of the settlement cost attributable to the noncovered exposure from the insured to the insurer (and, thereby, to other members of the risk pool who may not share the noncovered risk).

Allowing insureds to settle claims whenever there is a coverage issue is not in the collective interest of the insurance-buying public. If the insured is allowed to settle the entire claim whenever the insurer has reserved its rights, the insurer will be deprived of the ability to bargain for lower settlements by forcing cases to trial if the claimants will not settle. For every claim, there is an expected verdict value (though the parties may disagree on what that is), and around that value, there is a range of reasonableness (reflecting both the uncertainty of any expectation and disagreements about what should be expected). One would expect that the



alternative of having to try the case to result in bargained settlements generally near the middle of the range of reasonableness.

But if the insured is allowed to settle, the settlement amounts will be higher. Putting aside fraud and collusion, the insured has no incentive at all to minimize any payment assigned to the insurer and every incentive to agree to any amount that will resolve the case without payment (or with a minimum payment) by the insured. So, the insured can be expected to agree to almost anything the plaintiff proposes that the insurer should be required to pay.

The only incentive that the plaintiff has to limit that amount is the fear that the court may find the agreement unreasonable. Trial courts tend to be favorably disposed toward (1) settlements that have removed cases from their trial dockets and (2) compensation of injured parties at the expense of insurance companies. So, they generally tend to see a broad range of settlements as reasonable. A plaintiff can be expected to select a figure that is near the upper end of the range of reasonableness, perhaps with some margin of safety to guard against disapproval of the settlement. Moreover, that figure will be set in light of the plaintiff's knowledge of the judge's views of reasonableness.

The result will be to deprive insurers of the ability to bargain for a settlement based on what they see as an expected verdict value by forcing the case to trial if the plaintiff will not agree to such a settlement. What will be substituted will be settlements at the upper end of a possibly elastic range of reasonableness. (Insurers believe that, where the law allows insureds to settle, the amounts permitted *considerably* exceed expected verdict values.) Consequently, permitting insureds to settle the covered portions of the claims against them would increase insurance costs.

The only benefit from that increase would be to (at least partially) protect the policyholders who are permitted to settle against liability for the uninsured portions of the claims

against them. Because a contrary rule would still permit policyholders to settle uninsured exposures at their own expense, the result is simply to transfer some or all of the cost of settling noncovered claims from the policyholders who incur such exposures to their insurers and, thereby, to the risk pool.

It is improper to increase insurance costs merely to protect policyholders against the costs of paying noncovered claims, because the purchasers of insurance have no apparent reason to want to pay for such protection. Insurers make money by assuming risks in return for a premium. An exclusion from coverage (unless compelled by law or designed to segment the market between different types of policy) necessarily reflects a conclusion that there is no market demand to insure that offering broader coverage at an appropriate price would produce enough sales to make it worthwhile. Absent some reason to conclude that such a judgment is wrong, the presumption should be that policyholders do not want to buy coverage for that risk at the price that would be required. If policyholders do not want to purchase the coverage at the full price, they presumably do not want to have the price of the coverage they do want to purchase inflated by x% of that price in order to have some ancillary doctrine, such as a right to settle when the insurer reserves rights, protect them against the excluded risk in the x% of the cases where that ancillary doctrine would have that effect.

If the insurance is actually available but the particular policyholder failed to purchase it, those who purchased some other type of insurance—and may have purchased insurance for the risk which has now befallen the policyholder—would have no reason to contribute to indemnifying the policyholder from the consequences of the policyholder's own purchasing decision.

No reason is given for encouraging insurers to drop weak (though tenable) coverage defenses.<sup>117</sup> Even weak defenses sometimes succeed, and pressuring insurers to drop them would necessarily inflate premium costs for members of the insurance pool who do not share the noncovered risks to which those defenses pertain. The divided control of settlement allowed by standard policy language obviates any justification for denying enforcement to the standard settlement restrictions merely because there is a coverage issue.

In sum, an insurer that defends its insured under reservation of rights and does not otherwise breach the policy ought not to be required to pay any settlement made contrary to the Settlement Restrictions.

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<sup>117</sup> Asserting coverage defenses that lack a reasonable basis would subject the insurer to bad faith liability. *See* WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION*, §§ 3.08[3], 5.02-.03. Chapter 2 of the Principles, which is the concern here addresses only obligations apart from breach of the duty of good faith.