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ARTICLES

When the Insurer's and the Insured's Interests Diverge on Whether to Settle an Underlying Claim

Key steps in analyzing and handling a liability insurance claim, as well as some of the most common coverage issues that arise in handling such claims.

By Karin S. Aldama, Rina Carmel, Tred R. Eyerly, and Winter Wheeler

In efforts to settle an underlying liability claim, disagreements may arise between the insurer and insured. The two sides may disagree on the value of the claim. The insurer may be asked to settle a case despite having questioned or disputed coverage as outlined in a reservation of rights letter. Consequently, the insurer may ask the insured to contribute to a settlement while coverage issues remain in dispute. If both the insurer and insured agree to make a joint offer to the underlying claimant, they may value the claim differently. Can the insurer place a limit on its contribution based on how it values the claim, requesting that the insured contribute its own funds if it wants to increase the amount of an offer? Would the insurer act in bad faith by seeking a contribution from its insured?

This article addresses these and related issues, noting how various courts have viewed insurers' obligations, allegations insureds might make of bad faith in negotiating settlements where such disputes arise, and insurers' possible responses to such allegations. (1)

Tests for Determining Bad Faith in Responding to Settlement Offers

At least three tests are used to determine whether an insurer's actions in settlement negotiations constitute bad faith. First, under the equal-consideration test applied by the majority of jurisdictions, the insurer must give equal consideration to the insured's and its own interests. (2) Formulations of this test may vary as to whether the insurer must give at least equal consideration or whether equal consideration is sufficient. Second, the negligence test asks

whether the insurer's conduct is with that degree of care that is used by an ordinarily prudent person in managing his or her own business. [3] Third, the good-faith test requires the insurer to assess the situation in good faith with an emphasis on the financial interests of its insured. [4] Under this third test, an insurer can be held liable only upon a showing of subjective culpability, which is generally considered more than "mere" negligence but less than dishonest intent. [5]

But in practice, these various rules often merge. When applying these tests, courts generally consider various factors in light of the circumstances of the particular case in deciding whether the insurer has fulfilled its obligations. [6] Factors considered by the courts often include the following:

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

Proper Insurer Investigations

The insurer must usually conduct a full investigation so that it is familiar with the facts of the underlying matter and can accurately evaluate the claim. [8] This includes an investigation of the facts and of the probable extent of liability. Otherwise, the insurer may be found liable for breach of the duty to settle. [9] For example, in *Riske v. Truck Insurance Exchange*, the Eighth Circuit noted that Truck's attorney had decided not to depose the injured claimant because the injury was described in a medical report. At trial, the doctor testified that the medical report was inaccurate and that the injury was more severe than the report reflected. Consequently, the Eighth Circuit reversed the trial court's vacating of the jury verdict against the insurer. The insurer having neglected to conduct an appropriate investigation, the court concluded that, under Minnesota law, the insurer had failed to settle the underlying claim in good faith. [10]

In such circumstances, the analysis focuses on whether the insurer has acted appropriately in light of information it should have discovered (whether it actually did so or not) and whether the failure to settle was improper given that information. For example, in one case, when an insurer rejected offers to settle and went to trial without interviewing eyewitnesses to evaluate potential liability, the insurer breached its duty. (11) In another case, the insurer's and its coverage counsel's inadequate investigation led the insurer to believe there was a defense to liability when the insurer would have known that defense was inapplicable, had a proper investigation been conducted. Consequently, the insurer breached its duty. (12)

If an insurer does not undertake a full investigation and misses information it should have uncovered, it cannot complain that it lacked adequate information to evaluate a claim and a settlement demand. (13) In *Fertitta v. Allstate Insurance Co.*, for example, the insurer was aware of the extent of the victim's injuries, but eight months later, it had not yet adequately investigated the claim. The court found that the insurer had acted in bad faith by failing to timely and thoroughly investigate the claim or to consider the extent of its insured's exposure. (14)

The insurer's investigation may be complicated by several facts. Where the insured is entitled to a defense by independent counsel, independent counsel may be less likely than panel counsel to provide timely or adequate defense reports. The insurer then may not have the information it needs to evaluate liability and exposure, the first factor many courts consider in evaluating an insurer's response to a settlement demand. (15) With respect to "bodily injury" claims, for example, underlying claimants sometimes refuse to provide a recorded statement or authorization to obtain medical records. Such a refusal may allow the insurer to respond that any settlement demand is not capable of acceptance, especially in cases in which the extent of the third-party claimant's alleged injuries is not clear. The reason is that, if the insurer has not been provided with medical records, it may be deprived of the opportunity to evaluate liability and exposure issues. (16) Likewise, the insured may be deprived of the opportunity to determine its position as to whether or not it would like the underlying claim to be settled. (17)

Requests for Insured Contributions to Settlements Within Policy Limits

Insurers must be careful when asking their insureds to contribute to settlements when the settlement amount is within policy limits. In one case, the insurer was aware there was liability, and the claim was within the $5,000 policy limits. (18) The claimant's demand was only $3,000, well below policy limits, but the insurer asked the insured to contribute one-half of that amount,

or $1,500. The insured refused to contribute and a judgment was entered for $12,000. [19] The insurer's demand that the insured pay one-half of the $3,000 demand allowed the underlying case to proceed to judgment for more than double the policy limits. Consequently, the insurer had acted in bad faith.

Courts tend to view differently, however, an insurer's request for a contribution to settlement from the insured if there is a deductible or self-insured retention under the policy. [20] Further, when the settlement demand is above policy limits or when the underlying claims include uncovered claims, the insurer may seek a contribution from the insured to settle the claim. For example, where the underlying claimant sought punitive damages that were not covered by the policy, the insurer was justified in seeking a contribution from the insured to settle the case. [21] Similarly, if an insurer issues a reservation of rights and serious coverage issues have not been resolved, the insurer may seek a contribution from the insured so long as both the insurer and the insured execute full releases. [22]

Seeking a contribution from the insured is especially common where the insured allegedly acted intentionally and where indemnification for willful conduct is prohibited by state law. [23] Because the insurer cannot indemnify the insured for such amounts and a verdict may be based on intentional conduct, it may be to the insured's advantage to contribute to a settlement rather than find itself solely liable for a judgment because the insurer has no duty to indemnify.

In requesting a contribution to settle, the insurer should usually be cautious as to how it words the request and consider making the request in writing, because case law holds that the insurer may not "unreasonably coerce" an insured to contribute to a settlement under a general liability policy. [24]

Insurer Departures from Advice of Defense Counsel

If an insurer ignores the advice of its chosen defense counsel when evaluating a claim, it may be found to have acted unreasonably. For example, in a case in which an insurer failed to investigate an accident, interview witnesses, familiarize itself with the underlying claimant's injuries, and follow the advice of defense counsel (given both before and during trial) to accept offers to settle within policy limits, the insurer was liable for the excess judgment obtained by the claimant. [25]

If an insurer's claims personnel are proficient at evaluating claims, not following the advice of defense counsel may be excusable because there may be legitimate disagreements between experienced claims adjusters and defense counsel. The insurer takes a risk, however, by ignoring the advice of defense counsel to settle and allowing the case to go to trial. (26) In this situation, the insurer should usually document the file with the facts and reasons for disagreement with defense counsel's evaluation.

A case before the Ninth Circuit considered under Oregon law an insurer's offer to the underlying claimant that was below policy limits, against the advice of defense counsel, and even below the claims manager's valuation of the case. (27) The claimant offered to settle for less than policy limits. The insured was self-insured for $25,000 and had policy limits of $250,000. The insurer also provided excess coverage for losses exceeding $275,000. After the insurer refused to settle for $125,000 as recommended by defense counsel, a jury awarded $701,834 to the victim. (28)

The Ninth Circuit reversed the district court's ruling that the insurer had acted in good faith, instead finding that the insurer had breached its fiduciary duty to handle the claim with caution by unreasonably refusing to settle where a verdict in excess of coverage was very likely. The Ninth Circuit explained:

None expected a verdict less than the offer, yet [the claims manager] rejected it out of hand despite counsel's urging that it be accepted. He made no counteroffer, but seemed rigidly committed to offering only the rock-bottom minimum of $100,000, although even he believed that the probable minimum verdict would be $170,000. This could make sense only if he reasonably anticipated a defense verdict[—]which he did not. Thus, he took the risk that the verdict might be more than the maximum he had considered likely. Such a risk was completely out of proportion to the chances of a favorable outcome. In our view of these facts, that conduct was arbitrary and capricious and amounted to a breach of the insurer's duty of good faith. (29)

In *Kinder v. Western Pioneer Insurance Co.*, (30) the insurer similarly ignored its defense counsel's advice. The insured was negligent in causing a four-car collision. Kinder was seriously injured. The insurance policy had a limit of $10,000 per person. Initially, Kinder demanded $9,500. During trial, the demand was reduced to $8,000. The insurer offered only $7,500. The verdict came in at $30,000. Defense counsel had recommended that up to $9,500 might be needed to settle. The claims manager, however, had believed the case was one of no liability. Defense counsel ultimately had predicted "the verdict might go as high as $25,000." (31) The court found that "[t]he

[insurance] company had the duty of consulting qualified persons on the matter of settlement," i.e., the lawyer. (32) The lower court's judgment that the insurer had acted in bad faith by refusing to accept settlement offers within policy limits was affirmed. (33)

In *Royal Transit, Inc. v. Central Surety & Insurance Corp.*, (34) the claimant suffered catastrophic injuries. The claimant secured a judgment that was $17,000 in excess of the insurer's policy limits. The insured's policy provided coverage in amounts up to $45,000. The trial court found that the insurer had "stubbornly, persistently, unreasonably, unintelligently and in bad faith refused to accept any offer" to settle the case. (35) The underlying case could have settled for $40,000, but the insurer had refused and had made no counteroffer, notwithstanding the advice of its defense counsel that the claim be settled for $35,000. Affirming the judgment in favor of the insured for the $17,000 excess, the Seventh Circuit, applying Wisconsin law, agreed that the insurer's refusal to settle had been arbitrary, capricious, and without any rational basis, and that the finding of bad faith was amply supported. (36)

In another case, defense counsel twice recommended that the insurer surrender its policy limits of $5,000 to settle an underlying claim, which the insurer refused to do. Given the claimant's serious injuries, defense counsel advised that there was no defense to the underlying suit and that the judgment would exceed the policy limits. The claimant was awarded a judgment of $13,000. The insurer was found to have acted in bad faith. (37) The court concluded that the insurer had sought to coerce its insured into contributing a portion of the insurer's liability in order to effect a settlement, thereby seeking to allow the insurer to avoid having to pay a larger sum through the judgment that had been likely to result from a trial. (38)

Contribution Demands and Reasonable but Mistaken Coverage Determinations

An insurer may require a contribution from the insured to respond to a settlement demand because the insurer believes there is no—or only limited—coverage under the policy. The insurer's coverage position may be reasonable, but a court may subsequently disagree. If the insurer has reasonably evaluated the coverage issue, has it breached its duty to settle? The majority of cases hold yes; even a reasonable coverage decision that is subsequently determined to be incorrect may not allow an insurer to avoid a finding that it has breached its duty to settle. (39)

In *Johansen v. California State Automobile Association Inter-Insurance Bureau*, a driver injured Johansen in an auto accident. The driver's mother had a $10,000/$20,000 policy. The insurer

defended under a reservation of rights but questioned whether the car involved in the accident was an insured vehicle. Before the coverage issue was decided, the insurer agreed to a policy limits demand of $10,000 but insisted that it place the amount in escrow until the coverage issue could be resolved. Johansen rejected the offer. The underlying case went to trial and resulted in an excess verdict.

In *Johansen*, the Supreme Court of California rejected the insurer's argument that its reasonable doubts about coverage justified its refusal to pay the demand unconditionally. Instead, the insurer had an automatic duty to settle if it was determined that there was coverage. The court reasoned that "[a]n insurer who denies coverage *does so at its own risk and* . . . , if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract." (40) The insurer could have paid the demand but reserved rights to contest the coverage issue and sought reimbursement from the insured if it was later determined there was no coverage. (41)

A minority of courts, on the other hand, allow insurers to resolve debatable coverage issues before contributing to a settlement without that constituting a breach of the insurers' duty to settle. In one case, an adjuster concluded that the insured was probably liable for injuries caused in an auto accident and that liability would exceed the $16,000 policy limits. (42) Nevertheless, the adjuster determined there was no coverage because the insured did not own the automobile at issue. The insurer rejected a policy-limits demand before trial. After the trial court found coverage under the policy, the insurer then offered policy limits, and a stipulated judgment was entered against the insurer for $16,000 and the insured for $175,000. The insured assigned policy rights to the victim. (43)

The Wisconsin Supreme Court reversed the trial court's holding that the insurer had breached its duty to defend and had acted in bad faith when it refused to settle the victim's claim within policy limits. The court found the decisions in *Johansen* and *Comunale* unduly oppressive and concluded those decisions would force insurers to settle claims where coverage may be dubious. (44) According to the court, a carrier could commit bad faith only when denying a claim without a reasonable basis, i.e., when the claim was not fairly debatable. (45)

Similarly, in a case decided by the Fifth Circuit, a judgment was entered by a state court against an employee of the insured for injuries suffered in an auto accident. (46) While the coverage action was pending in federal district court, the victim's offer to settle for amounts within policy limits

was rejected by the insurer because there were issues as to whether the driver was an insured under the employer's policy. The court considered it repressive to require the insurer to settle a claim before there was a full opportunity to litigate a serious question of coverage, and the appellate court affirmed the district court's entry of judgment for the insurer. (47)

Conclusion

Insurers should usually use caution when considering how to respond to an offer to settle underlying claims at or below policy limits. They should treat their insureds fairly and should usually give the insureds' financial interests equal, if not greater, consideration than their own interests. Nonetheless, if there are disputed issues of coverage that have not been resolved, or if significant non-covered claims are alleged in a mixed action, insurers may make reasonable decisions to orchestrate settlements, including requesting contributions from their insureds and seeking mutual releases of any outstanding coverage claims.

Karin S. Aldama is a partner in the Phoenix office of Perkins Coie LLP. Rina Carmel is counsel in the Los Angeles office of Anderson, McPharlin & Conners LLP. Tred R. Eyerly is a director at Damon Key Leong Kupchak Hastert in Honolulu. Winter Wheeler is a mediator in the Atlanta office of Miles Mediation & Arbitration.

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Endnotes

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Authors

Karin S. Aldama
Partner

Karin S. Aldama is a partner in the Phoenix office of Perkins Coie LLP.

Rina Carmel
Counsel

Rina Carmel is counsel in the Los Angeles office of Anderson, McPharlin & Conners LLP.

Tred R. Eyerly
Director

Tred R. Eyerly is a director at Damon Key Leong Kupchak Hastert in Honolulu.

Winter Wheeler
Mediator

Winter Wheeler is a mediator in the Atlanta office of Miles Mediation & Arbitration.