Developments in Excess Judgment Liability

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William T. Barker
Dentons U.S., L.L.P.
Chicago IL 60611
william.barker @dentons.com

Lisa M. Campisi
Blank Rome LLP
New York, New York
lcampisi@blankrome.com

J. James Cooper
Reed Smith LLP
Houston, Texas
jcooper@reedsmith.com

Julia Molander
JAMolander Consulting
San Francisco, CA
jamolander@sbcglobal.net

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CHAPTER 1 Understanding Insurance Bad Faith Litigation

SYNOPSIS

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§ 1.04 Contractual Consequences of Breach of Duty To Defend

* * * *

[3] Payment of Judgment Resulting From Lack of (or Inadequate) Defense, Possibly Beyond Coverage or Policy Limits

What if, after the insurer refuses to defend, the insured suffers a judgment that is wholly or partially outside the indemnity coverage of the policy or beyond its monetary limit? The general rule is that "a refusal to defend in and of itself does not expose the insurer to greater [indemnity] liability than that contractually provided in the policy."[18] As the California Supreme Court has explained:

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[18] *See, e.g.:*

Arizona: State Farm Mut. Auto. Ins. Co. v. Paynter, 122 Ariz. 198, 204 (Ariz. 1979) (absent any opportunity to settle within limits, refusal to defend did not render insurer liable for portion of judgment exceeding policy limit);

Illinois: Conway v. Country Cas. Ins. Co., 92 Ill. 2d 388, 398 (1982) (insurer erroneously but reasonably withdrew defense after exhausting its limits; liable for insured's costs of assuming defense but not, absent showing of lost opportunity to settle for less, for above limits amount insured paid to settle);

Maryland: Mesmer v. Maryland Auto. Ins. Fund, 725 A.2d 1053, 1060–64 (Md. 1999);

Minnesota: Mannheimer Bros. v. Kansas Cas. & Sur. Co., 149 Minn. 482, 486 (1921).

> if the insured has employed competent counsel to represent him, there is no ground for concluding that the judgment would have been for a lesser sum had the defense been conducted by insurer's counsel, and therefore it cannot be said that the detriment suffered by the insured as the result of a judgment in excess of the policy limits was proximately caused by the insurer's refusal to defend.[19]

But where the insured reasonably relies on the insurer to provide a defense, and the insurer fails to do so, the entire amount of the resulting default judgment (including any portion outside coverage or in excess of limits) may be regarded as caused by the failure to defend.[20] Similar results would follow if the insured were financially unable to mitigate damages by defending himself.[21] One could argue for similar results if the insured defended, but the defense was inadequate due to an inability to fund an adequate defense. Some courts hold (at least implicitly) that, because policyholders insure liabilities that they cannot afford to bear, lack of a defense (or inadequate defense) could be considered a natural consequence of an insurer's breach.[22] This might occur even where the insurer's duty is only to indemnify for defense costs, rather than to actually defend, as cases do not seem to sharply distinguish between the

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[19] Comunale v. Traders & General Ins. Co., 50 Cal. 2d 654, 659–60 (1958).

[20] Gray v. Grain Dealers Mut. Ins. Co., 684 F. Supp. 1108, 1113 (D.D.C. 1988).

[21] *E.g.*,

California: Amato v. Mercury Cas. Co., 53 Cal. App. 4th 825, 832 (1997);

Michigan: Stockdale v. Jamison, 330 N.W.2d 389, 392–93 (Mich. 1981) (where insurer refuses to defend, insurer's liability for consequential damages is limited by the insured's duty to mitigate-unless insured unable to defend); *but see*

US/Massachusetts: Scottsdale Ins. Co. v. Byrne, 2018 U.S. Dist. LEXIS 73974, at *7–8 (D. Mass. May 2, 2018) (policy limit applied to excess default judgment against investment fund in receivership, without analyzing its ability to have defended).

[22]

Georgia: Khan v. Landmark Am. Ins. Co., 326 Ga. App. 539, 757 S.E.2d 151, 156 (Ga. Ct. App. 2014);

Illinois: Delatorre v. Safeway Ins. Co., 2013 IL App (1st) 120852, ¶¶ 32–34;

Massachusetts: Boyle v. Zurich Am. Ins. Co., 472 Mass. 649, 661 (2015) (where negligent errors in the handling of the insured's claim prevented the insurer from defending or settling the suit against insured, insurer liable for resulting default judgment in excess of limits);

Nevada: Andrew v. Century Sur. Co., 134 F. Supp. 3d 1249, 1255 (D. Nev. 2015) ("When the insurer breaches the duty to defend, a default judgment is a reasonably foreseeable result because, in the ordinary course, when an insurer refuses to defend its insured, a probable result is that the insured will default.");

Wisconsin: Hamlin v. Hartford Acc. & Indem. Co., 86 F.3d 93, 94 (7th Cir. 1996) (dictum; "An insurance company that refuses a tender of defense by its insured takes the risk not only that it may eventually be forced to pay the insured's legal expenses but also that it may end up having to pay for a loss that it did not insure against. If the lack of a defender causes the insured to throw in the towel in the suit against it, the insurer may find itself obligated to pay the entire resulting judgment or settlement even if it can prove lack of coverage."); Maxwell v. Hartford Union High Sch. Dist., 2012 WI 58, ¶ 54 ("Damages which naturally flow from an insurer's breach of its duty to defend include … the amount of the judgment or settlement against the insured plus interest"), *quoting* Newhouse v. Citizens Sec. Mut. Ins. Co., 176 Wis. 2d 824, 838 (1993).

two duties.[23] Liability for consequential damages is not constrained by the policy limits on indemnity coverage.[24]

In theory, the insurer should not be liable except to the extent that proper defense would have prevented or reduced the judgment.[25] The Seventh Circuit applied that rule in *Hyland v. Liberty Mutual Fire Insurance Co.*[26] Hyland was injured while a passenger in a car driven by Smith and owned by Perkins. Smith was under age and was convicted of aggravated reckless driving; she did not have any insurance of her own, but would be covered by a Liberty Mutual policy issued to Perkins if she were a permissive user. Liberty Mutual concluded that Smith was not a permissive user and refused to defend. Smith defaulted in Hyland's suit and the state court entered judgment for $4.6 million. Hyland assigned her rights to Smith. The district court found that Liberty Mutual had breached its duty to defend and entered judgment against it for the entire amount of the tort judgment against Smith. Liberty Mutual appealed, arguing that its $25,000 policy limit capped its liability.[27]

The Seventh Circuit found no evidence of any consequential damages from the breach of the duty to defend. Even had Smith been provided a defense, Smith's liability was too clear for argument. Had lack of a defense resulted in an enlarged judgment, that could have been a consequential damage. But, after the default, the state court had determined that Hyland had suffered $4.6 million in damages, and, in the insurance action, Hyland offered neither argument nor evidence that proper defense would have produced a lower judgment. Liberty Mutual owed a duty to indemnify, but no consequential damages for breach of the duty to defend.[28]

Where a Missouri insured rejected an insurer's defense under reservation of rights, took a

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[23] *See* RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 22(2) & Reporters' Note (2019) (stating that defense cost indemnity policies requiring advancement of defense costs on an ongoing basis should be treated similarly to duty to defend policies for various purposes and collecting cases so holding).

[24]

Nevada: *Andrew*, 134 F. Supp. 3d at 1256–58 (collecting cases); *Contra*

Maryland: Mesmer v. Md. Auto. Ins. Fund, 353 Md. 241, 264–65 (1999) (absent proof of bad faith, policy limit applied); 725 A.2d at 262–63 (duty of good faith re settlement arises only if insurer undertakes defense (*see* § 2.03[6][e], *below*).

[25]

Nevada: *Andrew*, 134 F. Supp. 3d at 1259 n. 2 (insurer not liable for default judgment resulting from breach of duty to defend if the judgment would be the same had the case been defended);

Arizona: Rogan v. Auto-Owners Ins. Co., 832 P.2d 212, 217 (Ariz. Ct. App. 1991) (same);

Florida: Thomas v. W. World Ins. Co., 343 So.2d 1298, 1302 (Fla. Ct. App. 1977) (stating "the insurer may be liable for an excess judgment where (1) due to the actions of the insurer, the insured suffers a default or final judgment without benefit of an attorney, and (2) the insured can prove the final judgment would have been lower had the suit been properly defended");

US/South Dakota: Triple U Enters., Inc. v. New Hampshire Ins. Co., 766 F.2d 1278, 1282 (8th Cir. 1985) (policy limit applies absent showing of bad faith refusal to defend or insured's inability to defend).

[26] Hyland v. Liberty Mut. Fire Ins. Co., 2018 U.S. App. LEXIS 6460 (7th Cir. Mar. 15, 2018).

[27] 2018 U.S. App. LEXIS 6460, at *1–2.

[28] 2018 U.S. App. LEXIS 6460, at *11–13.

covenant not to execute, and allowed the claimant to conduct an uncontested trial, resulting in a $16 million judgment, the Missouri Supreme Court held that, in the absence of proof of bad faith, the insurer's liability was only for the $1 million policy limit.[29] But, while the court did not say so, the covenant not to execute, given before the insured refrained from contesting the trial shielded the insured from suffering any damage from the excess judgment.[30] (*See* § 4.03[4][c], *below*.)

Notwithstanding the logic and authority limiting the breaching insurer's liability for noncovered amounts to the amount by which proper defense would have reduced the ultimate judgment, there is authority for holding that the entire amount of any default judgment is recoverable as a consequential damage for failure to defend.[31]

If consequential damages are established, the policy limit imposes no maximum. In *Newhouse v. Citizens Security Mutual Insurance Co.*,[32] the Wisconsin Supreme Court held an insurer that breached its duty to defend liable for the full amount of a resulting default judgment, including the amount in excess of limits. Citizens had defended until it obtained a declaratory judgment that it had no duty to do so. Citizens withdrew its defense, and the insured did not participate in the ensuing trial of the tort case, which resulted in an excess judgment. The judgment on duty to defend was then reversed, holding that there was such a duty and rendering withdrawal of the defense a breach. In these circumstances, the Wisconsin Court of Appeals held that Citizens was liable only for the portion of the judgment within policy limits, but the Supreme Court reversed.[33]

The court stated the

> general rule … that where an insurer wrongfully refuses to defend on the grounds that the claim against the insured is not within the coverage of the policy, the insurer is guilty of a breach of contract which renders it liable to the insured for all damages that naturally flow from the breach. Damages which naturally flow from an insurer's breach of its duty to defend include: (1) the amount of the judgment or settlement against the insured plus interest; (2) costs and attorney fees incurred by the insured in defending the suit; and (3) any additional costs that the insured can

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Missouri: Allen v. Bryers, 512 S.W.3d 17, 36–39 (Mo. 2016).
See

Washington: Greer v. Nw. Nat'l Ins. Co., 743 P.2d 1244, 1250 (Wash. 1987) (default after refusal to defend and purchase for a nominal sum of a covenant not to execute; policy limit applied without mentioning the covenant).

[30] There are also cases, in the context of first-party coverages, stating a rule that, absent bad faith, no consequential damages can be recovered for breach of an insurance contract. *E.g.*, Nationwide Life Ins. Co. v. Commonwealth Land Title Ins. Co., 2011 U.S. Dist. LEXIS 16446, at *87–88 (E.D. Pa. Feb. 17, 2011). Such a rule has been supported by noting that contract consequential damages have generally not be recoverable for breach of a contract to pay money. Burleson v. Ill. Farmers Ins. Co., 725 F. Supp. 1489, 1496–98 (S.D. Ind. 1989). Breach of the duty to defend is distinguishable, both because that duty is one to provide a service, rather than simply to pay money, and because the consequences of failure to defend are much more foreseeable at the time of contracting.

[31] *E.g.*, Capitol Reproductions, Inc. v. Hartford Ins. Co., 800 F.2d 617, 624 (6th Cir. 1986); *but see*, Total Petroleum, Inc. v. Hartford Acc. & Indem. Co., 1997 U.S. App. LEXIS 31861, at *10–13 (6th Cir. Nov. 7, 1997) (expressing view that *Capitol Reproductions* had misinterpreted Michigan law, but panel could not overrule it).

[32] Newhouse v. Citizens Sec. Mut. Ins. Co., 176 Wis. 2d 824 (Wis. 1993).

[33] 176 Wis. 2d at 829–33.

> show naturally resulted from the breach.[34]

The question was whether the policy limit capped the damages for the judgment amount. The court concluded that it did not: "The insurance company must pay damages necessary to put the insured in the same position he would have been in had the insurance company fulfilled the insurance contract. Policy limits do not restrict the damages recoverable by an insured for a breach of the contract by the insurer."[35]

Newhouse did not inquire into whether some part of the judgment would have been rendered even with proper defense, and such an inquiry would be necessary to properly assess what portion of the judgment was actually caused by the lack of a defense. But Citizens did not ask that such an inquiry be made. In any event, the case holds that the policy limit does not apply to an award of consequential damages.

In *Burgraff v. Menard, Inc.*,[36] the Wisconsin Supreme Court confirmed that *Newhouse* did not render a breaching insurer liable for judgment amounts that would have been incurred even without the breach. Burgraff was injured while Menard's employee was loading materials onto Burgraff's trailer. Menard had its own insurance, with a $500,000 self-insured retention ("SIR"). It was also covered (as a permissive user) by Burgraff's $100,000 auto policy, issued by Millers First Insurance Co ("Miller's"). Millers defended and then settled by paying $40,000 for discharge of itself and one-sixth of Menard's liability. It then withdrew its defense and sought a declaratory judgment that it had no further obligations.[37] The supreme court ruled that the SIR was other insurance, so Millers would only be liable for one-sixth of any judgment against Menard.[38] But it had breached its duty to defend, because its policy

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[34] 176 Wis. 2d at 837–38 (citations omitted).

[35] 176 Wis. 2d at 838 (citing Comunale v. Traders & Gen. Ins. Co., 50 Cal. 2d 654, 328 P.2d 198, 201 (1958); Nielsen v. TIG Ins. Co., 442 F. Supp. 2d 972, 980–81 (D. Mont. 2006) (insurer was liable for entirety of stipulated judgment based on insurer's breach of its duty to defend, even though the judgment amount exceeded the policy limit, based on the rationale that the insurer was liable for "the natural and ordinary consequences" of its breach of contract but without considering whether the same judgment would have been entered even if the insurer had provided a defense); Bucci v. Essex Ins. Co., 323 F. Supp. 2d 84, 93 (D. Me. 2004), *aff'd on other issues*, 393 F.3d 285 (1st Cir. 2005) (insurer liable for portion of stipulated judgment paid by insured where insured settled case for which there was no indemnity coverage because it could not afford to defend after insurer wrongly refused to do so); Gray v. Grain Dealers Mut. Ins. Co., 684 F. Supp. 1108 (D.D.C. 1988) (insurer liable for full judgment where its inadvertent failure to defend led to default judgment in excess of limit); Thomas v. Western World Ins. Co., 343 So. 2d 1298, 1303 (Fla. Dist. Ct. App. 1977) (where insured defaulted after insurer wrongly refused to defend, full amount of judgment could be consequential damage if insured could not afford to defend and if defense would have defeated the claim); Polaroid Corp. v. Travelers Indem. Co., 414 Mass. 747, 764 (1993) ("Because an insurer should be liable for the natural consequences of a breach of contract that places its insured in a worse position, an obligation to pay settlement costs could result from a breach of the duty to defend. For example, if an insured lacks financial resources sufficient to maintain a proper defense, an insured's losses in the underlying claim could well be the result of a breach of the duty to defend.") (dictum); Stockdale v. Jamison, 416 Mich. 217, 330 N.W.2d 389, 392–93 (1982) ("An insurer's duty to defend is independent of its duty to pay, and damages for breach of that duty are not limited to the face amount of the policy. When Farm Bureau breached its duty to defend, it became liable for any damages arising 'naturally from the breach or * * * in the contemplation of the parties at the time the contract was made' "; "we do not see any justification for a special rule limiting the amount of damages recoverable for an insurer's failure to defend [to the policy limit] or any reason why it should not be held to be responsible, just as any other party to a contract who fails to perform it, for all the loss arising naturally from the breach.")).

[36] Burgraff v. Menard, Inc., 2016 WI 11.

[37] 2016 WI 11, ¶¶ 1–18.

[38] 2016 WI 11, ¶¶ 23–41.

was not exhausted, even if it had paid its own maximum liability.[39] Damages for the breach were to be determined on remand, but the supreme court provided guidance on how those should be determined.

Menard argued that *Newhouse* required that Miller's pay the entire judgment. The supreme court disagreed. It approvingly discussed *Hamlin Inc. v. Hartford Accident & Indemnity Co.*,[40] in which the Seventh Circuit held that an insured that, after breach of the duty to defend, had provided its own defense by excellent counsel could not recover from the insurer judgment amounts that could not be shown to have been caused by the breach.[41] The court then held that the same analysis governed Menard's claim:

> Just as in *Hamlin*, Menard cannot demonstrate that the amount of the jury verdict was a result of the breach. Menard chose its own counsel and there is no assertion that it would have achieved a better result at trial had Millers First chosen Menard's counsel. Unlike the excess judgment against the defendant in Newhouse, the jury verdict against Menard was for less than the policy limits. Thus, Menard is not entitled to damages in the amount of the jury verdict *because the verdict amount does not flow naturally from the breach*.[42]

In *Amato v. Mercury Casualty Co.*,[43] the insurer refused to defend and the insured was unable to defend and suffered a default judgment in excess of the policy limit. (The insurer was found to have no duty to indemnify, so the issue was purely one of damages for the breach of the duty to defend.) The court held that the insurer was liable for the entire amount, as consequential damages, though the court found that the refusal to defend was in bad faith, which broadened the scope of recoverable damages.

The court relied on the observation that

> [t]he obligation of the insurer to defend is of vital importance to the insured. "In purchasing his insurance the insured would reasonably expect that he would stand a better chance of vindication if supported by the resources and expertise of his insurer than if compelled to handle and finance the presentation of his case. He would, moreover, expect to be able to avoid the time, uncertainty and capital outlay in finding and retaining an attorney of his own." "The insured's desire to secure the right to call on the insurer's superior resources for the defense of third party claims is, in all likelihood, typically as significant a motive for the purchase of insurance as is the wish to obtain indemnity for possible liability."[44]

While the court applied tort damages analysis, which looks to foreseeability at the time of the tort, not at the time the contract was made, the foregoing proposition arguably indicates that increased damages from failure to defend were foreseeable at the time of contracting.

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[39] 2016 WI 11, ¶¶ 44–57.

[40] Hamlin Inc. v. Hartford Acc. & Indem. Co., 86 F.3d 93 (7th Cir. 1996) (WI law). *Hamlin* is discussed in more detail in § 1.05[6][a], *below*.

[41] *Burgraff*, 2016 WI 11, ¶¶ 62–63.

[42] 2016 WI 11, ¶ 64 (emphasis added, citation omitted).

[43] Amato v. Mercury Cas. Co., 53 Cal. App. 4th 825 (1997).

[44] 53 Cal. App. 4th at 832 (citations omitted).

* * * *

CHAPTER 2 Liability Coverages: Duty To Settle

SYNOPSIS

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§ 2.03 Insurer Has Duty To Make Reasonable Settlement Decisions

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[6] Prerequisites for Duty To Settle

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[d] Opportunity To Settle Within Limits

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[ii] Breach of Duty To Defend, Standing Alone, Ordinarily Does Not Expose Insurer To Liability Beyond Policy Limits

Even where the law imposes no requirement of a demand within limits, the insurer cannot be held liable for bad faith failure to settle within the policy limits if there was no chance to settle. For example, breach of the duty to defend, followed by an excess judgment does not subject the insurer to liability for any of the excess unless either (1) a proper defense which the insured was unable to mount would have resulted in a lesser judgment (*see* § 1.04[3]–[4])[288] or (2) the insurer's conduct resulted in a loss of an opportunity to settle.[289] (See also § 2.07[c] on the effect of coverage questions on the duty to settle.)

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[288] *See also* George R. Winchell, Inc. v. Norris, 6 Kan. App. 2d 725, 729 (1981).

[289]

Texas: Employers Nat'l Ins. Corp. v. Zurich Am. Ins. Co., 792 F.2d 517, 520–21 (5th Cir. 1986) (collecting cases);

Illinois: Nat'l Union Fire Ins. Co. v. Cont'l Ill. Corp., 673 F. Supp. 267, 273 (N.D. Ill. 1987) (collecting cases); LaRotunda v. Royal Globe Ins. Co., 87 Ill. App. 3d 446, 455–56 (1980) (bad faith breach of duty to defend exposes insurer to liability above limits);

Arizona: State Farm Mut. Auto. Ins. Co. v. Paynter, 122 Ariz. 198, 204–05 (Ct. App. 1979) (collecting cases) (overruled in part by *In re* Alcon, 202 Ariz. 62 (2002));

Kansas: Heinson v. Porter, 244 Kan. 667, 676–77 (1989) (*overruled in part by* Glenn v. Filming, 247 Kan. 296 (1990));

Florida: First of Ga. Ins. Co. v. Dube, 376 So. 2d 910, 911 (Fla. Dist. Ct. App. 1979).
But see:

Loss of an opportunity to settle can be established by an offer made before or after the refusal to defend and the insurer's failure to accept that offer.[290] It has been held that, once the insurer has refused to defend, the insured is not obliged to relay offers to the insurer.[291]

#Comment Begins

Practice Pointer: Plaintiffs can increase their prospects of enforcing liability in excess of limits by making a limits offer when the insurer has refused to defend, unless the insurer reconsiders its coverage position and agrees to the demand.

#Comment Ends

Most jurisdictions require the insured to allege[292] and prove[293] the existence of an opportunity to settle. But a few take the view that where the insurer's inaction creates doubt whether there was an opportunity to settle, the insurer should bear the burden of dispelling that doubt.[294] The latter cases

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Alaska: U.S. v. CNA Fin. Corp., 214 F. Supp. 2d 1044, 1045–47 (D. Alaska 2002) (causation not required where breach of duty to defend was in bad faith); Lloyd's & Institute of London Underwriting Cos. v. Fulton, 2 P.3d 1199, 1205 (Alaska 2000) (bad faith handling of investigation subjected insurer to liability even in absence of coverage and beyond policy limits);

Montana: Nielsen v. TIG Ins. Co., 442 F. Supp. 2d 972 (D. Mont. 2006) (holding breaching insurer liable for excess judgment resulting from unopposed prove up, but without addressing excess issue separately).

[290] *E.g.*:

Virgin Islands: Buntin v. Cont'l Ins. Co., 525 F. Supp. 1077, 1082–83 (D.V.I. 1981);

California: Samson v. Transam. Ins. Co., 30 Cal. 3d 220, 237 (1981);

Louisiana: Trahan v. Cent. Mut. Ins. Co., 219 So. 2d 187, 194 (La. Ct. App. 1969);

Missouri: Landie v. Century Indem. Co., 390 S.W.2d 558, 563–64 (Mo. Ct. App. 1965).

[291] Am. Fid. Fire Ins. Co. v. Johnson, 177 So. 2d 679, 683 (Fla. Dist. Ct. App. 1965).

[292] Cotton States Mut. Ins. Co. v. Fields, 106 Ga. App. 740, 741–42 (1962) (mere supposition that settlement might have resulted not enough).

[293] *E.g.*:

Oregon: Baton v. Transam. Ins. Co., 584 F.2d 907, 913 (9th Cir. 1978); Goddard *ex rel.* Estate of Goddard v. Farmers Ins. Co., 173 Or. App. 633, 638–39 (2001);

Illinois: Ranger Ins. Co. v. Home Indem. Co., 741 F. Supp. 716, 723 (N.D. Ill. 1990);

Iowa: Henke v. Iowa Home Mut. Cas. Co., 250 Iowa 1123, 1130 (1959).

[294]

South Carolina: Hodges v. State Farm Mut. Auto. Ins. Co., 488 F. Supp. 1057, 1063 (D.S.C. 1980);

Kansas: Coleman v. Holecek, 542 F.2d 532, 538 n 7 (10th Cir. 1976); Pac. Empl. Ins. Co. v. P.B. Hoidale Co., Inc., 796 F. Supp. 1428, 1432–33 (D. Kan. 1992);

misapply the rule that a wrongdoer must bear the consequences of uncertainty caused by the wrong. That rule applies only to the amount of harm caused by the wrong; no wrong has been established unless and until the plaintiff has shown that the defendant's conduct caused some injury to plaintiff. Mere misconduct, absent proven injury is not enough to shift the burden on the issue of injury.

[iii] Division of Jurisdictions on Whether Insurer Has Affirmative Duty To Negotiate

[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.[295] As the Third Circuit has put it:

> 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.[296]

But even where a demand is normally required, that requirement may be excused where insurer misconduct at least may have prevented the demand.[297]

Florida: Lee v. Progressive Express Ins. Co., 909 So. 2d 475, 477 (Fla. Dist. Ct. App. 2005).

[295] *E.g.*:

Pennsylvania: Puritan Ins. Co. v. Canadian Univ. Ins. Co., 775 F.2d 76, 82 (3d Cir. 1985) (insurer usually has no obligation to initiate offers);

Mississippi: Hemphill v. State Farm Mut. Auto. Ins. Co., 805 F.3d 535, 539–40 (5th Cir. 2015) (predicting no duty absent demand, based on lack of Mississippi authority suggesting otherwise);

California: 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);

Illinois: Haddick v. Valor Ins. Co., 198 Ill. 2d 409, 417 (2001) (insurer usually has no duty to make offers);

Iowa: Wierck v. Grinnell Mut. Reins. Co., 456 N.W.2d 191, 195 (Iowa 1990);

Texas: 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).

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").

[296] *Puritan*, 775 F.2d at 82 (citations omitted).

[297]

California: Boicourt v. Amex Assur. Co., 78 Cal. App. 4th 1390, 1392 (2000) (refusing, when requested, to disclose policy limits or seek insured's consent to disclosure);

But other jurisdictions do require insurers to initiate settlement negotiations if that is an appropriate method of resolving the case.[298] 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 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.[299]

Florida: Davis v. Nationwide Mut. Fire Ins. Co., 370 So. 2d 1162, 1163 (Fla. Dist. Ct. App. 1979) (misinforming claimant that policy limit was less than medical lien).
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New York: 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);

Florida: 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."); Welford v. Liberty Ins. Corp., 190 F. Supp. 3d 1085, 1095–98 (N.D. Fla. 2016) (duty to initiate settlement negotiations arises only where insured's liability is clear);

Kansas: Guar. Abstract & Title Co. v. Interstate Fire & Cas. Co., 228 Kan. 532, 537 (1980) *superseded by statute 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);

Louisiana: Kelly v. State Farm Fire & Cas. Co., 169 So. 3d 328, 339–41 (La. 2015);

Oregon: Goddard v. Farmers Ins. Co., 173 Or. App. 633, 638 (2001);

Washington: Cox v. Cont'l Ins. Co., 2014 U.S. Dist. LEXIS 68081, at *9 (W.D. Wash. May 14, 2014) (predicting that Washington will not require a firm demand);

Wisconsin: Alt v. Am. Family Mut. Ins. Co., 71 Wis. 2d 340, 351 (1976).
See:

Georgia: 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).
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Kansas: Coleman v. Holacek, 542 F.2d 532, 537 (10th Cir. 1976) (Kansas law), *quoted with approval,* Guar.

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 then uncertain on whether a demand was necessary, *Kingsley v. State Farm Mutual Insurance Co.*,[300] 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."[301]

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*,[302] 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 fault. The insurer paid personal injury protection ("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 10-day time limit demand, which was not acted on within the 10-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.[303] 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

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Abstract & Title Co. v. Interstate Fire & Cas. Co., 228 Kan. 532, 537 (1980) (internal citations omitted).
See also

Oklahoma: Badillo v. Mid-Century Ins. Co., 2005 OK 48, ¶¶ 33–34;

Oregon: 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).

[300] Kingsley v. State Farm Mut. Ins. Co., 353 F. Supp. 2d 1242 (N.D. Ga. 2005), *aff'd mem*, 153 Fed. Appx. 555 (11th Cir. 2005).

[301] *Kingsley*, 353 F. Supp. 2d at 1252; Linthicum v. Mendakota Ins. Co., 2015 U.S. Dist. LEXIS 98328 (S.D. Ga. July 28, 2015) (agreeing with "triggering event" requirement; dictum).

[302] Roberts v. Printup, 422 F.3d 1211 (10th Cir. 2005) (KS law).

[303] *Roberts*, 422 F.3d at 1212–14.

to a claim being made.[304]

Where the information available to the insurer did not establish damages exceeding the policy limit, it was reasonable for the insurer to defer initiating settlement negotiations until the claimant provided medical records or an authorization to obtain those records.[304.1]

[B] California Rule Is in Dispute, but Currently Imposes No Duty to Initiate Settlement Negotiations

[1] Ninth Circuit Creates Doubts

A Ninth Circuit decision in 2012 initially appeared to treat California as requiring the insurer to initiate settlement negotiations, though the court retreated from that position by modifying its opinion on petition for rehearing. In *Du v. Allstate Insurance Co.*,[305] the insured, Kim, was involved in a June 17, 2005 accident in which four occupants of the other vehicle were injured. Policy limits of Deerbrook Insurance, an Allstate subsidiary, were $100,000 per person and $300,000 per accident. In the year after the accident, Du incurred medical expenses of $108,742.92 and the other three claimants incurred medical expenses totalling about $34,000 (none more than $14,000 individually). Allstate accepted liability and sought information on damages. That was first provided on June 9, 2006, along with a global demand for $300,000 to settle with all four claimants. Allstate offered $100,000 to settle Du's claim, but that was rejected. Du obtained a verdict of $4,126,714.46 against Kim, and took an assignment of Kim's bad faith claim in return for a covenant not to execute.[306]

At trial, Du proposed a jury instruction that one factor to be considered was whether Allstate "did not attempt in good faith to reach a prompt, fair, and equitable settlement" of Du's claim. The district court instead instructed the jury that there could be no breach of the duty of good faith unless Deerbrook had rejected a reasonable settlement demand. The jury found it had not, and judgment was entered against Du.[307]

The Ninth Circuit affirmed. It first purported to "hold that, under California law, an insurer has a duty to effectuate settlement where liability is reasonably clear, *even in the absence of a settlement demand*."[308] Nonetheless, it had not been error to refuse Du's requested instruction because "there was no evidentiary basis for Du's proposed jury instruction."[309] Seemingly, the latter conclusion rendered the prior purported "holding" mere *dictum*, because the "holding" did not support the affirmance of the judgment. In any event, the court amended the opinion to state that it "need not resolve" the issue of

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[304] *Roberts*, 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).

[304.1] Aboy v. State Farm Mut. Auto. Ins. Co., 2010 U.S. Dist. LEXIS 22798, at *12–17 (S.D. Fla. Jan. 4, 2010).

[305] Du v. Allstate Ins. Co., 681 F.3d 1118, *amended*, 697 F.3d 753 (9th Cir. 2012).

[306] 681 F.3d at 1120–21.

[307] 681 F.3d at 1121.

[308] 681 F.3d at 1122 (emphasis added).

[309] 681 F.3d at 1122.

whether a demand was required, because there was no factual foundation for Du's instruction.[310] Thus, the former "holding" on that point was dropped.

[II] State Cases Require Claimant To Make Demand or, At Least, Indicate Interest in Settling

[aa] Cases Requiring Within-Limits Demand

In fact, there was and is strong basis in California law to support the district court's conclusion that a demand is necessary. In *Merritt v. Reserve Insurance Co.*,[311] Meritt was injured in a collision with a truck insured by Reserve. Based on its investigation, Reserve determined that there was a clear lack of liability to Merritt, such that it was not worth making a settlement offer. Merritt's complaint demanded $400,000 in damages, increased just before trial to $650,000, amounts far in excess of the $100,000 bodily injury policy limit. Merritt never made any demand other than the amounts prayed for in the complaint. He obtained a verdict for $434,000, of which Reserve paid its $100,000 limit. Reserve's insured assigned its bad faith claim to Merritt and paid $20,000 for a covenant not to execute. Merritt recovered a judgment of $499,000 against Reserve, which appealed.[312] The court of appeal reversed and directed judgment for Reserve.[313]

It reasoned that

> [w]hile much remains obscure in this field of the law it is apparent from this summary that (1) the legal rules relating to bad faith come into effect only when a conflict of interest develops between the carrier and its insured; (2) a conflict of interest only develops when an offer to settle an excess claim is made within policy limits or when a settlement offer is made in excess of policy limits and the assured is willing and able to pay the excess.[314]

In *Merritt*,

> [s]ince no offer to settle was ever made, either within policy limits (the normal prerequisite for conflict of interest) or above policy limits but within feasibility limits of the assured's resources, we conclude that no conflict of interest ever developed between assured and carrier, and therefore the issue of the carrier's bad faith in relation to its assured never arose.[315]

Merritt argued that, had Reserve made settlement overtures, a within-limits settlement could have been achieved, though the court described this theory as "supported by no evidence whatsoever."[316] Regardless, none of the factors cited by Merritt would have made any difference:

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[310] 697 F.3d at 758.

[311] Merritt v. Reserve Ins. Co., 34 Cal. App. 3d 858 (1973).

[312] 34 Cal. App. 3d at 861–66.

[313] 34 Cal. App. 3d at 884.

[314] 34 Cal. App. 3d at 877. This test was quoted as authoritative in *Coe v. State Farm Mut. Auto. Ins. Co.*, 66 Cal. App. 3d 981, 990 (1977), though that case turned on issues regarding a workers compensation lien.

[315] 34 Cal. App. 3d at 877.

[316] 34 Cal. App. 3d at 878.

> No settlement offer was ever made, either within policy limits, or within policy limits supplemented by the assured's net worth. No demand for settlement was ever presented by the assured to the carrier. No suggestion that settlement was feasible was ever made prior to judgment by anyone connected with the suit. The case, therefore, does not involve a conflict of interest and does not present a situation in which the carrier can be found to have acted in bad faith toward its assured. On the contrary, the interests of carrier and assured remained parallel at all times, and no divergence of interests ever developed. Consequently, no cause of action arose on behalf of Stafford Co. against Reserve for bad faith refusal to settle, and the trial court should have entered judgment for defendant Reserve notwithstanding the verdict on the cause of action for bad faith.[317]

The *Merritt* court thus treated the lack of a settlement demand as establishing that Reserve had no duty to settle.

The initial opinion in *Du* sought to distinguish *Merritt* as turning on the lack of any evidence that a settlement could have been achieved, even had Reserve made settlement overtures.[318] While that arguably might have been a possible basis for the result, the *Merritt* court clearly treated that as simply a ground for dismissing one of Merritt's arguments for not requiring a demand. The decision itself clearly rested on the lack of a demand, not on the lack of evidence that an offer by Reserve would have produced a settlement.

The initial opinion in *Du* also relied on *Gibbs v. State Farm Mutual Automobile Insurance Co.*[319] But Gibbs (the injured child's father) had repeatedly told State Farm's insured and its investigator that he was willing to accept the policy limit; only after State Farm had failed to offer it did he retain counsel and take the case to trial. "Though no formal written offer existed, the jury could find that Gibbs statements gave State Farm a reasonable opportunity to settle the claim within policy limits."[320] They were the functional equivalent of the demand required by *Merritt*.

The initial opinion in *Du* also relied on California Insurance Code § 790.03(h), which defines as an unfair claim settlement practice "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear,"[321] and on a decision concluding that "[i]t is reasonably clear that California courts will interpret the California statute as imposing upon an insurance company the duty actively to investigate and attempt to settle a claim by *making*, and by accepting, reasonable settlement offers once liability has become reasonably clear."[322] The *Du* court recognized that the latter decision was based a later-rejected private right of action under the statute.[323] Still, it argued that "subsequent courts have found that violations of section 790.03(h) can serve as

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[317] 34 Cal. App. 3d at 879.

[318] Du v. Allstate Ins. Co., 681 F.3d 1118, 1123–24, *amended*, 697 F.3d 753 (9th Cir. 2012).

[319] Gibbs v. State Farm Mut. Auto. Ins. Co., 544 F.2d 423 (9th Cir. 1976).

[320] 544 F.2d at 427.

[321] CAL. INS. CODE § 790.03(h).

[322] 681 F.3d at 1124, *quoting* Pray *ex rel.* Pray v. Foremost Ins. Co., 767 F.2d 1329, 1330 (9th Cir. 1985).

[323] 681 F.3d at 1124, *discussing* Moradi-Shalal v. Fireman's Fund Ins. Cos., 46 Cal. 3d 287 (1988) (which rejected any private right of action under § 790.03).

evidence that an insurer had breached the implied covenant of good faith and fair dealing."[324] But the cases it relied on involved first-party bad faith on a claim for the insured's own losses and do not support the existence of a duty to make offers with respect to a third-party claim. Moreover, the California courts have repeatedly warned that the statutory language "provides no toehold for scaling the barrier of *Moradi-Shalal*."[325]

[bb] Cases Suggesting That Settlement Overtures May Suffice Without a Demand

This issue was again examined in *Reid v. Mercury Insurance Co*.[326] On June 24, 2007, Mercury's insured, Huang, failed to stop at a red light and collided with Reid's car in a multi-car accident, causing Reid major injuries. Mercury quickly accepted 100% liability. On July 18, 2007, while Reid was still in intensive care, her son had authority to act for her, and asked for disclosure of the policy limits (which were $100,000 per person and $300,000 per accident). Mercury responded that it could not disclose those without Huang's consent. A few days later, Mercury wrote to Reid saying that its investigation was incomplete, asking for medical records authorizations, and asking for a recorded interview.[327]

On July 19, Reid's son retained counsel for her, because he felt that he was being "jerked around." Reid also had $250,000 in underinsured motorist coverage which she could not access until the claim against Huang was resolved.[328]

Mercury set its reserve for Reid's claim at $100,000; the other claims were initially reserved at a total of $69,500 and eventually settled for a total of $132,500. Thus, the per-accident limit was never implicated. The limits were disclosed to counsel in August, 2007. Reid testified that counsel told him that Mercury was not prepared to offer limits at that time, though he would definitely have accepted them to access the UIM coverage.[329]

By November, 2007, Mercury had given its adjuster authority to settle for $100,000, but Reid never made any demand. In May, 2008, Mercury offered its limits, which Reid rejected. A bench trial resulted in a $5.9 million judgment against Huang, and an assignment of Huang's rights to Reid by Huang's bankruptcy trustee.[330] The superior court granted Mercury summary judgment in the bad faith case because Reid never made a demand.[331]

The court of appeal affirmed, though suggesting a less absolute rule. It ruled, consistently with *Merritt*, that "bad faith liability cannot be founded solely upon an insurer's failure to initiate settlement

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[324] 681 F.3d at 1124–25, *citing* Shade Foods, Inc. v. Innovative Prods. Sales & Mktg., Inc., 78 Cal. App. 4th 847, 916 (2000); Jordan v. Allstate Ins. Co., 148 Cal. App. 4th 1062, 1078 (2007).

[325] Safeco Ins. Co. v. Super. Ct., 216 Cal. App. 3d 1491, 1494 (1990) ("To permit plaintiff to maintain this action would render *Moradi-Shalal* meaningless"); Textron Financial Corp. v. National Union Fire Ins. Co., 118 Cal. App. 4th 1061, 1070 (2004) ("parties cannot plead around *Moradi-Shalal's* holding merely by relabeling their cause of action as one for unfair competition"); Maler v. Super. Ct., 220 Cal. App. 3d 1592, 1598 (1990) ("[S]ection 1861.03 cannot be construed to supersede *Moradi-Shalal's* ban on a private action for damages under section 790.03").

[326] Reid v. Mercury Ins. Co., 220 Cal. App. 4th 262 (2013).

[327] 220 Cal. App. 4th at 265–67.

[328] 220 Cal. App. 4th at 267.

[329] 220 Cal. App. 4th at 267–68.

[330] 220 Cal. App. 4th at 268–70.

[331] 220 Cal. App. 4th at 271.

discussions or offer its policy limit."[332] In its view,

> For bad faith liability to attach to an insurer's failure to pursue settlement discussions, in a case where the insured is exposed to a judgment beyond policy limits, there must be, at a minimum, some evidence either that the injured party has communicated to the insurer an interest in settlement, or some other circumstance demonstrating the insurer knew that settlement within policy limits could feasibly be negotiated. In the absence of such evidence, or evidence the insurer by its conduct has actively foreclosed the possibility of settlement, there is no "opportunity to settle" that an insurer may be taxed with ignoring.[333]

It stated that "[o]ther Courts of Appeal have disagreed with *Merritt*'s statement that a conflict of interest develops 'only' when a formal settlement offer has been made."[334] Nonetheless,

> none of these cases suggests that an insurer has a duty to initiate settlement discussions—or an "opportunity to settle"—in the absence of any indication from the injured party that he or she is inclined to settle within policy limits (or at some higher figure where the insured is willing to pay the excess over policy limits).[335]

As the *Du* court noted, § 790.03(h)(5) of the California Insurance Code declares "not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear" an unfair practice; while not itself actionable, a violation of the statute may be evidence of bad faith.[335.1] But the *Reid* court observed that the statute did not define circumstances constituting a breach, and "nothing in the statute requires or suggests the conclusion that an insurer's failure to *initiate* settlement negotiations, in the absence of any expression of interest in settlement from the claimant, may give rise to a bad faith claim."[335.2]

Reid thus provides a solid holding that California imposes no duty to initiate settlement discussions absent settlement overtures or other indications of interest from the claimant. It does suggest that there might be a duty to respond to overtures less than a firm demand, though that suggestion is, strictly speaking, dictum, as no such facts were before the court.

The issue was considered again in *Travelers Indemnity v. Arch Specialty Insurance Co.*[336] The

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[332] 220 Cal. App. 4th at 272 (capitalization omitted).

[333] 220 Cal. App. 4th at 272.

[334] 220 Cal. App. 4th at 273.

[335] 220 Cal. App. 4th at 273. *See* Graciano v. Mercury Gen. Corp., 231 Cal. App. 4th 414, 425 (2014) (stating absolute rule: "An insured's claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable offer to settle the claims against the insured for an amount within the policy limits. The offer satisfies this first element if (1) its terms are clear enough to have created an enforceable contract resolving all claims had it been accepted by the insurer, (2) all of the third-party claimants have joined in the demand, (3) it provides for a complete release of all insureds, and (4) the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure."); 231 Cal. App. 4th at 427 (citing more qualified *Reid* rule as authoritative, on facts where difference between rules nonexistent).

[335.1] *Reid*, 220 Cal. App. 4th at 276.

[335.2] 220 Cal. App. 4th at 276 (emphasis original).

[336] Travelers Indem. v. Arch Specialty Ins. Co., 2013 U.S. Dist. LEXIS 169453 (E.D. Cal. Nov. 26, 2013).

court there recognized that the original *Du* opinion was not controlling, but found it "highly persuasive."[337] It found that whether Travelers (the primary insurer) had acted reasonably was a jury question.[338] Liability had been uncertain but damages clearly large (reflected in an ultimate judgment of $22.5 million, at the high end of a high-low). In the court's view, "Travelers missed many opportunities to settle."[339] It was not liable for failing to accept a demand for its $2 million policy limit, because that demand had been induced by a false interrogatory response that failed to disclose a $25 million Arch excess policy.[340] But that demand indicated an interest in settlement and Travelers could have made a counteroffer (or tendered its limit to Arch to do so), it could have responded to a letter expressing an interest in mediation, and it could have made an offer (or tendered its limits) when the plaintiff filed a mediation statement valuing the claim at $15 million.[341] Thus, despite the stated persuasiveness of the original *Du* opinion, the holding of the case appears to go no further than *Reid.*

Planet Bingo, LLC v. Burlington Insurance Co.[1] deviated from any strict requirement of a within-limits demand in a new, but apparently quite limited way. The court succinctly summarized the facts and its holding as follows:

> An electronic gaming device designed and supplied by Planet Bingo, LLC (Planet Bingo), caused a fire in the United Kingdom. Several third parties made demands that Planet Bingo pay their damages resulting from the fire. However, the Burlington Insurance Company (Burlington), Planet Bingo's liability insurer, denied coverage. Planet Bingo therefore filed this action for breach of contract and bad faith against Burlington.
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> In a previous appeal, we held that Burlington's policy did afford coverage, though only if one of the third party claimants filed suit against Planet Bingo in the United States or Canada. Lo and behold, just such a suit was then filed. Burlington accepted the defense and managed to settle the suit for its policy limits. In this action, the trial court granted summary judgment for Burlington; in essence, it ruled that Burlington had provided all of the benefits due under the policy.
>
> Planet Bingo appeals. It contends … that Burlington wrongfully failed to settle the third party claims; instead, Burlington denied coverage, in the hope that the claimants would sue Planet Bingo in the United Kingdom, which would have let Burlington off the coverage hook. Planet Bingo asserts (and, for purposes of the motion for summary judgment, Burlington did not dispute) that it lost profits because the fire claims remained pending and unsettled.
>
> We will hold that Planet Bingo made out a prima facie case that Burlington is liable for failure to settle. Even though none of the claimants made a formal offer to settle within the policy limits, one subrogee sent a subrogation demand letter; according to Planet Bingo's expert witness, in light of the standards of the insurance industry, this

[337] 2013 U.S. Dist. LEXIS 169453, at *24.
[338] 2013 U.S. Dist. LEXIS 169453, at *29.
[339] 2013 U.S. Dist. LEXIS 169453, at *28.
[340] 2013 U.S. Dist. LEXIS 169453, at *15–22.
[341] 2013 U.S. Dist. LEXIS 169453, at *28–29.
[1] Planet Bingo, LLC v. Burlington Ins. Co., 62 Cal. App. 5th 44 (2021).

> represented an opportunity to settle within the policy limits…. We … do not decide whether lost profits are recoverable as damages, because this issue was not raised below.[2]

Before the denial, Burlington's own cause and origin expert had concluded that Planet Bingo was likely liable, and this was further supported by the report of the Fire Brigade. But the distribution agreement between Planet Bingo and Leisure Electronics, Ltd ("Leisure"), its customer (who had leased the devices to a bingo hall in London), required that any suit be brought in England, while the policy limited coverage to suits in the United States or Canada. Burlington took the position that Planet Bingo was not liable and that there were (unspecified) coverage issues. While informed that Planet Bingo was losing business because the fire claim remained unpaid, Burlington closed its file after nine months in which no suit was filed.[3]

After a lull of three years, lawyers for AIG Europe Ltd. ("AIG") wrote to Planet Bingo to report that Leisure had settled with the bingo hall for £1.6 million, which AIG had paid and for which it demanded payment as Leisure's subrogee. Planet Bingo reported the demand to Burlington, which denied coverage on the grounds that the fire and the suit were both outside the United States or Canada. Litigation then ensued with the results summarized by the court. Planet Bingo sued Burlington, and its expert testified that (1) "'the failure to promptly pay the fire claim damaged Planet Bingo's business reputation and ultimately caused its entire business in the United Kingdom to fail; as a result, it suffered lost profits of over $9.3 million'" and (2) a letter like that from AIG to Planet Bingo "'is routine in industry practice and offers a clear invitation to negotiate a settlement for less than that amount … .' Moreover, there is a 'very well[-]known industry custom in such subrogation claims of accepting policy limits for a full release o[f] the insured.'"[4] For purposes of summary judgment Burlington did not contest the existence and amount of Planet Bingo's loss.[5]

The court acknowledged that this case differed the usual failure to settle case because (1) there had never been a clear demand within the $1 million policy limit and (2) there had never been an excess judgment.[6] But Burlington's motion for summary judgment was based only on the lack of a within-limits demand, so only that was at issue on appeal. But, in another case, *Boicourt,* liability for failure to settle had been found based on refusal to disclose the policy limits[7] That authority "has been read broadly, as standing for the proposition that '[a] formal settlement demand is not an absolute prerequisite to a bad faith action when the insurer engages in conduct that prevents settlement opportunities from arising … .'"[8] But the court found it unnecessary to decide that issue, because a narrower grond was available:

> At a minimum, *Boicourt* means that the existence of an opportunity to settle within the policy limits can be shown by evidence other than a formal settlement offer….
>
> It is significant that AIG was claiming as subrogee, and its letter was a subrogation demand letter. Planet Bingo's expert witness testified that a subrogation demand letter "offers a clear invitation to negotiate a

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[2] 62 Cal. App. 5th at 47 (citation omitted).
[3] 62 Cal. App. 5th at 48-50.
[4] 62 Cal. App. 5th at 50-51.
[5] 62 Cal. App. 5th at 51.
[6] 62 Cal. App. 5th at 54.
[7] 62 Cal. App. 5th at 56, relying on Boicourt v. Amex Assur. Co., 78 Cal. App. 4th 1390, 1393-99 (2000).
[8] 62 Cal. App. 5th at 56, relying on H. WALTER CROSKEY, REX HEESEMA, JR. & THOMAS W. JOHNSON, CAL. PRACTICE GUIDE: INSURANCE LITIGATION ¶ 12:293, p. 12B-17 (2020).

> settlement for less than that amount … .” She also testified that there is a “very well[-]known industry custom in such subrogation claims of accepting policy limits for a full release o[f] the insured.” This raised a triable issue of fact as to whether the letter represented an opportunity to settle within the policy limits.[9]

The court’s holding thus appears to be limited to subrogation demands in excess of limits and leaves a factual issue about the accuracy of the expert’s testimony regarding the asserted industry custom. At most, the excess subrogation demand would be treated as the sort of settlement overture that *Reid* found to support a claim for failure to settle.

In sum, the cases collectively hold that California imposes no duty to initiate settlement discussions absent settlement overtures or other indications of interest from the claimant. There are suggestions, but no clear decision, that there might be a duty to respond to “soft” settlement overtures. On balance, California seems properly classified as rejecting any duty to initiate, perhaps with an asterisk noting the possible duty to respond.

[C] Public Policy Analysis

Dean 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.[342] But he points that such a requirement places insurers at the mercy of jury interpretations of the settlement strategies in particular cases and concludes that such a standard is likely to change bargaining strategies in all cases, not just those where settlement is appropriate, resulting in overpayment that will be “a cost to all insureds.”[343] Moreover, if claimants knew that a reasonable offer within limits was necessary to obtain any excess judgment recovery, it would be difficult for insurers to manipulate negotiations in a way that led the plaintiff not to make such a demand.

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.

But if the claim’s expected value is far greater than the policy limit, the injured party may instead

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[9] 62 Cal. App. 5th at 56-57.

[342] Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1166–67 (1990).

[343] 76 VA. L. REV. at 1168.

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 recovery of 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. Such an 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.[344]

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*,[345] 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

[344] Miller v. Kenny, 325 P.3d 278, 297–98, at ¶ 85 (Wash. Ct. App. 2014).
[345] Gutierrez v. Yochim, 23 So. 3d 1221 (Fla. Dist. Ct. App. 2009).

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.[346] The lawyer apparently had the medical records, but sent only an authorization.[347]

On February 1, 2004, shortly after obtaining the hospital records, Dairlyland 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 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.[348]

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."[349]

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 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.[350] "Because the claimant bears little risk of losing the opportunity to

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[346] 23 So. 3d at 1222–23.
[347] 23 So. 3d at 1225.
[348] 23 So. 3d at 1223–24.
[349] 23 So. 3d at 1225.
[350] Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 851 n.18 (1994).

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.[351] And if the insurer's offer is below limits, the injured party can reasonably expect it to rise.[352]

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.[353] For the reasons just stated, that rule is better than the one requiring the insurer to initiate offers.

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.[354] 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.[355] But a claimant's informal statements that the claimant was only seeking the policy limits can constitute a demand.[356]

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.[357]

[D] The Restatement of the Law of Liability Insurance

The Restatement of the Law of Liability Insurance allows a jury to find that an insurer's failure to make a settlement offer or counteroffer was unreasonable.[357.1] (See § 2.03[2][h], *above*, for a discussion of the general approach taken by the Restatement.) It justifies its treatment of this issue as follows:

> This Section adopts a reasonableness standard, not a hard and fast rule regarding an insurer's obligation to make settlement offers or counteroffers. As with an insurer's settlement decisions generally, the question is what a reasonable insurer would do under the circumstances. In the absence of a reasonable offer by the plaintiff, there may be circumstances in which it would be unreasonable for the insurer not to make a settlement offer before trial, such as, for example, when the facts known to the insurer make clear that the policy limits are significantly less than the reasonable settlement value of the underlying case, (perhaps because the claimant's damages are indisputable and very large and the likelihood of the insured's being found liable is very high). In such circumstances, the insurer's obligation to attempt to protect its insured from an excess judgment may include making a reasonable settlement offer to the claimant. By making such an offer and by otherwise

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[351] 876 S.W.2d at 851 n.18.

[352] 876 S.W.2d at 851 n.18.

[353] 876 S.W.2d at 851.

[354] 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).

[355] *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).

[356] Gibbs v. State Farm Mut. Auto. Ins. Co., 544 F.2d 423, 427 (9th Cir. 1976) (CA law).

[357] Baton v. Transamer. Ins. Co., 584 F.2d 907, 913–14 (9th Cir. 1978) (OR law).

[357.1] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 24, cmt. *f* (2019).

> behaving reasonably in the settlement negotiations, an insurer can eliminate its potential liability for an excess judgment, even if the offer is rejected. It is important to emphasize, however, that there may be good reasons for an insurer not to make an offer. For example, it may be strategically useful, from the perspective of a reasonable insurer that bears the full risk of a judgment, to refrain from making a settlement offer in order to gather more information, to encourage the claimant to reveal more about its case, or to place pressure on the claimant to initiate settlement discussions. Of course, the insurer's strategic reasons for not making a settlement offer must relate solely to the legal action at issue, not to the insurer's interest in managing its portfolio of legal actions.[357.2]

But failure to make an offer is not the same as rejection of a demand:

> An insurer's decision to reject a reasonable settlement offer made by a claimant potentially has different consequences than an insurer's decision not to make its own reasonable settlement offer, even in those situations in which a reasonable insurer would have made such an offer. The difference comes from the causation requirement in an action for breach of the duty.
>
> When an insurer breaches the duty by failing to accept a settlement offer (in situations where failing to accept the offer constitutes a breach of duty) and the case goes to trial, resulting in an excess judgment against the insured, the causation requirement is satisfied: had the insurer accepted the settlement offer, 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 situations where failing to make its own offer constitutes a breach of the duty), and the case goes to trial and an excess judgment ensues, causation remains in question. The insurer's failure to make an 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.[358]

[E] Dennis Wall's Affirmative Duty Article

One article criticized the then-draft Restatement of the Law of Liability Insurance for not more clearly requiring insurers to initiate settlement negotiations where the liability of the insured is clear and a judgment in excess of policy limits is likely.[358.1] Among other things, that article (the "Affirmative Duty

[357.2] RESTATEMENT, § 24, cmt. *f*.

[358] RESTATEMENT, § 24, cmt. *g*.

[358.1] Dennis J. Wall, *The American Law Institute and Good Faith Settlement Duties of Liability Insurers: The Scope of the Duty to Initiate Settlement Negotiations, What the ALI Restatement of the Law of Liability Insurance Has to*

Article") criticizes the Reporters and the authorities they cite for stating that " '[t]here is a split of authority on the question whether the duty to settle includes a requirement that the insurer affirmatively explore settlement negotiations should the claimant not come forward with a settlement offer.' "[358.2] One of the authorities so criticized is this publication.[358.3] The Affirmative Duty Article counts 16 states as supporting, at least in some circumstances, a duty to initiate negotiations and only three rejecting such a duty.[358.4] That article then contends that "16 Courts or cases in favor and at most 3 against is not much of a 'split' presenting 'majority' and 'minority' views unless the 'majority' in this instance is more accurately described as an overwhelming majority and the 'minority' is openly cast as a cluster of outliers on the issue."[358.5]

The Affirmative Duty Article proposed that a new subsection (6) be added to § 24 of the draft Restatement, providing that:

> (6) The lack of a formal settlement demand is only one factor to be considered in determining bad faith. Where liability is clear, and injuries so serious that a judgment in excess of the policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations. Whether and how a liability insurer initiates settlement negotiations, if at all, depends on the facts of each case.[358.6]

The discussion here makes two points. First, the Affirmative Duty Article has not accurately portrayed the balance of the authorities on this issue. Second, as explained in § 2.03[6][d][iii][C], *above*, there are good reasons why the law ought not to impose on insurers a duty to initiate settlement negotiations. The cases which support imposition of such a duty do not appear to have been presented with arguments advancing such reasons, so courts in those jurisdictions might reconsider those decisions. In any event, courts in jurisdictions that have not yet addressed the issue ought not to follow the decisions which support imposition of such a duty. (Interestingly enough, the Restatement, which the Affirmative Duty Article criticizes, is closer to that article's view on that duty than to the view expressed in this publication.)[358.7]

To be clear, there should not be an absolute rule that an insurer can never be liable for failure to settle if the claimant never made a within-limits offer. Such arguments have sometimes been made by insurers, but have properly been rejected. Insurers have other duties regarding defense or settlement which, if breached, can subject them to liability for failure to settle. (*See, e.g.*, §§ 2.03[4][a], *above*, 2.03[6][d][x], *below*.) The argument here is that, in the absence of some other impropriety in the handling of a claim, an insurer ought not to be liable merely for failure to initiate settlement negotiations.

Say About It, and the ALI Reporters Notes, 37 INS. LITIG. RPTR. 597 (2016) ("Affirmative Duty Article" or "ADA").

[358.2] *Id.* at 598–99, *quoting* RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 24, Reporters' Note *e* (Council Draft No. 1 Sept. 25, 2015).

[358.3] *See* § 2.03[6][d][iii], *above* (discussing split of authority). The other reference criticized is ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW, 874 (4th ed. 2007) ("In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless a settlement offer within limits is made by the plaintiff.").

[358.4] ADA, 37 INS. LITIG. RPTR. at 601–04.

[358.5] 37 INS. LITIG. RPTR. at 600.

[358.6] 37 INS. LITIG. RPTR. at 607.

[358.7] *See* RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 24, cmt. *f* (Prop. Final Dr. No. 2 April 13, 2018), *quoted in* § 2.03[6][d][iii][D], above.

The sub-sub-sub-sub sections that follow will examine, in order, the jurisdictions the Affirmative Duty Article classifies as (1) having declared a duty to initiate negotiations, (2) having authority suggesting there might be such a duty, and (3) having rejected such a duty. Based on the analysis there, the count could be said to be 12 jurisdictions favoring a duty to initiate and 11 rejecting such a duty. A jurisdiction, Rhode Island, was overlooked by both sides of the debate described here, and has repeated dicta suggesting no requirement to initiate negotiations. But there are enough uncertainties that it seems enough to say that authority is essentially equally divided. Certainly, the jurisdictions rejecting such a duty are not "a few outliers."

[F] Jurisdictions the Affirmative Duty Article Classifies as Having Declared a Duty To Initiate Negotiations

[1] Overview

The Affirmative Duty Article says that "[t]here are ten jurisdictions from which cases have been reported … in which the Courts have declared a legal duty for insurance companies to initiate settlement negotiations even in the absence of a settlement demand from the claimant."[358.8] It lists (1) Arizona, (2) Florida, (3) Georgia, (4) Kansas, (5) Michigan, (6) New Jersey, (7) New Mexico, (8) Oklahoma, (9) Oregon, and (10) Washington.[358.9] This seems correct as to Arizona,[358.10] Florida,[358.11] Kansas,[358.12] New Jersey,[358.13] New Mexico,[358.14] Oklahoma,[358.15] Oregon,[358.16] and Washington.[358.17] To those, one should

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[358.8] ADA, 37 INS. LITIG. RPTR. at 601.

[358.9] 37 INS. LITIG. RPTR. at 601.

[358.10] Fulton v. Woodford, 545 P.2d 979, 984 (Ariz. Ct. App. 1986). While stated as a "holding," this was actually dictum, because the court went on to hold that there was no such duty on the facts of the case. *Id.* at 984–85. Nonetheless, the court, after analyzing the issue, purported to lay down a legal rule. Subject to possible alteration by the supreme court, that seems to be the law of Arizona. *See* Safeway Ins. Co. v. Botma, 2003 U.S. Dist. LEXIS 28663, at *60 (D. Ariz. Mar. 7, 2003) (stating that as a legal rule, but finding no breach, because there were demands and limits were offered).

[358.11] Gutierrez v. Yochim, 23 So. 3d 1221, 1226 (Fla. Dist. Ct. App. 2009); Powell v. Prudential Prop. & Cas. Ins. Co., 584 So. 2d 12, 14 (Fla. Dist. Ct. App. 1991). While *Powell* might arguably be read more narrowly in light of its facts, see above, it appears to be accepted as more broadly authoritative. Moreover, *Powell* has been approvingly cited on this point, albeit in dictum, by the Florida Supreme Court. Harvey v. GEICO Gen. Ins. Co., 2018 Fla. LEXIS 1705, *13–14 (Sept. 20, 2018).

[358.12] Guar. Abstract & Title Co. v. Interstate Fire & Cas. Co., 618 P.2d 1195, 1199 (Kan. 1980); Roberts v. Printup, 422 F.3d 1211, 1215–16 (10th Cir. 2005) (but finding no duty to initiate negotiations before a claim has been asserted).

[358.13] Rova Farms Resort, Inc. v. Investors Ins. Co., 323 A.2d 495, 506–07 (N.J. 1974). *Rova Farms* involved failure to contribute limits to an available settlement where the insured was willing to contribute the balance, *Id.* at 501. But, like *Fulton*, the court laid down a fully considered legal rule, which now appears to be the law.

[358.14] City of Hobbs v. Hartford Fire Ins. Co., 162 F.3d 576, 583–84 (10th Cir. 1998). This is a prediction by a federal court of what state law will be, but it seems reliable for purposes of this chapter.

[358.15] Badillo v. Mid Century Ins. Co., 2005 OK 48, ¶¶ 31–32. Like *Powell*, *Badillo* might arguably be read more narrowly in light of its facts, see above, the court, after analyzing the issue, purported to lay down a legal rule. *But see* SRM, Inc. v. Great Am. Ins. Co., 798 F.3d 1322, 1326–27 (10th Cir. 2015) (excess insurer had no duty to initiate negotiations until primary insurance exhausted, even though primary insurer had tendered its limits).

[358.16] Maine Bonding & Cas. Co. v. Centennial Ins. Co., 693 P.2d 1296, 1299, 1303 (Or. 1985); Goddard v. Farmers Ins. Co., 22 P.3d 1224, 1227 (Or. Ct. App.2001) (stating rule, but point not at issue), *review denied*, 34 P.3d 1178 (Or. 2001); Spray v. Cont'l Cas. Co., 739 P.2d 40, 43–44 (Or. Ct. App. 1987) (affirming liability where insurer failed to make offer after claimant demanded twice limits).

[358.17] Cox v. Cont'l Cas. Co., 2014 U.S. Dist. LEXIS 68081, at *9 (W.D. Wash. May 16, 2014). While only a

add Louisiana,[358.18] Wisconsin,[358.19] seemingly, Tennessee[358.20] and, possibly, West Virginia[358.21]—states not mentioned in the Affirmative Duty Article.

Of the jurisdictions identified as declaring a duty to initiate settlement negotiations, Georgia and Michigan are disputed here; Georgia has now held that an insurer need only respond to demands.

[II] Georgia

Regarding Georgia, the Affirmative Duty Article relies on *Delancy v. St. Paul Fire & Marine Insurance Co.*[358.22] The cited passage summarizes authorities relied upon by Delancy in support of imposing a duty to initiate settlement negotiations. As the article notes, the court then states that " '[a]s the foregoing discussion shows, Georgia law does not clearly require the insured to show that the insurer refused an offer within the policy limits to establish liability for tortious failure to settle, but it does not foreclose the argument that such an offer is required before the insured may recover.' "[358.23] Nonetheless, the court did not rule on what duty would be imposed by Georgia law, a question not answered by prior cases. Rather, as the court states near the beginning of its opinion:

> *We assume for the sake of argument that the plaintiffs correctly state Georgia law.* We nonetheless affirm the district court's grant of summary judgment to St. Paul, as the plaintiffs have not introduced competent evidence showing a genuine issue of material fact on an element of their case on which they have the burden of proof: they have not shown that St. Paul ever knew or in the exercise of ordinary care should have known that the suit against Dr. Delancy could have been settled within the policy limits.[358.24]

Delancy thus took no position on the legal issue which the Affirmative Duty Article and this book debate. But the Georgia Supreme Court has since held that an insurer need only respond to demands.[358.25]

[III] Michigan

Regarding Michigan, the Affirmative Duty Article relies on *Commercial Union Insurance Co. v.*

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prediction by a federal district court, it seems reliable for purposes of this discussion.

358.18 Kelly v. State Farm Fire & Cas. Co., 169 So. 3d 328, 338 (La. 2015) (demand not required).

358.19 Alt v. Am. Family Mut. Ins. Co., 237 N.W.2d 706, 711–14 (Wis. 1976).

358.20 State Auto. Ins. Co. v. Rowland, 427 S.W.2d 30, 31–32 (Tenn. 1968). *Rowland*, like *Powell*, might arguably be read more narrowly in light of its facts, see above. Unlike *Powell*, it is not clear that the court was laying down any broad and considered rule. So, it is unclear whether *Rowland* is actually contrary to the position argued here.

358.21 Daniels v. Horace Mann Mut. Ins. Co., 422 F.2d 87 (4th Cir. 1970) (concluding that district court's finding of no bad faith was clearly erroneous, in case where there was no demand, but without discussing that point; relying in part on inadequate investigation). Because the issue was never focused and in light of the other misconduct, it is unclear what the court actually held. Moreover, it is a prediction of state law by a federal court. While this gives some support to a duty to initiate negotiations, that support is limited.

358.22 Delancy v. St. Paul Fire & Marine Ins. Co., 947 F.2d 1536, 1550–51 (11th Cir. 1991), *relied upon*, 37 INS. LITIG. RPTR. at 601 & n.17.

358.23 ADA, 37 INS. LITIG. RPTR. at 601 n.17, *quoting* *Delancy*, 947 F.2d at 1551.

358.24 *Delancy*, 947 F.2d at 1537 (emphasis added).

358.25 First Acceptance Ins. Co. of Ga. v. Hughes, 305 Ga. 489, 489–90 (2019).

Liberty Mutual Insurance Co.[358.26] Liberty Mutual was the primary insurer and Commercial Union the excess. An excess judgment resulted in favor of Webster, paid by Commercial Union, which brought this suit against Liberty Mutual. It alleged that

> Liberty Mutual (1) failed to make settlement offers and ignored numerous settlement demands between May, 1971, and the commencement of the first Webster trial in October, 1973, (2) failed to communicate each and every settlement demand made throughout the pendency of the Websters' claim, (3) failed to respond properly to settlement offers at figures below the first jury award while the first Webster case was pending on appeal, (4) chose to ignore the advice of its attorney to make efforts to settle the case following the Court of Appeals reversal of the first Webster case, but before the second trial, and (5) failed to communicate all material developments as they occurred throughout the pendency of the Websters' claim.[358.27]

The jury gave a verdict for Liberty Mutual, but the Michigan Supreme Court determined that the jury had been improperly instructed on what constitutes "bad faith" in this context.[358.28] The proper definition was held to be "arbitrary, reckless, indifferent, or intentional disregard of the interests of the person owed a duty [of good faith]."[358.29] The court went on to identify

> supplemental factors which may be considered in determining whether liability exists for bad faith. These factors clarify the "indicators" pronounced in the trial court's bad-faith instruction in the instant case … . Because the facts of each individual case will vary in any given situation, the trial court, in its discretion, will have the option of determining which factors, if any, are to be included in instructions to the jury. The recommended factors are not exclusive. No single factor shall be decisive. Among the factors which the factfinder may take into account, together with all other evidence in deciding whether or not the defendant acted in bad faith are:
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> …
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> 3) failure to solicit a settlement offer or initiate settlement negotiations when warranted under the circumstances … .[358.30]

The description of Commercial Union's allegations does not indicate that failure to initiate settlement negotiations was actually involved in the case, nor is there any indication that the court gave focused attention to the issue of whether an insurer should be obliged to initiate settlement negotiations. Moreover, those allegations suggest that one of the problems in the case was failure to keep the insured (and Commercial Union) informed regarding settlement developments, which might have led Commercial

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[358.26] Commercial Union Ins. Co. v. Liberty Mut. Ins. Co., 393 N.W.2d 161, 165 (Mich. 1986), *relied upon*, 37 INS. LITIG. RPTR. at 601 & n.19. The ADA cites the second party as "Medical Protective Co." rather than Liberty Mutual, but this appears to be a citation error, of no consequence to the argument.

[358.27] *Commercial Union Ins. Co.*, 393 N.W.2d at 162.

[358.28] 393 N.W.2d at 162–63.

[358.29] 393 N.W.2d at 164.

[358.30] 393 N.W.2d at 165.

Union to offer a contribution. Failure to communicate might support liability without a demand. Whether or not that could be so does not appear relevant to the case, because there actually were demands. Not even in dictum does the court say that an insurer ever has a duty to initiate settlement negotiations; it necessarily leaves open whether there ever will be circumstances which warrant imposing such a duty.

In short, neither Georgia nor Michigan belongs on either side of the scales in determining the balance of authority.

[G] Jurisdictions the Affirmative Duty Article Classifies as Having Recognized a Possible Duty To Initiate Negotiations

[I] Overview

The Affirmative Duty Article identifies six states in which cases "have recognized that at least there might be a duty on the liability carrier to initiate settlement negotiations without a settlement demand":[358.31] (1) California, (2) Idaho, (3) Illinois, (4) Ohio, (5) Pennsylvania, and (6) Texas.[358.32] To these might be added Massachusetts.[358.33] As explained in §§ 2.03[6][d][iii][B], *above*, and 2.03[6][d][iii][H], *below*, California and Illinois should be classified as holding that there is no duty to initiate settlement negotiations, with minor qualifications that circumstances not yet found might create such a duty. As to Texas, the very case the Affirmative Duty Article cites holds the opposite,[358.34] and the article recognizes Texas as having more recent authority holding that an insurer ordinarily has no duty to initiate settlement negotiations.[358.35] Idaho also belongs on the other side of the scales, and Pennsylvania probably does; certainly Pennsylvania authority does not support imposing a duty to initiate negotiations. Ohio, like Georgia and Michigan, belongs on neither side of the scales. The discussion here will address Ohio, Texas, Pennsylvania, and Idaho, in that order.

[II] Ohio

Regarding Ohio, the Affirmative Duty Article relies on *Miller v. Kronk*.[358.36] The facts and the alleged misconduct are not clearly stated. But the court does say that the insured "has not cited any case law in support of its position that the failure of an insurer to initiate settlement negotiations, where none had previously been instituted by the party bringing the action, amounts to bad faith."[358.37] The court found it unnecessary to address that issue, because the insured did not allege any conduct meeting Ohio's

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[358.31] ADA, 37 INS. LITIG. RPTR. at 602.

[358.32] 37 INS. LITIG. RPTR. at 602–03.

[358.33]

Massachusetts: Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. 115, 123 (1994) (rejecting claim that trial court made existence of a firm offer a condition of settlement, thereby mooting claim that doing so was error; trial court properly refused to instruct jury that insurer had affirmative duty to explore settlement possibilities because "[o]n the negligence test we now adopt, the question would be whether it was unreasonable at one or more points for New Hampshire not to explore settlement (i.e. no reasonable insurer would have failed in the circumstances to pursue settlement possibilities").

[358.34] *See* discussion at § 2.03[6][d][iii][G][III], *below*.

[358.35] ADA, 37 INS. LITIG. RPTR. at 603 & n. 34, *citing* Rocor Int'l v. Nat'l Union Fire Ins. Co., 77 S.W.3d 253, 261–61 (Tex. 2002), as a decision that "addressed this issue seemingly head on."

[358.36] Miller v. Kronk, 519 N.E.2d 856 (Ohio Ct. App. 1987), *relied upon*, 37 INS. LITIG. RPTR. at 602 & n.29.

[358.37] *Miller*, 519 N.E.2d at 858.

definition of bad faith.[358.38] Nothing in the case suggests any conclusion on whether Ohio would impose a duty to initiate settlement negotiations under any circumstances. Ohio belongs on neither side of the scales.

[III] Texas

Regarding Texas, the Affirmative Duty Article relies for support of a duty to initiate settlement negotiations on *American Physicians Insurance Exchange v. Garcia*.[358.39] This case arose from a medical malpractice suit by the Cardenases against Dr. Garcia, APIE's insured. Dr. Garcia had various policies in successive years, including an APIE occurrence-based policy for 1983, with a $500,000 limit.[358.40]

Dr. Garcia received notice of the Cardenas claim in 1983, and promptly reported it to APIE. But APIE determined that only one of Cardenas's visits was within its policy period, and concluded in an internal memo that the "lion's share" of the claim arose out of treatment performed while another insurer, ICA, had provided coverage. ICA retained defense counsel, with APIE agreeing to share payment and to share any settlement or judgment " 'on a pro rata coverage basis.' " The Cardenases filed five amended petitions, none alleging malpractice in APIE's policy period. APIE eventually notified Dr. Garcia that it provided no coverage because the alleged conduct occurred prior to its policy period, though it continued to pay defense costs for several weeks, through judgment.[358.41]

Defense counsel told the Cardenases that $600,000 in coverage was available. They demanded that amount, then substituted a demand for $1.1 million on the discovery that there was a second ICA policy. Defense counsel then asserted that coverage was limited to $500,000. On discovery of the third ICA policy, the demand was raised to $1.6 million. No offers were made. After APIE asserted that there was no coverage under its policy, Dr. Garcia entered into an agreement with the Cardenases assigning to them all of his rights against APIE and ICA in return for an agreement not to execute on noninsurance assets. On the day of trial, the Cardenases again amended their petition, this time to allege malpractice in 1983, during APIE's policy period. The case was tried to the court, which found continuing negligence from September, 1980 through February, 1983 and rendered judgment for $2,235,483.30.[358.42]

ICA settled out and a jury rendered a verdict against APIE. The Texas Supreme Court quickly disposed of all claims other than breach of the duty to settle (known in Texas as a "*Stowers*" claim).[358.43] It held that "because APIE never received a settlement demand within its policy limits, it did not breach its *Stowers* duty to settle."[358.44] Accordingly, it rendered judgment for APIE.[358.45]

The court described that duty as one of care "in responding to settlement demands within the

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[358.38] 519 N.E.2d at 859.

[358.39] Am. Physicians Ins. Exch. v. Garcia ("*APIE*"), 876 S.W.2d 842, 851 n.18 (1994), *relied upon*, 37 INS. LITIG. RPTR. at 602–03 & n.31.

[358.40] *APIE*, 876 S.W.2d at 843–44 ("In 1980, Garcia was covered by an ICA 'claims-made' 3 medical malpractice insurance policy with limits of $100,000. In 1981 and 1982, Garcia was covered under two consecutive one-year ICA 'occurrence' policies, each providing him with $500,000 in coverage. In 1983, Garcia purchased an APIE occurrence policy with a $500,000 limit per occurrence, the policy involved in this appeal." Because the claim was made in 1983, the 1980 policy could never provide coverage. 876 S.W.2d at 843 n.3.).

[358.41] 876 S.W.2d at 843–44.

[358.42] 876 S.W.2d at 844–45.

[358.43] 876 S.W.2d at 846–48.

[358.44] 876 S.W.2d at 843.

[358.45] 876 S.W.2d at 843.

policy limits."[358.46] "A demand above policy limits, even though reasonable, does not trigger the *Stowers* duty to settle."[358.47] Here, there was never a demand within limits unless APIE was mistaken in believing that the coverages could not be stacked.[358.48]

A dissent urged that the *Stowers* duty included an affirmative duty to explore settlement possibilities.[358.49] The court viewed the dissent's proposed rule as shifting "the burden of making settlement offers" to the insurer.[358.50] It concluded that cases imposing such an affirmative duty "generally involve affirmative misconduct by the insurer to subvert or terminate settlement negotiations."[358.51] It "disagree[d] with any reading of the no-demand cases that would require insurers rather than claimants to make settlement offers."[358.52] It rejected a requirement to do so "when 'there is a high potential of claimant recovery and a high potential of [excess] damages,' "[358.53] "because settlement is particularly unlikely when substantial excess damages are virtually certain. By requiring insurers to observe an ineffective ritual on pain of waiving all policy limits, [that requirement] represents a trap for the unwary."[358.54]

As to public policy analysis, *see* § 2.03[6][d][iii][C], *above*. But there can be no doubt that, contrary to the Affirmative Duty Article's reading, the court squarely rejected any affirmative duty to initiate settlement negotiations, absent some other misconduct by the insurer. This point is confirmed by *Rocor International, Inc. v. National Union Fire Insurance Co.*,[358.55] a case even the article admits to reject any such duty.[358.56] Relying on *Garcia*, the *Rocor* court stated that "in Texas, the common law imposes no duty on an insurer to … make or solicit settlement proposals."[358.57] Moreover, the statutory duty to reasonably attempt settlement when the insured's liability has become reasonably clear "is not triggered until the claimant has presented a proper settlement demand within limits that an ordinarily prudent insurer would have accepted."[358.58]

The Affirmative Duty Article's classification of *Garcia* as supporting imposition of such a duty is simply wrong. At most, *Garcia* acknowledged the possibility that such a duty might arise from other misconduct by the insurer. To be sure, the Affirmative Duty Article properly concludes that *Garcia* rejects an absolute requirement that the claimant make a demand. But, as already explained, rejection of that requirement is not very significant. (*See* § 2.03[6][d][iii][E], *above*.)

[358.46] 876 S.W.2d at 848.
[358.47] 876 S.W.2d at 848.
[358.48] 876 S.W.2d at 848.
[358.49] 876 S.W.2d at 862–65 (dissenting op.).
[358.50] 876 S.W.2d at 850.
[358.51] 876 S.W.2d at 850 n.17.
[358.52] 876 S.W.2d at 850 n.17.
[358.53] 876 S.W.2d at 850 n.17, *quoting* Fulton v. Woodford, 545 P.2d 979, 984 (Ariz. Ct. App. 1986). This is also the formulation used by Mr. Wall's proposed addition to Restatement § 24. 37 INS. LITIG. RPTR. at 607.
[358.54] 876 S.W.2d at 850.
[358.55] Rocor Int'l v. Nat'l Union Fire Ins. Co., 77 S.W.3d 253, 261 (Tex. 2002).
[358.56] ADA, 37 INS. LITIG. RPTR. at 602 & n.29.
[358.57] *Rocor*, 77 S.W.3d at 261.
[358.58] 77 S.W.3d at 262.

[IV] Pennsylvania

Regarding Pennsylvania, the Affirmative Duty Article relies on *Puritan Insurance Co. v. Canadian Universal Insurance Co.*[358.59] This was a suit by an excess insurer, Canadian, against a primary, Puritan, for alleged bad faith failure to settle. The district court rendered judgment for Canadian, because it found bad faith in Puritan's rigid "no liability, no offer" stance.[358.60] The Third Circuit reversed because the insured (which had a $100,000 deductible) had consented to try the case, rather than settle, and this consent was an insurmountable barrier to Canadian's equitable subrogation claim.[358.61] The court went on to also address the duty to initiate issue:

> Nor do we agree that on this record Canadian had an affirmative duty to initiate settlement negotiations with Donahue. The same factors that militate against a finding of bad faith in refusing to settle are relevant in this instance as well. An insurance carrier may be required to broach settlement negotiations under some circumstances but this case does not present them.
>
> 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.[358.62]

While the court declined to rule out the possibility that there might be circumstances supporting imposition of a duty to initiate settlement negotiations, it certainly offered no support for the proposition that there might be such circumstances. The second paragraph indicates a strong leaning against that possibility. Pennsylvania probably should be classified as rejecting imposition of a duty to initiate settlement negotiations.[358.63]

[V] Idaho

As to Idaho, the Affirmative Duty Article relies on *Morrell Construction, Inc. v. Home Insurance Co.*[358.64] Morrell claimed that Home had acted in bad faith by refusing to investigate or initiate settlement negotiations before suit was filed. After suit was filed, Morrell settled with the plaintiff for $125,000, which exceeded its $100,000 policy limit. The $25,000 excess was contingent on success in the bad faith

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[358.59] Puritan Ins. Co. v. Canadian Univ. Ins. Co., 775 F.2d 76, 82 (3d Cir. 1985), *relied upon*, 37 INS. LITIG. RPTR. at 602 & n.30.

[358.60] *Puritan*, 775 F.2d at 80.

[358.61] 775 F.2d at 80.

[358.62] 775 F.2d at 82.

[358.63] *But see* Dewalt v. Ohio Cas. Ins. Co., 513 F. Supp. 2d 287, 297–98 (E.D. Pa. 2007) (concluding that Pennsylvania does not require that the insurer reject a demand, but granting summary judgment on other grounds, rendering that conclusion dictum).

[358.64] Morrell Construction, Inc. v. Home Ins. Co., 920 F.2d 576 (9th Cir. 1990) ("*Morell II*"), *relied upon*, 37 INS. LITIG. RPTR. at 602 & n.27.

action. The district court rendered summary judgment for Home. Initially, the Ninth Circuit certified to the Idaho Supreme Court questions whether there were duties to investigate or initiate settlement negotiations before suit was filed.[358.65] After the Idaho Supreme Court declined to answer those questions, the Ninth Circuit concluded that Idaho would not impose a duty to do either, and affirmed the summary judgment.[358.66] The court noted the division of authority on whether insurers have a duty to initiate settlement negotiations,[358.67] then concluded that "[w]hile it may make some sense to impose an obligation on insurers to initiate settlement negotiations in certain third party situations, we decline to hold that the Idaho Supreme Court would impose such a tort duty on all insurers."[358.68]

While the facts of the case relate only to pre-suit duties, the court chose to address the question regarding initiation of settlement negotiations more broadly. (That is not surprising, as there appears to be no authority distinguishing between the pre-suit context and the post-suit context regarding this duty.) By declining to hold that the Idaho Supreme Court would impose such a duty, and by affirming the summary judgment, the Ninth Circuit effectively predicted that Idaho would not impose such a duty.

[H] While Some Illinois Cases Appear To Suggest a Possible Duty To Initiate Settlement Negotiations, That Possibility Is an Illusion

Cases that seem to suggest a possible duty to initiate settlement negotiations are *Adduci v. Vigilant Insurance Co.*[358.69] and *Haddick v. Valor Insurance Co.*[358.70]

Adduci arose from a one-car accident, resulting in an excess judgment in favor of one of the two passengers. A collective time-limit demand for limits was made and allowed to expire. The limit, $25,000 for all injuries, was later offered to the two collectively and refused. One claim was settled before trial for $7,500. The verdict for the remaining claim was $70,000, leaving an excess judgment of $52,500 after the remaining policy limit was paid. Adduci sued for bad faith and the trial court dismissed the complaint. The appellate court agreed that no cause of action was alleged.[358.71]

That court did not find a breach of the duty of good faith, where Vigilant had offered the limits only 72 days after the demand and 40 days after it "expired." The only reason alleged for refusal to accept this offer was that further preparation of the claims for trial was conducted, thereby necessitating a different attorney fee arrangement between plaintiffs' counsel and all three plaintiffs, which foreclosed the opportunity for settlement.[358.72] No details were offered to flesh out this "bald allegation," and the court was of the opinion that "[n]o facts sufficiently indicate why the claimants found it impossible to accept the offer at this time, so as to fairly place the blame for failure of settlement upon Insurer."[358.73]

The Adducis also argued that Vigilant had breached the duty by failing to initiate settlement

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[358.65] Morrell Construction, Inc. v. Home Ins. Co., 899 F.2d 875 (9th Cir. 1990) ("*Morell I*").
[358.66] *Morell II*, 920 F.2d at 577–78.
[358.67] 920 F.2d at 580–81.
[358.68] 920 F.2d at 581.
[358.69] Adduci v. Vigilant Ins. Co., 424 N.E.2d 645 (Ill. Ct. App. 1981), *relied upon*, 37 INS. LITIG. RPTR. at 602 & n.28.
[358.70] Haddick v. Valor Ins. Co., 763 N.E.2d 299 (Ill. 2001), *relied upon*, 37 INS. LITIG. RPTR. at 602 & nn. 28.
[358.71] *Adduci*, 424 N.E.2d at 646–50.
[358.72] 424 N.E.2d at 477.
[358.73] 424 N.E.2d at 477. Questions could be raised about the soundness of that reasoning, but it is beside the point here.

negotiations. The court rejected this argument:

> It is settled in Illinois that insurance companies are not required to initiate negotiations to settle a case. The basis for this rule is that the imposition of such a requirement would put the insurer into a negotiating disadvantage which is imposed on no other litigant. While an exception is recognized where the probability of an adverse finding on liability is considerable and the amount of probable damages would greatly exceed the insured's coverage, we believe that this exception should be sparingly used, and then only in the most glaring cases of an insured's liability, since "[t]rial attorneys are not endowed with the gift of prophecy so as to be able to predict the precise outcome of personal injury litigation." No facts are alleged here to demonstrate the probable liability of Insured for high-figure damages to each of the passengers in her auto. Thus, as a matter of law, Insurer cannot be said to have breached its duty by failing to initiate settlement negotiations in this case.[358.74]

The limitation of the "exception" to "the most glaring cases of an insured's liability," is supported by the fact that Illinois treats the duty to consider settlement as arising only where there is a "reasonable probability" of liability, itself interpreted to require that liability be more likely than not.[358.75] (*But see* § 2.03[2][d][ii], *above*.) The "exception" is only said to apply "where the probability of an adverse finding on liability is considerable," something significantly greater than 50%. Moreover, in *Adduci*, the very existence of the exception was dictum, as it was not found to apply.

The authority *Adduci* relied upon to support existence of this exception was *Kavanaugh v. Interstate Fire & Casualty Co.*[358.76] Sheehan, Kavanaugh's passenger, had obtained an excess judgment for her injuries when his car rear-ended a truck being towed by a co-defendant's tractor. Kavanaugh had a Royal policy with a $10,000 limit and an Interstate excess policy with a $15,000 limit. Trial was bifurcated, with liability found on September 30 and $45,000 in damages assessed on October 4. The bad faith case went to the jury on the theory that the insurers failed to offer their limits; there was never a demand less than $60,000. The bad faith jury returned a $20,000 verdict in favor of Sheehan and judgment was entered accordingly.[358.77]

As in *Adduci*, the appellate court found, as a matter of law, no breach of the duty of good faith. In general, Illinois law does not "impose[] a duty on an insurance company to initiate negotiations to settle a case."[358.78] The court stated that "[t]here is a well-recognized exception to the general principle when the probability of an adverse finding on liability is great and the amount of probable damages would greatly exceed the coverage."[358.79] But that exception did not apply in *Kavanaugh*, where:

> liability was not clear cut. Kavanaugh was subject to a low degree of care under the Illinois guest statute whereas his co-defendants were charged with simple negligence, thus favoring his probability of success. Moreover, Johnson possessed a statement from the claimant Sheehan

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358.74 424 N.E.2d at 649–50 (citations omitted).

358.75 Powell v. Am. Serv. Ins. Co., 7 N.E.3d 11, ¶ 6 (Ill. App. Ct. 2014).

358.76 Kavanaugh v. Interstate Fire & Cas. Co., 342 N.E.2d 116 (Ill. App. Ct. 1975).

358.77 342 N.E.2d at 117–20.

358.78 342 N.E.2d at 121.

358.79 342 N.E.2d at 121.

> exonerating Kavanaugh from any charge of speeding and admitting that she had never questioned his ability to control the automobile on the night of the accident. Trial attorneys are not endowed with the gift of prophecy so as to be able to predict the precise outcome of personal injury litigation. Nor does the mere fact that the insurance company was unsuccessful in the trial of a case show that their defense was made in bad faith.[358.80]

Again, the very existence of the exception is dictum, as it was not found to apply. Moreover, of the three cases cited to support existence of the exception, two are cases where demands were made and refused;[358.81] neither mentioned any duty to initiate. The third case was one where, despite repeated importunities, the insurer refused to disclose the policy limits;[358.82] while absence of a demand was not fatal in that context, there was no mention of any duty to initiate. On this point, the *Kavanaugh* dictum was completely unsupported. Moreover, neither *Kavanaugh* nor *Adduci* appears to have given this dictum much consideration.

Nonetheless, the *Adduci* dictum on this point was approvingly cited in *Haddick*:[358.83]

> To survive a motion to dismiss a bad-faith claim, the plaintiff must allege facts sufficient to establish the existence of the duty to settle in good faith … . The duty of an insurance provider to settle arises when a claim has been made against the insured and there is a reasonable probability of recovery in excess of policy limits and a reasonable probability of a finding of liability against the insured. *Since Illinois law generally does not require an insurance provider to initiate settlement negotiations* this duty also does not arise until a third party demands settlement within policy limits.
>
> *There is an exception to this general rule where the probability of an adverse finding on liability is great and the amount of probable damages would greatly exceed policy limits.*[358.84]

On the facts of *Haddick*, there had been a demand,[358.85] and the court held that there was a jury question on whether the insurer had acted in bad faith in refusing that demand. There was no issue regarding initiation of settlement negotiations, so the approving restatement of the *Adduci* dictum was itself dictum, and, again, seemingly off hand dictum, not carefully considered analysis.

In the wake of *Haddick*, courts have frequently stated that Illinois does not require insurers to initiate settlement negotiations without noting any exception.[358.86] One case mentioned the exception but

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[358.80] 342 N.E.2d at 121.

[358.81] Bailey v. Prudence Mut. Cas. Co., 429 F.2d 1388, 1390 (7th Cir. 1970); Smiley v. Manchester Ins. & Indemn. Co., 301 N.E.2d 19, 20 (Ill. App. Ct. 1973).

[358.82] Cernocky v. Indemnity Ins. Co., 216 N.E.2d 198, 205 (Ill. App. Ct. 1966).

[358.83] Haddick v. Valor Ins. Co., 763 N.E.2d 299 (Ill. 2001).

[358.84] 763 N.E.2d at 304 & n.1 (citations omitted, emphasis added to language relying on *Adduci*).

[358.85] 763 N.E.2d at 301.

[358.86] Fox v. Am. Alternative Ins. Corp., 757 F.3d 680, 685 (7th Cir. 2014) (no demand after primary insurance exhausted, so excess insurer had no duty to settle); Surgery Ctr. at 900 N. Mich. Ave., LLC v. Am. Physicians Assur. Corp., 2015 U.S. Dist. LEXIS 173034 (N.D. Ill. Dec. 30, 2015) (no duty to settle because insured's liability

found it inapplicable.[358.87]

Only one reported case has considered actually applying the exception, *Ranger Insurance Co. v. Home Indemnity Co.*[358.88] Home was the primary insurer of Mid-States General & Mechanical Contracting Corp. ("Mid-States"), with a limit of $500,000, Ranger the excess insurer. Paul Hall sued Mid-States and Archer-Daniels-Midland ("ADM") for injuries suffered at an ADM plant while employed by Corrigan Co. ADM settled the case for $1.5 million plus indemnity for the workers' compensation lien, then pursued Mid-States and Corrigan for indemnity. A jury found Mid-States 48% liable, and a judgment for $788,989 was entered against it. Ranger paid $288,989 to ADM, then sued Home for failure to settle.[358.89]

The court began its legal analysis by citing *Kavanaugh* for the general rule that a primary insurer is not obliged to initiate settlement negotiations, so that an excess insurer must show that the primary insurer rejected an offered settlement.[358.90] That also would normally be necessary to show proximate cause of the excess judgment.[358.91]

There had been negotiations after ADM had settled the Hall claim, in which ADM's counsel suggested the possibility of an even three-way split. Because the settlement lien was about $150,000, that would have required a payment on behalf of Mid-States of $550,000. At a later point, Ranger offered to contribute $50,000 if Home would contribute its limit. Thus, had there been a firm demand, there could have been a settlement. But defense counsel's suggestion was unauthorized, so there was no firm demand.[358.92]

But Ranger also sought application of the "exception" to the demand requirement. But, at least in *Ranger*, the exception could not be applied because proximate cause could not be established:

> Under the exception, … the plaintiff must affirmatively show that had the primary insurer offered terms of settlement within its limits, the judgment creditor, who had not otherwise so indicated, would ultimately have accepted the offer. Yet, paradoxically, although the exception may benefit an excess carrier's bad faith action by expanding the scope of the primary carrier's obligations to pursue settlement, it works to the detriment of the excess carrier on the issue of proximate cause. Since the exception applies only where the probability of an adverse finding of liability is considerable and the amount of probable damages greatly exceeds primary coverage, the likelihood that a settlement offer within primary limits would be acceptable to a judgment creditor would

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not more likely than not); Bashaw v. Am. Family Mut. Ins. Co., 2006 U.S. Dist. LEXIS 88947, at *15–16 (N.D. Ill. Dec. 8, 2006) (summary judgment denied because evidence would permit jury to find that demand had been made for slightly less than limits); Powell v. Am. Serv. Ins. Co., 7 N.E. 3d 11, ¶ 18 (Ill. App. Ct. 2014) (same); John Crane, Inc. v. Admiral Ins. Co. 991 N.E.2d 474, ¶ 35 (Ill. App. Ct. 2013) (no liability because failure to settle not shown to damage plaintiff insurers); Chandler v. Doherty, 879 N.E.2d 396, 400–01 (Ill. App. Ct. 2007) (no liability because no demand before judgment in underlying suit).

[358.87] Swedish Am. Hosp. Ass'n v. Ill. St. Med. Inter-Ins. Exch., 916 N.E.2d 80, 100 (Ill. App. Ct. 2009).

[358.88] Ranger Ins. Co. v. Home Indemn. Co., 741 F. Supp. 716 (N.D. Ill. 1990).

[358.89] 741 F. Supp. at 717–18.

[358.90] 741 F. Supp. at 718.

[358.91] 741 F. Supp. at 718–19.

[358.92] 741 F. Supp. at 719–22.

> necessarily be drastically reduced. That fact leads us to question the efficacy of the exception in providing relief in the extreme case.[358.93]

That is, if liability were almost certain and damages were far in excess of limits, the claimant would have little reason to accept a limits settlement if an excess insurer (or a solvent defendant) was available to pay the excess judgment. In the *Ranger* context, there would be no reason to accept a $550,000 settlement if liability of Mid-States were clear: ADM could expect to collect more from a judgment.

Regardless, Ranger simply had not proven that ADM would have accepted a $550,000 offer, had such an offer been made.[358.94]

All of the Illinois authority for recognizing a duty to initiate settlement is dictum, and not very carefully considered. Even that dictum says that the exception is to be "sparingly used, and then only "in the most glaring cases of an insured's liability."[358.95] In nearly 50 years since the "exception" was first described, no reported case has found it applicable. If it were applicable, damages could not be found in the absence of proximate cause, and there would be obstacles to such a finding. The "exception" appears to have little practical effect. As a practical matter, Illinois should be classified as rejecting any duty to initiate settlement negotiations, with a footnote reflecting the theoretical possibility that circumstances might someday be found to require an insurer to do so.

[I] Jurisdictions the Affirmative Duty Article Classifies as Rejecting a Duty To Initiate Negotiations

The Affirmative Duty Article recognizes three states as having authority rejecting any duty to initiate negotiations Alaska, Mississippi, and Texas. That is certainly correct as to Texas. (*See* § 2.03[6][d][iii][G][III], *above*.) The Eleventh Circuit has predicted that Mississippi will not require an insurer to initiate settlement negotiations,[358.96] which is at least as solid as basis as that for the contrary conclusions about New Mexico and Washington.[358.97]

As to Alaska, the Affirmative Duty Article relies on *Jackson v. American Equity Insurance Co.*[358.98] In that case there was a demand and no issue about the duty to initiate. But the court did say that "[w]hen a plaintiff makes a policy limits demand, the covenant of good faith and fair dealing places a duty on an insurer to tender maximum policy limits to settle a plaintiff's demand when there is a substantial likelihood of an excess verdict against the insured."[358.99] That says that the demand triggers the duty, but does not clearly say that there would be no duty without the demand. And, it appears to be an offhand statement, not a considered ruling. So, *Jackson* supports rejection of a duty to initiate, but only weakly.

[358.93] 741 F. Supp. at 723.
[358.94] 741 F. Supp. at 723–24.
[358.95] Adduci v. Vigilant Ins. Co., 424 N.E.2d 645, 649–50 (Ill. App. Ct. 1981).
[358.96] Hemphill v. State Farm Mut. Auto. Ins. Co., 805 F.3d 535, 539–40 (5th Cir. 2015).
[358.97] *See* § 2.03[6][d][iii][F][I], *above*.
[358.98] Jackson v. Am. Equity Ins. Co., 90 P.3d 136 (Alaska 2004), *relied upon*, 37 INS. LITIG. RPTR. at 603 & n.32.
[358.99] *Jackson*, 90 P.3d at 142.

[J] Developments in Rhode Island

Both sides of the debate over the Affirmative Duty Article overlooked Rhode Island. The issue was first addressed there in *Asermely v. Allstate Insurance Co.*,[358.100] where the Supreme Court announced:

> [I]f it has been afforded reasonable notice and *if a plaintiff has made a reasonable written offer to a defendant's insurer to settle within the policy limits*, the insurer is obligated to seriously consider such an offer. If the insurer declines to settle the case within the policy limits, it does so at its peril in the event that a trial results in a judgment that exceeds the policy limits, including interest.[358.101]

This suggests that a demand is necessary to trigger any insurer duty. But in *Asermely* itself, there had been a court-annexed arbitration, producing an award within policy limits, which Asermely accepted but Allstate did not.[358.102] Asermely's acceptance of that award was effectively a within-limits demand, which Allstate rejected, leading to an excess judgment and an assignment of the insured's rights to Asermely.[358.103] So the suggestion that a demand was necessary to trigger the duty was dictum.

The issue of an insurer's duty to protect its insured against excess judgments was again touched upon in *Skaling v. Aetna Insurance Company*.[358.104] That was an underinsured motorist insurance bad-faith case. But, in addressing Skaling's claims, insurer should have offered more UIM benefits, the court commented that, in the third-party liability context, "an insurer has a fiduciary obligation 'to act in the "best interests of its insured in order to protect the insured from excess liability" ' and to refrain from conduct that demonstrates 'greater concern for the insurer's monetary interest than the financial risk attendant to the insured's situation.' "[358.105] That stated the duty in a form not dependent on a within-limits demand, but that was dictum, as the case involved first-party benefits.

The issue was yet again touched on in *Summit Insurance Co. v. Stricklett*.[358.106] The precise issue there was whether the insurer owed a duty to a third-party claimant to settle without any demand having been made. But in the course of holding that an insurer owed no such duty, the court described the duty to an insured by quoting the language of *Asermely* quoted above and distinguishing *Asermely*, in part, on the ground that there had been no demand in *Stricklett*. While the lack of any duty to the claimant was the main point in *Stricklett*, the lack of a demand was still treated as significant. Thus, while there is still no definitive ruling on the issue, Rhode Island seems best classified as requiring a within-limits demand.

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[xiv] [Reserved]

358.100 Asermely v. Allstate Ins. Co., 728 A.2d 461 (R.I. 1999).

358.101 728 A.2d at 464 (emphasis added).

358.102 728 A.2d at 462.

358.103 728 A.2d at 462–63.

358.104 Skaling v. Aetna Ins. Co., 799 A.2d 997 (R.I. 2002).

358.105 799 A.3d at 1005, *quoting Asermely*.

358.106 Summit Ins. Co. v. Stricklett, 199 A.3d 523 (R.I. 2019).

[xv] Insurer Must Act Reasonably When Claimant Seeks Information About Other Possible Sources of Payment

[A] Overview

Even if an insurer offers its limits, if the claim has significant value exceeding those limits, the claimant may reasonably inquire whether the insured may have other coverage which would also be available to pay any judgment, whether the insured has any other assets that could be reached to satisfy any judgment, and whether any other party might be liable for the insured's negligence. By reserving control of settlement and undertaking to provide a defense, the insurer has undertaken a duty to manage settlement negotiations. Information about other insurance and the insured's assets typically needs to be obtained from the insured. But, unless defense counsel does so, the insurer typically needs to inform the insured about any request for information and about the possible consequences of failing to provide it.[440.14a]

[B] *Harvey v. GEICO General Insurance Co.*: Facts

Harvey v. GEICO General Insurance Co.[440.15] is illustrative of the potential for liability based on mishandling of this task. Harvey was insured by GEICO under an auto policy with a $100,000 limit. He was involved in an accident with Potts, who was fatally injured, leaving behind a wife and three children. Two days after the accident, on August 10, 2006, GEICO concluded that Harvey was liable. On August 11, GEICO adjuster Korkus advised Harvey of the risk of excess exposure and of his right to hire his own attorney regarding that exposure.[440.16]

On August 14, Tejeda, a paralegal employed by counsel for the Potts estate, requested a statement from Harvey, regarding his assets, any other insurance, and whether he had been acting in the scope of any employment at the time of the accident. Korkus did not immediately communicate this request to Harvey and, according to Tejeda, rejected the request. On August 17, Korkus tendered the $100,000 policy limit to the estate's attorney, Domnick.[440.17]

Domnick responded with a letter, acknowledging the tender and what he described as Korkus's refusal to provide a statement from Harvey. Korkus received this letter on August 31 and faxed it to Harvey, who learned for the first time that a statement had been requested. On the same day, Korkus also had a phone conversation with Domnick, whose letter confirming that conversation said that Korkus had asked the purpose of the statement and that Domnick had responded with the reason previously stated by Tejeda, to determine what other coverage or assets would be available to cover the incident. Korkus did not respond to Domnick's letter.[440.18]

On September 1, Harvey called Korkus to discuss Domnick's letter. Harvey said he was going to meet with his lawyer (hired at Korkus's suggestion) to review financial documents and provide the information requested, but that the lawyer would not be available until September 5. Korkus's own log note stated: "*Insured does not want claimant attorney to think we are not acting fast enough and asked what we can do to let the claimant's attorney know we are working on this*. I told insured that we will

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[440.14a] Mosley v. Progressive Am. Ins. Co., 2018 U.S. Dist. LEXIS 199078, at *16–22 (S.D. Fla. Nov. 25, 2018).
[440.15] Harvey v. GEICO Gen. Ins. Co., 2018 Fla. LEXIS 1705 (Sept. 20, 2018).
[440.16] 2018 Fla. LEXIS 1705, at *4.
[440.17] 2018 Fla. LEXIS 1705, at *4–5.
[440.18] 2018 Fla. LEXIS 1705, at *5.

discuss letter with management and get back to him."[440.19] Korkus's supervisor instructed Korkus to relay Harvey's message to Domnick, but Korkus failed to do so.[440.20]

On September 13, 2006, Domnick returned GEICO's check and filed suit against Harvey. A jury found Harvey 100% at fault and assessed the estate's damages at $8.47 million, and judgment was entered accordingly.[440.21] At the bad faith trial, Korkus admitted that the request for a statement was reasonable, and the estate's expert testified that the requested information was necessary to properly advise the estate on settling. Domnick testified that, if he had been properly informed about Harvey's assets, he would have recommended accepting the policy limit offer, and Potts's widow testified that she would have accepted such a recommendation.

According to the estate's bad faith expert, David Doucette,

> a serious claim such as this one would require "a sense of urgency" on behalf of the insurer. He stated that it would have been in Harvey's best interests for Korkus to inform Domnick that he had retained an attorney, as this would have facilitated the recorded statement. Doucette also explained that because GEICO was handling the claim, Harvey could not contact Domnick directly. Instead, Harvey had to use Korkus as "a go-between given his duty to cooperate with his insurer."[440.22]

The estate also presented evidence that Korkus had been having trouble managing her files a year before the accident and that GEICO knew that and knew that it had not been corrected in the intervening year.[440.23]

The jury found bad faith, and judgment was entered for $9.2 million in favor of the estate. An intermediate court reversed the judgment finding that the evidence was insufficient to show bad faith and that, even if deficient, GEICO's actions did not cause the excess judgment.[440.24] It reasoned that an insurer cannot be liable for a judgment caused, at least in part, by the insured.[440.25] The Florida Supreme Court reversed and reinstated the trial court judgment.[440.26]

[C] *Harvey v. GEICO General Insurance Co.*: Breach of Duty

The court reviewed its prior caselaw on insurer duties regarding protection of insureds from excess judgments. In *Boston Old Colony Insurance Co. v. Gutierrez*,[440.27] the general duties of a liability

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[440.19] 2018 Fla. LEXIS 1705, at *6 (emphasis by the court).

[440.20] 2018 Fla. LEXIS 1705, at *6.

[440.21] 2018 Fla. LEXIS 1705, at *6–7.

[440.22] 2018 Fla. LEXIS 1705, at *8. As to Harvey's supposed inability to contact Domnick about giving a statement, this opinion seems highly dubious (though no objection to it is noted). But even if Harvey was free to make such contact, there seems to be no evidence that he knew that, nor that he could not properly rely on Korkus to inform Domnick about what was going on.

[440.23] 2018 Fla. LEXIS 1705, at *8–9.

[440.24] 2018 Fla. LEXIS 1705, at *9–10.

[440.25] 2018 Fla. LEXIS 1705, at *10.

[440.26] 2018 Fla. LEXIS 1705, at *3.

[440.27] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980)

insurer in handling claims against the insured:

> "in handling the defense of claims against its insured," the insurer "has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business." This duty arises from the nature of the insurer's role in handling the claim on the insured's behalf—because the insured "has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured."[440.28]

Boston Old Colony also explained implications of these duties where the insured faces a risk of an excess judgment:

> "This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Because the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, negligence is relevant to the question of good faith."[440.29]

The latter obligations

> are not a mere checklist. An insurer is not absolved of liability simply because it advises its insured of settlement opportunities, the probable outcome of the litigation, and the possibility of an excess judgment. Rather, the critical inquiry in a bad faith is whether the insurer diligently, and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment. "[T]he question of whether an insurer has acted in bad faith in handling claims against the insured is determined under the 'totality of the circumstances' standard." Further, it is for the jury to decide whether the insurer failed to "act in good faith with due regard for the interests of the insured."[440.30]

Boston Old Colony was reaffirmed in *Berges v. Infinity Insurance Co.*,[440.31] where the court had stated that the insurer "owe[s] a fiduciary duty to act in [the insured's] best interests."[440.32]

[440.28] *Harvey*, 2018 Fla. LEXIS 1705, at *11–12, *quoting* *Boston Old Colony*, 386 So. 2d at 785.

[440.29] 2018 Fla. LEXIS 1705, at *12, *quoting* *Boston Old Colony*, 386 So. 2d at 785.

[440.30] 2018 Fla. LEXIS 1705, at *13 (citations omitted). The *Harvey* court also criticized federal cases that had misread its prior decisions. 2018 Fla. LEXIS 1705, at *14–15.

[440.31] Berges v. Infinity Ins. Co., 896 So. 2d 665 (Fla. 2004).

[440.32] *Harvey*, 2018 Fla. LEXIS 1705, at *12, *quoting* *Berges*, 896 So. 2d at 677.

The court found ample evidence that GEICO had failed to act properly to protect Harvey from an excess judgment:

> GEICO failed to act as if the financial exposure to Harvey was a "ticking financial time bomb." The evidence shows that GEICO completely dropped the ball and failed to fulfill its obligation to Harvey to "use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business." Instead of doing everything possible to facilitate settlement negotiations, GEICO'S claims adjuster, Korkus, was a considerable impediment to both Harvey and the estate. When Domnick, the estate's attorney, requested a statement from Harvey, Korkus refused the request, despite acknowledging that such statements were standard practice. Additionally, not only did Korkus refuse the request, but she did not inform Harvey of the request until two weeks later, when Korkus received a letter from Domnick stating that the request had been denied. Even when Harvey informed Korkus that he intended to meet with his attorney to compile the information necessary for the statement, Korkus did not relay this information to Domnick. In fact, Korkus wholly failed to communicate with Domnick at all after receiving his letter.[440.33]

Based on Domnick's testimony, the jury could have found that, had Domnick been informed that Harvey would be providing a statement he would have deferred filing suit and, after receiving that statement, would have recommended accepting the policy limits, a recommendation the jury could have found would have been accepted.[440.34]

> Thus, had GEICO acted "with due regard" for Harvey's interests, the excess judgment could have been prevented. There can be no doubt that had GEICO been faced with paying the entire multi-million-dollar judgment returned by the jury in this case, an amount that was completely foreseeable given the clear liability and catastrophic damages, it would have done everything possible to comply with the estate's reasonable demands.[440.35]

The intermediate court had "acknowledged that 'GEICO could have acted more efficiently in handling the insured's claim,' " but concluded that "the evidence 'merely show[ed] that GEICO could have perhaps "improved its claims process," not that it acted in bad faith.' "[440.36] That court also opined that even were negligence shown, that would not prove bad faith.[440.37] But that missed the mark. "While it is true that negligence is not the standard, we made clear in *Boston Old Colony* that '[b]ecause the duty of

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[440.33] 2018 Fla. LEXIS 1705, at *17–18 (citations omitted).

[440.34] 2018 Fla. LEXIS 1705, at *18–19.

[440.35] 2018 Fla. LEXIS 1705, at *19 (citation omitted).Two dissenting justices took issue with the court's analysis of *Boston Old Colony*, which the dissent characterized as "completely divorcing that [case's] general language from the specifically enumerated obligations and effectively adopt[ing] a negligence standard for bad faith actions, even though negligent claims handling does not amount to bad faith failure to settle." 2018 Fla. LEXIS 1705, at *46 (dissenting op.).

[440.36] 2018 Fla. LEXIS 1705, at *20 (citations omitted), *quoting* GEICO Gen. Ins. Co. v. Harvey, 208 So. 3d 810, 816 (Fla. Dist. Ct. App. 2017).

[440.37] 2018 Fla. LEXIS 1705, at *20.

good faith involves diligence and care in the investigation and evaluation of the claim against the insured, *negligence is relevant* to the question of good faith.' "[440.38] Moreover, the intermediate court had completely failed to consider "whether GEICO 'use[d] the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business.' "[440.39]

The intermediate court had given great weight to the fact that GEICO had tendered its limits only nine days after the accident. But the supreme court responded that nothing in its prior cases "can be read to suggest that an insurer's obligations end by tendering the policy limits. To the contrary, the insurer's duty to act in good faith 'in handling the defense of claims against its insured' continues through the duration of the claims process."[440.40]

[D] *Harvey v. GEICO General Insurance Co.*: Causation

The intermediate court also blamed Harvey for the failure of the settlement negotiations, because he "never provided a statement to the estate despite having the assistance of legal counsel for several days before suit was eventually filed."[440.41] This was error, because "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured."[440.42] That focus was appropriate because the insured has "surrendered to the insurer [*23] all control over the handling of the claim."[440.43]

The intermediate court had stated that "where the *insured's own actions or inactions* result, at least in part, in an excess judgment, the insurer cannot be liable for bad faith."[440.44] While the supreme court had stated that "there must be a causal connection between the damages claimed and the insurer's bad faith,"[440.45] it had "never held or even suggested that an insured's actions can let the insurer off the hook when the evidence clearly establishes that the insurer acted in bad faith in handling the insured's claim."[440.46] To the contrary, where both the insurer's actions and those of the insured contributed to the outcome, causation is an issue of fact.[440.47]

Two dissenting justices disputed the court's causation analysis:

> The majority paints the picture that Harvey only had $85,000 of assets, that he agreed to provide his financial information to the estate's attorney, and that the wrongful death suit against Harvey would have settled for the $100,000 policy limits if only GEICO had informed the estate's attorney that Harvey was working on providing the information.

[440.38] 2018 Fla. LEXIS 1705, at *20, *quoting* *Boston Old Colony*, 386 So. 2d at 785 (emphasis by the *Harvey* court).
[440.39] 2018 Fla. LEXIS 1705, at *21, *quoting* *Boston Old Colony*, 386 So. 2d at 785.
[440.40] 2018 Fla. LEXIS 1705, at *22, *quoting* *Boston Old Colony*, 386 So. 2d at 785.
[440.41] 2018 Fla. LEXIS 1705, at *22 (citation omitted), *quoting* GEICO Gen. Ins. Co. v. Harvey, 208 So. 3d 810, 816 (Fla. Dist. Ct. App. 2017).
[440.42] 2018 Fla. LEXIS 1705, at *22 (citation omitted), *quoting* Berges v. Infinity Ins. Co., 896 So. 2d 665, 677 (Fla. 2004).
[440.43] 2018 Fla. LEXIS 1705, at *22 (citation omitted), *quoting* *Boston Old Colony*, 386 So. 2d at 785.
[440.44] 2018 Fla. LEXIS 1705, at *24 (citation omitted), *quoting* GEICO Gen. Ins. Co. v. Harvey, 208 So. 3d 810, 816 (Fla. Dist. Ct. App. 2017) (emphasis by the intermediate court).
[440.45] 2018 Fla. LEXIS 1705, at *24 (citation omitted), *quoting* Perera v. United States Fid. & Guar. Co., 35 So. 3d 893, 902 (Fla. 2010).
[440.46] 2018 Fla. LEXIS 1705, at *24.
[440.47] 2018 Fla. LEXIS 1705, at *24.

> The record reveals that Harvey and his wife had assets well in excess of $1 million, Harvey was already discussing his coverage and assets with potential legal counsel on the day of the accident, Harvey provided his asset information to his personal attorney three weeks before suit was filed, Harvey and his attorney knew of the estate's attorney's request for information, and Harvey never once offered to provide the information. It is not that the Fourth District erroneously "blamed Harvey for failing to do more to avoid the excess judgment." Rather, it is that Harvey and his attorney—not GEICO—controlled the only relevant decision that needed to be made.[440.48]

According to the dissent, as soon as Harvey was informed, on August 11, of the potential for excess exposure, he consulted his company lawyer about that. On August 17, Harvey gathered financial information and set up a meeting with that lawyer, which was held August 23. Testimony is said to have "revealed that Harvey owned certain liquid assets exceeding $900,000, plus four motor vehicles and two houses."[440.49] But "[t]he estate's attorney testified that in his view, the only asset available to the estate as "collectible" was $85,000 in the operating account of Harvey's business."[440.50]

Assuming that the dissent's portrayal of the evidence is accurate (and the court never disputes that portrayal), there still appears to be an issue of fact. Even if all of the assets described would have been available to satisfy any judgment, the estate's attorney testified that he believed that they would not have been available and that he would have recommended acceptance of the policy limits had they been timely disclosed. If he really held that belief, then failure to provide the statement could have caused the excess judgment, despite the possible incorrectness of that belief. Whether he did hold that belief would have been a question for the jury.

And, while Harvey knew on August 31 that a statement had been requested, he arguably should have been told that on August 14, so he is not solely to blame for the delay in providing it. Moreover, had Korkus told Domnick that a statement was being prepared, Domnick testified that he would have deferred filing suit to allow the statement to be completed. Again, causation appears to present a factual question.

[E] *Harvey v. GEICO General Insurance Co.*: Comment

Harvey illustrates that liability for failure to settle may depend on either or both of two aspects of its conduct: (1) whether the insurer failed to offer its policy limit and (2) whether it mishandled other aspects of settlement negotiations. Arguably, the standards for judging these two aspects may be different. Assuming that bad faith and negligence are different standards *(but see* § 2.03[2][c], *above*), the insurer's' evaluation of settlement value still might support liability only if it was in bad faith, even if (as *Harvey* suggests) the handling of settlement negotiations might support liability even if only negligent. Because *Harvey* presented no issue about evaluation of settlement value, it simply does not address the standard applicable to such an issue.

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[440.48] 2018 Fla. LEXIS 1705, at *28–29 (dissenting op.).
[440.49] 2018 Fla. LEXIS 1705, at *39 (dissenting op.).
[440.50] 2018 Fla. LEXIS 1705, at *39 (dissenting op.).

§ 2.09 Duties and Rights of Excess Insurers

[1] Excess Insurer That Is Injured by Primary Insurer's Bad Faith Failure To Settle Has Same Right To Recover as Insured Would Have in Absence of Excess Insurance

If an insured purchases excess insurance, that provides protection from some of the consequences of any possible bad faith of the primary insurer in failing to settle within the primary limits. But "[t]he primary insurer's duty to act with due care and in good faith does not disappear simply because the insured purchased excess insurance."[1] "If the insured purchases excess coverage, he in effect substitutes an excess insurer for himself. It follows that the excess insurer should assume the rights as well as the obligations of the insured in that position."[2]

The generally recognized mechanism for this substitution is equitable subrogation. This is a legal fiction employed by courts when one person, acting involuntarily or under some obligation, pays a debt that, in right and justice, another should pay. The payor is said to be equitably subrogated to the rights of the person to whom the primary obligor owed the obligation. An insurer whose bad faith causes an excess judgment or necessitates an excess settlement is primarily liable to the insured on that account, and the excess insurer is entitled, upon discharging the insured's obligations, to assert the insured's rights against the primary insurer.[3]

According this right to the excess insurer encourages appropriate settlements by maintaining the primary insurer's incentive to settle within limits and to refrain from gambling with the excess insurer's money when it would not gamble with its own.[4] It also prevents an unfair distribution of losses between

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Indiana: Certain Underwriters of Lloyd's etc. v. Gen. Accident Ins. Co., 909 F.2d 228, 232 (7th Cir. 1990).

Pennsylvania: United States Fire Ins. Co. v. Royal Ins. Co., 759 F.2d 306, 309 (3d Cir. 1985).

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Minnesota: Cont'l Cas. Co. v. Reserve Ins. Co., 307 Minn. 5, 8–9 (1976);

Arizona: Hartford Acc. & Indem. Co. v. Aetna Cas. & Sur. Co., 164 Ariz. 286, 289–91 (Sup. Ct. 1990) (collecting cases);

Florida: Ranger Ins. Co. v. Travelers Indem. Co., 389 So. 2d 272, 274–75 (Fla. Dist. Ct. App. 1980).
See also Phillips v. Bramlett, 288 S.W.3d 876 (Tex. 2009) (statutory cap on physician liability does not limit liability of insurer that improperly refused to settle within limits).

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Pennsylvania: Greater N.Y. Mut. Ins. Co. v. North River Ins. Co., 85 F.3d 1088, 1095 (3d Cir. 1996);

Hawaii: St. Paul Fire & Marine Ins. Co. v. Liberty Mut. Ins. Co., 135 Haw. 449, 453–56 (2015) (collecting cases and following majority to approve right of equitable subrogation);

Texas: Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 482–483 (Tex. 1992);
RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 28 (2019).

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California: Northwestern Mut. Ins. Co. v. Farmers Ins. Grp., 76 Cal. App. 3d 1031, 1045 (1978);

primary and excess insurers and undue inflation of excess insurance premiums. Like the insured, the excess insurer cannot settle without risking loss of the primary insurer's contributions, and the excess insurance is priced well below the cost of primary insurance on the basis that the primary insurer will cover all claims not exceeding the primary policy limits, including those that should be settled within those limits.[5] While protecting the excess insurer, allowing it to assert a bad faith claim by equitable subrogation does not increase the burden on the primary insurer:

> Under the doctrine of equitable subrogation, the duty owed an excess insurer is identical to that owed to the insured. The excess will not be able to force the primary into accepting any settlement which his duty to the insured would not require accepting. In considering whether it will settle a claim, the primary insurer may consider its own interests, but it must equally consider the interests of the insured, which become the interests of the excess insurer by subrogation.[6]

An excess insurer asserting an equitable subrogation claim cannot avoid an assessment of the equities of its own position. In *Travelers Indemnity v. Arch Specialty Insurance Co.*[7] Arch was an excess insurer that had paid $20.5 million in addition to Travelers' primary limit of $2 million. Among its theories was that Travelers should have accepted a $2 million statutory settlement demand. But that demand had been induced by a false interrogatory response failing to disclose the $25 million Arch excess policy. While there was some dispute about responsibility for the false interrogatory response, the court held that Arch was not equitably entitled to take advantage of that response or of the possibility that the plaintiff might not have discovered its policy:

> Arch had contracted with FT to provide an excess insurance policy. No one disputes that the policy covered the accident involving Diana. Arch was obligated to perform pursuant to the terms of the contract. The fact that Arch can point to various factual possibilities under which through inadvertence or malfeasance its policy may have gone undiscovered in the Mejia action does not change Arch's legal obligation. Concerning the 998 Offer, the court cannot find that Arch is in a superior equitable position. Arch's theory relies on an injured nine-year old girl being fraudulently or negligently mislead as to the amount of insurance coverage. It further relies on the Arch policy not being discovered at a

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Kansas: West Am. Ins. Co. v. RLI Ins. Co., 698 F.3d 1069, 1075 (8th Cir. 2012);

Maryland: Fireman's Fund Ins. Co. v. Cont'l Ins. Co., 308 Md. 315, 321 (1987);

Michigan: Commercial Union Ins. Co. v. Medical Protective Co., 426 Mich. 109, 119 (1986).
RESTATEMENT § 28, cmt. *a* (2019) ("Such a rule provides primary insurers with appropriate incentives to make reasonable settlement decisions and preserves the intended allocation of risk between primary and excess insurers, consistent with the law of restitution and unjust enrichment").
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Minnesota: Cont'l Cas. Co. v. Reserve Ins. Co., 307 Minn. 5, 9–10 (1976);

New Jersey: Estate of Penn v. Amalgamated Gen. Agencies, 148 N.J. Super. 419, 423–24 (App. Div. 1977) (internal citations omitted).

[6] Peter v. Travelers Ins. Co., 375 F. Supp. 1347, 1350 (C.D. Cal. 1974).

[7] Travelers Indem. v. Arch Specialty Ins. Co., 2013 U.S. Dist. LEXIS 169453 (E.D. Cal. Nov. 26, 2013).

> minor settlement hearing, and FT not coming forward before the settlement is approved to correct or supplement its discovery responses. Lastly, Arch's scenario requires that once the policy was discovered, the court would not set aside the minor settlement approval assuming initial approval. Under California equitable subrogation law, Arch stands in the position of the insured, FT, and FT verified false interrogatory responses which failed to disclose Arch's excess policy. FT is not entitled to benefit from the false responses, and Arch proceeding under a theory based on equity is not entitled to benefit from the false responses.[8]

In some jurisdictions, a primary insurer's refusal to settle for a reasonable amount frees the insured to settle. (*See* § 4.03[2][a], *below*.) If that rule applies, lack of an excess judgment does not preclude an action by the excess insurer against the primary insurer. As the Missouri Supreme Court explained:

> The insurer's duty is to protect the insured's financial interests, which are impacted by an insurer's breach of duty whether the breach results in an excess judgment or an excess settlement. Requiring an excess judgment would force the insured to go to trial after its insurer wrongfully refuses to settle instead of permitting the insured to protect itself from further liability by settling. There is "no attraction to a rule that rewards bad faith by relieving the insurer of excess liability if it forces harsh choices onto an insured facing a huge judgment." Allowing a bad faith refusal to settle claim when the insured settles fosters Missouri's policy encouraging settlements.[9]

Some jurisdictions deny an excess insurer any right to sue a primary insurer for bad faith failure to settle. Missouri was formerly thought to fall in this camp.[10] That rule is unjust, as it makes recovery by the injured excess insurer contingent on enforcement by an insured that has suffered no injury and has no direct interest in assisting the excess insurer. Moreover, it was said to be accompanied by a rule characterizing the claim for bad faith failure to settle as a personal injury claim whose assignment is forbidden by law.[11] The only parties benefitted by such rules are primary insurers that have breached their duties to settle, thereby requiring excess insurers to contribute to payment of excess judgments which ought never to have occurred. The Missouri Supreme Court has now upheld the right of an excess insurer to sue as equitable subrogee.[12] It also upheld the right to sue as assignee.[13] A federal district court has held that an excess insurer that has received an assignment can pursue both claims.[14]

Under Alabama law, no equitable subrogation claim is recognized where, after an excess judgment, the primary and excess insurers settled the claim, because the insured never suffered any direct

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[8] 2013 U.S. Dist. LEXIS 169453, at *20–21.

[9] *Missouri:* Scottsdale Ins. Co. v. Addison Ins. Co., 448 S.W.3d 818, 827–28 (Mo. 2014) (citation omitted; collecting cases). *Accord*
Louisiana: RSUI Indem. Co. v. Am. States Ins. Co., 768 F.3d 374, 379–81 (5th Cir. 2014).

[10] Am. Guar. & Liab. Ins. Co. v. United States Fid. & Guar. Co., 693 F. Supp. 2d 1038, 1048–49 (E.D. Mo. 2010).

[11] 693 F. Supp. 2d at 1049–50.

[12] *Scottsdale*, 448 S.W.3d at 832.

[13] *Scottsdale*, 448 S.W.3d at 829–830.

[14] Axis Specialty Ins. Co. v. YMCA, 2016 U.S. Dist. LEXIS 105948, *6–8 (W.D. Mo. Aug. 11, 2016).

injury for which a subrogated claim could be asserted.[15] But the fact that the excess insurer was obliged to protect and did protect the insured from the injury caused by the primary insurer's bad faith ought not to shield the primary insurer from liability for that injury.[16]

Even where equitable subrogation is recognized, such claims are subject to the same defenses as an insured's own bad faith claim. Thus, *New Jersey Manufacturers Insurance Co. v. National Casualty Co.*[17] holds that a primary insurer, sued by the excess insurer for failure to settle, is entitled to defend on the ground that the excess insurer would not have settled even had the primary insurer tendered its limits and is entitled to discovery from the excess insurer regarding that defense.

An employee of Grinnell Haulers sideswiped a car occupied by Bernard and Gloria Brodsky, which came to rest on the shoulder of the road. The Brodskys got out of the car. A car driven by William Horsman hit Mr. Brodsky then the Brodsky car, which hit Mrs. Brodsky. Mr. Brodsky died and Mrs. Brodsky was seriously injured.[18] Horsman was uninsured and was discharged in bankruptcy. Grinnell had a $1 million primary policy with NJM and a $4 million excess policy with NCC. The Brodskys first demanded $5 million, later reducing that to $3.5 million. Grinnell offered $400,000 and later $750,000. The Brodskys' lawyer stated that the case would never settle for $1 million or less, but only well into the excess policy.[19]

At trial, the only issue was apportionment of fault between Grinnell and Horsman and the amount of damages. The jury found that Grinnell had 60% of the fault and awarded $1,640,000 in damages, plus prejudgment interest. But the jury had been told, improperly, that a 60% apportionment would permit recovery of the full damages from Grinnell, and a new trial was ordered.[20]

NCC was told that NJM had authorized payment of its full limit, but requested that the Brodskys not be informed of this, so NCC could try to settle within the primary limit. The Brodskys lowered their demand to $1.5 million, but NCC offered to pay only $100,000, demanding that NJM pay $1.4 million. NJM refused to pay anything above its limit, and the apportionment was again tried, with the same result. NJM paid its $1 million limit, NCC paid $640,000, and they agreed to divide prejudgment interest of $580,322.07 and litigate about that later. This case is that litigation.[21]

NJM initially obtained summary judgment that it was liable only for its policy limit. The

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[15] Federal Ins. Co. v. Travelers Cas. & Sur. Co., 843 So. 2d 140, 144–45 (Ala. 2002).

[16] RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT, § 24 (2011) ("(1) If the claimant renders to a third person a performance for which the defendant would have been directly liable, the claimant is entitled to restitution from the defendant as necessary to prevent unjust enrichment. (2) There is unjust enrichment in such a case if (a) the claimant acts in the performance of the claimant's independent obligation to the third person, or otherwise in the reasonable protection of the claimant's own interests; and (b) as between the claimant and the defendant, the performance or the part thereof with respect to which the claimant seeks restitution is primarily the obligation of the defendant."); RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 28, cmt. *b* (2019) ("In some states, courts have held that excess insurers lose their right to settle subrogation claims against primary insurers if the excess insurer settles the claim before the insured is required to make a payment, but such a result is a misapplication of equitable subrogation. Failure to allow the excess insurer to bring an equitable subrogation claim against the primary insurer in such cases would result in unjust enrichment.").

[17] New Jersey Manufacturers Ins. Co. v. National Casualty Co., 413 N.J. Super. 94 (App. Div. 2010).

[18] 413 N.J. Super. at 97–98.

[19] 413 N.J. Super. at 97–98, 102.

[20] 413 N.J. Super. at 98.

[21] 413 N.J. Super. at 98–99.

Appellate Division reversed, holding that NJM could be liable in excess of its policy limit if it had breached its duty to settle. The existence of an excess policy did not reduce that duty. The evidence before the trial court on summary judgment was not adequate to determine whether the duty had been breached. The case was remanded for an evidentiary hearing.[22] NJM sought discovery regarding NCC's own conduct in relation to settlement, especially after NJM tendered its own limits. NCC objected, arguing that only NJM's conduct was at issue. The trial court overruled the objection, but NCC was granted leave to appeal that ruling. The Appellate Division now affirmed.[23]

Even if NJM had breached a duty to offer its limit earlier than it did, it could assert an affirmative defense that no settlement would have resulted, even had it made the required tender.[24] Even without the requested discovery, there was an issue whether there would have been a settlement before the first trial: the Brodskys' insisted on more than $1 million to settle and there was some record evidence suggesting that NCC may have been unwilling to contribute even had there been a tender. Once NJM had made the tender, there was certainly evidence that NCC might have caused the failure to settle by what may have been an improper demand that NJM contribute $1.4 million to meet the $1.5 million demand. Accordingly, NCC's settlement position was relevant at both stages, and NJM was entitled to discovery regarding that position.[25]

The Appellate Division also observed, for the guidance of the trial court, that NJM would not be liable for prejudgment interest accruing before NJM breached whatever duty it may have had to offer its policy limit. To the extent that the insurers retained use of the policy proceeds on which the prejudgment interest was imposed, that might be considered in determining damages.[26]

In *Ohio Casualty Co. v. Twin City Fire Insurance Co.*,[27] excess insurer Ohio sued primary insurer Twin City for failure to settle within its $1 million limit. Ohio urged that a report by defense counsel indicating a 50% chance of liability and possible damages as high as $5 million made it unreasonable not to offer the limit. Twin City contended that it then reasonably evaluated the case as within limits (even though it later settled for $5 million after liability was found in a bifurcated trial). It argued that the reasonableness of its evaluation was supported by the fact that, Ohio, despite receiving the same report. did not notify its reinsurers of a possible claim. The court held that this evidence cleared the very low bar of relevance to be admissible in the trial.[28] But Ohio's post-verdict conduct regarding settlement was not relevant to evaluation of Twin City's pre-verdict conduct.[29]

Once an excess carrier's equitable subrogation rights have arisen, a release from the insured will not necessarily bar them.[30]

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[22] 413 N.J. Super. at 99–100, *describing* New Jersey Mfrs. Ins. Co. v. Nat'l Cas. Co., 393 N.J. Super. 340 (App. Div.), *certif. denied*, 192 N.J. 481 (2007).

[23] 413 N.J. Super. at 100, 106.

[24] 413 N.J. Super. at 101–02. Whether that issue should be an affirmative defense or part of the plaintiff's burden of proof is discussed in William T. Barker & Ronald D. Kent, *SNR Denton on* Allstate Insurance Co. v. Miller: *Failure to Inform Insured of Settlement Opportunity as a Basis for Excess Judgment Liability*, LEXISNEXIS® EMERGING ISSUES ANALYSES, 2010 Emerging Issues 4948 (April 2010). That issue does not matter in the case at hand.

[25] 413 N.J. Super. at 102–03.

[26] 413 N.J. Super. at 105.

[27] Ohio Cas. Co. v. Twin City Fire Ins. Co., 2019 U.S. Dist. LEXIS 50504 (E.D.N.Y., Mar. 26, 2019).

[28] 2019 U.S. Dist. LEXIS 50504, at *3–5, *9–13.

[29] 2019 U.S. Dist. LEXIS 50504, at *13–15.

[30] Steadfast Ins. Co. v. Agric. Ins. Co., 2013 OK 63, ¶¶ 9–14.

[2] Few Jurisdictions Recognize Any Direct Duties Between Primary and Excess Insurers

Allowing the excess insurer to be equitably subrogated to the insured's claim against the primary insurer presupposes that the insured has a valid claim. But a claim by the insured may be barred if the insured has contributed to the failure to settle by either failure to cooperate or by objecting to a settlement. (*See* § 2.05, *above*.) In such circumstances, equitable subrogation will provide no benefit to the excess insurer.[31]

A few courts have chosen to protect excess insurers against this risk by imposing on the primary insurer a direct duty to the excess insurer.[32] A California court similarly imposed a duty of "triangular reciprocity," including a duty on an insured with respect to its own self-insured retention.[33] The imposition of a duty on the insured has been repudiated by the California Supreme Court, though that court may not have passed on existence of a direct duty between the insurers.[34]

Most courts that have addressed the issue have rejected existence of a direct duty.[35] There is, of

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[31] Certain Underwriters of Lloyd's, etc. v. Gen. Accident Ins. Co., 909 F.2d 228, 232–33 (7th Cir. 1990) (IN law).

[32]

New York: Hartford Acc. & Indem. Co. v. Mich. Mut. Ins. Co., 61 N.Y.2d 569, 574 (1984); St. Paul Fire & Marine Ins. Co. v. United States Fid. & Guar. Co., 43 N.Y.2d 977, 977 (1978) (applying principle to an insurer's duty to "manage its insured's defense in good faith");
see

New Jersey: Estate of Penn v. Amalgamated Gen. Agencies, 148 N.J. Super. 419, 423–24 (App. Div. 1977) (language seemingly finding direct duty, coupled with language seemingly limiting duty to equitable subrogation, in case where there would be no difference in result); CNA Ins. Co. v. Selective Ins. Co., 354 N.J. Super. 369, 383–84 (App. Div. 2002) (limiting any direct duty to true excess insurers, as opposed to co-primary insurers rendered excess by an "other insurance" provision).

Illinois: Cent. Ill. Pub. Serv. Co. v. Agric. Ins. Co., 378 Ill. App. 3d 728, 732–35 (5th Dist. 2008) (seemingly approving direct duty in case where equitable subrogation would have produced same result).

[33] Transit Cas. Co. v. Spink Corp., 94 Cal. App. 3d 124, 134–35 (1979).

[34] Commercial Union Assur. Cos. v. Safeway Stores. Inc., 26 Cal. 3d 912, 917–18, 921 (1980) (disapproving imposition of settlement duty on insured and observing that existing California cases allowing recovery by excess insurers against primary insurers were all based on equitable subrogation).

[35] *E.g.,*

Illinois: Twin City Fire Ins. Co. v. Country Mut. Ins. Co., 23 F.3d 1175, 1178 (7th Cir. 1994) (collecting cases on direct duty and finding no basis to predict that Illinois would adopt it; in analyzing that question, the Seventh Circuit noted, but did not answer the following questions: "Should courts strain to create novel tort duties on behalf of insurance companies? Do insurance companies need the protection of tort law against their own insureds and other insurance companies." 23 F.3d at 1180–81); Liberty Mut. Ins. Co. v. Am. Home Assur. Co., 348 F. Supp. 2d 940, 957–60 (N.D. Ill. 2004) (insurer that was excess over SIR owed no direct settlement duty to second-level excess);

Louisiana: Great Sw. Fire Ins. Co. v. CNA Ins. Cos., 557 So. 2d 966, 969–70 (La. 1990);

Massachusetts: Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. 115, 124 (1994);

Michigan: Commercial Union Ins. Co. v. Medical Protective Co., 426 Mich. 109, 119–25 (1986);

course, no contractual relationship between primary and excess carriers out of which a duty of good faith and fair dealing could arise. (That is the very reason that resort to equitable subrogation has been thought necessary.) Courts have been unwilling to grant excess insurers greater rights than insureds.[36] Creating a direct duty would impose something similar to a cause of action for *negligent* interference with contract, something normally protected only from *intentional* interference.[37] And excess insurers could protect themselves contractually:

> The excess insurer can bargain for any obligation it seeks to impose upon its insured. If the insured breaches a duty owed to the excess insurer, the excess insurer can refuse coverage or pursue an action against its own insured. In this way, legitimate expectations of all three parties, the insured, the primary insurer, and the excess insurer, can be traced to bargained-for agreements. Such an arrangement promotes certainty in the setting of rate structures, which in turn keeps insurance costs down and encourages policyholders to carry excess insurance, … .[38]

The Restatement of the Law of Liability Insurance rejects any direct duty to an excess insurer.[39]

In New York, which recognizes a direct duty, but sets a very high bar for duty to settle claims (*see* § 2.03[2][a][ii], *above*), the excess insurer must show: "that (1) the primary insurer exhibited "gross disregard" for the interests of the excess insurer under New York's multi-factor test; and (2) this gross disregard caused the loss of an actual opportunity to settle the case within the primary policy limit."[40]

Agreement by all insurers to a high-low after a lower-level insurer has failed to take an alleged settlement opportunity within its limits does not bar an excess judgment claim by a higher-level excess insurer for failure to take the settlement opportunity. *Columbia Casualty Co. v. Ironshore Specialty Insurance Co.*[41] arose from a medical malpractice case against Rhode Island Hospital ("RIH"), which was owned by Lifespan. Lifespan provided $6 million in self-insured "coverage," Columbia provided $15 million in excess coverage, and Ironshore provided $11 million above that. Defense counsel advised that the case could be settled for $15 million, and Lifestyle tendered its limit. Columbia refused to offer more than $500,000 of its limit. It did offer a total of $15 million on the second day of trial, but that was rejected. All parties later agreed to a high-low, with a minimum recovery of $15 million and a maximum of $31.5 million. The verdict exceeded $31.5 million and Ironshore paid $11,011,044. Ironshore sought to recover its payment from Columbia. Columbia argued that the suit was barred by agreement to the settlement with the plaintiffs.[42]

Missouri: Scottsdale Ins. Co. v. Addison Ins. Co., 448 S.W.3d 818, 834 (Mo. 2014);

Washington: Truck Ins. Exch. v. Century Indem. Co., 76 Wn. App. 527, 535 (1995).

[36] 76 Wn. App. at 535.

[37] 557 So. 2d at 969–70.

[38] 426 Mich. at 122. *See also Twin City Fire Ins. Co.*, 23 F.3d at 1180 (if excess insurer is to have a remedy for the insured's failure to settle, the remedy should be a defense against the insured, not a claim against the underlying insurer).

[39] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 24, cmt. *j* (2019).

[40] Scottsdale Ins. Co. v. Indian Harbor Ins. Co., 994 F. Supp. 2d 438, 451 (S.D.N.Y. 2014).

[41] Columbia Cas. Co. v. Ironshore Specialty Ins. Co., 2016 U.S. Dist. LEXIS 65998 (D.R.I. May 19, 2016).

[42] 2016 U.S. Dist. LEXIS 65998, at *2–6.

The court disagreed:

> The settlement executed by the parties did not result in a settlement of the underlying litigation; it merely set upper and lower limits to damages determined by a potential jury verdict. The gravamen of Ironshore's bad-faith claims is that, by refusing to settle the underlying claim up to its $15 million policy limits, Columbia risked negative consequences to RIH from a potential high jury verdict, as well as the complete exhaustion of RIH's remaining coverage under Ironshore's third tier excess insurance for the account year. While a complete settlement of the underlying case might have foreclosed any claims Ironshore is now asserting against Columbia, the existence of the "high-low" agreement, by itself, does not preclude Ironshore's counterclaims.[43]

[3] Most Jurisdictions Hold That Excess Insurer Ordinarily Has No Duty To Defend or Settle Unless and Until Primary Coverage Is Exhausted

[a] Excess Insurer's Duty To Defend Does Not Attach Until Primary Coverage Is Exhausted

"The majority rule is that 'where the insured maintains both primary and excess policies, the excess liability insurer is not obligated to participate in the defense until the [primary] policy limits are exhausted.' "[44] (Policy language may even require actual payment of the underlying limits before the

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[43] 2016 U.S. Dist. LEXIS 65998, at *8–9.

[44] *E.g.*,

Illinois: Fox v. Am. Alternative Ins. Corp., 757 F.3d 680, 684 (7th Cir. 2014);

Louisiana: XL Specialty Ins. Co. v. Bollinger Shipyards, Inc., 954 F. Supp. 2d 440, 446–47 (E.D. La. 2013);

Georgia: Cont'l Cas. Co. v. Synalloy Corp., 667 F. Supp. 1523, 1540 (S.D. Ga. 1983) (acknowledging that although some courts have held that an excess carrier must participate in the defense where it is clear that judgment may be greater than primary policy limits, such a conclusion would "fly in the face of the policy language" and would make the excess insurer a coinsurer with the primary carrier with a coextensive duty to defend);

California: Signal Companies, Inc. v. Harbor Ins. Co., 27 Cal. 3d 359, 367 (1980) (requiring excess carrier to defend before primary carrier's policy limit was exhausted was an "untenable" result absent some compelling equitable consideration because the excess carrier's policy explicitly stated that its liability would not attach until the primary carrier's coverage was exhausted);

New Hampshire: Old Republic Ins. v. Stratford Ins., 132 A.3d 1198, 1200 (N.H. 2016);

Texas: Keck, Mahin & Cate v. Nat'l Union Fire Ins Co., 20 S.W.3d 692, 700 (Tex. 2000) (collecting authorities; noting that "majority rule is supported by the reasonable expectations of the insured and its insurance carriers. Excess insurers are able to provide relatively inexpensive insurance with high policy limits because they require the insured to contract for underlying primary insurance with another carrier.");

Colorado: Colorado Farm Bur. Mut. Ins. Co. v. North Am. Reins. Co., 802 P.2d 1196, 1198 (Colo. Ct. App. 1990);

Maryland: Fireman's Fund Ins. Co. v. Rairigh, 59 Md. App. 305, 323 (1984);

excess insurer is obliged to participate in the defense.)[45] (*See* § 2.09[6], *below*.) But, at least where the excess policy includes umbrella coverage, a denial of coverage by the putative underlying insurer can trigger the excess insurer's duty to defend.[45.1] Because an excess insurer has no duty to defend before the underlying insurance has been exhausted, it is also not required to reserve its rights regarding possible grounds to decline coverage until that duty has arisen and should not be subject to any estoppel for failure to do so.[45.2] A few courts hold that an excess insurer must participate in and share the cost of the defense if it is clear or there is a reasonable possibility that the insured is exposed to a potential judgment in excess of the primary policy limit.[46] While such questions depend on the language of the particular excess policy at issue, there seems no public policy reason to favor triggering the excess insurer's duty before the primary coverage has been exhausted. The insured is as well protected with one defending insurer as with two. Because the primary insurer must set its prices without knowing whether the insured will purchase

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Kansas: Assoc. Wholesale Grocers, Inc. v. Americold Corp., 261 Kan. 806, 830 (1997);
RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 39(1) (2019).

[45] Estate of Bradley v. Royal Surplus Lines Ins. Co., 647 F.3d 524, 530–531 (5th Cir. 2011) (even actual entry of judgment exceeding underlying limits did not require excess insurer to participate).

45.1

Minnesota: Hawkins Chem. v. Westchester Fire Ins. Co., 159 F.3d 348, 354–55 (8th Cir. 1998);

Georgia: Am. Family Life Assur. Co. v. United States Fire Co., 885 F.2d 826, 832 (11th Cir. 1989);

Washington: Weyerhauser Co. v. Comm'l Union Ins. Co., 15 P.3d 115, 134–35 (Wash. 2000).

45.2

US/Pennsylvania: TIG Ins. Co. v. Tyco Int'l, Ltd., 919 F. Supp. 2d 439, 458–59 (M.D. Pa. 2013), *quoting* Douglas R. Richmond, *Excess Insurance & Umbrella Coverage, in* 4 NEW APPLEMAN ON INSURANCE, LIBRARY EDITION, § 24.04 (Jeffrey E. Thomas & Aviva Abramovsky, eds. 2011);

Texas: Keck Mahin & Cate v. Nat'l Union Fire Ins. Co., 20 S.W.3d 692, 701 (Tex. 2000) (rejecting arguments that, while the primary insurer was defending, excess insurer should have "explored coverage issues more diligently, reserved its rights against the insured, investigated the merits of the third-party claim more thoroughly, hired independent counsel to monitor the third-party claim, supervised its claims adjuster more closely, and demanded to settle the claim months before trial"). *But cf.*
RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 22(2)(b) (2019) (defense-cost indemnification insurer must reserve rights on same basis as defending insurer).

[46]

Connecticut: Cambridge Mut. Fire Ins. Co. v. Ketchum, 2012 U.S. Dist. LEXIS 115618 (D. Conn. 2012) (predicting that Connecticut would adopt that rule);

South Carolina: Royal Ins. Co. of America v. Reliance Ins. Co., 140 F. Supp. 2d 609, 618 (D.S.C. 2001) (holding that excess carrier's duty to defend "became 'absolute' " at the moment the complaint was filed as the complaint contained a prayer for relief that "clearly implicated the excess coverage");

Colorado: Millers Mut. Ins. Ass'n v. Iowa Nat'l Mut. Ins. Co., 618 F. Supp. 301 (D. Colo. 1985);
E.g.,

Michigan: Celina Mut. Ins. Co. v. Citizens Ins. Co., 133 Mich. App. 655, 661 (1984);

Nevada: Am. Excess Ins. Co. v. MGM Grand Hotels, Inc., 102 Nev. 601, 604 (1986).

excess insurance, it must make full allowance for defending all claims in the premium rates it charges. Accordingly, there is no apparent reason why the excess insurer should have to relieve the primary insurer of any of the burden it was paid to assume. Of course, the excess insurer may not actively disrupt the defense, even if it is not obliged to participate.[47]

Even if an excess policy does not itself provide for a duty to defend, it may be held to impose such a duty if it follows form to a primary policy that includes a duty to defend and the excess policy does not negate such a duty.[47.1]

In *Fritz v. St. Paul Fire & Marine Insurance Co.*,[47.2] St. Paul was an excess insurer. The primary insurer disclaimed coverage and St. Paul was never notified of the suit. The insureds suffered a default judgment, followed by an uncontested prove-up. They then agreed with the Fritzes to assign their rights against both insurers and to substitute a $20 million consent judgment for the default judgment.[47.3] The Fritzes sued St. Paul, which was held to have no duty to defend, because the underlying coverage was not exhausted, and it had no obligation to pay a consent judgment to which it had not agreed.[47.4]

Different rules may apply where multiple policies written as primary insurance cover the same claim, with one or more insurers being designated as excess pursuant to "other insurance provisions.[48] (An insurer designated as excess in this way is said to be "excess by coincidence.")[49] In such cases, the "excess" insurer will have priced its policy to include defense coverage, though presumably with some allowance for cases when another insurer would be rendered primary.

The primary insurer's tender of its limits for settlement does not transfer the duty to defend to the excess insurer unless, under the language of the primary policy (*see* § 2.09[3][a]), that tender terminates the duty to defend under the primary policy.[50] (*See also* § 3.09[5][a].)

If the primary insurer claims to be exhausted but the excess insurer contests that, the primary insurer must continue to defend while the dispute is resolved, but is entitled to reimbursement from the excess insurer for any costs incurred after its duty to defend actually terminated.[51] As between the insured and the excess insurer, the insured has the burden to prove exhaustion of the underlying coverage.[52]

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[47] Nat'l Union Fire Ins Co. v. Ins. Co. of N. Am., 955 S.W.2d 120, 138 (Tex. App. 1997), *aff'd sub nom.*, Keck, Mahin & Cate v. Nat'l Union Fire Ins Co., 20 S.W.3d 692 (Tex. 2000).

[47.1] Johnson Controls, Inc. v. London Mkt., 2010 WI 52, ¶¶ 32–46 (Sup. Ct. 2010).

[47.2] Fritz v. St. Paul Fire & Marine Ins. Co., 2019 U.S. Dist. LEXIS 135066 (E.D. Tenn. Aug. 12, 2019).

[47.3] 2019 U.S. Dist. LEXIS 135066, at *2–10.

[47.4] 2019 U.S. Dist. LEXIS 135066, at *16–21.

[48] *Compare*

Maine: Progressive Cas. Ins. Co. v. Travelers Ins. Co., 735 F. Supp. 15, 19 (D. Me. 1990) (car's insurer excess to driver's insurer and therefore not obliged to defend), *with*

Montana: American States Ins. Co. v. Angstman Motors, Inc., 343 F. Supp. 576, 586–87 (D. Mont. 1972) (even though garage policy was primary to driver's policy for purposes of indemnity, both insurers shared obligation to defend).

[49] NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE § 30.38[4].

[50] Texas Employers Ins. Ass'n v. Underwrit'g Members of Lloyds, 836 F. Supp. 398, 409–10 (S.D. Tex. 1993).

[51] Hartford Acc. & Indem. Co. v. Super. Ct. (Syntex Corp.), 23 Cal. App. 4th 1774, 1781–82 (1994).

[52] Nat'l Elec. Mfrs. Ass'n v. Gulf Underwrs. Ins. Co., 162 F.3d 821, 826 (4th Cr. 1998).

If the insurance is excess over only an SIR and the insured obtains primary insurance to cover the SIR, the excess insurer may have co-primary responsibility for defense costs after the SIR is exhausted if the primary insurance is not.[53]

[b] Insurer's Duty To Settle Does Not Attach Until Primary Coverage Has Been Exhausted or Tendered for Settlement

As a matter of self-protection, the excess insurer will often monitor or even participate in settlement exploration. But most courts hold that it is not obliged to do so unless and until the primary coverage has been exhausted or tendered.

An excess insurer's duty to settle is independent of any duty to defend.[54] "Even when it has not assumed the defense or control of settlement negotiations, an excess insurer has the right under the policy to consent to any settlement reaching its coverage level. The excess insurer has an implied obligation to exercise that right in good faith."[55] But, until the primary insurer has offered its limits, the excess insurer has "no obligation to pay anything or to evaluate seriously" the claim against the insured.[56] In particular, it need not offer any contribution to a settlement within the underlying limits, even if its own layer of coverage is potentially exposed.[57]

A primary insurer (or underlying excess insurer) whose policy limit is inadequate to settle a case may be obliged (in order to protect the insured) to tender its limits to the excess insurer, so as to trigger its duty to consider settlement and to permit settlements to be made.[58]

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[53] Lexington Ins. Co. v. Va. Surety Co., 486 F. Supp. 2d 173, 178–79 (D. Mass. 2007).

[54]

Texas: Keck, Mahin & Cate v. Nat'l Union Fire Ins Co., 20 S.W.3d 692, 701 (Tex. 2000); *see also* § 2.03[6][e], *above*.

But see

Illinois: Fox v. Am. Alternative Ins. Corp., 757 F.3d 680, 684 (7th Cir. 2014) (no duty to settle unless insurer has duty to defend).

[55] Assoc. Wholesale Grocers, Inc. v. Americold Corp., 261 Kan. 806, 830 (1997).

[56]

Alaska: Grace v. Ins. Co. of N. Am., 944 P.2d 460, 466–67 (Alaska 1997);

California: Highlands Ins. Co. v. Cont'l Cas. Co., 64 F.3d 514, 518–19 (9th Cir. 1995);

Iowa: Berglund v. State Farm Mut. Auto. Ins. Co., 121 F.3d 1225, 1228 (8th Cir. 1997) (IA law);

Texas: Keck, Mahin & Cate, 20 S.W.3d at 701 (excess insurer's duty not triggered until primary insurer has tendered its policy).

[57] Grace v. Ins. Co. of N. Am., 944 P.2d 460, 466–67 (Alaska 1997).

[58]

Florida: Gen. Acc. Fire & Life Assurance Corp. v. Am. Cas. Co., 390 So. 2d 761, 765–66 (Fla. Dist. Ct. App. 1980) (within-primary-limits demand not requirement for bad faith liability where insured has excess insurance or substantial nonexempt assets);

It has been held, under Oklahoma law, that an excess insurer has no duty to investigate or initiate settlement negotiations until the underlying limits have been paid, even though the primary insurer had offered its limits to the excess insurer.[59] (Oklahoma primary insurers do have a duty to initiate settlement negotiations.)[60] The policy language provided that the duty to investigate and defend did not attach until the underlying limits had been exhausted by payment.[61] But liability was clear and the primary limit was clearly not enough to settle the case.[62] The underlying limit in this single-victim case could not be exhausted by payment until the case settled. Once the underlying insurer has offered its limit, it could do no more to settle the case unless the excess insurer provided authority to an offer within its limits. The duty to settle does not require that the insurer be defending (or obligated to defend). (*See* § 2.03[6][c][i], *below*.) So the duty to consider settlement ought to have passed to the excess insurer once the primary offered its limits.[63] If the excess insurer required investigation that had not yet occurred, it could have called upon the primary insurer to do that. But it ought not to have been permitted to remain totally inactive until the primary limit had been paid.

Even an excess insurer that has no duty to participate in settlement negotiations may assume such a duty by informing its insured that it is investigating and will, if necessary, provide a defense.[64]

Because an excess insurer is not obliged to act regarding settlement until the primary insurer tenders its limits, the primary carrier ordinarily cannot defend a failure to settle suit by the excess insurer by arguing that the excess insurer's pre-tender conduct (e.g., failure to urge settlement) constituted contributory negligence.[65]

If a primary insurer rejects a reasonable settlement demand (or refuses to contribute its limits) and if the jurisdiction allows the insured in such circumstances to settle without the primary insurer's consent

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Illinois: Cent. Ill. Pub. Serv. Co. v. Agric. Ins. Co., 378 Ill. App. 3d 728, 737 (2008);

Massachusetts: Clegg v. Butler, 424 Mass. 413, 422 n. 8 (1997);

Texas: Employers Nat'l Ins. Corp. v. Gen. Accident Ins. Co., 857 F. Supp. 549 (S.D. Tex. 1994) (liability for wrongful failure to tender and obstruction of excess insurer's participation in settlement consideration); RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 24, cmt. *h* (2018). ***but see***

New York: Calif. Union Ins. Co. v. Excess Ins. Co., 780 F. Supp. 1010, 1012 (S.D.N.Y. 1991) (where excess insurer is fully informed of demand in excess of primary limits and does not propose settlement, primary insurer not liable for failure to tender its limits);

Texas: Westchester Fire Ins. Co. v. Am. Contractors Ins. Co. Risk Retention Grp., 1 S.W.3d 872 (Tex. App. 1999) (even though demand was reasonable in valuing the tort claim, the fact that it exceeded the primary insurer's limits meant that its rejection of that demand did not breach its duty to settle).

[59] SRM, Inc. v. Great Am. Ins. Co., 798 F.3d 1322, 1326–27 (10th Cir. 2015).

[60] 798 F.3d at 1325.

[61] 798 F.3d at 1326–27.

[62] 798 F.3d at 1324.

[63] State Farm Mut. Auto. Ins. Co. v. Mendoza, 2006 U.S. Dist. LEXIS 709, at *26 (D. Ariz. Jan. 5, 2006) (excess insurer's duty to consider settlement arose, at the latest, when the primary insurer tendered its limits).

[64] 2006 U.S. Dist. LEXIS 709, *29–31.

[65] *Keck, Mahin & Cate,* 20 S.W.3d at 701–02.

and sue the primary insurer, the excess insurer may do likewise.[66] Arguably, that course might be required as a way to mitigate the excess insurer's losses.

[c] Insured Must Provide Evidence Sufficient to Establish, Prima Facie, That Underlying Limits Have Been Exhausted

There is very little authority on what must be done to trigger an excess insurer's duty to begin providing benefits (whether defense or indemnity) based on the underlying insurers' exhaustion. That issue was analyzed in *Sinclair Oil Corp. v. Allianz Insurance Co.*[67] The court concluded that Allianz had a duty to defend once the underlying insurance was exhausted.[68] As to bodily injury, claims within the "completed operations hazard" and the "products hazard" were subject to aggregate limits in the primary policy, while all other claims were subject only to the per-occurrence limit.[69] As to property damage, some claims would be subject to various aggregates (depending on the nature of the type of occurrence generating the claim).[70] To trigger the excess insurer's duty to defend, the insured must show that the claim is potentially within the coverage of the policy.[71] Where the policy provides primary insurance, this can be done by looking only to the allegations of the complaint, but where the insurance is excess, an additional showing must be made regarding exhaustion:[72]

> we hold that, in order to trigger such a duty to defend, the umbrella carrier must have "actual notice" of the potential exhaustion of the aggregate limits of the underlying insurance policy. We find that "actual notice" is notice sufficient to allow the insurer to make a preliminary determination that the limits of the underlying insurance policy have potentially been exhausted as to the claim or claims for which the insured is seeking coverage. The umbrella insurer is entitled to more than an insured's allegation of exhaustion. At a minimum, the insurer must be in possession of some evidence of actual payments, made by the underlying insurance company or the insured, that potentially meet or exceed the aggregate limits of the underlying policy that is applicable to the claim for which the insured is seeking coverage. Once the umbrella carrier is in possession of such evidence of payments made, the burden is on the insurer to resolve any potential issues regarding exhaustion. At that point in time, if the complaint comes within the potential coverage of the excess policy, the umbrella insurer has a duty to defend the insured. Accordingly, if the umbrella carrier wishes to litigate the issue of underlying exhaustion or assert any other defense to coverage [without risking forfeiture of indemnity coverage defenses if a duty to defend is

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Pennsylvania: Greater N.Y. Mut. Ins. Co. v. North River Ins. Co., 85 F.3d 1088, 1094–96 (3d Cir. 1996);

California: Valentine v. Aetna Ins. Co., 564 F.2d 292, 296–98 (9th Cir. 1977);

Minnesota: Cont'l Cas. Co. v. Reserve Ins. Co., 307 Minn. 5, 9 n.4 (1976).

67 Sinclair Oil Corp. v. Allianz Ins. Co., 2015 IL App (5th) 140069.

68 2015 IL App (5th) 140069, ¶ 38.

69 2015 IL App (5th) 140069, ¶ 38.

70 2015 IL App (5th) 140069, ¶ 38.

71 2015 IL App (5th) 140069, ¶ 48.

72 2015 IL App (5th) 140069, ¶ 49.

> found], it must defend the insured under a reservation of rights or seek a declaratory judgment.[73]

The record contained insufficient evidence to show exhaustion of the bodily injury limits. The parties had not briefed the issue of whether the claims at issue were even subject to the aggregate limit. Moreover, the settlement with the primary insurer was expressly allocated to property damage claims only. While Sinclair had apparently made substantial payments, there was no showing which ones were for bodily injury or of what evidence regarding these claims had been provided to Allianz. Thus, there remained material issues of fact whether any duty to defend such claims had been triggered.[74]

The primary insurer had made payments allocated to property damage sufficient to exhaust its aggregate limit for claims subject to that limit, and Allianz had been provided evidence of that. While there was a question about what types of claims were subject to which aggregate limit, Allianz was the party bearing the burden of clarifying that. Because Allianz neither defended nor sought a judicial determination of its duty, Illinois law provided that it had breached its duty to defend property damage claims.[75]

The duty to defend result might differ in states allowing more extensive use of extrinsic evidence on that issue than does Illinois. (*See* § 3.02[4][b], *below*.)

[4] If Primary Insurer Is Insolvent or Wrongfully Refuses To Defend, Excess Insurer May Be Obliged to "Drop Down" and Provide Defense or Indemnity, Depending on Policy Language and Local Law

Where there is excess insurance, insureds may ask an excess insurer to "drop down" into the place of a primary insurer or lower level insurer in three situations: the insured may have failed to maintain the primary or lower level insurance specified in the excess policy; the primary or lower level insurer may have become insolvent; or an insurer with an apparent duty to defend or to reimburse defense costs may have refused to do so.

Excess insurance policies usually require the insured to maintain the specified underlying coverage without reduction in limits or alteration in terms.[76] Failure to maintain that insurance does not void the excess coverage, but makes the insured responsible for what would have been covered by that insurance had it been maintained.[77] Such provisions are enforced and generally obviate any obligation to "drop down" on account of the insured's failure to maintain the underlying insurance.[78]

Courts have been reluctant to impose "drop down" requirements unless the policy language calls for that:

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[73] 2015 IL App (5th) 140069, ¶ 51 (footnote omitted).
[74] 2015 IL App (5th) 140069, ¶¶ 53–54.
[75] 2015 IL App (5th) 140069, ¶ 55.
[76] NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, § 30.40.
[77] NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, § 30.40.
[78] *E.g.*,

California: Reserve Ins. Co. v. Pisciotta, 30 Cal. 3d 800, 815 (1982) (insured must fill gap in coverage created by change in underlying limits);
RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 39(3) & cmt. *e* (2019).

> Excess liability insurers contract to provide inexpensive insurance with high policy limits by requiring the insured to contract for primary insurance with another carrier. The premium is also held down by the fact that the duty to defend rests primarily on the primary insurer, falling on the excess liability carrier only when the primary carrier is not required to defend because the loss is not covered by the primary policy. If excess liability carriers are required to defend in cases where the primary carrier would have defended except for insolvency, then the risk of the primary carrier's insolvency is placed on the excess carrier. Such a "rule would require insurance companies to scrutinize one another's financial well-being before issuing secondary policies. The insurance world is complex enough; to impose this additional burden on companies such as [the excess carrier] would only further our legal system's lamentable trend of complicating commercial relationships and transactions."[79]

The effect of insolvency of an underlying insurer depends on the language of the excess policy. If it is declared to be excess over "amounts collectible" or "recoverable" under the underlying policy, the excess insurer will generally be required to "drop down," because the insolvency renders amounts due under the underlying policy uncollectible.[80] If the excess policy is declared to be excess over the limits or amounts insured under the underlying policies, subject to reduction of those limits by actual payment of losses, the excess insurer will not be required to "drop down."[81] Where the excess policy is excess over the underlying limits plus "amounts collectible" under other insurance, there is a split of authority, but most of the cases do not require the excess insurer to "drop down."[82] Where the excess policy requires the

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[79] Harville v. Twin City Ins. Co., 885 F.2d 276, 278–79 (footnotes omitted), *quoting* Cont'l Marble & Granite v. Canal Ins. Co., 785 F.2d 1258, 1259 (5th Cir. 1986); RESTATEMENT, § 39, cmt. *e* ("when excess insurers price their policies, they take into account various facts about the underlying insurer, including the likelihood of insolvency. Nevertheless, the excess insurer does not choose the underlying insurer. In fact, the party most responsible for 'assembling the tower' of liability coverage, at least in commercial settings, is the insurance broker. If the broker determines that the underlying insurer poses a serious risk of insolvency, then the insurance broker's duty of reasonable care may require the broker to advise the policyholder to purchase underlying coverage from a different insurer or, alternatively, to insist that the excess policy include an express drop-down provision.").

[80] *E.g.,*

Louisiana: Kelly v. Weil Assoc. Moving & Storage Co., 563 So. 2d 221, 222 (La. 1990) (collecting and classifying cases);

California: Pisciotta, 30 Cal. 3d at 814–15;

Illinois: Donald B. MacNeal Inc. v. Interstate Fire & Cas. Co., 132 Ill. App. 3d 564, 566 (1985).

[81] *E.g.,*

Louisiana: Kelly v. Weil Assoc. Moving & Storage Co., 563 So. 2d at 222;

Missouri: Interco Inc. v. Nat'l Sur. Corp., 900 F.2d 1264, 1267–68 (8th Cir. 1990);

Ohio: Kelley v. Ernst, 108 Ohio App. 3d 207, 211–12 (1995).

[82] *E.g.,*

underlying limits to be "exhausted," but does not specify how that must occur, there is a division of authority whether the exhaustion must be by payment (precluding "drop down") or whether insolvency exhausts the underlying policy.[83]

A requirement that the amount of the underlying coverage be actually paid may preclude any obligation to "drop down."[84] But it may not be necessary that all of the required payment be made by the insured or its liability insurer.[85]

A tender of the underlying limits for settlement did not constitute exhaustion until those limits are actually paid (at least where tender did not terminate the duty to defend under the primary policy).[86] Nor, in the absence of policy language so providing, does the tender, coupled with the inevitable exhaustion of the primary policy create any equitable duty for the excess insurer to assume or participate in the defense.[87]

Where an excess insurer's policy includes a duty to defend or to reimburse defense costs and does not limit that duty by a requirement that the underlying limits have been paid, the excess insurer some courts may be require it to "drop down" and provide a defense if the primary insurer refuses to do so.[88]

Louisiana: Kelly v. Weil Assoc. Moving & Storage Co., 563 So. 2d at 222–23 (collecting cases and declining to require "drop down");

Florida: Shapiro v. Associated Int'l Ins. Co., 899 F.2d 1116, 1122–23 (11th Cir. 1990) (declining to require "drop down").

[83] *Compare*

Washington: Fed. Ins. Co. v. Scarsella Bros., Inc., 931 F.2d 599, 604 (9th Cir. 1991) ("exhausted" is ambiguous and insolvency should be deemed to exhaust), *with*

Illinois: New Process Baking Co. v. Fed. Ins. Co., 923 F.2d 62, 63–64 (7th Cir. 1990) ("exhaustion" requires payment).

[84]

Texas: Laster v. Am. Nat'l Fire Ins. Co., 775 F. Supp. 985, 993 (N.D. Tex. 1991), *aff'd without op.*, 966 F.2d 676 (5th Cir. 1992);

California: Span, Inc. v. Assoc. Int'l Ins. Co., 227 Cal. App. 3d 463, 476 n.7 (1991);

New Jersey: Shaler *ex rel* Shaler v. Toms River Obstetrics & Gynecology Assocs., 383 N.J. Super. 650, 659–60 (App. Div. 2006).

[85] Waste Mgmt., Inc. v. Transcont. Ins. Co., 502 F.3d 769, 773–74 (8th Cir. 2007) (payors included insurance guaranty association and plaintiffs' underinsured motorist insurer).

[86] Nat'l Union Fire Ins. Co. v. Travelers Ins. Co., 214 F.3d 1269, 1272–73 (11th Cir. 2000).

[87] 214 F.3d at 1273–74.

[88] *E.g.*,

Minnesota: Hawkins Cehmical, Inc. v. Westchester Fire Ins. Co., 159 F.3d 348, 355 (8th Cir. 1998);

Georgia: Am. Family Life Assur. Ass'n v. United States Fire Co., 885 F.2d 826, 832 (11th Cir. 1989);

This rule may be applied where the primary insurer is insolvent.[89]

[5] Insured That Has Control of Settlement Is Usually Not Required to Consider Interests of Its Insurers in Exercising That Control

The court in *Transit Casualty Co. v. Spink Corp.*[90] reasoned that the duty of good faith was mutual, so an insured ought to commit its own funds to protect an excess carrier on the same basis that a primary insurer is obliged to commit its funds to protect an insured against excess exposure. But the California Supreme Court disapproved that result in *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*,[91] holding that an insured has no obligation to commit its own funds for the protection of its excess insurer. It reasoned that, while the duty of good faith was mutual, that duty was only one to respect the other party's reasonable expectations of benefits, and that the expectations here were not symmetrical.[92] If the insurer wished to impose a duty to settle on the insured, it should have made that clear by explicit language.[93] (A policy including a provision of that sort was considered in *Liberty Mutual Insurance Co. v. Wheelwright Trucking Co.*[94]

Washington: N.H. Indem. Co. v. Budget Rent-A-Car Sys., 148 Wn. 2d 929, 938 (2003) ("The insured should not be left without a prompt and proper defense and if a primary insurer fails to assume the defense, for any reason, the secondary insurer which has a duty to defend should provide the defense and, to do justice, should be entitled to recoup its costs from the primary insurer.").
Contra

California: Republic Western Ins. Co. v. Fireman's Fund Ins. Co., 241 F. Supp. 2d 1090, 1099 (N.D. Cal. 2003) ("If [the excess insurer's] duty to defend were to arise instead from any refusal by the primary carrier to provide coverage or to defend an insured, whether or not that action was correct based on the policy, then the umbrella carrier, in underwriting its own policy, would also have to consider the track record of the primary carrier for good faith assumption of its duty to defend.").

[89] *E.g.,* Ross v. Canadian Indem. Ins. Co., 142 Cal App. 3d 396, 403 (1983) (excess insurer responsible for defense in absence of specific contrary language).

[90] Transit Cas. Co. v. Spink Corp., 94 Cal. App. 3d 124, 131 (1979), *partially overruled by*, Liberty Mut. Ins. Co. v. Am. Home Assurance Co., 348 F. Supp. 2d 940 (N.D. Ill. 2004); Commercial Union Assur. Cos. v. Safeway Stores, Inc., 26 Cal 3d 912 (1980).

[91] Commercial Union Assur. Cos. v. Safeway Stores, Inc., 26 Cal 3d 912, 164 Cal. Rptr. 709, 610 P.2d 1038 (1980).

[92] 26 Cal 3d at 919–21.

[93] *Accord*

New Jersey: Employers Mut. Cas. Co. v. Key Pharmaceuticals, 75 F.3d 815, 817, 819–20 (2d Cir. 1996), *aff'g on op. below,* 871 F. Supp. 657 (S.D.N.Y. 1994) (when insured steps into shoes of insolvent primary insurer, it does not assume any duty to settle within primary limits);

Arizona: Twin City Fire Ins. Co. v. Super. Ct., 164 Ariz. 295, 297 (1990);

Texas: Int'l Ins. Co. v. Dresser Indus., Inc., 841 S.W.2d 437, 444–46 (Tex. App. 1992).
But see

Illinois: Twin City Fire Ins. Co. v. Country Mut. Ins. Co., 23 F.3d 1175, 1180 (7th Cir. 1994) (criticizing that rule).

[94] Liberty Mut. Ins. Co. v. Wheelwright Trucking Co., 851 So. 2d 466, 485 (Ala. 2002) (SIR endorsement provided that "You [the insured] shall be responsible for the investigation, defense and settlement of any 'claim' or 'suit' for damages with the Self-Insured retention, and for the payment of all 'Allocated Loss Adjustment Expenses.' You

Regardless of how one views *Safeway, Spink* was wrongly decided. It involved professional liability policies, each requiring the insured's consent to settle.[95] The very purpose of such provisions (in contracts that otherwise grant insurers control of settlement) is to allow the insured to protect collateral interests (such as reputation) that might be injured by settlement. So, the insured cannot have an implied duty to sacrifice such interests for the protection of the insurers. Moreover, the contracts themselves provided protection for the insurers' interests, by limiting the insurers' liability to the amount of a settlement precluded by the insured's lack of consent.[96]

The *Spink* court incorrectly concluded that the right to consent to settlement does not permit unreasonable rejection of settlements, though allowing the insured to argue to a jury that the rejection was reasonable in light of the collateral interests being protected.[97] At very least, that rule would improperly construe an ambiguous contract in favor of the insurer. (The court construed the provision narrowly pursuant to the policy of promoting settlements,[98] but that policy does not justify overriding a provision specifically designed to restrict settlement.) At most, the policyholder's duty to the insurers should be to exercise this power in subjective good faith, which the evidence in *Spink* showed had occurred. To be sure, the insured's decision appears to have been ill-founded and based on inadequate investigation, but the policies did not require that the insured conduct any investigation.

Safeway is a closer case, as the insured's control of settlement resulted solely from the fact that its policy provided for a self-insured retention, keeping control of defense and settlement until that was exhausted. It thus placed itself in a position analogous to that of a primary insurer, arguably subjecting itself to the same implied duties. But, ultimately, this does seem to be a situation where the insurer should have protected itself by contract, if it wished to have protection.

[6] There Is a Division of Authority on Whether Underlying Limits Must Actually Be Paid To Trigger an Excess Insurer's Duty To Indemnify—Leading Cases

Whether underlying limits must actually be paid to trigger an excess insurer's duty to indemnify is important in multi-layer insurance programs, as insureds wish to be able to compromise each layer separately and then move to the next higher layer. If full payment of the underlying insurance is required, compromise of one layer precludes access to higher layers. (*See also* § 3.09[5][b], *below*.)

In *Zeig v. Massachusetts Bonding Co.*,[99] the excess policy required that the underlying insurance be " 'exhausted in the payment of claims to the full amount of the expressed limits." The insurer argued that this required the insured to collect the full amount of the underlying policy before excess coverage was triggered. The Second Circuit disagreed:

> Such a construction of the policy sued on seems unnecessarily stringent. It is doubtless true that the parties could impose such a condition precedent to liability upon the policy, if they chose to do so. But the defendant had no rational interest in whether the insured collected the

shall exercise the utmost good faith, diligence and prudence to settle all 'claims' and 'suits' within the Self-Insured Retention.").

[95] 94 Cal. App. 3d at 129 n.1.

[96] 94 Cal. App. 3d at 129 n.1.

[97] 94 Cal. App. 3d at 136.

[98] 94 Cal. App. 3d at 136.

[99] Zeig v. Massachusetts Bonding Co., 23 F.2d 665 (2d Cir. 1928).

> full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable. A result harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it.
>
> We can see no reason for a construction so burdensome to the insured. Nothing is said about the "collection" of the full amount of the primary insurance … . The claims are paid to the full amount of the policies, if they are settled and discharged, and the primary insurance is thereby exhausted. There is no need of interpreting the word "payment" as only relating to payment in cash. It often is used as meaning the satisfaction of a claim by compromise, or in other ways. To render the policy in suit applicable, claims had to be and were satisfied and paid to the full limit of the primary policies. Only such portion of the loss as exceeded, not the cash settlement, but the limits of these policies, is covered by the excess policy.[100]

While the court recognized that a requirement of actual payment could be imposed, it concluded that more specific language would be necessary to do so. *Zeig* is very widely followed,[101] but it does not enunciate a public policy precluding a requirement of actual collection, though insureds sometimes treat it as if does. It only demands that such a requirement be expressed in more explicit language than that at issue there.[102]

But different language may more clearly require actual payment. Or a different court (less persuaded by *Zeig's* view of the rationality of such a requirement) might find even language like that in *Zeig* sufficient to impose such a requirement. Thus, in *United States Fire Insurance Co. v. Lay*,[103] the Seventh Circuit disagreed with *Zeig's* conclusion that the excess insurer had no rational reason to insist on actual payment:

> We can conceive of good reasons for an excess carrier to be unwilling to

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[100] 23 F.2d at 666.

[101]

Indiana: Trinity Homes LLC v. Ohio Cas. Ins. Co., 629 F.3d 653, 658–59 (7th Cir. 2010);

Pennsylvania: Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996).

[102] *Zeig* remains good law in New York. Hopeman Bros., Inc. v. Cont'l Cas. CO., 307 F. Supp. 3d 433, 472 (E.D. Va. 2018). LaSorte v. Those Certain Underwriters at Lloyds Subscribing to Policy Nos. 115NAP108111970, 115NAP109111970, 995 F. Supp. 2d 1134, 1143 (D. Mont. 2014). It is widely followed. *E.g.,*

Pennsylvania: Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3rd Cir. 1996);

Virginia: Maximus Mut. Life Ins. Co. v. Twin City Fire Ins. Co., 856 F. Supp. 2d 797, 800–04 (E.D. Va. 2012);

Florida: Reliance Ins. Co. v. Transam. Ins. Co., 826 So. 2d 998, 999–1000 (Fla. Dist. Ct. App. 2001).

[103] *See* United States Fire Ins. Co. v. Lay, 577 F.2d 421 (7th Cir. 1978).

> accept liability unless the amount of the primary policy has actually been paid. A settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty to represent the interests of the excess carrier. Here the primary insurer had no incentive whatsoever to reach a settlement at a figure between $70,000 and $100,000. Moreover, the settlement agreement terminating Comador's liability to the administratrix made her subsequent wrongful death action against Comador a sham. Neither Comador nor the primary insurer, which purported to defend the action, had any interest whatsoever in the outcome.[104]

In *Lay*, Comador's primary insurer agreed to pay $70,000 of its $100,000 limit and the plaintiff, Lay, agreed not to collect any judgment except from the excess insurer (United States Fire), and entered into a consent judgment of $150,000. The excess policy promised to indemnify against "ultimate net loss in excess of the [primary] limit," with "ultimate net loss" defined as "[a]ll sums which the insured or any company as his insurer, or both become legally obligated to pay." Under this language, Lay argued that, in accordance with *Zeig* "the satisfaction of a judgment by agreement and compromise constitutes payment within the meaning of the quoted condition." The Seventh Circuit disagreed:

> The short answer is that the condition becomes applicable only when there is coverage. Because the insured never became liable for an amount exceeding $100,000, there is no coverage. It is therefore immaterial whether, if there had been coverage, the underlying carrier would be considered to have "paid the amount of retained limit."[105]

The result in *Lay* probably reflects a concern with the consent judgment, so it would not apply to a judgment that was either actually litigated or permissible despite the restrictions on settlements made without the (excess) insurer's consent. (*See* Ch. 4, *below*.) But it could still be useful to an excess insurer demanding actual payment of the underlying limits.

The most prominent recent case favoring an excess insurer on this issue is *Qualcomm, Inc. v. Certain Underwriters at Lloyd's*.[106] The Underwriters had issued Qualcomm a policy of excess directors & officers insurance, with an underlying $20 million policy from National Union Fire Insurance ("National"). Qualcomm incurred $29 million in settlement costs and defense expenses regarding employee suits concerning unvested company stock options. It settled with National for $16 million. It then sued the Underwriters for the $9 million excess over the $20 million underlying limit. The excess policy contained a "Maintenance of Underlying Policies" clause (the "maintenance clause"). Incorporating its definitions, that clause provided:

> "This Policy provides excess coverage only. It is a condition precedent to the coverage afforded under this Policy that [Qualcomm] maintain [the National policy] with retentions/deductibles, and limits of liability (subject to reduction or exhaustion as a result of loss payments), as set forth in Items F. and G. of the Declarations. This Policy does not provide

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[104] 577 F.2d at 423 (citations omitted).

[105] 577 F.2d at 423.

[106] Qualcomm, Inc. v. Certain Underwrs. at Lloyd's, 161 Cal. App. 4th 184 (2008). *See also* Comerica, Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007).

> coverage for any loss not covered by the [National policy] except and to the extent that such loss is not paid under the [National policy] solely by reason of the reduction or exhaustion of the Underlying Limit of Liability through payments of loss thereunder. In the event [National] fails to pay loss in connection with any claim as a result of the insolvency, bankruptcy or liquidation of said insurer, then those insured hereunder shall be deemed self-insured for the amount of the Limit of Liability of said insurer which is not paid as a result of such insolvency, bankruptcy or liquidation."[107]

In a "Limit of Liability" section, the excess policy also contained a clause (the "exhaustion clause") providing that " 'Underwriters shall be liable only after the insurers under each of the Underlying Policies [the National policy] have paid or have been held liable to pay the full amount of the Underlying Limit of Liability.' "[108]

The court summarized Qualcomm's arguments as follows:

> Urging us to interpret ambiguity in Underwriters's excess policy in its favor, and pointing to *Zeig* and cases following it, Qualcomm contends we must interpret the excess policy's language in this case so as not to forfeit excess insurance in the event of its below-limits settlement with the primary insurer. Qualcomm reasons Underwriters is "chargable" with knowing that its policy language—specifically the "have paid or have been held liable to pay" portion of the exhaustion clause—has been widely interpreted to permit an insured to exhaust primary policy limits by entering into a below-limits settlement with the primary insurer, and such judicial construction should be read into the excess policy. Qualcomm maintains the parties' economic bargain and reasonable expectations were shaped by *Zeig* and its progeny.
>
> Qualcomm further asks us to reject Underwriters's arguments that the excess policy's maintenance clause imposed a duty upon it not to "compromise" the primary policy limits by settling with the primary insurer for an amount below policy limits. Pointing to secondary authorities stating that the purpose of a maintenance clause is to preclude any "drop down" obligation by the excess insurer to provide primary coverage, Qualcomm contends the maintenance clause does no more than require it to pay the premiums as they came due to maintain the underlying policy, which it did. Finally, relying on the proposition that insurance policy exclusions must be plain, conspicuous and clear, Qualcomm asserts that the last sentence of the maintenance clause cannot be interpreted by negative implication to prohibit Qualcomm from self-insuring in the event of a below-limits settlement with the primary insurer.[109]

But the premise of these arguments was ambiguity of the policy language, and the court found no

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[107] 161 Cal. App. 4th at 189.

[108] 161 Cal. App. 4th at 189.

[109] 161 Cal. App. 4th at 192–93.

such ambiguity. Subjective expectations of the insured, even if engendered by cases, could not create ambiguity.[110] Interpreting the words of the policy in their ordinary and popular sense, the court found their meaning "clear and explicit."[111] "In our view, the phrase 'have paid … the full amount of [$20 million],' particularly when read in the context of the entire excess policy and its function as arising upon exhaustion of primary insurance, cannot have any other reasonable meaning than actual payment of no less than the $20 million underlying limit."[112] Nor was this conclusion altered by the Limits of Liability language providing coverage after the underlying insurers "have paid or have been held liable to pay the full amount of the Underlying Limit of Liability." Qualcomm did not argue that "that the settlement between it and National required National to accept responsibility or liability for the full amount of the $20 million limit on the underlying policy. Nor does the complaint plead that National was obligated to pay $20 million pursuant to a court order or judgment, which would plainly fall within such policy language."[113]

The court rejected *Zeig* because "the court appeared to place policy considerations (i.e., the promotion of convenient settlement or adjustment of disputes) above the plain meaning of the terms of the excess policy."[114] Nor could Qualcomm rely on a supposed uniform construction to support a reasonable expectation of coverage, because there were cases to the contrary.[115] Finally, the court rejected an argument that public policy precluded any requirement of actual payment.[116]

The Restatement of the Law of Liability Insurance treats *Zeig* as the default rule,[117] subject to modification where "otherwise stated in the excess insurance policy."[118] But the default rule does require that an amount equal to the limit of the underlying policy "has been paid … by or on behalf of the underlying insurer or the insured."[119]

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[110] 161 Cal. App. 4th at 193.

[111] 161 Cal. App. 4th at 195.

[112] 161 Cal. App. 4th at 195.

[113] 161 Cal. App. 4th at 196. *Compare* Rummel v. Lexington Ins. Co., 123 N.M. 752, ¶¶ 24–33 (1997) (where insured had suffered a judgment in favor of the plaintiff before settling with the underlying insurers, it had "been held liable to pay the full amount" of the underlying limit, so full payment was not required to trigger excess policy).

[114] 161 Cal. App. 4th at 197–98.

[115] 161 Cal. App. 4th at 200–01.

[116] 161 Cal. App. 4th at 204. *Qualcom* has been followed often, where courts found unambiguous policy language requiring actual payment of the full policy limit:
E.g.,

Ohio: Goodyear Tire & Rubber Co. v. Nat'l Union Fire Ins. Co., 694 F.3d 781 (6th Cir 2012);

Texas: Citigroup Inc. v. Fed. Ins. Co., 649 F.3d 367, 372 (5th Cir. 2001).

[117] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE, § 39(2) & cmt. *c* (2019).

[118] RESTATEMENT, § 39.

[119] RESTATEMENT, § 39(2). The issue is extensively examined in Douglas R. Richmond, *The Tiresome Problem of Exhaustion in Excess Insurance,* in NEW APPLEMAN CURRENT CRITICAL ISSUES IN INSURANCE LAW, at 1 (Spr. 2014).

[7] Where an Underlying Insurer Has Improperly Refused To Settle, an Equitable Subrogation Claim Does Not Necessarily Require That an Excess Judgment Have Been Entered

Where an underlying insurer has improperly refused to settle within its limits, may an excess insurer (without any excess judgment having been entered) participate in a later settlement exceeding the underlying insurer's limits without forfeiting its equitable subrogation claim for the initial refusal to settle? There is currently a division of authority between divisions of the California Court of Appeal, but the better reasoned cases permit such a settlement without forfeiture of the equitable subrogation claim.

The issue was first decided by the court of appeal in *Fortman v. Safeco Insurance Co.*[120] Fortman sued Austin Hardware & Supply and others on a product liability claim. Safeco was Austin's primary insurer with a $300,000 limit. Excess insurer U.S. Fire had a $2 million limit. Safeco repeatedly refused to settle within its limit. During trial, all parties agreed to a settlement to which the excess insurer contributed $1,125,000 and assigned its equitable subrogation claim to Fortman. The jury then found Austin to have no responsibility for the $24 million in injuries that it found. Fortman then sued Safeco on the assigned claim. Safeco argued that there could be no claim absent an excess judgment.[121] The court approved earlier dictum stating that

> "[w]e entertain no doubt that an excess insurer which has *settled and discharged the insured's liability* may recover from the primary insurer an amount in excess of the primary insurer's policy limits if the excess insurer can prove the primary insurer's unreasonable refusal to settle within its policy limits resulted in loss to the excess insurer in an amount in excess of the policy limits of the primary insurer it would not otherwise have had."[122]

The court reasoned that

> Safeco repeatedly, and allegedly in bad faith, refused settlement offers below its policy limits. Had the case been settled for any of those amounts, U.S. Fire would have paid nothing. Instead, U.S. Fire actually paid $1,125,000 toward the eventual settlement. If we adopted Safeco's position, U.S. Fire would suffer that loss without a remedy. On the other hand, an excess insurer who proceeded to trial and was required to pay any portion of a resulting judgment would be able to prosecute a similar action. Doing so might expose the excess insurer to a bad faith claim by the insured. Such a rule would encourage trials in cases which otherwise might settle.[123]

The cases *Safeco* relied on were concerned with what must be shown by an insured to assert a bad faith claim. The court distinguished those cases as follows:

> In the cases cited by Safeco, the insured must show the existence, not actual payment, of an excess judgment. In the equitable subrogation

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[120] Fortman v. Safeco Ins. Co., 221 Cal. App. 3d 1394 (1990).

[121] 221 Cal. App. 3d at 1396–98.

[122] 221 Cal. App. 3d at 1399–1400 (emphasis by the *Fortman* court), *quoting* Nw. Mut. Ins. Co. v. Farmers' Ins. Group, 76 Cal.App.3d 1031, 1049 (1978).

[123] *Fortman*, 221 Cal. App. 3d at 1401.

> context before us, the excess insurer must show it actually paid an amount in excess of the primary insurer's policy limits. Courts easily could distinguish equitable subrogation cases with facts suggesting a collusive settlement from cases like this one in which the excess insurer actually paid a settlement. The trial court erred in requiring an excess judgment.[124]

Another division of the court disagreed in *RLI Insurance Co. v. CNA Casualty*.[125] CNA was the primary insurer and RLI the excess, each with a $1 million limit. On a claim for an auto accident, CNA rejected an offer to settle for its limit. Later, there was a settlement in which each insurer paid its limit. RLI sued to recover its payment. Because the insured had not suffered any excess judgment (or any loss at all), the court held that he had no claim to which RLI could be subrogated.[126] It declined to follow *Fortman*, reasoning that it had applied equitable contribution analysis when the issue required equitable subrogation analysis.[127] It also relied on *Hamilton v. Maryland Casualty Co.*,[128] where the California Supreme Court had stated that an "insured's right to recover from the primary insurer hinges upon 'a judgment in excess of policy limits."

In *Ace American Insurance Co. v. Firemans's Fund Insurance Co.*,[129] a third division of the court of appeal agreed with *Fortman*. This grew out of a personal injury claim where Fireman's Fund provided primary coverage of $2 million and an umbrella policy of $3 million; Ace American provided $50 million excess coverage over the umbrella. Fireman's Fund rejected demands within its limits, but the case was later settled with Ace American contributing substantial amounts within its limits. It sued Fireman's Fund, which demurred based on *RLI*. The superior court sustained the demurrer and Ace American appealed.

The *Ace American* court rejected *RLI's* reading of *Hamilton*. *Hamilton* dealt with an attempt to treat a stipulated nonrecourse judgment against the insured, entered despite the fact that the insurer was defending, as an injury recoverable in a bad faith action. "The focus of *Hamilton*, therefore, was whether there was sufficient evidence that the insured had suffered actual damages—not whether damages came in the form of an excess judgment versus an excess settlement."[130] Moreover, *Hamilton* had, albeit in dictum, approved liability without an excess judgment:

> "when an insured, faced with the insurer's unreasonable refusal to pay a settlement demand within the policy limits and exposed to potential personal liability substantially beyond the policy limits, actually contributes payment to conclude the settlement (in which the insurer also participates), the insured may recover the amount of his or her payment from the insurer in an action for bad faith failure to settle. In those circumstances, a bad faith action may be brought by the insured, or the

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[124] 221 Cal. App. 3d at 1402.

[125] RLI Ins. Co. v. CNA Cas., 141 Cal. App. 4th 75 (2006).

[126] 141 Cal. App. 4th at 81–83.

[127] 141 Cal. App. 4th at 83–84.

[128] Hamilton v. Md. Cas. Co., 27 Cal. 4th 718, 725 (2002).

[129] Ace Am. Ins. Co. v. Firemans's Fund Ins. Co., 206 Cal. Rptr. 3d 176), *rev. granted*, 209 Cal. Rptr. 3d 302 (Cal. 2016). The grant of review deprives the decision below of precedential effect in California. CAL. R. CT. 8.1105(e)(1)(B), 8.1115(e). But it can still have persuasive value.

[130] 206 Cal. Rptr. 2d at 186.

> claimant as the insured's assignee, despite the absence of a litigated excess judgment."[131]

The *Ace American* court extensively reviewed other authorities, in California and elsewhere, finding that they supported *Fortman*.[132] While Fireman's Fund argued that the *Fortman* rule would discourage primary insurers from engaging in settlements involving excess insurers, the court disagreed:

> our holding places no additional duties upon primary insurers that they do not ordinarily have. Primary insurers already have the duty to accept reasonable settlement offers within policy limits, and liability for resulting damages when they breach that duty. Moreover, our decision protects insureds, because insurers whose mishandling of settlement offers causes damages will be liable for the losses they cause. The *RLI* rule, on the other hand, leaves insureds without recourse when primary insurers mishandle reasonable early settlement offers, resulting in later excess settlements. Moreover, "when a primary insurer breaches its good-faith duty to settle within policy limits, it imperils the public and judicial interests in fair and reasonable settlement of lawsuits."[133]

Fortman and *Ace American* are the better reasoned cases. They are likely to be followed by the California Supreme Court and, regardless, should be followed by courts elsewhere.

The California Supreme Court granted hearing in *Ace American*,[134] and later dismissed review pursuant to the joint request of the parties.[135]

[8] Where an Insured Is Insolvent, Failure Pay Its Self-Insured Retention Will Not Excuse the Insurer's Duty To Pay Amounts in Excess of That Retention.

Where an insurance policy provides for a self-insured retention ("SIR"), the policy is typically structured as an excess policy, treating the SIR as if it were primary insurance. Thus, such policies typically provide that the insurer has no responsibilities until the SIR has been exhausted. If insolvency of the insured prevents the SIR from being exhausted, rules that might prevent an obligation to pay where underlying insurance has not been exhausted will typically not apply.

That result is dictated by the fact that liability insurance policies typically provide (and are often required by statute to provide) that coverage shall not be defeated by insolvency of the insured. (*See* § 2.02[4], *above*.) Thus, in *Admiral Insurance Co. v. Grace Industries*,[136] Grace was in bankruptcy and Admiral's policy insuring Grace included a $50,000 SIR. Admiral contended that it had no duty to defend or indemnify with respect to any suit until Grace had paid its SIR. Admiral argued that any other holding would effectively require Admiral to drop down and pay amounts within the SIR. As the court recognized,

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[131] 206 Cal. Rptr. 2d at 187, *quoting* *Hamilton*, 27 Cal. 4th at 731.

[132] 206 Cal. Rptr. 2d at 188–94.

[133] 206 Cal. Rptr. 2d at 195.

[134] Ace American Ins. Co. v. Fireman's Fund Ins. Co., 382 P.3d 1135 (Cal., Nov. 9, 2016).

[135] Ace Am. Ins. Co. v. Fireman's Fund Ins. Co., 2017 Cal. LEXIS 1873 (Cal., Mar. 15, 2017).

[136] Admiral Ins. Co. v. Grace Indus., 409 B.R. 275 (E.D.N.Y. 2009).

> Because of its insolvency, of course, Grace cannot fund the SIR much less pay out a covered claim. The practical effect for Admiral is a Morton's fork—the choice to defend the claims within the SIR before the costs reach $ 50,000 or the equally undesirable choice to tarry until the smaller claims ultimately exceed the $ 50,000 SIR because they were not defended or settled.[137]

Still, requiring Admiral to pay amounts above the SIR did not require Admiral to pay amounts within the SIR: "It is only obligated to do what it contracted to do and that obligation is not relieved by Grace's bankruptcy because "[s]ection 365 of the Bankruptcy Code makes it clear that even in the absence of an applicable statutory provision … the failure of a bankrupt insured to fund a self-insured retention does not relieve the insurer of the obligation to pay claims under the policy."[138] Moreover, "Illinois law, the law governing there, makes specific provision that the failure of a debtor insured to fulfill its obligations under an insurance contract does not excuse performance by the insurer."[139] To the extent that Admiral paid amounts within the SIR, it might have a prepetition against Grace's bankruptcy estate.[140]

Defense costs that an insurer voluntarily paid within the SIR of an insolvent insured did not erode the SIR.[141]

[9] Policy Language Will Determine Whether Payment by Other Insurance Can Be Used To Satisfy a Self-Insured Retention

In *Von's Cos. v. United States Fire Insurance Co.*,[142] Von's was an additional insured under its landlord's policy, which paid $1 million for a premises injury. The total settlement was over $1.5 million, and Von's sought payment from its own CGL insurer. The policy had a $1 million SIR, and the insurer took the position that only payment by Von's itself could satisfy that. The court disagreed, finding nothing in the policy that precluded satisfaction by other insurance.[143]

But a different result was reached in *Forecast Homes, Inc. v. Steadfast Insurance Co.*,[144] where a developer had required subcontractors to indemnify it and name it as an additional insured on their liability insurance policies. They did so, but the policies had SIR's that the subcontractors had not satisfied. The court found that the policy language prevented the developer from satisfying the SIR's, meaning that the insurers had no duty to defend.[145]

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[137] 409 B.R. at 280.

[138] 409 B.R. at 280, *quoting* Am. Safety Indem. Co. v. Vanderveer Estates Holding, LLC (*In re* Vanderveer Estates Holding, LLC), 328 B.R. 18, 25 (Bankr. E.D.N.Y. 2005). *Accord In re* Federal Press, 104 B.R. 56, 62–64 (Bankr. N.D. Ind. Aug. 17, 1989); Liberty Mut. Ins. Co. v. Wheelwright Trucking Co., 851 Sop. 2d 466, 485–87 (Ala. 2002); Rollo v. Servico N.Y., Inc., 914 N.Y.S. 2d 811, 813–14 (A.D. 2010).

[139] *Admiral*, 409 B.R. at 280, *citing* 215 ILL. INS. CODE, § 5/388.

[140] 409 B.R. at 281.

[141] Kleban v. Nat'l Union Fire Ins. Co., 771 A.2d 39, ¶¶ 11–13 (Pa. Super. Ct. 2001).

[142] Von's Cos. v. United States Fire Ins. Co., 92 Cal. Rptr. 2d 597 (Cal. Ct. App. 2000).

[143] 92 Cal. Rptr. 2d at 601–05.

[144] Forecast Homes, Inc. v. Steadfast Ins. Co., 105 Cal. Rptr. 3d 200 (Cal. Ct. App. 2010).

[145] 105 Cal. Rptr. 3d at 208–11.

[10] Whether Notice to an Excess Insurer Was Late May Depend on When the Insured Should Have Recognized a Risk of an Excess Judgment

Sentry Insurance v. Ironshore Specialty Insurance Co.[146] arose out of a fatal accident involving a truck driven by Levon Alls in the scope and course of his employment with Stafford Transport, Inc. Alls and Stafford each had a $1 million policy with Sentry. Stafford also had a $4 million commercial umbrella policy with Ironshore. Both insurers were given prompt notice of the accident, but when suit was brought on May 5, 2011, only Sentry was notified. The case went to trial on May 22, 2014, and resulted in a net verdict of $3,013, 500. Only then was Ironshore notified of the suit. Sentry and Ironshore agreed to jointly fund the $1,015,000 in excess of Sentry's limits and litigate responsibility later.[147]

The Ironshore policy provided that:

> 2. If a claim is made or **Suit** is brought against any **Insured** which is reasonably likely to involve this Policy, you must notify us in writing as soon as practicable.
>
> 3. You and any other involved **Insured** must:
>
> a. immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or **Suit**;

The court held that

> the phrase "reasonably likely" "clearly contemplates that the insured is not required to give notice every time there is a claim against it." Thus, "[w]hen notice is required is, necessarily, a question of judgment," and "[t]his standard requires the insured to base its judgment regarding the amount of the claim against it upon sound reasons."[148]

If "the insured exercised due diligence and relied on the advice of its competent attorneys when it made its evaluation of the case, the insured's failure to give earlier notice [would be] reasonable as a matter of law."[149] Here,

> Sentry retained competent counsel for Stafford and Alls. None of the defense attorneys involved in the representation predicated the verdict would reach $2 million. Moreover, the attorneys concluded that the defendants' liability seemed questionable. Lovell stated "there was a 60–70% chance of convincing a jury Edins was 50% or more negligent in causing the accident." Dinges predicted that liability would be equal for each party, meaning that, under Georgia law, the plaintiff could not recover. In sum, this evidence demonstrates that Stafford reasonably believed that its liability would not exceed $2 million.[150]

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[146] Sentry Ins. v. Ironshore Specialty Ins. Co., 2016 U.S. Dist. LEXIS 85706 (N.D. Ga. June 30, 2016).

[147] 2016 U.S. Dist. LEXIS 85706, at *1–6.

[148] 2016 U.S. Dist. LEXIS 85706, at *12 (footnotes omitted), *quoting* Evanston Ins. Co. v. Stonewall Surplus Lines Ins. Co., 111 F.3d 852, 860 (11th Cir. 1997).

[149] 2016 U.S. Dist. LEXIS 85706, at *12.

[150] 2016 U.S. Dist. LEXIS 85706, at *15.

While neither Sentry nor defense counsel ever determined what was "reasonably likely" with respect to the Ironshore policy, notice was not required so long as "Stafford, based on the defense attorneys' and the insurer's evaluation of the underlying case, reasonably believed that the verdict would not exceed the Sentry policy limits."[151] Accordingly, the court granted summary judgment to Sentry.[152]

[11] Unless Authorized by Specific Policy Language, an Excess Insurer May Not Contest Exhaustion of Underlying Coverage on the Ground that Payments by the Underlying Insurer Improperly Eroded Its Coverage, Unless the Payments Were Fraudulent or in Bad Faith

Axis Reinsurance Co. v. Northrup Grumman Corp.[153] involved a three-level fiduciary insurance program for Northrup-Grumman ("Northrup"): National Union Fire Insurance Co. had primary coverage of $15 million, Continental Casualty Co. ("CNA") had a $15 million excess layer, and Axis Reinsurance Co. had a $15 million secondary excess layer. Northrup was sued, in separate suits, by the Department of Labor ("DOL suit") and by its retirement plan (the "*Grabek* suit") for conduct allegedly prohibited by the Employee Retirement Income Security Act ("ERISA") with respect to the Plan. Northrup settled the DOL suit without any findings or admissions by agreeing to pay certain amounts to the Plan and to the DOL. National Union paid its $15 million limit toward settlement of the DOL suit, and CNA paid the rest of the settlement, without exhausting its policy limit. Northrup then settled the *Grabek* suit for $16,750,000. CNA paid the balance of its limit, leaving $9,706,237.92 unpaid. Northrup turned to Axis to pay this amount. Axis paid but told Northrup that it intended to seek reimbursement on the ground that National Union and CNA had improperly eroded their own limits by pay amounts that did not constitute covered losses. When suit was brought, the district court agreed and granted Axis summary judgment.[154]

Under the Axis policy, its coverage was not available until the underlying limits had been exhausted by payment of "covered loss." The underlying policies defined "loss" to include damages, judgments, settlements, and defense costs, but not "matters which may be deemed uninsurable under [applicable state] law." Axis contended that the DOL settlement was or included disgorgement, rendering it "uninsurable under [California] law" and, therefore, an "uncovered loss" under the terms of the primary and excess policies.[155]

In the absence of controlling precedent, the Ninth Circuit adopted the rule it concluded represented the weight of limited authority on the issue: " 'an excess insurer may not challenge the underlying insurers' payment decisions in order to argue that their policy limits were not (or should not have been) exhausted … unless there is an indication that the payments were motivated by fraud or bad faith.' "[156]

The Ninth Circuit concluded that the rule proposed by Axis:

> that excess insurers generally may contest the soundness of underlying insurers' payment decisions—"would undermine the confidence of both insureds and insurers in the dependability of settlements," eliminating

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[151] 2016 U.S. Dist. LEXIS 85706, at *16.

[152] 2016 U.S. Dist. LEXIS 85706, at *19.

[153] Axis Reins. Co. v. Northrup Grumman Corp., 975 F.3d 840 (11th Cir. 2020).

[154] 975 F.3d at 842–44.

[155] 975 F.3d at 842–44.

[156] 975 F.3d at 845, *quoting* Costco Wholesale Corp. v. Arrowood Indem. Co., 387 F. Supp. 3d 1165, 1173–74 (W.D. Wash. 2019).

> one of the primary incentives for obtaining insurance in the first place. Furthermore, such a rule would introduce a host of inefficiencies into the insurance industry, with no obvious countervailing benefits to insurers or policyholders.[157]

This would not force excess insurers to pay noncovered losses (the *Grabek* settlement was itself covered). As the court explained:

> an excess insurer remains free to contest claims submitted to it during the claims adjustment process, even when an underlying insurer has already determined that the same claim falls within the scope of coverage. But, absent a specific contractual provision, it may not second-guess other insurers' payments of earlier claims without first showing that those payments were motivated by fraud or bad faith.[158]

The Ninth Circuit did not think:

> there are many instances where an insurance company will pay out claims—let alone its policy's limit—when it is not obligated to do so (at least in cases not involving fraud or bad faith). But even if AXIS were correct that insurers sometimes choose to settle claims that fall outside their scope of coverage "for what they perceive[] as legitimate business reasons," nothing prevents AXIS or any other excess insurer from raising and leveraging this concern during contractual negotiations with their policyholders. For example, the excess insurer could request higher premiums to account for this contingency, or it could insert specific policy language reserving its right to contest "improper erosion" by the underlying insurers under certain conditions—so long as the provision does not conflict with applicable law or public policy.[159]

Turning to construction of the Axis policy, the court concluded that simply requiring that the underlying limits be exhausted by payment of "covered losses," standing alone was not sufficient to create a right to contest alleged "improper erosion." The court did note another case where policy language arguably did establish such a right.[160]

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[157] 975 F.3d at 846.

[158] 975 F.3d at 846.

[159] 975 F.3d at 847.

[160] 975 F.3d at 846 n.4 ("*Cf. AXIS Surplus Ins. Co. v. Innisfree Hotels, Inc.*, No. CIV.A. 05-0527-WS-C, 2006 U.S. Dist. LEXIS 73230, 2006 WL 2882373, at *9 n.22 (S.D. Ala. Oct. 6, 2006) (noting that "the Axis Excess Policy … states that amounts paid by underlying insurance for losses that would not have been payable under the Axis Excess Policy *do not count* towards the $10 million" liability limit, and that, "[a]s a result, any amounts that the Primary Policy paid for flood losses *do not erode* the $10 million threshold, creating a possibility of a gap in coverage between layers for which [the insured] itself would be responsible" (emphasis added)).").

Developments in Excess Judgment Liability
New York and New Jersey Update/Addendum

American College of Coverage Counsel
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Lisa M. Campisi
Amy J. Spencer, Esq.
Alexander H. Berman, Esq.
Blank Rome LLP
New York, New York
lcampisi@blankrome.com

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I. Must There be a Demand Within Policy Limits to Trigger Excess Liability?

A. New Jersey Law – Rova Farms

At the risk of telling every New Jersey insurance coverage practitioner (and many outside of New Jersey) what they already know, the seminal case in New Jersey on the imposition of excess liability on an insurer for its bad faith refusal to settle is *Rova Farms Resort, Inc. v. Investors Insurance Co. of America*, 323 A.2d 495 (N.J. 1974). *Rova Farms* is so well understood as the lodestar that in New Jersey a settlement demand letter to an insurer is referred to as a "Rova Farms" letter.

Among the reasons for *Rova Farms*' significance is that on the question of whether an insurer has an affirmative duty to initiate settlement negotiations—even in the absence of a plaintiff's/claimant's demand within policy limits—*Rova Farms* answers that question with a clear "yes": "We, too, hold that an insurer, having contractually restricted the independent negotiating power of its insured, ***has a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy coverage***." *Id*. at 507 (emphasis added). The only exception or limitation on this affirmative duty to negotiate is, as the *Rova Farms* court put it, where "the insurer, by some affirmative evidence, demonstrates there was not only no realistic possibility of settlement within policy limits, but also that the insured would not have contributed to whatever settlement figure above that sum might have been available." *Id*.

Nonetheless, as clear as *Rova Farms* is on the insurer having an affirmative duty to initiate negotiations, the opinion stopped short of imposing a bright line rule of strict liability based upon an insurer refusing to settle within policy limits. Instead, despite acknowledging (i) that any time an insurer refuses to settle such a decision is "perforce a selfish one," and (ii) the inherent conflict of interests between the insurer and insured, the court retained the then existing rule that an insurer would not face excess liability unless it acted in "bad faith":

> One day, in an appropriate issue, it may be necessary to separate these conflicting interests. The insured has the right to expect that the amount of protection he has purchased will be offered in compromise where necessary to effect an end to the litigation. On the other hand, the insurer may pursue its own interests and decline to settle a case, for whatever reason (so long as not in bad faith or similarly wrongful).

Id.

Despite it not clearly enunciating a strict liability rule, *Rova Farms* is generally viewed as a watershed pro-policyholder ruling, and in the decades that followed, it has been relied on extensively to impose liability on insurers for refusing to settle claims. Nonetheless, decisions in the more recent past have relied on the lack of a strict liability rule in *Rova Farms* to find that an insurer's liability in excess of its limits for failing to settle requires a factual inquiry into whether that refusal was in "bad faith."

Wood v. New Jersey Manufacturers Insurance Co. is illustrative. No. 1768-082, 2010 WL 2990960, at *11 (N.J. Super. Ct. App. Div. July 28, 2010), *aff'd as modified*, 21 A.3d 1131

(N.J. 2011). In *Wood*, the insurer continually refused to offer is full policy limit of $500,000 in settlement, and ultimately the plaintiffs in the underlying action obtained a verdict against the insured of more than $1.4 million. *Id.* at *7. The insurer paid its $500,000 limit to the plaintiffs, and the plaintiffs, in their capacity as the insured's assignee, then brought suit against the insurer for the amount of the verdict in excess of the insurer's policy limit. *Id.* at *5. The trial court entered summary judgment against the insurer and directed it to pay the plaintiffs the amount of the verdict in excess of the insurer's limit. *Id.* at *7. The Appellate Division reversed, finding that genuine issues of fact precluded entry of summary judgment. *Id.* at *13.

In its decision reversing the trial court's entry of summary judgment, the appellate court traced the history of New Jersey law on an insurer's liability for refusal to settle that preceded *Rova Farms*, including the Supreme Court's decision in *Radio Taxi Serv., Inc. v. Lincoln Mut. Ins. Co.*, 157 A.2d 319 (N.J. 1960). As described by the *Wood* court, *Radio Taxi* "adopted a legal standard that requires good faith by an insurer in foregoing an opportunity to settle a tort action against its insureds for a sum within the applicable policy limits." *Wood*, 2010 WL 2990960, at *8 (citing *Radio Taxi* at 157 A.2d at 319). The *Wood* court then went on to state that *Radio Taxi* did not impose a strict liability rule, and that ultimately the *Rova Farms* court retained the *Radio Taxi* standard, and did not go beyond it to impose a strict liability standard:

> Nevertheless, the Court declined in *Rova Farms* to revise the applicable legal standards it had previously announced in *Radio Taxi*, and ***eschewed a per se rule making a carrier bear the financial consequences of an excess verdict in all cases where there was an opportunity to settle within the policy limits***.

Id. at *10 (citations omitted) (emphasis added).

Thus, while acknowledging that *Rova Farms* imposed on the insurer "a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy coverage," the *Wood* court further opined that *Rova Farms* required a factual finding that the insurer was "actually dishonest, unreasonably optimistic or otherwise in bad faith, or infected with negligence such as to impede the reaching, or having the capacity to reach, a 'good faith' decision" before excess liability could be imposed. *Id*. at *11 (citations omitted).

It is worth noting that while the *Wood* court was not incorrect to say that the *Rova Farms* court refrained from imposing a strict liability rule, as the *Wood* court also acknowledged, a key reason why the *Rova Farms* court did so refrain was because the facts in *Rova Farms* were so egregious that the court had little trouble imposing excess liability on the insurer even in the absence of strict liability rule:

> The Court found it particularly unnecessary to consider that possibility in *Rova Farms* because the proofs, which had notably been developed in a plenary fashion at the non-jury trial, had adequately supported the trial judge's finding that the insurer had acted unreasonably and had thereby breached its duties to the insured.

Id. at *10 (citations omitted).

In fact, omitted from the *Wood* decision is that the *Rova Farms* court acknowledged that in the appropriate case, crafting a different and stricter rule could be warranted:

> However, which [sic] the carrier chooses not to offer the limits of coverage, one wonders whether it should not bear the unhappy financial result of that unilateral decision, since it along profits from the opposite result of the gamble. ***This resolution would enable the insurer to pursue its own interests in great measure without sacrificing those of its insured so long as it was clear by whom the burden of mistake should be borne***.
>
> * * *
>
> Finally, and most importantly, there is more than a small amount of elementary justice in a rule that would require that, in this situation where the insurer's and insured's interests necessarily conflict, the insurer, which may reap the benefits of its determination not to settle, should also suffer the detriments of its decision. ***As indicated, it is unnecessary in the instant case to embrace such an extended rule. But since this Court as all other courts, seeks to prevent the law from inflicting unjust results, it is not discordant with its obligation, to foresee the probability or the possibility thereof***.

Rova Farms, 323 A.2d at 509-10 (citing *Crisci v. Sec. Ins. Co. of New Haven*, 426 P.2d 173, 177 (Cal. 1967) (*en banc*) (citations omitted) (emphasis added)).

In light of the foregoing, one of the amici in the *Wood* case "urged [the *Wood* court] to … revisit these well-established principles and to instead endorse a strict liability approach to a carrier's responsibility to settle cases within policy limits." *Wood*, 2010 WL 2990960, at *11. The court "declined to do so," noting that it was not its "function as an intermediate appellate court to rewrite the Supreme Court's holdings." *Id.*

Instead, the *Wood* court applied the standard set out in *Radio Taxi* and found that the trial court had erred in entering summary judgment against the insurer because it did not conduct a sufficient factual inquiry into the insurer's conduct:

> [W]e are persuaded that the trial court here acted too swiftly in granting summary judgment to plaintiffs on the question of NJM's alleged bad faith. Although we appreciate many of the criticisms leveled by plaintiffs against NJM about its inflexible settlement position prior to the jury's verdict, we do not share the trial court's confidence-at least on this paper record-that the proofs compel a conclusion that NJM was "actually dishonest, unreasonably optimistic or otherwise [acting] in bad faith, or infected with negligence such as to impede the reaching, or having the capacity to reach, a 'good faith' decision."

Id. at * 12 (quoting *Rova Farms*, 323 A.2d at 495).

Despite having reversed the trial court's entry of summary judgment against the insurer, the *Wood* court specifically did not find that judgment against the insurer was unwarranted. Moreover, it also expressly stated that in some cases, entry of summary judgment against the insurer for bad faith liability could be warranted. But, it found that in the case before it, the factual record was not sufficiently developed by the lower court to conclusively determine that the refusal to settle was in bad faith:

> For these numerous reasons, we conclude that summary judgment was prematurely granted to plaintiffs on the bad faith issues. There are genuine fact-sensitive determinations that need to be made about the reasonableness of NJM's handling of settlement negotiations in the underlying tort action. That assessment of reasonableness will hinge, to some degree, upon the credibility and persuasiveness of fact witnesses. It may also depend upon the testimony of expert witnesses opining about what went wrong here on the settlement front and why it went wrong. Prudence dictates that these pivotal questions of reasonableness and bad faith be decided in this case after a full-blown evidentiary presentation before the factfinder. ***By no means are we saying that summary judgment in favor of an insured is never appropriate in a bad faith case, but simply that there is enough proof on both sides of the ledger here to warrant a plenary disposition***.

Wood, 2010 WL 2990960, at *14 (emphasis added).

The *Wood* decision left open the question of whether the court or a jury was the proper factfinder on the bad faith issue. That question, along with *Wood* court's reversal of the trial court's entry of summary judgment, was appealed to the New Jersey Supreme Court. The high court affirmed the appellate court's reversal of summary judgment, but held that the plaintiffs were entitled to a trial by jury on the bad faith issue. *See Wood v. New Jersey Mfrs. Ins. Co.*, 21 A.3d 1131 (N.J. 2011) (holding as a matter of first impression that assignee's claim was a contract claim to which right to trial by jury attached).

Since *Wood* was decided, at least three other courts have cited to the New Jersey Supreme Court decision in *Wood* for the proposition that the bad faith issue requires a factual inquiry. Of those, one court held that questions of fact precluded entry of summary judgment in favor of the insurer, while another denied of cross motions for summary judgment. *See Hartford Cas. Ins. v. Liberty Mut. Fire Ins. Co.*, No. 18-CV-0044, 2021 WL 1186759, at *5 (D.N.J. Mar. 30, 2021) (citing *Wood*, 2010 WL 2990960, at *14) (denying cross motions for summary judgment where "[b]oth parties have produced compelling evidence regarding whether [primary insurer] engaged, or failed to engage in 'good faith' settlement negotiations"); *Ware Indus., Inc. v. St. Paul Fire & Marine Ins. Co.*, No. CV1813895WHWCLW, 2019 WL 1470129, at *6 (citing *Wood*, 21 A.3d at 1136) (D.N.J. Apr. 3, 2019) (denying insurers' summary judgment motion on bad faith issue because they had "not shown the absence of a genuine dispute as to the material fact of whether they complied with their contractual and fiduciary obligation to use ordinary care during settlement negotiations."). The third court reversed a grant of summary judgment in favor of the insurer where the insured was deprived of the opportunity to introduce expert testimony of the issue. *See Penn Nat'l Ins. Co. v. Grp. C Commc'ns, Inc.*, No. A-0754-

15T1, 2018 WL 3625424, at *12 (N.J. Super. Ct. App. Div. July 31, 2018) (reversing grant of summary judgment to insurer).

B. Though New York Law Does Not Appear to Require an Insurer to Initiate Negotiations, Liability Can Still Attach Even Without a Demand.

Unlike in New Jersey, New York's highest court has not held that an insurer has an affirmative duty to initiate settlement negotiations or offer its policy limit in the absence of a demand. *See Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 24, 28 (N.Y. 1993) ("proof that a demand for settlement was made is a prerequisite to a bad-faith action for failure to settle"). *Ohio Casualty Insurance Co. v. Twin City Fire Insurance Co.*, No. 14-CV-858 (NGG) (PK), 2019 WL 2582527, at *24 (E.D.N.Y. June 24, 2019), in which the federal court applied New York law, made this point expressly.

In *Ohio Casualty,* an excess insurer brought suit against the primary insurer claiming breach of fiduciary duty by failing to settle an underlying personal injury action involving an automobile accident. *Id.* at *1. During the pendency of the action, Ohio Casualty sent a so-called "hammer letter" to Twin City demanding that Twin City settle the action within primary limits. *Id.* at *18. Ohio Casualty's letter was premised on its "mistaken understanding that there had been a $1 million settlement demand, which would have been within Twin City's layer, when in fact there was no such demand." *Id.* at *10. Rather, the only settlement demand made in the case was $5 million. *Id.*

The court noted that a claim for bad faith failure to settle requires the proponent to establish two elements—not only that the insurer's conduct constituted a "gross disregard" of the insured's or excess insurer's interests considering the *Pavia* factors—but also, "the existence of a causal connection between the insurer's bad faith and the loss of an ***actual opportunity*** to settle." *Id.* at *19 (emphasis added). Thus, "[e]ven if the court were to find that Twin City had acted in bad faith, it cannot be held liable here unless its purported 'gross disregard' cost an 'actual opportunity' to settle the Underlying Action within the policy limit." *Id.* at 23.

Noting that "there is no requirement for an insurer to initiate negotiations by offering money when there has been no demand" (*id.* at 24), the court distinguished the insurer's obligations to pursue negotiations following a demand from its obligation to initiate negotiations absent a demand:

> In *New England Insurance*, the Second Circuit reaffirmed that an insurer has an affirmative obligation to "pursue" settlement negotiations. But that obligation does not equate to an obligation to *initiate* settlement negotiations by making an offer without having received a demand. Both *New England Insurance* and *Young* involved actual demands tendered by the claimants.… Here, where Aguilar never made a settlement demand, this line of case law is inapposite. To the extent that it is relevant it all, Twin City satisfied its obligation by instructing defense counsel to solicit demands from Aguilar's attorneys and by following up on each and every settlement overture received from Aguilar's attorneys.

Id. at 24 (internal citations omitted).

1. *In New York the Absence of a Demand Does Not Per Se Insulate an Insurer From Liability if the Insurer's Conduct Resulted in a Lost Opportunity to Settle*

While New York law does not appear to impose a duty to initiate settlement negotiations, it does not provide for a *per se* rule insulating an insurer from bad faith exposure because there was no demand at all, or because a settlement demand was not within, but exceeded, the policy limit. Instead, as noted in Section 2.03(6)(d)(iii)(A) of the main volume above, "even where a demand is normally required, that requirement may be excused where insurer misconduct at least may have prevented the demand." *See* AMERICAN COLLEGE OF COVERAGE COUNSEL, DEVELOPMENTS IN EXCESS JUDGMENT LIABILITY ("Main Volume"), § 2.03(6)(d)(iii)(A) (2021) (citing *Hartford Ins. Co. v. Methodist Hosp.*, 785 F. Supp. 38, 41 (E.D.N.Y. 1992)).

Numerous New York courts, both state and federal, have acknowledged that, provided the "gross disregard" standard is met, bad faith can be shown by a "lost opportunity" to settle, even in the absence of a demand within limits. *See, e.g.*, *Scottsdale Ins. Co. v. Indian Harbor Ins. Co.*, 994 F. Supp. 2d 438, 458 (S.D.N.Y. 2014) ("even if [claimant] never made an explicit, documented $1 million offer to settle the case…the factfinder could still conclude, based on the totality of the evidence, that Indian Harbor had the *opportunity* to settle the case for $1 million [within limits], and that its gross disregard for Scottsdale's interest in the handling of settlement negotiations caused the loss of that opportunity."); *Quincy Mut. Fire Ins. Co. v. New York Cent. Mut. Fire Ins. Co*., 89 F. Supp. 3d 291 (N.D.N.Y. 2014) ("A lost opportunity to settle can be established even when a settlement demand exceeds limits of primary coverage").

(a) *Quincy Mutual*—A Primer for Insurers on What Not to Do in the Face of an Opportunity to Settle

With respect to the lost opportunity to settle, *Quincy Mutual* provides a road map of how a primary carrier can squander multiple settlement opportunities, both within and beyond primary limits, and thus expose itself to bad faith liability. In *Quincy Mutual*, the court found after a bench trial that by failing to offer its policy limit to the claimant (Horton), the primary insurer (New York Central), whose policy provided a $500,000 limit, had breached its good faith duty to the excess insurer Quincy Mutual. As to the opportunity to settle, the court found that:

> [T]he potential opportunity to settle the underlying matter arose at two distinct points in time. At trial, Quincy Mutual adduced evidence that, had New York Central tendered its policy in December 2005, Horton's attorney, at that point unaware of the existence of excess coverage, would have recommended that she accept the offer. Indeed, [Horton's] [a]ttorney … testified that he had his client's full authority to settle the case for $500,000 in December 2005. This testimony is sufficient to satisfy Quincy Mutual's burden of establishing, by a preponderance of the evidence, that there existed "an actual opportunity to settle" the claim at that time.

Quincy Mutual, 89 F. Supp. 3d at 307–08 (quoting *New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co.*, 295 F.3d 232, 244 (2d Cir. 2002) (internal citations omitted).

The court then went on to note that in the face of such evidence, "the next inquiry is whether Quincy Mutual has set forth sufficient evidence that, in December 2005, 'all serious doubts about the insured's liability were removed.'" *Id*. at 308 (quoting *New England Ins. Co*., 295 F.3d at 241) (internal citations omitted). Among the facts the court relied on to find there were no such "serious doubts" were the following:

- In November 2004, while the claimant's motion for summary judgment was pending defense counsel appointed by New York Central advised New York Central's adjuster (Monahan) that:

  > (i) he expect[ed] . . . the liability would be assessed against Warden [the insured] at trial;
  >
  > (ii) he would be opposing the claimant's summary judgment motion "without the use of a report from an accident reconstructionist because New York Central's reconstruction expert would 'not give an opinion'"; and
  >
  > (iii) [e]ven if [New York Central] survive[s] the summary judgment motion, [it] will be in a very difficult position at trial because it is unlikely that the jury would find contributory negligence under these [circumstances].

- In May 2005, upon summary judgment being entered in favor of the claimant, and defense counsel filing an appeal of that ruling, defense counsel advised Monahan that the appeal had "little chance of succeeding," and that New York Central "would have a difficult time at trial disputing liability based on our insured's statements (never saw [Horton]; never looked left a second time) and his guilty plea on the traffic ticket"; and

- During the bad faith trial, "Monahan testified that he authorized the appeal to the Appellate Division despite the fact that it did not have 'much of a chance of succeeding.'"

Id. at 308–09 (alterations in original).

Based on these facts, the court found that, despite the pendency of the appeal, there was little doubt that the opportunity to settle in December 2005 was lost due to New York Central's conduct:

> [T]he foregoing evidence supports a conclusion that, at the time Horton's attorney made his demand of $500,000, there was no "serious doubt[ ]" regarding [the insured's] liability. Based on the record evidence, it appears that both [defense counsel] and Monahan also concluded that there was little hope of Warden escaping liability. For this reason, and because I find [claimant's counsel's] testimony credible regarding his authority from Horton to accept an offer in the amount of $500,000 in December 2005, I conclude that New York Central "lost an actual

> opportunity to settle the ... claim at a time when all serious doubts about [the insured's] liability were removed."

Id. at 309 (first alteration in original) (internal citations omitted).

As for the second lost opportunity to settle, the court pointed out that by July 2007, New York Central was aware that the claimant's damages had increased and then exceeded the combined policy limits of $1,500,000 of the New York Central and Quincy Mutual policies. *Id*. at 311. Nonetheless, the claimant's attorney advised the insured's independent counsel that the claimant was willing to settle for $750,000; the insured's independent counsel then wrote to Monahan that the claimant would be willing to accept "'less than $1 million in tot[al]' if New York Central offered its policy limit of $500,000." *Id*. The court further noted that at trial Quincy Mutual's in-house counsel testified that Quincy Mutual would have met the $750,000 figure by offering $250,000 if New York Central had offered its policy limit. *Id*.

In addition, the court further noted that in June 2007, the trial court in the underlying action "severely criticized" New York Central's settlement position, and that despite Monahan testifying in the bad faith trial that New York Central viewed the case as significant, "it never increased its initial offer, dating back to December 2005, of $75,000 until late September 2009, just days before it announced its intention to tender the full policy limit." *Id*. Given these facts, the court found that:

> Quincy Mutual has established, by a preponderance of the evidence, that New York Central lost a second opportunity to settle with Horton, at that point for $750,000 in July 2007. Had New York Central tendered its full $500,000 policy at that time, Quincy Mutual would have been responsible for only $250,000, which is $750,000 less than it actually paid.[1]

Id. at 311.

In its defense in the bad faith trial, New York Central attempted to argue that it did not squander the opportunity to settle, and instead "Quincy Mutual caused or contributed to the failure to achieve settlement." *Id*. at 312. In rejecting this argument, the court noted that the law imposes no obligation on an excess carrier to settle absent exhaustion of the primary coverage:

> [T]he law places no legal obligation on an excess carrier in Quincy Mutual's position to negotiate a claim unless and until primary coverage is exhausted . . . . Quincy Mutual persuasively argues that, in essence, to find otherwise would unfairly place an excess carrier in the position of a primary carrier.

---

[1] The underlying litigation ultimately settled in November 2009 for nearly $1.5 million, "and a stipulated judgment was entered in state court on November 6, 2009, providing for payment to Horton in the amount of $1,069,726.20, with interest, calculated from May 20, 2005 [the date of the summary judgment ruling], in the amount of $427,831.87." *Id*. at 305. Of this nearly $1.5 million, Quincy Mutual paid "$572,168.13 toward the stipulated judgment, plus an additional amount of $427,831.87 in accrued interest, for a total of $1 million." *Id*.

Id. at 312.

The court further pointed out that New York Central's argument also failed as a practical matter:

> New York Central has also failed demonstrate how such negotiations could have resolved the matter. Surely Quincy Mutual could not have reduced its excess coverage exposure below $1 million through negotiations without the consent of its insured, consent that undoubtedly would have been withheld until New York Central tendered its policy and the insured could be guaranteed he would not face excess liability. Nor has New York Central proffered any evidence suggesting that, once Quincy Mutual was able to negotiate a tentative settlement conditioned upon New York Central's tender, New York Central would then have tendered its entire policy. I therefore reject the argument that the damages now claimed by Quincy Mutual were caused through its own conduct or inaction. Without question, by negotiating directly with Horton's counsel in an effort to limit its exposure, Quincy Mutual would have opened itself to a claim by Warden that it was acting in bad faith by placing its interests ahead of his as the insured.

Id. at 312.

As if the above described conduct of New York central were not enough, a final factor that appeared to push the *Quincy Mutual* court over the edge was that in the end, most of New York Central's $500,000 primary limit was reinsured, such that New York Central's out of pocket cost was slightly more than $130,000:

> The appearance of bad faith is even more pronounced in this case due to the fact that, after receiving reimbursement from General Reassurance Company, New York Central paid only $132,479 on behalf of its insured in connection with the Horton claim. ***In other words, while it exposed Quincy Mutual to liability for up to $1 million, and its insured to potential excess liability above $1.5 million, New York Central risked only payment of an additional amount of $57,479 above its $75,000 offer by adhering to that untenable position***. And, significantly, during the period the case languished, New York Central had the use of, and was therefore able to earn interest on, the full $132,479.

Id. at 312-313 (emphasis added).

The court concluded that "[t]hese facts epitomize bad faith negotiations, suggesting gross disregard for the interests of Quincy Mutual and Warden and placing those of New York Central above them." *Id*. at 313. It thus determined that Quincy Mutual was entitled to judgment of $1,000,000 and to recover that sum from New York Central:

> As a result of New York Central's bad faith settlement position, Quincy Mutual was denied the opportunity to settle the Horton litigation for the balance of the

> New York Central policy limit in December 2005, which was approximately $500,000. More specifically, had such a settlement been effectuated . . . the remaining available coverage under its primary policy . . . leaving Quincy Mutual to pay nothing. Plaintiff Quincy Mutual has therefore suffered damage in the amount of $1,000,000, and is entitled to recover judgment for that amount against New York Central based upon the court's finding of bad faith.

Id.

Moreover, the court also concluded that Quincy Mutual was entitled to prejudgment interest on the $1,000,000 judgment beginning on January 1, 2006 (i.e., after the opportunity to settle was lost in December 2005):

> Under New York law, a plaintiff who prevails on a claim for breach of contract is entitled to prejudgment interest as a matter of right . . . . In New York, the statutory rate for prejudgment interest in a breach of contract action is nine percent per year. Accordingly, in this case, in addition to recovering damages, Quincy Mutual is entitled to recover prejudgment interest, calculated from January 1, 2006, at a rate of nine percent per year, on the damage amount of $1,000,000 to the date of the entry of judgment.

Id. at 313 (internal quotations omitted).

As *Quincy Mutual* illustrates, even in New York, an insurer who looks to call a claimant's bluff by holding fast to a lowball offer and thus squander an opportunity to settle despite obvious liability in excess of limits does so at its peril.

II. Effects of Demands on Towers of Coverage

A. What is the Effect of a Demand Within the Primary Limits on the Tower of Coverage?

1. *Both New Jersey and New York Impose a Direct Duty Upon a Primary Insurer to the Excess Insurer*

(a) New Jersey Law

As noted in Section 2.09(2) of the Main Volume, only a small number of jurisdictions impose a direct duty on primary insurers to excess insurers in the context of a primary insurer's failure to settle. Both New Jersey and New York are among this small group.

As also noted in Section 2.09(2), among the earlier cases in New Jersey to recognize this duty was *Penn's Estate v. Amalgamated General Agencies*, 372 A.2d 1124, 1127 (N.J. App. Div. 1977) ("Accordingly, we hold that the primary carrier owes to the excess carrier the same positive duty to take the initiative and attempt to negotiate a settlement within its policy limit that it owes to its assured."). More recently, in *New Jersey Manufacturers Insurance Co. v. National Casualty Co.*, 923 A.2d 315 (N.J. App. Div. 2007), the New Jersey Appellate Division likewise

recognized this duty, and directed the trial court to apply *Rova Farms* to determine whether the primary insurer's settlement tactics violated its duty to the excess insurer. *See id.* at 324 ("Here, [the primary insurer] retained the use of the policy's $1 million while the case proceeded through the various adjudicatory levels. Confronted by these facts, the trial court must determine whether [the primary insurer's] adoption of this 'hardball' settlement strategy amounted to a violation of its fiduciary duty under both *Kotzian* and *Rova Farms*.").

That such a "positive duty" exists in New Jersey as between a primary and excess insurer was most recently recognized earlier this year in *Hartford Casualty v. Liberty Mutual*, which is also discussed above in Section I of this Addendum. In *Hartford Casualty,* a truck driven by the insured's employee ran a red light and struck the claimant's automobile. 2021 WL 1186759, at *1. During the course of the tort action brought by the claimant, the excess insurer indicated its wish to settle the case. *Id*. at *2. The primary insurer, whose policy provided a $1 million limit, wrote to the excess insurer stating that it understood the excess insurer's "directive," but that it does "not pay cases at [its] limits to satisfy an excess carrier when the factual merits of the case do not support a pay out at the [then] current demand of $750,000." *Id*. at *2 (alteration in original).

After this exchange, the primary insurer offered the claimant $350,000 to settle, which the claimant rejected. Several months later, the primary insurer offered $600,000, but the claimant rejected that offer as well. *Id.* The case proceeded to verdict, with the jury awarding $1.4 million. The primary insurer paid its remaining policy limit to the claimant, and the excess insurer paid the amount in excess of that remaining limit, which totaled more than $600,000. *Id.*

The excess insurer brought suit against the primary seeking recovery of the excess payment, asserting that the primary insurer breached its duty to the excess insurer by failing to offer its full remaining policy limit. *Id.* Relying on *New Jersey Manufacturers Insurance Co.*, the District Court relied on *Rova Farms* to articulate a three pronged test to assess whether the primary insurer had breached its duty:

> Under the seminal case of *Rova Farms Resort, Inc. v. Investors Ins. Co.*, a primary insurer is liable to an excess insurer for an excess verdict where the primary insurer failed to settle with a third-party claimant within the primary policy limit prior to trial, and where, prior to trial, (1) a jury could have potentially found liability for the third-party claimant and the potential verdict could have exceeded the primary policy limit, (2) the third-party claimant was willing to settle within the primary policy limit, and (3) the primary insurer did not negotiate in "good faith."

Hartford Casualty, 2021 WL 1186759, at *3 (internal citations omitted).

Noting that it was undisputed that the first two *Rova Farms* prongs were met, the court further noted that the primary insurer primary insurer's "negotiation strategy" with the third-party claimant must have a "reasonable prospect for a successful outcome" for both itself and the excess insurer. *Id*. (citing *New Jersey Mfrs. Ins. Co.*, 923 A.2d at 318). Upon considering the *Rova Farms* factors and the evidence, the *Hartford Casualty* court found disputed issues of fact precluding entry of summary judgment in favor of the excess insurer, including whether the

settlement value was reasonably calculated, and whether the primary insurer's "hardball" negotiation tactics were made in good faith. *Id*. at *4-5.

(b) New York Law

As with a primary insurer's duty to settle owed to its insured, courts in New York apply the same "gross disregard" test to a primary insurer's obligation to the excess insurer, as set forth in *Pavia*, 626 N.E.2d at 27. As stated by the New York Appellate Division:

> Under New York law, since an insurer has exclusive control over a claim against its insured once it assumes defense of the suit, it has a duty to act in "good faith" when deciding whether to settle and may be held liable for breach of that duty. This duty also applies where an excess insurer is exposed to liability and requires a primary insurer to give as much consideration to the excess carrier's interests as it does to its own.

Fed. Ins. Co. v. N. Am. Specialty Ins. Co., 921 N.Y.S.2d 28, 29 (N.Y. App. Div. 2011) (internal citations omitted).

As discussed in Section I above, federal courts in New York, including *New England Insurance* and *Quincy Mutual*, have likewise recognized this duty and imposed bad faith liability on a primary insurer that breached its duty of good faith to an excess insurer. *See New England Ins. Co.*, 295 F.3d at 244 (citing *inter alia*, *Pavia*, 626 N.E.2d at 27) ("An insurer's duty to act in good faith is owed also to excess insurance carriers."); *Quincy Mutual*, 89 F. Supp. 3d at 306 (citing and quoting *New England Ins. Co.*, 295 F.3d at 241 ("An insurer's duty of good faith is not limited to the insured, extending to excess carriers where the primary insurer is defending in a case in which both insurance companies have provided coverage. In such circumstances, '[a] primary insurer discharges its duty of good faith by giving as much consideration to the excess carrier's interests as it does to its own.'") (citations omitted).

Despite the existence of such a duty, as the *Quincy Mutual* court noted, "New York courts have acknowledged the existence of a strong presumption against bad faith on the part of a primary insurer." *Quincy Mutual*, 89 F. Supp. 3d at 306. Yet, even in the face of such a presumption, as the discussion of *Quincy Mutual* in Section I above shows, if the facts warrant it, New York courts will impose such liability on a primary insurer. *New England Insurance*, upon which *Quincy Mutual* relied, likewise provides a blueprint for what a primary insurer should not do vis à vis an excess insurer.

In *New England Insurance*, the underlying litigation was controlled by Healthcare Underwriters Mutual Insurance Company ("Healthcare") which had issued a $1 million primary insurance policy. *Id*. at 234. The excess insurer, New England Insurance Company ("New England") provided $3 million in excess coverage. *Id*. at 234. Healthcare, however, never made any settlement offer on behalf of its insured at any time prior to or during the malpractice litigation, believing in certain weaknesses in the case. *Id*. at 235. The initial settlement demand by the claimants was $500,000, or one half of Healthcare's primary limit. *Id*. at 235.

After the claimants raised their demand to $1 million, New England demanded that

Healthcare settle and warned of the "enormous verdict potential." *Id.* at 235. Healthcare, however, allowed the case to proceed to trial. *Id.* at 235. During the course of the trial, the claimants successively raised their demand, from $2 million up to a demand of $4 million. *Id.* at 235–36. At the trial, witness and expert testimony clearly demonstrated potential liability on the part of the defendants. *Id.* at 236. For example, the hospital's expert witness "conceded a 'departure' from medical procedure." *Id.* at 236. After the jury returned a verdict of $9.6 million, and the case ultimately settled for $2.1 million.

New England then tried its bad faith action against Healthcare to a jury, and the jury returned a verdict in New England's favor. Healthcare then renewed a motion for judgment as a matter of law that it had previously and unsuccessfully brought prior to the jury returning its verdict. *Id.* at 239–240. After the district court denied Healthcare's second motion, Healthcare filed a post-trial motion whereby it renewed its motion for judgment as a matter of law for a third time, which the district court granted. New England appealed. *Id.*

The Second Circuit reversed. In so doing, the court held that "[t]he evidence adduced at trial was legally sufficient to sustain the jury's finding of bad faith." *Id.* at 244. The evidence included that the victim was likely to succeed based on witness testimony; that the potential damages were "enormous" and that Healthcare, the primary insurer was "was aware that damages could very well exceed the $4 million combined policy limits." *Id.* at 245. Further, there was evidence that "New England (with $3 million in coverage at stake), not Healthcare (with $1 million in coverage at stake), could bear the financial brunt of a big plaintiffs' verdict." *Id.* at 245. The Second Circuit noted that there were additional factors presented to the jury which pointed to Healthcare's conduct having met the "gross disregard" standard, including: (1) Healthcare's refusal to make any settlement offer prior to or at any time during the malpractice action, despite written demands from the insured, and five written demands from New England, (2) Healthcare's failure to inform the insured of an early $500,000 settlement offer; and (3) Healthcare's failure to properly investigate the claim. *Id.* at 245.

Moreover, given its "review[] [of] the entire record below, including several statements by the district court about the legal sufficiency of the evidence," the Second Circuit held "that it would be inappropriate now to order a new trial." *Id.* at 248. Instead, noting that the jury appropriately considered "all of the facts and circumstances existing at the time the decisions were made," it not only reversed the district court, but also directed the district court to enter judgment in the New England's insurer's favor in accordance with the jury's verdict. *Id.* at 249.

B. Case Law in New Jersey Allows Insurers in a Tower to "Settle Around" a Recalcitrant Insurer

Another conundrum that arises during settlement negotiations where there is a tower of coverage is where there is a demand for the entire tower limits, but one or more of the insurers in the tower refuses to settle. In some states, including New Jersey, courts have acknowledged that the insured and the participating insurers have the right to settle with the claimant, and leave the remaining non-settling insurer's limits exposed. Such settlements are referred to in New Jersey

as "Deblon" settlements, which are named for the seminal case that first recognized such a right.[2]

In *Deblon v. Beaton*, 247 A.2d 172 (N.J. Super. Ct. Law. Div. 1968), the widow of a man killed in a car accident entered a settlement agreement with the driver, the vehicle owner, and the owner's primary insurance carrier, Allstate. The driver's excess automobile insurance carrier, Jersey Insurance Company of New York of the Pacific of New York Group ("Jersey"), refused to pay anything toward the settlement with the widow, and thus was not a party to that settlement agreement. *Id.* at 174. In that settlement agreement, the plaintiff agreed that although she would proceed to judgment against the insured defendants, she would seek to collect only from Jersey, and thus impleaded Jersey directly into her action against the insured defendants. *Id.*

Jersey moved to dismiss, arguing that because the plaintiff had released the insureds under its policy, there was no liability for which Jersey could be responsible. The Superior Court disagreed. It instead held that the plaintiff had successfully released the named insureds only as to their personal assets and their rights to insurance coverage from their primary insurer, reserving the right to seek damages against the insureds' excess insurance coverage. *Id.*

Though not definitively stated in *Deblon*, it is generally understood that Deblon settlements protect the remaining non-settling insurer from a bad faith liability even in the face of an excess judgment. In dicta, the *Deblon* court stated that the partial settlement was not prejudicial to Jersey, and in fact *helped* Jersey because the "release of the individual defendants as to their personal assets will preclude any exposure of Jersey to liability beyond its policy limit." *Id.* at 176. *See also* DENNIS J. WALL, LITIGATION AND PREVENTION OF INSURER BAD FAITH § 3:20 (noting that some courts have observed that "carriers with excess insurance policies still at risk in these cases cannot thereafter be liable for bad faith" and that "[t]he insured can never be exposed to excess liability and the non-settling carriers cannot be liable beyond policy limits" (citing *Deblon*, Florida and Minnesota case law)).

Thus, under a Deblon settlement, even when the claimant obtains a huge excess judgment, the remaining non-settling insurer(s) will likely be able to avoid liability in excess of its/their policy limits.

III. Does the Wrongful Denial of a Defense Automatically Allow for Damages in Excess of the Policy Limits?

In New Jersey, there is support for the proposition that an unjustified breach of the duty to defend—even without bad faith—may subject an insurer to liability in excess of policy limits when a verdict or good-faith settlement exceeds those limits.

New Jersey law provides that, when an "insurer wrongfully refuses coverage and a defense to its insured, so that the insured is obliged to defend himself in an action later held to be covered by the policy, the insurer is liable for the amount of the judgment obtained against the

[2] As discussed in Section 3.20 of Dennis J. Wall's Litigation and Prevention of Insurer Bad Faith, other states besides New Jersey also recognize the propriety of such settlements. Such states include Indiana, Louisiana and Wisconsin. *See* DENNIS J. WALL, LITIGATION AND PREVENTION OF INSURER BAD FAITH § 3:20.

insured or of the settlement made by him." *Fireman's Fund Ins. Co. v. Security Ins. Co. of Hartford*, 367 A.2d 864, 868 (N.J. 1976).

In *Fireman's Fund*, Security Insurance had issued a $50,000 professional-malpractice insurance policy for a law firm, and Fireman's Fund had issued an excess policy for $250,000. Both insurers had hired a single attorney to defend the law firm after a malpractice lawsuit was filed against it. *Id.* at 866. Before trial, the underlying claimants had offered to settle for $147,000 on a claim for which an adverse verdict might yield more than $400,000 of liability, but Security refused to settle or to contribute its $50,000 limit toward the settlement despite the request of its insured, Fireman's Fund, and the trial attorney it had hired. *Id.*

Fireman's Fund and the insured eventually settled the matter for $135,000, and Fireman's Fund, as assignee of the insured, filed an action seeking recovery of the $50,000 from Security Insurance, which it alleged acted in bad faith in refusing to settle. Security did not challenge that it had acted in bad faith in refusing to settle, instead it argued that it was defending its insured, and its policy's no-action provision gave it control of settlement. *Id*. at 868.

The court stated that the insurer's right to control settlement is forfeited when the insurer "violates its own contractual obligation to the insured." *Id*. The court acknowledged that even though Security had not breached its duty to defend, it breached the implied covenant of good faith and fair dealing in refusing to settle. *Id*. at 872. Because Security had breached the implied duty, the insured was free to protect its own interest in minimizing a potential liability in excess of the policy limit by agreeing to a reasonable good-faith settlement and by recovering the policy limit from Security. *Id.*

Importantly, the court held regardless of the kind of breach—whether a breach of the duty to defend, or "its implied obligation to make a timely investigation of the claim[,] or of its implied obligation to exercise, in good faith and with concern for the interests of the insured, its reserved power with respect to settlements[,]"—damages are essentially the same. "In each of those situations, it is uniformly held, as the cases cited earlier in this opinion disclose, that the measure of the insured's damages is [e]ither the amount of the judgment entered against the insured in the negligence action [o]r the amount paid by the insured in making a reasonable good faith settlement of the negligence action before trial." *Id.*

Consistent with its pro-insurer reputation, New York law, on the other hand, does not appear to impose excess liability on an insurer for breach of its defense obligation. As with many New York appellate decisions, factual details are sparse, but in *U. S. Fid. & Guar. Co. v. Copfer*, 400 N.E.2d 298, 298 (N.Y. 1979), the insurer disclaimed liability and refused to defend the son of its insureds. The insured's retained independent counsel for their son, who kept the insurer informed of the progress of the litigation and repeatedly requested it to defend the action.

The policy limit was $25,000, and judgment was eventually entered against the son for $79,000. The insurer commenced a declaratory judgment action against the insureds to determine coverage under the policy, and both parties moved for summary judgment. The trial court entered judgment for the insureds for the entire judgment, as well as fees and costs expended in the defense. The insurer appealed, and the Fourth Department held that although the insurer was liable for its policy limits and defense costs, it could not be liable for that portion

of the judgment in excess of its policy limits absent a finding of bad faith. *See also Gordon v. Nationwide Mut. Ins. Co.*, 285 N.E.2d 849, 854 (N.Y. 1972) "[f]or a breach of the obligation to defend, the measure of damage is the cost of defense to the insured and the amount of recovery, if any, against the insured within the policy limits.").

Developments in Excess Judgment Liability
California Update/Addendum

American College of Coverage Counsel
2021 Annual Meeting

Intercontinental Chicago
September 22-24, 2021

Julia Molander
JAMolander Consulting LLC
San Francisco, CA
jamolander@sbcglobal.net

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I. Must There be a Demand Within Policy Limits To Trigger Excess Liability?

California has long held that there must be a demand within policy limits in order for an insurer to be held liable for an excess judgment. ***Johansen v. California State Auto Assn.***, 15 Cal.3d 9, 15-16 (1975); ***Heredia v. Farmers Ins. Exchange***, 228 Cal.App.3d 1345 (1991) (insurer not liable for excess judgment where demand to continue to pay defense fees coupled with policy limits demand); ***Walbrook Ins. Co. v. Liberty Mutual Ins. Co.***, 5 Cal.App.4th 1445 (1992) (no bad faith claim against insurer for ignoring settlement demand in excess of limits); ***Graciano v. Mercury General Corp.***, 231 Cal.App.4th 414, 425 (2014) ("an insured's claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable effort to settle the claims against the insured for an amount within the policy limits").

A recent case casts doubt on that requirement. In ***Planet Bingo LLC v. The Burlington Insurance Co.***, 62 Cal.App.5th 44 (2021) held that a subrogating insurer did not have to make a demand within policy limits. Instead, the court held that because the "practice" in subrogation matters was to negotiate even in the absence of a demand, the insurer was liable for bad faith failure to settle even without a demand.

The facts of ***Planet Bingo*** are complicated, as is typical with subrogation matters. In 2008 a lithium battery in a handheld gaming device started a fire in a Beacon Bingo hall in London. The gaming device was designed by Planet Bingo but manufactured by another company, Jaco Industries, in California. Leisure Electronics distributed the Planet Bingo devices in the UK. The distribution agreement provided that all disputes between Leisure and Planet Bingo would be brought in England.

Planet Bingo tendered the matter to Burlington, which investigated. Ultimately Burlington determined that the damages were in the range of $2.6 million, well in excess of Planet Bingo's $1 million policy, but that no suit had been filed. Burlington closed its file and so informed Planet Bingo. However, Burlington did not tell Planet Bingo that it had determined that Planet Bingo's device was the cause of the fire, that Leisure and Beacon were in settlement negotiations, and that Leisure was likely to sue Planet Bingo.

In 2014 Leisure settled with Beacon for $2.6 million, paid by Leisure's insurer AIG. Leisure notified Planet Bingo of the settlement and demanded payment of the full amount. Planet Bingo notified Burlington of the demand. Burlington denied coverage on the grounds that the fire did not occur within the "coverage territory" which was limited to occurrences within the US and Canada, or worldwide, if the product sold was made in the US or Canada and the insured's liability adjudicated in a lawsuit.

Planet Bingo then sued Burlington for bad faith. The trial court sided with Burlington that no occurrence had taken place in the "coverage territory" because the fire took place in London and no lawsuit had been filed. The appellate court agreed with the coverage analysis, but also concluded that there was a potential of a future lawsuit filed within the coverage territory. The appellate court remanded for further proceedings on the bad faith claims.

In the meantime, AIG as Leisure's insurer sued Planet Bingo in the US rather than in England, as required in the distribution contract. Burlington defended Planet Bingo under

reservation of rights. In March 2019, Burlington settled with Planet Bingo for the policy limits of $1 million and AIG released all claims against Planet Bingo.

The bad faith case remained alive. No longer was Planet Bingo asserting that Burlington failed to defend or pay the limits. Instead Planet Bingo claimed damage to its business in the amount of $9.3 million, due to Burlington's pre-litigation handling. Burlington contended that it could not be held to have acted in bad faith because (1) AIG as Leisure's insurer never made a demand within policy limits and (2) no excess judgment was levied against Planet Bingo.

Again the trial court granted judgment in Burlington's favor, but the Court of Appeals reversed. The appellate court declined to rule on the issue of whether bad faith damages can be obtained where no excess liability judgment is asserted against the insured. Instead the court focused on the pre-litigation settlement discussions, concluding that a formal within-limits settlement demand was not required.

In so holding the appellate court relied on the testimony of Planet Bingo's expert, who stated that in subrogation claims there is a custom and practice of making demands in excess of the policy limits but settling for those limits. The court also relied on the case of ***Boicourt v. Amex Assurance Co.***, 78 Cal.App.4th 1390 (2000), which held that a formal demand was not necessary in circumstances where the insurer refused to disclose the policy limits. The court concluded that when Burlington originally declined coverage, it could be held liable for "bad faith claims handling, including failure to settle." ***Planet Bingo,*** 62 Cal.App.5th at p. 57. The court remanded to the trial court for a determination of whether Burlington could be held liable for lost profits and punitive damages.

Assuming that ***Planet Bingo*** remains citable authority, the issue for later cases is whether it will be restricted to subrogation matters or used more extensively.

II. What Are the Reasonableness Requirements to Establish Bad Faith for Refusing to Accept a Demand within Policy Limits?

The California pattern jury instructions, for failing to accept a reasonable settlement within liability policy limits, state three requirements for a bad faith claim: (1) that the claim was covered by the insurance policy; (2) that the insurer failed to accept a reasonable settlement demand for an amount within policy limits; and (3) that a monetary judgment was entered against the insured for a sum greater than the policy limits. CACI 2334.

The pattern instruction is fashioned from the Supreme Court ruling in ***Crisci v. Security Ins. Co. of New Haven***, 66 Cal.2d 425, 431 (1967) (liability insurer must accept policy limits settlement when the amount of the judgment is "likely" to exceed the limits; "the size of the judgment recovered in the personal injury action…, although not conclusive, furnishes an inference that the value of the claim is the equivalent of the amount of the judgment and that acceptance of an offer within those limits was the most reasonable method of dealing with the claim." *See also*, ***Johansen v. California State Auto Assn.***, 15 Cal.3d 9 (1975) (insurer that defends but mistakenly refuses settlement on the grounds of no coverage is responsible for the entire amount of the settlement or judgment).

A division has developed within the courts as to whether liability is triggered solely by the refusal a reasonable settlement offer, resulting in an excess judgment, or whether the insurer's failure to pay must be unreasonable as well. In ***Hamilton v. Maryland Cas. Co.***, 27 Cal.4th 718, 724-725 (2002), the California Supreme Court indicated in *dicta* that the insurer would be liable for the entire amount of the judgment for "an unreasonable refusal to settle" within policy limits. In ***Graciano v. Mercury General Corp.***, 231 Cal.App.4th 414, 425 (2014) the court held that bad faith based on a wrongful refusal to settle requires proof that the insurer unreasonably failed to accept an otherwise reasonable settlement offer. As of 2021, the Judicial Counsel has declined to amend the instructions until the Supreme Court issues a more definitive statement.

The most recent case to address this issue is ***Pinto v. Farmers Insurance Exchange***, 61 Cal.App.5th 676 (2021). Four people were seriously injured in a single car crash. There was an issue regarding who was driving at the time of the accident. The owner of the car had a policy with Farmers with limits of $50,000 per person and $100,000 per occurrence. One of the occupants, Pinto, was rendered a quadriplegic. Pinto made a time-limited demand for the per person policy limits of the Farmers policy, with the additional requirement of a declaration that neither the potential driver nor the owner was acting in the course of employment. Farmers accepted the demand within the time period, but failed to obtain a declaration from the potential driver. Pinto rejected the settlement.

Pinto sued the owner and the potential driver. The parties settled for the amount of $10 million, with $65,000 paid by Farmers and another insurer. Rights were assigned by the owner and the potential driver to Pinto as against Farmers. Pinto then sued Farmers for recovery of the remainder. Farmers argued that Pinto had to prove that Farmers acted unreasonably in failing to settle. The court declined to so instruct the jury. The jury found that Pinto made a reasonable policy limits settlement demand, that Farmers failed to accept it, that a judgment in excess of the demand was entered in the earlier lawsuit, and that the potential driver refused to cooperate with Farmers, despite Farmers' reasonable efforts to obtain the potential driver's cooperation. The jury held Farmers liable for $9,935,000 and the court entered judgment for that amount.

The appellate court reversed. The court found that the pattern instruction, CACI 2334, and the jury verdict form that adopted it, were fatally defective because they lacked the "crucial element" of unreasonable conduct on the part of the insurer. Despite some evidence that Farmers invited the error in the instruction, the court concluded that the error in the special verdict form was the fault of Pinto, who asked for and obtained a form that mirrored CACI 2334. Rather than remand the case to the trial court for retrial on the issue of Farmers' reasonableness, the court entered judgment for Farmers.

III. Does the Wrongful Denial of a Defense Automatically Allow for Damages in Excess of the Policy Limits?

In California, an insurer that denies a defense and a refuses a reasonable within-limits settlement demand may be subject to liability for an excess-of-limits settlement or verdict. ***Comunale v. Traders & General Ins. Co.***, 50 Cal.2d 654 (1958) (insurer that fails to accept a

reasonable settlement offer, after refusing to defend because of the mistaken belief that there is no coverage, is liable for excess judgment against an insured even when the insurer has a good faith belief in its coverage position); ***Samson v. Transamerica Ins. Co.***, 30 Cal.3d 220, 237 (1981) ("When, in addition to refusing to defend, the insurer also rejects a reasonable settlement offer within policy limits, it may become obligated to pay more than its limits … If an insurer honestly believes that its policy does not provide coverage and, therefore, chooses to reject a reasonable settlement offer, it must bear responsibility if coverage is found").

But what about a wrongful failure to defend when there is a later finding of no coverage? The case of ***Amato v. Mercury Casualty Co.*** provides a good illustration of the dilemma. The ***Amato*** case involved an auto accident that injured the insured's passenger, his mother-in-law. Mercury denied a defense, relying on the "resident relative" exclusion, even though it had information that Amato did not live with his in-laws. Mercury declined two opportunities to settle for the policy limits of $15,000. Amato defaulted and the court entered a judgment against him in the amount of $165,750.

Amato sued Mercury for bad faith. The jury found that in fact Amato was living with his mother-in-law at the time of the accident, so that the "resident relative" exclusion would apply. Notwithstanding this finding, the trial court held that Mercury had breached its duty to defend based on the facts known to it at the time. Mercury could not rely on the subsequently discovered facts or the jury's verdict to support its denial of a defense. The trial court concluded that Mercury's refusal to defend was a "non-malicious breach" of the duty of good faith and fair dealing. The trial court found that the measure of damages was all detriment caused by the breach, and awarded damages equal to the amount of the judgment, prejudgment interest, and court costs.

In the first appeal, ***Amato v. Mercury Cas. Co.***, 18 Cal.App.4th 1784 (1993) (***Amato I***), the court concluded that because there was no coverage, the proper measure of damages was the cost incurred in the defense of the underlying lawsuit rather than the amount of the judgment. The court remanded for calculation of the defense costs. On remand the parties stipulated that no defense costs were incurred because of the default. The trial court entered judgment for Mercury.

In the second appeal, ***Amato v. Mercury Cas. Co.***, 59 Cal.Ap.4th 825 (1997) (***Amato II***), the appellate court reconsidered its earlier decision, and concluded that where a default is entered because the insurer wrongfully refused to defend, the proper measure of damages is the full amount of the insured's liability. Having failed to defend when the facts were controverted, the insurer could not justify its decision by the jury's later finding that there was no coverage. See also, ***Pershing Park Villas v. United Pacific Ins. Co.***, 219 F.3d 895 (9th Cir. 2000) (same holding in the context of a commercial liability policy).

Developments in Excess Judgment Liability

Texas Policyholder Perspective

Addendum

American College of Coverage Counsel
2021 Annual Meeting

Intercontinental Chicago
September 22-24, 2021

Authored By:
J. James Cooper
jcooper@reedsmith.com
Dominic Rupprecht
drupprecht@reedsmith.com
Connor O'Carroll
cocarroll@reedsmith.com
Reed Smith LLP

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A. The *Stowers* Doctrine and Third Party Settlements

Texas common law imposes a duty on liability insurers to settle third party claims against their policyholders when reasonably prudent to do so. *See GA Stowers Furniture Company v. American Indemnity Company*, 15 S.W.2d 544 (Tex. 1929). An insurer has an essentially identical statutory duty to settle under section 541.060(a)(2)(A) of the Texas Insurance Code, as recognized in *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 262 (Tex. 2002).

An insurer's *Stowers* duty is triggered by a settlement demand if the following three conditions are met: "(1) the claim against the insured is within the scope of coverage, (2) the demand is within the policy limits, and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." *American Physicians Insurance Exchange v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994).

Similarly, under the Texas Insurance Code, an insurer will be liable for failing to settle when: "(1) the policy covers the claim, (2) the insured's liability is reasonably clear, (3) the claimant has made a proper settlement demand within policy limits, and (4) the demand's terms are such that an ordinarily prudent insurer would accept it." *See Rocor*, 77 S.W.3d at 262. Under the doctrine of equitable subrogation, an excess insurer is permitted to bring a *Stowers* claim against a primary layer insurer on behalf of the insured, effectively standing in the shoes of the insured. *See American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992); *General Star Indem. Co. v. Vesta Fire Ins. Corp.*, 173 F.3d 946, 950 (5th Cir. 1999).

Stowers applies only when "the settlement's terms [are] clear and undisputed." *Rocor*, 77 S.W.3d at 263. The offer "must also be unconditional" and cannot "carry[] risks of further liability." *Danner v. Iowa Mut. Ins. Co*., 340 F.2d 427, 429–30 (5th Cir. 1964).

The *Stowers* doctrine is largely mirrored in the Restatement of the Law of Liability Insurance. Consistent with Texas's *Stowers* doctrine, the Restatement provides that a liability insurer has a duty to make reasonable settlement decisions, and defines a "reasonable settlement decision" as "one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment" without regard to the limits of liability at issue, as set forth below:

> (1) When an insurer has the authority to settle a legal action brought against the insured, or the insurer's prior consent is required for any settlement by the insured to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.
>
> (2) A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.
>
> (3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

See Restatement of the Law of Liability Insurance § 24.

The common law *Stowers* doctrine – and its Insurance Code and Restatement corollaries – encourages prompt and reasonable settlements by eliminating a potential for conflict between insurer and policyholder in cases involving damage claims potentially exceeding the applicable policy limits. The conflict arises because the insurer has control over the settlement, but only limited liability. In the absence of the *Stowers* doctrine, an insurer, motivated by self-interest, may be tempted to resist reasonable settlement offers assuming that any adverse judgment will, at worst, exhaust the policy limits and, thus, proceeding to trial will put only the policyholder's or excess insurer's money at risk. *Stowers* penalizes this type of self-interest by raising the stakes for the insurer should it act unreasonably when presented with an opportunity to settle at or below policy limits. *Stowers* liability is designed to compensate the policyholder or excess insurer for damages suffered as a result of the primary insurer's unreasonable refusal to settle. *See generally* Restatement of the Law of Liability Insurance § 24 cmt (b) (explaining the duty to make reasonable settlement decisions is based on the need to solve a "conflict-of-interest problem" where, an insurer that elects to go to trial rather than accept a full-limits or near-limits settlement demand, "is effectively 'gambling with the insured's money,' or gambling with the excess insurer's money, because the insured or the insured's excess insurer will have to pay any verdict in excess of the policy limit.").

B. Stowerizing Excess Carriers

An issue arises when a claimant demands an amount above the limits of the insured's primary insurance coverage but within the limits of the insured's *excess* insurance policy. *See Keck, Mahin & Cate v. National Union Fire Ins. Co.*, 20 S.W.3d 692, 701 (Tex. 2000) ("An excess insurer owes its insured a duty to accept reasonable settlements, but that duty is also not typically invoked until the primary insurer has tendered its policy limits."); *Schneider Nat. Transp. v. Ford Motor Co.*, 280 F.3d 532, 539 (5th Cir. 2002) (refusing to allow an excess carrier to sue a primary insurer for equitable subrogation under a *Stowers* theory where there was never a demand within the primary limits).

In *Keck*, the primary insurer asserted as a defense to the excess insurers' equitable subrogation claim that the excess insurer handled the dispute negligently by not responding to the claimant's lower settlement demand earlier in the case. *See* 20 S.W.3d at 701. The court rejected the defense, noting that the primary insurer did not tender its limits until the trial began, which was well after the lower settlement demand had been withdrawn, and the excess insurer did not interfere with the insured's defense or assume control of the defense prior to the earlier demand. According to the court, under those circumstances the excess insurer's contributory negligence, e.g., failure to respond to the settlement demand, was irrelevant. *Id.* at 702. *See also Emscor Mfg., Inc. v. Alliance Ins. Group,* 879 S.W.2d 894, 901 (Tex. App.—Houston [14th Dist.] 1994, writ denied) ("[W]e note that the Stowers doctrine . . . has never been applied to an excess carrier . . . .").

1. Taking Control

As foreshadowed in *Keck*, Texas courts have imposed a *Stowers* duty on the excess carrier if the excess carrier assumed control over the settlement process. *See Rocor,* 77 S.W.3d at 253 (excess insurer owed a *Stowers* duty to the insured where it assumed control of settlement negotiations, canceled a scheduled mediation, and directed that no offer be made to plaintiffs); *Employers Nat'l Ins. Co. v. General Accident Ins. Co.,* 857 F. Supp. 549, 554-55 (S.D. Tex. 1994) (when excess liability is likely, an excess insurer may interject itself into settlement negotiations before tender by the primary insurer). Taking control of the settlement process includes negligently disclosing information to plaintiff's counsel in a third-party claim against the insured. *See Birmingham Fire Ins. Co. v. American Nat'l Fire Ins. Co.*, 947 S.W.2d 592, 596 (Tex. App.—Texarkana 1997, writ denied). Thus, actively participating in the negotiations may trigger *Stowers* for excess carriers.

2. Other Considerations—All Other Insurers Agree to Settle or the Insured is Willing to Pay the Difference.

The duty to settle may also attach to an excess insurer where all of the other excess insurers in the insured's tower of insurance have agreed to pay their policy limits. *See Cameron Int'l Corp. v. Liberty Ins. Underwriters, Inc. (In re Oil Spill By the Oil Rig "Deepwater Horizon" in the Gulf of Mexico)*, No. 2:10-md-02179-CJB-SS (E.D. La. Aug. 16, 2012) (Doc. No. 7129) (predicting Texas Supreme Court would find that settlement demand within limits of $250 million tower of insurance would trigger *Stowers* duty on the part of mid-level excess insurer with $50 million in coverage where all other insurers in the tower have agreed to fund the settlement).

A related issue is one in which a demand is made that exceeds the primary carrier's policy limits, but the insured is willing to pay the difference between the limits and the total of the demand. In footnote 13 of the *Garcia* opinion, the majority noted that:

> We do not reach the question of when, if ever, a *Stowers* duty may be triggered if an insured provides notice of his or her willingness to accept a reasonable demand above the policy limits, and to fund the settlement, such that the insurer's share of the settlement would remain within the policy limits.

Garcia, 876 S.W.2d at 849, fn. 13.

At least one state appellate court has adopted the view that if the insured is willing to contribute the difference between the insurance policy limit and the total settlement demand, then the *Stowers* duty on the part of the insurer would be triggered. In *State Farm Lloyds Insurance Company v. Maldonado*, the claimant offered to settle the suit for State Farm's policy limits of $300,000 plus $1 million from the insured's own pocket. 935 S.W.2d 805, 809 (Tex. App.—San Antonio 1996), *affirmed in part and reversed in part*, 963 S.W.2d 38 (Tex. 1998). The San Antonio Court of Appeals concluded that the "bifurcated nature" of the demand brought it within policy limits and triggered the *Stowers* duty. *Id*. at 815. The Supreme Court reversed the court of appeals on the specific facts of that case, and it ruled that the $1.3 million settlement demand "was not an unconditional offer to settle within policy limits and therefore did not trigger the *Stowers* doctrine." *Id*. at 41. The Court explained:

> In this case, State Farm claims Maldonado never made an unconditional offer to settle within State Farm policy limits. It is undisputed that Maldonado never made a settlement demand of less than $1.3 million. She nevertheless contends that Robert's offer to pay the $1 million above policy limits converted the $1.3 million demand into a $300,000 policy-limits demand. We disagree.

Id. However, in a footnote, the Court acknowledged that *Garcia* left open the question of whether a *Stowers* duty is triggered if an insured provides notice of his or her willingness to fund a settlement above the policy limits.

C. Multiple Claimants or Insureds

With the possible exception of one unpublished Texas court of appeals decision, it is generally accepted that a *Stowers* demand does not need to include all claimants or offer a release as to all insureds to be effective. *See Texas Farmers Insurance Co. v. Soriano*, 881 S.W.2d 312, 315 (Tex. 1994); *Pride Transp. v. Continental Cas. Co.,* 511 F. App'x 347 (5th Cir. 2013) (unpublished); *Travelers Indemnity Co. v. Citgo Petroleum Corp.,* 166 F.3d 761, 768 (5th Cir. 1999) (collecting cases across the nation); *American States Ins. Co. of Texas v. Arnold,* 930 S.W.2d 196, 202 (Tex. App.—Dallas 1996, writ denied).

In *Soriano*, for example, the insurer was faced with multiple claims to $20,000 of insurance proceeds. One of the claimants agreed to a complete release for $5,000. Farmers accepted the offer leaving insufficient funds to settle the additional claims against the insured. The insured argued that its insurer did not have the right to extinguish some claims against its insured at the expense

of other pending claims. The Texas Supreme Court rejected that argument in part because the insurer owes separate *Stowers* duties in connection with each settlement demand. In other words, Farmers was required under *Stowers* to exercise reasonable care in responding to the $5,000 demand by only one of the claimants. 881 S.W.2d at 315 ("Farmers was required under *Stowers* to exercise reasonable care in responding to that demand.") (emphasis added).

In *Citgo*, the Fifth Circuit extended *Soriano* to cases with multiple insured defendants. The court held that "an insurer is not subject to liability for proceeding, on behalf of a sued insured, with a reasonable settlement . . . once a settlement demand is made, even if the settlement eliminates . . . coverage for a co-insured as to whom no *Stowers* demand has been made." *Citgo*, 166 F.3d at 768. The court reached its holding with the express understanding that a settlement demand to less than all of the insureds is sufficient to trigger an insurer's potential excess exposure under *Stowers*. *Id*. at 767 ("A valid *Stowers* demand in the context of multiple insureds requires that the settlement offer be reasonable and the insured party reasonably fear liability over the policy limit. In other words, for the issue to come up at all there usually has to be an objective possibility that the liability of at least one of the insureds would ultimately exceed the policy limits.") (emphasis in original). Likewise, the Fifth Circuit in *Pride* — citing both *Soriano* and *Citgo* — assumed that a settlement demand will trigger the insurer's *Stowers* duty even if it only offers to release some insureds. *Pride*, 511 F.App'x at 352.

The *Citgo* court expressly rejected an attempt to expand the *Stowers* analysis to require consideration of all potential claims and all of the insured parties. *See Citgo*, 166 F.3d at 765 ("Citgo next attempts to argue that the reference to reasonable settlement in *Soriano* allows a court to examine whether settlement was proper in light of all potential claims against all the insured parties. However, as noted, the *Soriano* court made it clear that reasonableness would only be measured by looking at the initial demand for settlement in isolation.") (citing *Soriano*, 881 S.W.2d at 316 ("The test is whether 'a reasonably prudent insurer would not have settled the Lopez claim when considering solely the merits of the Lopez claim when considering solely the merits of the Lopez claim and the potential liability of its insured on the claim.'")).

In cases where an insured is liable for injuries to multiple plaintiffs, the policy limit represents the total compensation collectively available to all claimants. This dynamic creates a motivation for separate claimants not only to settle, but to settle quickly. As the Texas Supreme Court explained in *Soriano*, "[w]hen faced with a settlement demand arising out of multiple claims and inadequate proceeds, an insurer may enter into a reasonable settlement with one of the several claimants even though such settlement exhausts or diminishes proceeds available to satisfy other claims." 881 S.W.2d 312, 315 (Tex. 1994). Plaintiff attorneys should therefore structure their releases of liability so that *each* of the claimants they represent *entirely* relinquishes their claims to the insured for additional future recovery. Doing so will eliminate at least one basis for the carrier to reject a certain demand by claiming that it is unreasonable. And, in the context where competition exists between multiple claimants for the available policy limits, avoiding such a delay could prove the difference between securing full compensation for a particular client and encountering a depleted asset pool.

One Texas court of appeals attempted to buck the trend by arguably requiring that all claimants release all insureds sued by those claimants in order for a *Stowers* demand to be

effective. In *Patterson v. Home State Mutual Insurance Company*, No. 01-12-00365-CV, 2014 WL 1676931, at *10 (Tex. App.—Houston [1st Dist.] April 24, 2014, pet. denied), the underlying injury occurred when Diane Patterson was fatally struck by an eighteen-wheeler owned by Brewer Leasing and operated by Charles Hitchens, an employee of Texas Stretch. The decedent's husband, Marcus Patterson, filed a wrongful death action against Brewer, Hitchens and Texas Stretch. *See id*. Brewer had an insurance contract with Home State that also covered anyone driving a "covered auto" with Brewer's permission. *Id.*

Patterson sent Home State three separate letters inviting settlement. Patterson's first letter proposed that Home State pay out the policy limits to his and Diane's children, Daniel and Danae, and in relevant part read:

> *"Marcus Patterson* [] *will provide Brewer Leasing, Inc. with a full complete, total, and unconditional release of any and all claims against Brewer Leasing and its insurance company in exchange for the payment of the policy limits…This also applies to any claim against Brewer Leasing by, through, or under Charles Hitchens. But we are not releasing Mr. Hitchens, Texas Stretch or their insurance carriers."*

Id. at *21. As is clear from the excerpt above, this letter only purports to release the claims of the children, and not the claims of the father. Additionally, the children agreed to release Brewer, but not Hitchens, the driver. *Id.* In his follow up correspondence with Home State, Patterson confirmed these limitations: "I want to reaffirm that the settlement offer is made on behalf of Daniel Patterson and Diane Patterson. It does not include an offer of settlement from their father, Marcus Patterson, in his individual capacity." *Id*. at *22. In similar fashion, the second settlement proposal, which only included a release by Marcus Patterson and not the children, confirmed that not all of the *potential* insureds were being released:

> *"This letter is sent as a settlement offer on behalf of Marcus Patterson, individually, Marcus Patterson as administrator of Diane's estate, Marcus Patterson as next friend of both Daniel and Diane Patterson, and Larry Goffney. They will settle all of their claims against Brewer Leasing, Inc. and its insurance carrier for the policy limits."*

Id. Finally, in his third settlement offer, Patterson included all of the claimants but not all of the *potential* insureds, namely Hitchens:

> *"This letter is sent as a settlement offer on behalf of Marcus Patterson, individually, Marcus Patterson as administrator of Diane's estate, Marcus Patterson as next friend of both Daniel and Diane Patterson, and Larry Goffney. They will settle all of their claims against Brewer Leasing, Inc. and its insurance carrier for the policy limits."*

Id. All three proposals were eventually rejected by Home State. With regard to the first two settlement offers, the court explained:

> A settlement offer must be both unconditional and . . . propose to release the insured fully to trigger the insurer's *Stowers* duty to settle. The purpose of the *Stowers* doctrine is to shift the risk of an excess judgment onto the insurer when the insurer has the opportunity to prevent an excess judgment by settling within the applicable policy limits. . . . Here, Patterson's first and second settlement offers did not propose to fully release Brewer, as it would still have been liable to an excess judgment to either Marcus Patterson, his children, or his wife's estate, whichever was not named in the settlement demand. Indeed, by settling in the full amount of the policy limits with only one of the claimants, Home State could have potentially exposed Brewer to an excess judgment by one of the other claimants. Accordingly, we hold that the first and second settlement offers did not trigger Home State's *Stowers* duty to settle.

Id. at *8 (citations omitted). The court also found fault with the third settlement demand, which agrees to release all of the Patterson claimants. While that final demand released all claims against Brewer, it did not include Hitchens. According to the court,

> The insurance policy for Brewer expressly provided that those insured under the policy included "[a]nyone else while using with your permission a covered auto you own, hire, or borrow." Thus, Patterson's third settlement offer did not constitute an unconditional offer to fully release the insureds in exchange for a settlement.

Id. at *10. The court further pointed out that personal counsel for the Brewer and Stretch had advised that he did not want "any settlement demands to be accepted that didn't involve a release of all the Pattersons' claims against both Brewer Leasing and Mr. Hitchens." *Id*. The fact that the insured's counsel had apparently not wanted Home State to accept the offers was significant to the court.

Patterson arguably stands for the proposition that all claimants must release all *potential* insureds in order for a settlement offer to qualify as an effective *Stowers* demand. No court followed that same path prior to *Patterson* and no court has chosen to follow it since. Moreover, the decision in *Patterson* directly conflicts with the Texas Supreme Court's decision in *Soriano*. 881 S.W.2d at 312.

Though the Texas Supreme Court has still not spoken directly on the issue of whether an offer to settle must release all insureds, the Fifth Circuit has. *See OneBeacon Ins. Co. v. T. Wade Welch & Assoc.*, 841 F.3d 669 (5th Cir. 2016) (applying Texas law). In *OneBeacon*, a former client offered a full release of its legal malpractice claims against the insured law firm in exchange for policy limits, but the demand did not offer a release to the individual attorney who handled the client's case. *Id*. at 678. OneBeacon, the malpractice insurance carrier, rejected the demand because it did not offer to release all insureds—namely, the handling attorney, Wooten. *Id*. The

United States Court for the Southern District of Texas held that the former client's offer was a valid *Stowers* demand as a matter of law, despite its failure to include the individual attorney. *Id.* On appeal to the Fifth Circuit, OneBeacon urged the Court to apply *Patterson*, arguing the former client's demand did not constitute a valid *Stowers* demand because it did not offer to release all insureds. *Id*. The Fifth Circuit distinguished the Houston Court of Appeals' decision in *Patterson*, and instead relied on its prior decision in *Citgo* and the Texas Supreme Court's decision in *Soriano*:

> OneBeacon argues that to be a "true" *Stowers* demand, the offer to settle must offer to release all insureds (here the Welch Firm and Wooten). The Texas Supreme Court has not spoken directly on this issue. However, we have. In *Travelers Indemnity Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 764 (5th Cir. 1999), we held that, when faced with a settlement demand over a policy with multiple insureds, an insurer fulfilling its *Stowers* duty "is free to settle suits against one of its insureds without being hindered by potential liability to co-insured parties who have not yet been sued." In coming to this conclusion, we were persuaded by the Texas Supreme Court's decision in *Soriano*.
>
> Instead of following *Citgo*, OneBeacon urges us to follow a recent Texas appellate decision in which the court found no valid *Stowers* demand where only the insured employer and not the employee (an additional insured) would have been released. However, in that case, the insured employer had explicitly indicated to its attorney that it "did not want 'any settlement demands to be accepted that didn't involve a release of all the claims against both [the employer and the employee.]'"

Id. at 678-79 (internal citations omitted). Accordingly, the Fifth Circuit concluded the district court did not err in holding that the former client's demand letter was a valid *Stowers* demand that OneBeacon improperly rejected. *Id*. at 679.

Nonetheless, with the *Patterson* decision in the midst of other Texas *Stowers* decisions, claimants should be mindful that a demand from less than all of the claimants, and a release of less than all potential insureds, may not qualify as a valid *Stowers* demand under Texas law. And, the Fifth Circuit's decision in OneBeacon makes clear that—though not required by the policy—obtaining the insured's consent for a partial release may, as a practical matter, protect the carrier from an adverse finding of liability.

D. Can an Insurer Consider Disputed Coverage Issues in Analyzing Whether a Reasonably Prudent Insurer Would Accept the Policy Limits Demand?

As previously noted, the third prong of an insurer's *Stowers* duty is triggered when "the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." *Garcia*, 876 S.W.2d at 849. The weight of Texas authority confirms that an insurer is not justified in taking coverage arguments into account in refusing to accept the *Stowers* demand. An insurer's "good faith" belief in its coverage defenses is not a defense under the third prong of the *Stowers* test.

First, the "liability of the carrier" is irrelevant to whether an ordinarily prudent insurer would accept the settlement of its insured's liability. As the *Garcia* court clearly stated, the only

relevant factor to consider in determining the reasonableness of the settlement is "the likelihood and degree of the insured's potential exposure to an excess judgment." *Garcia*, 876 S.W.2d at 849. The insurers' assessment of its own liability cannot affect its evaluation of the reasonableness of the settlement offered to the insured.

Second, a good faith coverage defense is not a defense to *Stowers* liability. *See Garcia*, 876 S.W.2d at 850; *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.,* 246 S.W.3d 42, 46 (Tex. 2008) (". . . an insurer that rejects a reasonable offer within policy limits risks significant potential liability for bad-faith insurance practices if it does not ultimately prevail in its coverage contest.") (citing *Stowers*).

Third, a contrary position is incorrect because it would turn *Stowers* liability into a species of a bad faith claim, which the Texas Supreme Court has expressly rejected. *See, e.g., Soriano*, 881 S.W.2d at 318-319 (Hecht, J. concurring); *Maryland Ins. Co. v. Head Indus. Coatings & Servs., Inc.,* 938 S.W.2d 27, 28 (Tex. 1996). The Texas Supreme Court expressly refused to equate *Stowers* liability with bad faith: "A *Stowers* claim is not a bad faith claim." *Maryland Ins. Co.,* 938 S.W.2d at 28; *see also LSG Technologies, Inc. v. U.S. Fire Ins. Co.,* 2:07-CV-399, 2010 WL 5646054, at *16 (E.D. Tex. Sept. 2, 2010) ("A *Stowers* claim . . . . does not require bad faith on the part of the insurer."). *But see American Western Home Insurance Company v. Tristar Convenience Stores, Inc.,* 2011 WL 2412678 (S.D. Tex. June 2, 2011) (Werlein, J.) (coverage issue factors into whether the carrier reasonably rejected the demand).

E. Can an Oral Demand be a Valid *Stowers* Demand?

Although no Texas Court has ever ruled that a *Stowers* demand must be in writing, an unambiguous written demand is clearly the best course of action. As the Texas Supreme Court observed in *Rocor*, 77 S.W.3d at 263:

> In *Garcia,* we stated that the *Stowers* remedy of shifting the risk of an excess judgment onto the insurer is not appropriate unless there is proof that the insurer was presented with a reasonable opportunity to settle within policy limits. *Garcia,* 876 S.W.2d at 849. We implied that a formal settlement demand is not absolutely necessary to hold the insurer liable, *see id.,* although that would certainly be the better course. But at a minimum we believe that the settlement's terms must be clear and undisputed. That is because "settlement negotiations are adversarial and ... often involve [ ] hard bargaining by both sides." *Id.*

Nonetheless, at least two Texas courts have found that oral demands may be sufficient to trigger an insurer's *Stowers* obligation. In *Trinity Universal Ins. Co. v. Bleeker*, 944 S.W.2d 672 (Tex. App.—Corpus Christi 1997), *rev'd on other grounds*, 966 S.W.2d 489 (Tex. 1998), the Corpus Christi Court of Appeals rejected the insurer's argument that settlement offers need to be in writing to trigger the *Stowers* duty. According to the court, under contract law, oral offers are valid to the same extent as written offers. 944 S.W.2d at 675. In reversing the court of appeals' decision, the Texas Supreme Court did not reach the issue of whether or not an oral offer would

suffice under the *Stowers* doctrine because none of the offers in that case proposed to release the insured from the hospital lien. 966 S.W.2d at 491.

The validity of an oral *Stowers* demand was presented in part in *Westchester Fire Ins. Co. v. Admiral Ins. Co.,* 152 S.W.3d 172 (Tex. App.--Fort Worth 2004, pet. denied). In that case, the claimants provided contested testimony supporting an oral settlement demand within limits during mediation. The case did not settle at mediation, and a judgment was later rendered against the insured in excess of limits. On appeal from the subsequent *Stowers* lawsuit, the Fort Worth court of appeals addressed the issue of whether the oral settlement demand was sufficient to trigger the insurer's *Stowers* obligation. According to the court, the conversations between counsel at mediation were some evidence of an offer to settle within limits. *Id.* at 192-96. Consequently, this evidence amounted to more than a scintilla that there was a valid *Stowers* demand. *Id.*

F. Duty to Investigate or Negotiate

1. Texas Law Prior to *Garcia*.

In *Globe Indem. Co. v. Gen-Aero, Inc.,* 459 S.W.2d 205 (Tex. Civ. App.—San Antonio 1970), writ ref'd n.r.e., 469 S.W.2d 164 (Tex. 1971) (5th Circuit Judge Thomas Reavley dissented), the San Antonio Court of Appeals referred to some "guidelines" in determining whether an insurer is negligent in failing to accept an offer to settle. The court summarized the guidelines as follows:

(A) An opportunity to settle during the course of investigation or trial.

(B) Failure to carry on negotiations to settle or make a counter offer after receipt of an offer to settle. *See Chancey v. New Amsterdam Casualty Company*, 336 S.W.2d 763 (Tex. Civ. App.—Amarillo 1960, writ ref'd, n.r.e.); *Bell v. Commercial Insurance Co. of Newark*, N.J., 3 Cir., 280 F.2d 514 (1960).

(C) Failure to investigate all the facts necessary to protect properly the insured against liability.

(D) Question of liability—if liability is clear, greater duty to settle may exist.

(E) Element of good faith—whether insurer acts negligently, fraudulently, or in bad faith. *See Crisci v. Security Insurance Co. of New Haven, Conn.*, 66 Cal.2d 425, 58 Cal.Rptr. 13, 426 P.2d 173 (1967).

(F) If there are conflicts in evidence which increase the uncertainty of the insured's defense to the injured party's claim, the possibility of the insurer being held negligent increases.

The Globe Indemnity guidelines were applied 20 years later in *Stroman v. Fidelity and Cas. of New York,* 792 S.W.2d 257 (Tex. App.—Austin 1990, writ denied). Just prior to the *Stroman* decision, the Texas Supreme Court decided *Ranger County Mut. Ins. Co. v. Guin*, 723 S.W.2d 656 (Tex. 1987), its most expansive interpretation of the *Stowers* doctrine to date. In *Ranger*, the Supreme Court stated that the basis of an action against an insurer for negligence in

handling a claim is not limited to an insurer's failure to settle a claim within policy limits. Rather, an insurer's duty to the insured extends to the full range of the agency relationship, including investigation, preparation for defense of a lawsuit, trial of the case, and reasonable attempts to settle.

2. Texas Law After *Garcia.*

But all of these decisions pre-dated *Garcia*. In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994), the Supreme Court concluded that *Ranger's* broad language about the scope of the insurer's responsibilities was dicta. The *Garcia* court also noted that, with regard to *Ranger's* discussion of an insurer's duties *Stowers*, "evidence concerning claims investigation, trial defense, and conduct during settlement negotiations is necessarily subsidiary to the ultimate issue of whether the claimant's demand was reasonable under the circumstances, such that an ordinarily prudent insurer would accept it." *Id*. Does this mean that an insurer's failure to investigate is not a factor in deciding whether the demand was reasonable and should have been accepted, or does "necessarily subsidiary" mean that there is no independent *Stowers* duty to investigate a claim, engage in settlement negotiations, etc. (but it can be considered)?

It is clear that an insurer does not have an obligation to solicit a settlement demand or even negotiate with the underlying plaintiff. It is also clear that the *Stowers* duty does not contain a "good faith" element. So, at least two of the guidelines listed above are questionable under current law. Whether an investigation element still survives is questionable in light of the "necessarily subsidiary" language in *Garcia*.

Nonetheless, the insurer's reasonableness is judged by what it—or its agents—had access to at the time of the demand. *Bramlett v. Medical Protective Co. of Ft. Wayne, Ind.,* 2013 WL 796725 (N.D. Tex. March 5, 2013) (NO. 3:10-CV-2048-D) (Fitzwater, J.). While the insurer may not need to conduct an investigation during the settlement window, *Bramlett* dispels the notion that the insurer needs to know everything about the claim before it can satisfy its *Stowers* duties.

In *Bramlett*, the insurer sought summary judgment on the *Stowers* claim because the underlying plaintiff (now the plaintiff in the *Stowers* case) had not provided the statutorily-required expert report before its settlement demand expired. The district court rejected this argument. In doing so, the court observed that:

> There is no per se requirement that an insurer know all, or even most, of the facts of the case in order to have a *Stowers* duty. Indeed, early settlement is encouraged. *See Garcia*, 876 S.W.2d at 851 n. 18 ("If the claimant makes such a settlement demand early in the negotiations, the insurer must either accept the demand or assume the risk that it will not be able to do so later. In cases presenting *a real potential* for an excess judgment, insurers have a strong incentive to accept." (emphasis added)).

Id. at *4, fn. 10. The court held that "MedPro was aware of other facts that would enable a reasonable jury to find that a reasonably prudent insurer would have accepted the first *Stowers* demand despite the absence of an expert report."

The court added:

> For example, plaintiffs have produced evidence that, at the time of the first *Stowers* demand, MedPro (or Crawford as its claims adjuster) (1) had received a copy of Mrs. Bramlett's hospital records; (2) knew that Dr. Phillips performed a hysterectomy on Mrs. Bramlett; (3) knew that Mrs. Bramlett died from complications due to post-operative bleeding; (4) knew that Dr. Phillips was suspicious that Mrs. Bramlett was suffering from internal bleeding and therefore ordered a blood test; (5) knew that Dr. Phillips' office was informed that the blood test indicated that Mrs. Bramlett was bleeding internally; (6) knew that Dr. Phillips left the hospital to work out without checking the results of the blood test he had ordered; (7) knew that by the time Dr. Phillips learned of Mrs. Bramlett's status and returned to the hospital, it was too late to save her; (8) Crawford had met with Dr. Phillips and Davidson to discuss the case; (9) knew the case was very serious; and (10) Crawford had authority to settle the claim for $200,000, the policy limits. A reasonable jury could find from the evidence in the summary judgment record that, in response to plaintiffs' first *Stowers* demand, a reasonably prudent insurer would have settled within policy limits.

Id. at *4.

G. A "Policy Limits" Demand is Sufficient

To satisfy the requirements of *Stowers*, it is sufficient that the demand propose to release the insured for "the policy limits" rather than stating a sum certain. *See Garcia*, 876 S.W.2d at 848-849 ("Generally, a *Stowers* settlement demand must propose to release the insured fully in exchange for a stated sum of money, but may substitute 'the policy limits' for a sum certain."); *Yorkshire Ins. Co., Ltd. v. Seger*, 279 S.W.3d 755, 769 (Tex. App.—Amarillo 2007, pet. denied) ("[A] settlement demand that proposes to release the insured for 'the policy limits,' in lieu of a demand for a sum certain, is sufficient to satisfy the 'demand within limits' element of a *Stowers* action.").

H. Recent Developments Regarding the *Stowers* Doctrine.

1. *In re Farmers Texas Cty. Mut. Ins. Co.* (Tex. 2021).[1]

Operative Facts. Two months before the scheduled trial, a mediator proposed the case settle for $350,000 and the injured plaintiff notified Farmers he would accept. Farmers countered with an offer to settle for $250,000 and told Longoria, its insured, she could contribute $100,000 to secure a release. The plaintiff rejected Farmers' $250,000 offer and withdrew his own, advising he would seek $2 million in damages. Longoria's personal counsel reopened negotiations. The plaintiff agreed to settle for $350,000 and Farmers again refused to contribute more than $250,000. Longoria offered to pay the additional $100,000 without waiving her right to seek recovery from Farmers. The case settled on that basis.

Longoria sued Farmers for negligent failure to settle. Farmers moved to dismiss, arguing that Longoria's claim had no basis in law: that Texas law does not recognize negligent failure to settle—a *Stowers* claim—without a judgment against the insured exceeding policy limits.

Holding. The Texas Supreme Court held that:

- When a claim settles within policy limits, *Stowers* liability is not needed to resolve potential claims by an insured against its insurer. The insurance contract fully addresses the parties' common-law obligations under those circumstances.

- The Court has consistently recognized that an insured must be liable beyond policy limits—whether by judgment or settlement—in order to bring a *Stowers* claim. It declined to extend *Stowers* to cases in which no liability exists beyond policy limits. Longoria's claim for Farmers' negligent failure to settle within policy limits has no basis in law because her allegations, taken as true, do not entitle her to the relief she seeks under *Stowers*.

- Farmers concluded it was appropriate to structure a settlement under which both it and Longoria contributed money to obtain a release. But Longoria can assert a claim against Farmers for breach of its separate promise—under the policy—to pay the damages for which this settlement made her legally responsible.

- Farmers structured a within-limits settlement but did not pay it fully. The Court did not determine what the policy as a whole required, whether Farmers breached it by consenting to settle within policy limits but making the insured's release contingent on her contribution, or whether Longoria can prove damages. Instead, the Court clarified a narrow issue: *Stowers* and the other principles of Texas insurance law do not foreclose a claim for contract breach against an insurer regarding its indemnity obligation.

[1] *In re Farmers Texas Cty. Mut. Ins. Co.*, 621 S.W.3d 261 (Tex. 2021).

2. *Am. Guarantee & Liab. Ins. Co. v. ACE Am. Ins. Co.* (5th Cir. 2021).[2]

In *American Guarantee*, Mark Braswell died after his road bike collided with a stopped truck. His survivors (Plaintiffs) sued the truck's owner, the Brickman Group. ACE provided Brickman's primary layer of coverage (up to $2 million in liability coverage) and American Guarantee (AGLIC) served in an excess capacity ($10 million in excess of ACE's $2 million). At trial the Plaintiffs asserted Brickman caused Braswell's death under two negligence theories: (1) Brickman's driver stopped short directly in front of Braswell, and (2) Brickman's truck was parked in an inherently dangerous spot. But premised on his analysis of Braswell's comparative negligence, Brickman's ACE-appointed counsel believed Brickman had a strong case in defense. ACE controlled Brickman's settlement negotiations.

The facts were disputed. There was evidence that Brickman's truck had been stopped for four or five minutes, or one to two minutes, or that it had actually stopped short in front of Braswell. No orange cones had been placed around the truck despite Brickman's policy of using safety cones. Significantly, Braswell's helmet was cracked down the middle, indicating he was not watching where he was going. Brickman's driver admitted it was dangerous, though legal, to park where he did.

Brickman's counsel estimated settlement value to be $1.25 to $2 million. ACE also conducted juror research that yielded two conclusions: it was important to prove at trial that the truck did not stop short and that the truck was legally parked. After reviewing this material, AGLIC's case manager valued a "risk neutral" settlement at "no more than 500K, not primary's 2M." On the eve of trial, Plaintiffs' counsel made the first of three settlement offers, asking for $2 million. ACE counter-offered $500,000. The Plaintiffs rejected this counter, and the parties went to trial.

Events quickly turned against Brickman. The trial judge excluded evidence that Brickman's truck was legally parked; allowed Braswell's widow to testify about the "stop-short" statement of a Brickman employee; and allowed Braswell's widow to testify about her daughter's psychological trauma, self-harm, suicide attempts, and hospitalization, all caused by her father's death. Brickman's widow was an exceptional witness. After the Plaintiffs' closing statement, AGLIC's case manager communicated that a verdict in excess of $2 million was possible "[g]iven the adverse evidentiary . . . rulings."

The case was submitted to the jury. Before the jury reached a verdict, Plaintiffs' counsel made two more settlement demands. First, he orally offered Brickman a high/low of "$1.9MM to $2.0MM with costs." ACE believed this offer was outside of its settlement valuation, as the inclusion of "costs" would push the final settlement value beyond its $2 million policy limit. Brickman rejected the offer. Then the Plaintiffs' counsel emailed a third offer to Brickman's counsel:

> Plaintiffs renew their prior offer to settlement for the policy limits of $2 million. Such offer will expire when the jury announces that it has a verdict.

[2] *Am. Guarantee & Liab. Ins. Co. v. ACE Am. Ins. Co.*, 990 F.3d 842 (5th Cir. 2021).

Brickman declined that offer and countered. The Plaintiffs withdrew all offers. The next day the jury returned a verdict of nearly $40 million. After deducting 32% for Braswell's comparative negligence, the trial court rendered judgment against Brickman for nearly $28 million. The Plaintiffs and Brickman eventually settled for nearly $10 million (avoiding appellate litigation). ACE paid its policy limit of $2 million, and AGLIC furnished the excess amount of nearly $8 million.

AGLIC then sued ACE, urging that ACE had violated its *Stowers* duty to Brickman by rejecting the Plaintiffs' settlement offers. Texas law permits such actions between insurance carriers under the doctrine of equitable subrogation. *American Centennial*, 843 S.W.2d at 482-83; *Gen. Star Indem. Co.*, 173 F.3d at 950. Ruling on dueling summary judgment motions, the district court held that "all three demands" invoked the *Stowers* duty. Then, following a bench trial, the court held that the first rejection was reasonable under *Stowers* but the last two were not. The district court entered judgment for the entirety of AGLIC's excess payment and ACE appealed.

ACE raised two issues: (1) the district court erred by holding that all three offers triggered *Stowers*, and (2) the court erred in determining that ACE violated *Stowers* by rejecting the second and third settlement offers.

The Settlement Demands. The district court held that all three demands were "unconditional, within policy limits, and presented an offer for a full release," thus triggering *Stowers*. The Fifth Circuit disagreed regarding the second offer, but affirmed that the third offer did trigger a *Stowers* duty. The Plaintiffs' second offer sought "$1.9MM to $2.0MM with costs." The record indicated that the requested "costs" were ambiguous. ACE believed "costs" included litigation expenses and court costs. In contrast, AGLIC believed "costs" were limited to court costs. The result was that the second offer lacked the clear statement of a sum certain, and therefore did not invoke *Stowers*. ACE's principal argument as to why the third offer did not generate a *Stowers* duty was that Braswell's widow asserted claims alongside her minor children, whom she represented as next friend. According to ACE, this generated adverse interests and mandated at least court and perhaps guardian ad litem approval of any settlement. Whether these requirements of third-party approval made the plaintiffs' demand inherently conditional was an issue no Texas court had ruled on in the *Stowers* context.

Making an *Erie* guess, the Fifth Circuit noted that there was no evidence that the settlement offer was more favorable to Braswell's widow than her children or that the widow was operating with interests adverse to those of her children. ACE offered nothing in the record suggesting that, had the third settlement offer been accepted, Braswell's widow would have placed maximizing compensation for her own injuries above her children's claims.

Despite the caution that state courts observe when considering the rights of minors, the Fifth Circuit did not read Texas law to require guardian ad litem appointment—and thus third-party approval—in this or every case where a parent serves as next friend for her children. And because such appointments are not required, the Court could not conceive that every settlement generated in a case involving claims of a parent on behalf of herself and children violates *Stowers* because of a bare potential conflict of interest. Because the record was void of any specter of

adverse interests between Braswell's widow and her children had the third lump sum settlement offer been accepted, her children would have been bound by it. Accordingly, the offer generated a *Stowers* duty because it "proposed to release the insured fully" and it was not conditional.

Once its Stowers Duty was Triggered, ACE was Negligent in Rejecting the Third Settlement Demand. Finally, the Fifth Circuit rejected ACE's contention that the district court erred in concluding that ACE violated its settlement duty as to the third offer. Under *Stowers*, an insurer is required to exercise ordinary care in responding to qualifying settlement demands. When presented with a settlement demand within policy limits, an insurer cannot respond negligently. Whether an insurer responds negligently hinges on whether "the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." *Garcia*, 876 S.W.2d at 849.

ACE's challenge hinged solely on whether the trial court's adverse rulings were likely to be reversed on appeal, but ACE never argued that point to the district court (i.e., that as a legal matter *Stowers* requires consideration of appellate prospects). The Fifth Circuit concluded that ACE could not raise this novel legal theory for the first time on appeal, and did not address it. That said, the Court declared that even if it were to review ACE's evidentiary sufficiency challenge *de novo*, the evidence was clearly sufficient to support the bench trial verdict that, after considering the testimony at trial and the court's adverse evidentiary rulings, a reasonable insurer would have reevaluated the settlement value of the case and accepted the Plaintiffs' third offer.