WHEN INSURER AND INSURED DIFFER ON WHETHER TO SETTLE:  
BAD FAITH IMPLICATIONS  

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I. INTRODUCTION

Settling liability claims can be one of the most challenging areas of insurance law. The insurer and insured may disagree as to whether to settle, or how much to pay to settle. Multiple claimant/multiple insured claims, mixed claims, excess demands, demands for punitive damages, and claims where the insured has an affirmative claim for relief may further complicate the analysis and negotiations. Seeking a settlement contribution from the insured presents thorny issues, including whether that contribution can convert an excess demand into a demand within limits—which, in turn, impacts the standard for evaluating the insurer’s response.

Policyholders and third-party claimants are aware of these issues, and may look at settlement demands as an opportunity to try to subject insurers to liability for excess verdicts. Thus, the stakes for improperly declining a settlement demand can be quite high. Sections II, III and IV of this article discuss these issues under general liability policies. Section V addresses the significantly different issues presented under professional liability policies, which often allow the insured to refuse to consent to settlement. The article also suggests practical tips for both insurers and policyholders.

II. STANDARDS FOR THE DUTY TO SETTLE AND BAD FAITH RELATED TO SETTLEMENT UNDER GL POLICIES

ISO’s main CGL form gives the insurer discretion as to whether to settle a “suit.” It provides that the insurer “may, at [its] discretion, … settle any claim or ‘suit’ that may result” from an “occurrence” or claim or “suit.” ISO Form No. CG 00 01 04 13, ¶¶ I.A.1.a., I.B.1.a.

Courts in many states, however, have created a duty to settle, reasoning that such a duty arises from the implied covenant of good faith and fair dealing. This is especially the case where the demand is within limits, but the insured is at risk of an excess verdict. E.g., Comunale v. Traders & General Ins. Co., 50 Cal. 2d 654, 659 (1958); Mid-Continent Cas. Co. v. Eland Energy, Inc., 795 F. Supp. 2d 493, 505 n.7 (N.D. Tex. 2011) (under G.A. Stowers Furniture Co. v. Am. Indem. Co., 15 S.W.2d 544 (Tex. Comm’n App. 1929), insurer has duty to exercise ordinary care in settlement to protect insured against excess judgment), aff’d, 709 F.3d 515 (5th Cir. 2013). Policyholders also argue that such a duty is warranted because, under general liability policies, the insurer retains control over settlement in most situations. E.g., Western Polymer Technology, Inc. v. Reliance Ins. Co., 32 Cal. App. 4th 14, 24 (1995) (“In general, the insurer is entitled to control settlement negotiations without interference from the insured.”).

In many states, the insurer must give the insured’s interests equal consideration to its own. E.g., S. Gen. Ins. Co. v. Holt, 262 Ga. 267, 268, 416 S.E.2d 274, 276 (1992). In some states, the insurer must give the insured’s interests “at least equal consideration.” E.g., Landow v. Medical Ins. Exch. of Cal., 892 F. Supp. 239 (D. Nev. 1995); Magnum Foods, Inc. v. Cont’l Cas.

1 Portions of Section II are based on Rina Carmel & Elaine M. Pohl, Navigating Thorny Issues with Consent Judgments and Settlement of Coverage Claims (Defense Research Institute July 13, 2016).
Co., 36 F.3d 1491, 1504 (10th Cir. 1994) (Oklahoma law); Strahin v. Sullivan, 220 W. Va. 329, 334, 647 S.E.2d 765, 770 (2007). Failure to abide by these standards in rejecting a settlement demand within policy limits may subject the insurer to claims of, and liability for, bad faith.

Courts have articulated a wide range of factors to determine whether the insurer acted in bad faith in deciding whether to accept a settlement demand. Frequently applied factors include:

- The strength of the third-party claimant’s case on both liability and damages.
- The nature of the insurer’s investigation to determine the policyholder’s liability.
- The likelihood of an excess verdict.
- The likelihood of an adverse verdict.
- Defense counsel’s recommendations.
- Whether the insurer rejected the advice of its attorney or agent.
- Whether the policyholder was informed of all settlement demands and offers.
- Whether the policyholder demanded that the insurer settle within limits.
- Whether the insurer considered any offer by the policyholder to contribute to settlement.
- Any attempts by the insurer to induce the policyholder to contribute.
- The financial risk to the insurer and policyholder if the underlying action does not settle.
- Whether the policyholder misled the insurer as to the facts, so as to induce it not to settle.
- Any other factors that could establish or negate bad faith.


With respect to the likelihood of an adverse verdict, courts have differed as to whether an insurer can decline to settle if an adverse verdict appears unlikely. But it can be risky for an insurer to decline to settle on that basis. See O’Neill, 329 Ill. App. 3d 1166, 769 N.E.2d 100 (insurer held liable for bad faith where insurer’s vice president decided not to settle based on belief that insured was not liable, notwithstanding the claims department’s and defense counsel’s conclusions that insured’s liability was clear); Bobick v. United States Fid. & Guar. Co., 439 Mass. 652, 790 N.E.2d 653 (2003) (insurer must consider whether liability is “reasonably certain” under nebulous standards “in light of the situation as a whole” and under “over-all circumstances,” and if so, insurer may even be required to extend settlement offer on behalf of insured).

Notably, the above factors do not include whether the settlement demand is covered. That issue is quite complicated, and a detailed discussion is beyond the scope of this article. Very briefly, courts—even within a single state—have differed widely on this issue. Compare Johansen v. Cal. State Auto. Ass’n Inter-Ins. Bureau, 15 Cal. 3d 9, 12 (1975) (only consideration
in evaluating reasonableness of settlement demand is whether, based on third-party claimant’s injuries and insured’s liability, possibility of excess verdict exists) with *Hamilton v. Maryland Cas. Co.*, 27 Cal. 4th 718, 724 (2002) (“From the covenant of good faith and fair dealing implied by law in all contracts, and from the liability insurer’s duty to defend and indemnify covered claims, California courts have derived an implied duty on the part of the insurer to accept reasonable settlement demands on such claims within the policy limits.”) (emphasis added).

A few courts have stated that the duty to settle is not unqualified, meaning that an insurer usually has a duty to settle only if, based on facts the insurer knew or should have known, there is a reasonable possibility of an excess verdict—and then only if the insurer can settle within limits. E.g., *Riske v. Truck Ins. Exch.*, 490 F.2d 1079, 1082-83 (8th Cir. 1974) (Minnesota law); *Dairyland Ins. Co. v. Herman*, 954 P.2d 56, 61 (N.M. 1997). Assuming those factors are satisfied, an insurer is liable only if it unreasonably declined to settle.

In most states, an insurer can be liable for bad faith only if it had an opportunity to settle. E.g., *Chandler v. American Fire & Cas. Co.*, 377 Ill. App. 3d 253, 879 N.E.2d 396, 400 (2007). A few courts have imposed an affirmative obligation on the insurer to negotiate settlement, even if the third-party claimant has not made a demand. E.g., *Roberts v. Printup*, 422 F.3d 1211, 1215 (10th Cir. 2005) (Kansas law); *Moutsopoulos v. Am. Mut. Ins. Co. of Boston*, 607 F.2d 1185, 1187-88 (7th Cir. 1979) (Wisconsin law) (insurer’s “duty of good faith when rejecting a settlement” “requires that the insurance company actively pursue a settlement within the policy limits”).

**III. WHEN THE INSURED WANTS TO SETTLE A CLAIM UNDER A GL POLICY, BUT THE INSURER DOES NOT**

Once an underlying action is filed, the insured may want to settle more quickly, or for more money, than the insurer does. Because of the risks to the insured, in particular where there is a risk of an excess judgment, courts in most states have imposed settlement obligations on insurers.

Most states find that a pretrial stipulated judgment negotiated between the policyholder and the third-party claimant is enforceable against the insurer only if the insurer has breached its contractual obligation to defend, or has improperly denied coverage. E.g., *Old Republic Ins. Co. v. Ross*, 180 P.3d 427, 432 (Colo. 2008); *Pruyn v. Agric. Ins. Co.*, 36 Cal. App. 4th 500 (1995). Under the majority rule, when an insurer improperly breaches the duty to defend, the policyholder is justified in taking steps to limit its personal liability. *Id.* at 518. A pretrial stipulated judgment against an insurer who was not a party to the underlying settlement agreement will also be enforced if the insurer acted in bad faith. *Ross*, 180 P.3d at 432.

In *Ross*, the insurer defended a wrongful death case. The insurer paid the third-party claimants $200,000, asserting this was the maximum coverage available under an aviation policy. The insurer disputed coverage under the CGL policy, which had $1 million in policy limits. The third-party claimants offered to settle for an additional $800,000. The insurer
refused and filed a declaratory judgment action in federal court. The district court concluded that the maximum coverage was $1.7 million. The insurer then paid an additional $1.5 million.

Meanwhile, the third-party claimants entered into a settlement agreement with the insureds for $5.3 million. The settlement included an assignment of rights against the insurer under the insureds’ policy. The insurer was not a party to the settlement agreement, and argued it could not be bound by the agreement. The Colorado Supreme Court agreed with the insurer. Where the insurer conceded coverage and defended its insured, and where there was no finding of bad faith against the insurer, a stipulated judgment entered before trial, to which the insurer was not a party, could not be enforced against the insurer. Id. at 427.

In Mercado v. Allstate Insurance Co., 340 F.3d 824 (9th Cir. 2003) (California law), the third-party claimant rejected the insurer’s policy limits settlement offer plus the insured’s additional offer to contribute her own funds. The insured proceeded to enter into a stipulated judgment with the third-party claimant, in exchange for an assignment of the policyholder’s rights against the insurer to the third-party claimant—despite the insurer’s statement that it did not consent to the proposed transaction. The court held that the insurer was not liable for bad faith because a cause of action for breach of duty to settle does not accrue until “after a litigated excess judgment is obtained” against the insured. Id. at 827; see also McCollough v. Minnesota Lawyers Mut. Ins. Co., No. CV-09-95-BLG-RFC-CSO, 2013 WL 1789763, at *3 (D. Mont. Apr. 26, 2013) (recognizing that Montana law does “not impose a duty to settle cases—it imposes a duty to attempt in good faith to settle.”).

Several states, on the other hand, have held that a stipulated judgment can be enforceable if the insurer defends the claim under a reservation of rights. See, e.g., Great Divide Ins. Co. v. Carpenter, 79 P.3d 599, 609-10 (Alaska 2003); Safeway Ins. Co. v. Guerrero, 106 P.3d 1020, 1024 (Ariz. 2005); Patrons Oxford Ins. Co. v. Harris, 905 A.2d 819, 826-27 (Me. 2006); Miller v. Shugart, 316 N.W. 2d 729, 733 (Minn. 1982). In other words, if the insurer offers to defend the claim, but also provides notice that it may decline indemnity coverage, the insured may opt to enter a stipulated judgment rather than go through with the trial. If the coverage dispute is later resolved in the insured’s favor, the stipulated judgment may then be enforced against the insurer.

In United Services Auto. Ass’n v. Morris, 154 Ariz. 113, 741 P.2d 246 (Ariz. 1987), a leading case on whether the insurer must reimburse for a settlement entered into by the insured without the insurer’s participation, the court summarized the conflicting interests of an insurer and an insured where questions arise regarding coverage for the underlying claims. The court rejected the insurer’s argument that the policy’s “cooperation clause gave it a right to force the insureds to reject any settlement, no matter how reasonable, risk trial, and place themselves at danger of a judgment larger than the policy limits or one that might not be covered.” Id., 741 P.2d at 251. But the court also recognized the danger in not allowing an insurer to defend under a reservation of rights, and instead forcing it to choose between defending without reservation and declining to defend. After weighing these conflicting positions, the court concluded that the insurer who “reserves the right to deny the duty to pay should not be allowed to control the conditions of payment.” Id., 741 P.2d at 252.
Recognizing that *Morris* was the seminal case, the Pennsylvania Supreme Court faced this issue of first impression: what is the appropriate standard to apply in determining whether an insurer is liable under its policy for a settlement made by its insured without securing the insurer’s consent, when the insurer is defending under a reservation of rights? *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 131 A.3d 445, 455-56 (Pa. 2015). In *Babcock*, the third-party claimants alleged bodily injury and property damage caused by emissions from nuclear facilities owned by the insureds. A jury trial of eight test cases resulted in an initial verdict of over $36 million. A new trial was granted.

The insurers defended under a reservation of rights as the nuclear energy hazard, damages in excess of the policy limits, and claims for injunctive relief and punitive damages were not covered. Eventually, the insurer refused to consent to any settlement offers presented to it because it believed there was a strong likelihood of a defense verdict. Thereafter, the insureds settled with the third-party claimants for $80 million, which was substantially less than the $320 million in available limits.

The insureds then sought reimbursement for the settlement from the insurers. The insurers rejected the request because the policies contained standard consent to settlement provisions and cooperation clauses. The trial court adopted the fair and reasonable standard set forth in *Morris*. A jury subsequently determined that the settlement was fair and reasonable. The Pennsylvania Supreme Court agreed with these determinations. In determining whether the settlement was fair and reasonable, lower courts were instructed to consider the terms of the settlement, the strength of the insured’s defense against the claims, and whether there was any evidence of fraud or collusion on the part of the insured. *Id.* at 462.

Another consideration when the insured pays for a settlement is the policy’s “no voluntary payment” condition. This condition is enforceable where the insurer is defending the underlying action, and the insurer need not show prejudice. *Low v. Golden Eagle Ins. Co.*, 110 Cal. App. 4th 1532 (2003). This condition encourages an insurer to act promptly in accepting a tender of defense and thereby gain control over the resolution of the claim. “That means insureds cannot unilaterally settle a claim before the establishment of the claim against them …. In short, the provisions protects against coverage by fait accompli.” *Jamestown Builders, Inc. v. Gen. Star Indem. Co.*, 77 Cal. App. 4th 341, 346 (1999).

There may be exceptions to the prohibition on voluntary payments by the insured, however. The provisions may not be enforced where the insured is unaware of the identity of the insurer, the payment is necessary for reasons beyond the insured’s control, or the insured faces a situation requiring an immediate response to protect its legal interests. *Truck Ins. Exch. v. Unigard Ins. Co.*, 79 Cal. App. 4th 966, 977 n.15 (2000). Under these circumstances, the insured’s payment to settle claims is considered involuntary. *Tradewinds Escrow, Inc. v. Truck Ins. Exch.*, 97 Cal. App. 4th 704, 710-11 (2002). It should be noted, however, that *Unigard* and *Tradewinds* involved the issue of pre-tender defense costs, and have not been applied to the settlement context.
Yet another issue arises where an excess insurer contends that the primary insurer should have settled an underlying action within the primary limits. In *Ace Am. Ins. Co. v. Fireman’s Fund Ins. Co.*, 206 Cal. Rptr. 3d 176 (Ct. App. 2016), review granted, No. S237175, 2016 WL 6652493 (Cal. Nov. 9, 2016), the California Court of Appeal held that an excess insurer can state causes of action against a defending primary insurer for equitable subrogation and bad faith for failure to settle within primary limits, where that failure results in an excess settlement that the excess insurer paid. An excess judgment against the insured is not required. The court of appeal’s reasoning was based, essentially, on reading case law regarding excess judgments as applying to excess settlements. The California Supreme Court’s future ruling in review of this decision is likely to have a significant impact on the issue, particularly as it applies between primary and excess insurers.

The Hawai’i Supreme Court also recently held that an excess insurer could bring a cause of action, under the doctrine of equitable subrogation, against a primary insurer who in bad faith failed to settle a claim within policy limits. *St. Paul Fire & Marine Ins. Co. v. Liberty Mut. Ins. Co.*, 135 Haw. 449, 353 P.3d 991 (2015). There, the insured was sued for damages resulting from an accidental death. The excess insurer alleged that the primary insurer had rejected multiple pretrial settlement offers within the primary policy’s $1 million limits. A trial resulted in a verdict of $4.1 million against the insured. The case then settled for a confidential amount in excess of the primary policy limit, requiring the excess insurer to pay the excess.

The excess insurer then sued, alleging that the primary insurer had acted in bad faith by rejecting multiple settlement offers within policy limits. The primary insurer moved for judgment on the pleadings, arguing that the excess insurer lacked standing to assert its bad faith claim, and that the excess insurer had no claim for equitable subrogation. The federal district court certified to the Hawai’i Supreme Court the question of whether the excess insurer had a cause of action in equitable subrogation against the primary insurer.

The Hawai’i Supreme Court held that the excess insurer could bring a cause of action against the primary insurer under the doctrine of equitable subrogation. The primary insurer argued that the excess insurer could not be subrogated to the rights of the insured because the insured never faced direct liability, as the exposure was within the excess limit. Equitable subrogation, however, could be applied even without any showing that the insured had suffered any loss. Further, because an insured could recover from a primary insurer that refused reasonable settlement offers, the excess insurer, which discharged the insured’s liability, stood in the shoes of the insured and was permitted to assert all claims against the primary insurer that the insured itself could have pursued.

**IV. WHEN THE INSURER WANTS TO SETTLE A CLAIM UNDER A GL POLICY, BUT THE INSURED DOES NOT**

It may be more rare, at least under general liability policies, for the insurer to want to settle more than the insured does. However, sometimes insureds are motivated more by emotional considerations—wanting to prevail—than the practical advantages of resolving litigation. Insureds may also be worried about establishing a precedent that might encourage
future suits. But insureds that are being defended and have no defense costs may have no incentive to settle.

If the insurer is defending the underlying action, “[i]n general, the insurer is entitled to control settlement negotiations without interference from the insured.” Western Polymer Technology, Inc. v. Reliance Ins. Co., 32 Cal. App. 4th 14, 24 (1995). Consequently, the insurer usually decides whether and when to settle, with whom to settle, and for how much to settle—and the insurer can make these decisions even over the insured’s objection. In other words, an insured under a general liability policy can be required to settle the underlying action against it, even if it does not want to.2

The following situations present additional considerations for an insurer when considering whether and for how much to settle an underlying liability action. Some of these situations, such as an excess demand, may provide the insured with some control over settlement.

1. Mixed Actions and Settlement of Uncovered Claims

The term “mixed action” or “mixed claim” refers to an underlying action that contains at least one at least potentially covered claim as well as other, clearly non-covered, claims. E.g., Buss v. Superior Court, 16 Cal. 4th 35, 47-48 (1997). While it is clear that (1) an insurer is required to defend all claims in a mixed action (subject to potentially obtaining reimbursement from the policyholder for costs solely allocable to defending non-covered claims, e.g., id. at 47-48, 50, 52), and (2) is not required to indemnify against a judgment for non-covered claims, issues relating to the settlement of a mixed action are much more complicated.

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2 An insurer should obtain a release and dismissal with prejudice in favor of the insured(s) on behalf of which it settles, which should be confirmed in writing. If a third-party claimant advises that it does not intend to release the insured, the insurer may not be required to accept that demand. E.g., Graciano v. Mercury General Corp., 231 Cal. App. 4th 1017, 1021 (1993) (no bad faith where insurer “reject[s] a settlement offer that does not include a complete release of all of its insureds.”); Memphis Fire Ins. Co. v. Rose, No. C.A. 1202, 1988 WL 136394, at *1 (Tenn. Ct. App. Dec. 21, 1988) (where insurer paid limits to settle but did not obtain release, there was no settlement, and insurer’s duty to defend continued); Gunn Infinite, Inc. v. O’Byrne, 996 S.W.2d 854, 859-60 (Tex. 1999) (determining that terms “settle” and “settlement” “implicitly if not explicitly required” release of claims and thus insurer is not obligated to settle underlying claim unless insured is released). On the other hand, agreeing to a settlement without a release of the policyholder may expose the insurer to a bad faith claim. E.g., Pareti v. Sentry Indem. Co., 536 So. 2d 417, 424 (La. 1988) (“any payment of the policy limits which does not release the insured from a pending claim (e.g., unilateral tender of policy limits to the court, the claimant or the insured), even if sufficient to terminate the duty to defend under the wording of the policy involved, raises serious questions as to whether the insurer has discharged its policy obligations in good faith.”).
As discussed above, some states prohibit an insurer from considering coverage issues in evaluating a settlement demand. *E.g.*, *Johansen v. Cal. State Auto. Assn. Inter-Ins. Bureau*, 15 Cal. 3d 9, 16 (1975) (“Such factors as the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage, should not affect” insurer’s decision to settle); *Jessen*, 210 F. Supp. at 326-27 (insurer owes insured “the duty to exercise the utmost good faith” and to “give at least equal consideration to the interests of the insured” as it does to its own interests) (citation omitted); *Camelot by the Bay Condo. Owners’ Ass’n, Inc. v. Scottsdale Ins. Co.*, 27 Cal. App. 4th 33, 49 (1994) (“the only permissible consideration in evaluating the reasonableness of a settlement offer [is] whether … the ultimate judgment is likely to exceed the amount of the settlement offer”; “the insurer may not allow coverage beliefs or policy limits to control the settlement decision”) (emphasis in original).

Thus, unless it is undisputed that the underlying action includes non-covered claims, the insurer may be required to settle the entire case in order to protect the policyholder—and to protect itself against bad faith liability. *E.g.*, *Jessen*, 210 F. Supp. at 326-27; *but see Camelot by the Bay*, 27 Cal. App. 4th at 52 (“The insurer does not, however, insure the entire range of an insured’s well-being, outside the scope of and unrelated to the insurance policy, with respect to paying third party claims. It is an insurer, not a guardian angel.”).

If the insurer must settle the entire case and fund the entire settlement, including arguably uncovered claims, a few states allow the insurer to seek reimbursement for settling the uncovered claims, if certain prerequisites are satisfied. *E.g.*, *Blue Ridge Ins. Co. v. Jacobsen*, 25 Cal. 4th 489, 502 (2001) (insurer must timely reserve this right, notify insured of intent to accept such offer, and give insured opportunity to assume its own defense); *Phillips & Assocs., P.C. v. Navigators Ins. Co.*, 764 F. Supp. 2d 1174, 1175-77 (D. Ariz. 2011) (Arizona and California law same on this issue); *Travelers Prop. Cas. Co. of Am. v. Hillerich & Bradsby Co., Inc.*, 598 F.3d 257, 268 (6th Cir. 2010) (predicting that Kentucky would allow such reimbursement); *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 448 F.3d 252, 263-64 (4th Cir. 2006) (applying Maryland law and remanding case for apportionment of settlement between covered and uncovered claims).

In these jurisdictions, allocation is generally available where the settlement amount is reasonable, the insurer timely and expressly reserved its right to seek reimbursement (whether the policyholder agreed to the reservation or not), the insurer notified the policyholder of its intent to accept the proposed settlement, and the insurer offered the policyholder the opportunity to assume the defense of the underlying action or the policyholder already had meaningful control over the defense. *E.g.*, *Blue Ridge*, 25 Cal. 4th at 502; *Hillerich & Bradsby*, 598 F.3d at 268; *see also Nobel Ins. Co. v. Austin Power Co.*, 256 F. Supp. 2d 937 (W.D. Ark. 2003) (“absent an express agreement by the insured,” reimbursement of settlement amounts for uncovered claims is available “only if the insurer: 1) timely and explicitly reserved its right to recoup the costs; and 2) provided specific and adequate notice of the possibility of reimbursement”); *Med. Malpractice Joint Underwriting Ass’n of Mass. v. Goldberg*, 680 N.E.2d 1121, 1129 (Mass. 1997) (similar, under professional liability policy).

The public policy rationale for allowing reimbursement under these circumstances is that a policyholder could obtain a benefit it had not bargained or paid for by refusing to assume the
defense of the underlying action and refusing to agree to the settlement and reservation of rights, thereby forcing the insurer to pay for the settlement of uncovered claims. *E.g., Blue Ridge, 25 Cal. 4th* at 502. Moreover, permitting reimbursement “encourages insurers to defend and settle cases for which insurance coverage is uncertain,” thereby “transfer[ring] from the injured party to the insurer the risk that the insured may not be financially able to pay the injured party’s damages.” *Id.* at 503. The courts generally find an implied-in-law or implied-in-fact right to such reimbursement, relying on policy language establishing the insurer’s duty to indemnify covered claims only. *E.g., Hillerich & Bradsby Co., 598 F.3d* at 265 (“The majority of jurisdictions that have addressed the issue of whether an insurer defending under a reservation of rights can seek reimbursement funds expended on noncovered claims have found that when there is an implied-in-fact or implied-in-law contract, the insurer can seek reimbursement.”) (collecting cases).

Other states have rejected the *Blue Ridge* approach, at least where the policyholder did not expressly agree to the insurer’s reservation of its right to seek reimbursement. *Utica Mut. Ins. Co. v. Rohm & Haas Co.*, 683 F. Supp. 2d 368, 376-77 (E.D. Pa. 2010) (under Pennsylvania and Illinois law, right to reimbursement of settlement amounts cannot be created unilaterally by insurer; it exists only if explicitly included in the policy or agreed to by policyholder); *Excess Underwriters at Lloyd’s London v. Frank’s Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 43 (Tex. 2008) (“In Texas, an insurer that settles a claim against its insured when coverage is disputed may seek reimbursement from the insured should coverage later be determined not to exist if the insurer obtains the insured’s clear and unequivocal consent to the settlement and to the insurer’s right to seek reimbursement.”) (internal quotation marks and citation omitted); *see also Stryker Corp. v. XL Ins. Am., Inc.*, No. 1:05-CV-51, 2013 WL 504646 (W.D. Mich. Feb. 8, 2013) (“An insurer is not entitled to recoup from its insured a voluntary overpayment that the insurer made to a third party to settle a judgment against the insured,” at least where insurer “made a strategic decision” to settle rather than risk adverse consequences), *aff’d sub nom. Stryker Corp. v. XL Ins. Am.*, 576 F. App’x 496 (6th Cir. 2014).

The rationale underlying these decisions is that the policies at issue do not mention a right to reimbursement, and allowing an insurer to unilaterally reserve an extracontractual right would put the policyholder “in an untenable position where it is forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means, at a time when the insured is most vulnerable.” *Rohm & Haas, 683 F. Supp. 2d* at 376; *see also, e.g., Texas Ass’n of Counties County Government Risk Mgt. Pool v. Matagorda County*, 52 S.W.3d 128, 135 (Tex. 2000) (similar). Moreover, *Matagorda County* reasoned that it is “appropriate” under such circumstances to force the insurer to choose between risking a bad faith claim or paying to settle uncovered claims because “insurers are best positioned to handle this risk, either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claims in their rate structure.” *Id.* at 135-36. Allowing the insurer to sue its policyholder for reimbursement would also “foster … conflict and distrust in the relationship between an insurer and its insured.” *Frank’s Casing, 246 S.W.3d* at 46-47 (also noting potential conflict of interest for insurer-retained defense counsel) (internal quotation marks and citation omitted).
According to these decisions, the insured is not unjustly enriched because the insurer also obtains benefits from paying to settle uncovered claims: “When an insurer funds a settlement, the insurer benefits because settlement ends the obligation to pay defense costs, caps the insurer’s risk of liability, and may insulate an insurer from a future bad faith claim by the insured.” *Rohm & Haas*, 683 F. Supp. 2d at 376.

Alabama courts have articulated their rationale for adhering to the express-consent-only standard for reimbursement based on equitable considerations as follows “

It has been the law in Alabama for over 150 years that where one party, with full knowledge of all the facts, voluntarily pays money to satisfy the colorable legal demand of another, no action will lie to recover such a voluntary payment, in the absence of fraud, duress, or extortion.

*Mt. Airy Ins. Co. v. Doe Law Firm*, 668 So.2d 534, 537 (Ala. 1995) (involving malpractice claim under professional liability policy). The court found neither the risk of a bad-faith claim nor the insurer’s unconsented-to reservation of rights sufficient to make its settlement payment involuntary. *Id.* at 538.

Finally, in Utah, an insurer can obtain reimbursement for settlement amounts paid for uncovered claims only if the policy expressly provides such a right, rather than based on the extracontractual theory of unjust enrichment or an implied-in-fact or in-law contract. *U.S. Fid. v. U.S. Sports Specialty*, 2012 UT 3, ¶ 11, 270 P.3d 464, 468. The court explained that, under Utah law:

[A] claim of unjust enrichment cannot arise where there is an express contract governing the “subject matter” of a dispute[, such as an insurance policy]. Because an insurer’s right to reimbursement from an insured substantially affects the relative levels of risk assumed by each, Utah law does not allow an insurer to seek reimbursement or restitution through an extracontractual claim of unjust enrichment. Instead, we hold that an insurer’s right to reimbursement from an insured must be expressly provided in an insurance policy before it can be enforced.

*Id.*

2. **Multiple Third-Party Claimants and/or Multiple Insureds**

Underlying actions with multiple third-party claimants and/or multiple insureds present special issues, because the policy limits are frequently not sufficient to resolve all claims by all claimants against all insureds, even through settlement.

The majority rule with respect to situations involving multiple claimants is that a “liability insurer may, in good faith and without notification to others, settle part of multiple claims against its insured even though such settlements deplete or exhaust the policy limits so
that remaining claimants have no recourse against the insurer.” *Allstate Ins. Co. v. Evans*, 409 S.E.2d 273, 274 (Ga. App. 1991); *Farinas v. Fla. Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555, 561 (Fla. Dist. Ct. App. 2003) (insurer can in good faith settle for policy limits “with some claimants to the exclusion of others,” under rule established in *Harmon v. State Farm Mut. Auto. Ins. Co.*, 232 So. 2d 206, 207-08 (Fla. Dist. Ct. App. 1970), which stated: “It is generally held that where multiple claims arise out of one accident, the liability insurer has the right to enter reasonable settlements with some of those claimants, regardless of whether the settlements deplete or even exhaust the policy limits to the extent that one or more claimants are left without recourse against the insurance company.”). The rationale underlying this rule is that

Were the rule otherwise, an insurer would be precluded from settling any claims against its insured in such a situation and would instead be required to await the reduction of all claims to judgment before paying any of them, no matter how favorable to its insured the terms of a proposed settlement might be.

*Evans*, 409 S.E.2d at 274. That would expose the insured to a much greater risk of “total adjudicated liability in excess of his policy limits,” while also contravening the public policy favoring settlements. *Id.* It would also unduly increase insurers’ defense costs, resulting in likely premium increases.

The same rule typically also applies in situations involving multiple insureds. Insurers are permitted, in most states, to settle for policy limits with fewer than all insureds. *E.g.*, *Millers Mut. Ins. Ass’n of Illinois v. Shell Oil Co.*, 959 S.W.2d 864, 870 (Mo. Ct. App. 1997) (no bad faith where insurer entered into reasonable settlement for policy limits on behalf of one of two insureds). The rationale here is that “any settlement would benefit all insureds by decreasing the total amount of liability in the underlying suit.” *Id.* at 870.

California is a notable exception to these “first come, first served” approaches. In California, an insurer that settles on anything less than a global basis risks a finding of bad faith, because such a settlement leaves the insured(s) exposed to additional claims. *E.g.*, *Strauss*, 26 Cal. App. 4th at 1021 (no bad faith to reject policy-limits settlement offer that would have released claims only against one of several insureds); *Kinder v. W. Pioneer Ins. Co.*, 231 Cal. App. 2d 894, 902 (1965) (“a carrier, faced with multiple claims, must, with due regard for the interests of its insured, attend to [the insured’s] best protection against all of these.”). Consequently, an insurer can—and should—usually reject a demand to settle for policy limits with fewer than all claimants, or on behalf of less than all insureds, whether named or additional. Indeed, while acceptance of such a demand could expose the insurer to a bad faith finding, its rejection insulates the insurer from such a finding. *E.g.*, *Strauss*, 26 Cal. App. 4th at 1021; *Harp v. Converium Ins. (N. Am.) Inc.*, No. 5:12-CV-00760-ODW, 2013 WL 228701, at *1 (C.D. Cal. Jan. 22, 2013) (no bad faith to reject limits offer to settle with fewer than all insureds), *aff’d sub nom. Harp v. Converium Ins. (N. Am.) Inc.*, 593 F. App’x 686 (9th Cir. 2015); *Schwartz v. State Farm Fire & Cas. Co.*, 88 Cal. App. 4th 1329, 1338 (2001) (similar). Because of this rule, an insurer defending a California claim can, if it will not prejudice the defense, advise the third-party claimant or claimants of the policy limits and the reason why the insurer cannot settle on a
piecemeal basis. Third-party claimants are usually quick to settle once they realize that settlement funds are limited.

3. **Excess Demand**

The policy limits serve as a cap on the insurer’s duty to indemnify. Thus, an insurer typically has no obligation to accept an excess demand. *E.g.*, *Heredia v. Farmers Ins. Exch.*, 228 Cal. App. 3d 1345 (1991); *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994). Nonetheless, there often is a question whether the demand is, in fact, an excess demand, if the insured offers to contribute to settlement. In other words, does the amount of the insured’s proposed contribution reduce the amount of the demand so that it becomes a demand within limits?

Under Texas law, an insurer’s duty to reasonably attempt settlement of a claim against its insured is not triggered until the claimant has presented the insurer with a proper settlement demand within policy limits that any ordinarily prudent insurer would have accepted. *Rocor Int’l v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 262 (Tex. 2002). Hence, a demand above policy limits, even though reasonable, does not trigger a “*Stowers*” duty to settle. *American Physicians*, 876 S.W. 2d at 849.


The *Stowers* duty is not activated by a settlement demand unless three prerequisites 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. *Id.* at 849. If, however, the insurer is never presented with a demand within in limits, it has no duty to negotiate a settlement. *Birmingham Fire Ins. Co. v. Am. Nat’l Fire Ins. Co.*, 947 S.W. 2d 592, 597 (Tex. Ct. App. 1997).

In *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 41 (Tex. 1998), the insured allegedly defamed the third-party claimant. The insurer agreed to defend under a reservation of rights. Defense counsel advised the insurer that the insured’s “case was ‘horrible,’ that a ‘high dollar verdict can be expected,’” and finally that, from a liability standpoint, it was the worst case he had ever seen.” *Id.* at 39. The policy limits were $300,000, and the third-party claimant made a settlement demand of $1.3 million. The insurer did not accept the demand. The insured and third-party claimant then entered into an agreement, under which the insured agreed to pay $1 million from his personal assets, in exchange for an agreement not to collect on any later judgment against him. The parties also agreed to split the proceeds of any recovery against the
insurer. A bench trial resulted in a verdict of $2 million. In the ensuing coverage action, the insured argued that his agreement to pay $1 million converted the demand into an unconditional demand within limits, triggering Stowers. The court disagreed, stating:

Although [the third-party claimant] argues that “it was understood” that this $1.3 million settlement offer was bifurcated—$300,000 from [the insurer] and $1 million from [the insured]—there is no evidence that [the insurer] knew, at a point when it had a reasonable amount of time to respond, that [the insured] had made an unconditional offer to pay the excess.

*Id.* at 41.

California likewise does not require an insurer to accept an excess demand. *E.g.*, *Heredia*, 228 Cal. App. 3d 1345. However, in cases where an excess verdict appears likely, courts have indicated insurers can be liable for bad faith where they do not advise the insured of an excess demand, so as to give the insured the opportunity to contribute the excess amount toward settlement. *Id.; Cont’l Cas. Co. v. U. S. Fid. & Guar. Co.*, 516 F. Supp. 384 (N.D. Cal. 1981) (involving dispute between primary and excess insurers).

The Ninth Circuit considered the impact of an excess demand dilemma in *Springer v. Budget Rent-A-Car*, 1997 WL 449783, 121 F.3d 717 (9th Cir. July 20, 1997) (unpublished and cannot be cited to federal courts in the Ninth Circuit; Oregon law). The insured was sued by Springer after an auto accident. Springer’s demand to the insurer was for the $25,000 policy limits, “exclusive of liens and unpaid medicals.” The insurer rejected the offer, and Springer settled with the insured for $750,000. The settlement included a covenant not to execute in exchange for an assignment of Springer’s claims against the insurer.

With the assignment in hand, Springer sued the insurer. Summary judgment was awarded to the insurer on Springer’s claim that the insurer had breached its duty of care under Oregon law by not agreeing to a settlement for policy limits. On appeal, Springer argued that her offer was not an excess demand that deprived the insurer of the opportunity to settle the case within policy limits.

The Ninth Circuit disagreed. Each of Springer’s communications demanded policy limits, *plus* unpaid medical bills of an indeterminate amount that she said were continuing to grow. Nothing suggested that Springer would have settled the case (including unpaid medical expenses not covered under the policy) for only $25,000. The communications unambiguously made the demand into an excess one without a cap. The insurer had no chance to settle within policy limits and avoid exposure to its insured. Because an insurer could not be held liable for

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3 The court also held, briefly, that the bench trial, at which the insured presented no evidence, did not comply with a policy condition stating that the insurer could be sued only on a judgment “obtained after an actual trial.” *Id.* at 40-41.
failure to settle within the policy limits when no reasonable opportunity to settle within limits existed, the Ninth Circuit affirmed the summary judgment in favor of the insurer.

As a practical matter, an excess demand presents negotiating difficulties, especially when made at a mediation where the parties are under time pressure and are in close proximity to each other. When such a demand is made, the insured frequently demands that the insurer counter with an offer to pay the policy limits. But the insurer’s evaluation of the claim may indicate that liability is unlikely, or that exposure is less than the policy limits.

When faced with an excess demand, a united front between the insured and insurer against the third-party claimant is often an effective strategy at mediation, especially to force the third-party claimant to lower its demand. Once the demand begins to decrease, however, the united front may become more difficult to maintain. The insurer may have to advise the insured that its exposure evaluation is lower, perhaps significantly, than the policy limits, despite the initial excess demand. The insured often argues that the insurer must pay a demand within policy limits to avoid an excess judgment. Such discussions usually need to be conducted outside the view and hearing of the third-party claimant. The mediator may be useful in assisting in negotiations between the insurer and insured. The insured and/or insurer may have coverage counsel present at the mediation or available by phone.

If the insurer believes an excess demand is likely at mediation, it may wish to send a letter to the insured before mediation, advising of the possibility of excess exposure. The letter may advise the insured to put its excess carrier on notice, and that the insured may retain its own counsel to assist concerning excess issues.

4. Punitive Damages as Part of the Settlement Demand

Whether an insurer must consider exposure to punitive damages as part of its evaluation of a settlement demand that contains a punitive damages component is a separate issue from whether public policy allows indemnity for punitive damages. States have varied on this issue.

In states that permit indemnity for punitive damages, an insurer may pay punitive damages as part of a settlement. *E.g.*, *Fed. Ins. Co. v. Nat’l Distrib. Co.*, 203 Ga. App. 763, 768, 417 S.E.2d 671, 676 (1992) (holding insurer had to reimburse insured for its payment to settle punitive damages claims). In those states, insureds are likely to request—and should request—that the insurer include the insured’s exposure to punitive damages in the settlement evaluation.

In states that do not permit indemnity for punitive damages, approaches vary as to whether the insurer must consider the insured’s exposure to punitive damages as part of its settlement evaluation. In New York, an insurer can be found liable for bad faith by not settling within limits, even where the potential punitive damages award is larger than the potential compensatory damages award. *Ansonia Associates Ltd. P’ship v. Pub. Serv. Mut. Ins. Co.*, 257 A.D.2d 84, 692 N.Y.S.2d 5 (1999). *Ansonia* states that the reason for this rule is to prevent the insured from settling on its own (and running the risk of destroying its compensatory damages
coverage) in an effort to avoid the risk of a punitive damages verdict. *Id.*, 257 A.D.2d at 88, 692 N.Y.S.2d at 9.

In California, the insurer need not consider punitive damages exposure in evaluating a potential settlement. *Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co.*, 724 F.2d 1343, 1346 (9th Cir. 1983) (California law); *PPG Indus., Inc. v. Transamerica Ins. Co.*, 20 Cal. 4th 310 (1999) (holding insurer that did not settle within limits was not proximate cause of later award of punitive damages against insured because insured had violated safety standards in installing windshields, and insurer did not have to indemnify insured against punitive damages verdict); see Cal. Ins. Code § 533 (prohibiting indemnity for willful conduct). This approach can lead to challenging settlement negotiations. The insured may not want to pay a punitive damages settlement, or may be angry enough to want to take the case to trial. If a mediator cannot resolve these issues, there is a significant risk of the insured and third-party claimant working together to settle for a higher amount which they agree to characterize as solely compensatory in nature.

5. **Insured’s Affirmative Claims**

Where the insured has asserted an affirmative claim against the third-party claimant, or the insurer is aware that the policyholder intends to assert such a claim, the insurer usually cannot require the insured to forego the affirmative claim so that the insurer can settle the underlying action. *E.g.*, *Barney v. Aetna Cas. & Sur. Co.*, 185 Cal. App. 3d 966, 976-77 (1989). To the contrary, if the insurer exercises its discretion under the policy to enter, without the policyholder’s consent, into a policy limits settlement resulting in dismissal of the underlying action that that bars the policyholder from asserting or pursuing its affirmative claim, the insurer can be subject to, and liable for, a bad faith claim. *E.g.*, *Barney*, 185 Cal. App. 3d at 981 (insurer has “a duty of good faith and fair dealing, by virtue of its fiduciary relationship [with policyholder], to do nothing to interfere with” policyholder’s known rights to pursue affirmative claims). Even though subsequent California cases have confirmed that an insurer is not a fiduciary of an insured, *see, e.g.*, *Vu v. Prudential Prop. & Cas. Ins. Co.*, 26 Cal. 4th 1142, 1150-51 (2001), insurers should usually take the cautious approach of not precluding an insured from pursuing affirmative claims. The reason is that an “insured reasonably expects that the insurer, in using the authority granted under the policy, will not knowingly effect a settlement which works to the detriment of the insured” by denying the policyholder “all opportunity for redress for her injuries” in excess of the policy limit. *Barney*, 185 Cal. App. 3d at 977-78.

The general rule does not, however, apply under all circumstances. Thus, in *Hurvitz v. St. Paul Fire & Marine Ins. Co.*, 109 Cal. App. 4th 918, 929, 934 (2003), the court held that, under a professional liability policy giving the insurer the right to settle without policyholder consent, the insurer did not act in bad faith by settling an underlying action within policy limits, even though that settlement conclusively prevented the policyholder from asserting a malicious prosecution claim against the third-party claimant. This ruling was based on the court’s conclusion that:

A rule requiring an insurer to refuse a reasonable settlement merely because the insured hopes to someday prevail in a malicious prosecution
action would conflict with the insurer’s duty to handle claims efficiently and pay reasonable settlement offers in order to protect the insured from financial ruin caused by an excessive judgment.

_Id._ at 934 (also noting policyholders had not agreed “to give up their right to indemnity” in case of excess judgment, or “to give up their right to seek a bad faith recovery against [insurer] if a judgment was obtained against them in excess of policy limits”). The _Hurvitz_ court distinguished _Barney_ as a situation in which the insurer could simply have carved out the insured’s affirmative claims from the settlement agreement—something that was impossible in _Hurvitz_, because settlement meant that a malicious prosecution claim could not be brought as a matter of law. _Id._ at 929, 933.4

6. **Non-Coverage Considerations That May Impact Settlement**

Insureds may resist settlement based on concerns that the settlement will “open the floodgates” to similar claims against them. This is a particular concern for insureds that deal with a large group of individuals, such as landlords and employers. Although an insurer is not likely to face bad faith liability for a settlement that opens the floodgates, it may be wise to consider this factor, especially if the policy has high aggregate limits.

Insureds may also resist settlement for fear the settlement will harm their reputation or future insurability, including by raising the cost of obtaining insurance. General liability insurers are unlikely to face bad faith liability for settlements that have such effects. _E.g._, _Hurvitz_, 109 Cal. App. 4th at 929-30. But, as discussed below, reputational concerns are a significant factor in settling claims under professional liability policies.

If the settlement is partly allocable to non-covered claims, the insured’s financial ability to contribute to a settlement may become a factor. The insurer and insured should usually discuss these issues in advance of mediation to determine their positions.

Most states provide that the insurer cannot “unreasonably coerce” the insured to contribute to a settlement. _E.g._, _J.B. Aguerre v. American Guar. & Liab. Ins. Co._, 59 Cal. App. 4th 6, 15 (1997). Rather, “an attempt by the insurer to coerce or obtain an involuntary contribution from the insured in order to settle within the policy limits” is one of many factors that may determine whether an insurer is liable for bad faith failure to settle. _Commercial Union Ins. Co. v. Liberty Mut. Ins. Co._, 426 Mich. 127, 138, 393 N.W.2d 161, 165 (1986). To avoid the insured misconstruing a request to contribute to settlement, insurers can frame the request as an inquiry, or seek assistance from the mediator. Although few insureds choose to do so, they can independently offer to contribute to settlement.

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4 An additional issue to consider in the context of settlement of cases involving affirmative claims by the policyholder is whether the insurer can obtain a setoff from any recovery the policyholder obtains on those claims. The outcome will depend on the facts of the underlying action, how the third-party claimant and insured frame the settlement, and state law.

V. SPECIAL ISSUES UNDER PROFESSIONAL LIABILITY, EPLI AND D&O POLICIES

Settlement under professional liability policies, employment practices liability insurance (“EPLI”), and directors and officers (“D&O”) policies (collectively referred to as “PL policies,” for convenience) can present entirely different issues than settlement under general liability policies. PL policies typically contain “consent to settle” provisions, which allow the insured to refuse to consent to settlement or, if the insured has consented, to revoke its consent. Professionals may be opposed to settling malpractice claims due to reputational concerns. Employers may not wish to settle, due to the possibility of copycat suits or “floodgates” concerns. Policies with consent to settle provisions accordingly have higher premiums. But even PL policies with such provisions typically also contain so-called “hammer clauses,” under which the insured shares the risk of declining to consent to settlement.

A. Consent to Settle Provisions

A consent to settle provision may provide: “The Company will not settle any Claim without the consent of the Named Insured.” RLI Corp. Form No. MML311 (10/12), available at https://www.rlicorp.com/sites/default/files/downloads/rockbridge/MML311.pdf. Some provisions include a reasonableness requirement, which typically provides that the insurer “shall … not settle any CLAIM without the written consent of the NAMED INSURED which consent shall not be unreasonably withheld.” *Freedman v. United Nat’l Ins. Co.*, No. CV 09-5959 AHM CTX, 2011 WL 781919, at *1 (C.D. Cal. Mar. 1, 2011). Consent to settle provisions may be set forth in the same section of the PL policy as the hammer clause, or in a different section.

An insurer that settles an underlying action despite the insured’s refusal to consent is not necessarily liable for bad faith, however. *J-U-B Engineers, Inc. v. Security Insurance Co. of Hartford*, 146 Idaho 311, 193 P.3d 858 (2008), was based on an underlying action against the insured engineering firm. The insurer appointed panel counsel to defend the underlying action, and the court granted summary judgment on the merits in favor of the insured. The insured informed panel counsel that it wanted to seek attorneys’ fees and costs, to “punish” the third-party claimants and deter copycat suits. The PL policy, which had burning limits, defined “claim expenses” to include attorneys’ fees and costs, and contained a consent to settle provision that stated that the insurer “will not settle any CLAIM without the written consent of the first Named

Insured … shown in the Declarations …”  J-U-B Engineers, Inc. v. Sec. Ins. Co. of Hartford, No. CV-OC-0615585, 2007 WL 7072001 (Idaho 4th Dist. Ct. Ada Cty. July 6, 2007). Panel counsel advised the insured that it was the insurer’s decision whether to seek attorneys’ fees and costs, and that the cost of seeking them would greatly exceed any recovery. Two days before the hearing on the third-party claimants’ motion for reconsideration and the insured’s motion for a certificate of final judgment, the third-party claimants offered to settle for a dismissal with prejudice in exchange for a waiver of attorneys’ fees and costs. That call concluded after 5 p.m. Panel counsel left a message for the insured’s chair of the board the next morning, but did not convey the terms of the settlement offer in the message. An associate had a noon flight to another city for the hearing. Panel counsel called the insurer and advised that it was the insurer’s decision whether to seek attorneys’ fees and costs, and the insurer directed panel counsel to accept the offer. Panel counsel accepted the offer shortly before noon. The insured’s chair did not return panel counsel’s call until shortly before 5 p.m.

The insured sued panel counsel and the insurer, alleging legal malpractice, breach of contract and bad faith, and arguing that the settlement was harming its reputation as a “pugnacious litigator.”  J-U-B, 146 Idaho at 318, 193 P.3d at 865. The insured’s chair submitted an affidavit, asserting that settlement would result in copycat suits; the insured’s reputation was harmed as a result of this settlement, making it harder to obtain and retain clients, and making it a target of litigation; and that a “policy without a settlement consent clause would be worth only half the value of the premium paid ($27,089).”  Id., 146 Idaho at 315, 193 P.3d at 862. The Idaho Supreme Court held that the trial court properly struck all of these assertions as improper opinion with no factual basis, and affirmed summary judgment in favor of the insurer.  Id., 146 Idaho at 315-18, 193 P.3d at 862-65.

Where there are multiple insureds under a policy, some courts have held that a consent to settle provision that applies to “the insured” means the first named insured only, and that other insureds do not have a right to refuse to consent to settlement. For example, in Jayakar v. North Detroit General Hospital, 451 N.W.2d 518 (Mich. Ct. App. 1990), the PL policy, issued to the hospital, provided that the insurer had the right to settle “with the written consent of the Insured.”  Id., 451 N.W.2d at 111. The hospital consented to settle a medical malpractice suit, but an individual physician, also a defendant to that suit, did not consent. The insurer settled the underlying action. The individual physician then sued, and the court held that the insurer was not required to seek her consent, because under the policy, the “hospital sought to insure members of its medical staff while giving [the insurer] broad authority to defend defendant hospital and its employees,” but the individual physician’s argument that each individual physician had a right to refuse to consent “would virtually paralyze [the insurer] in its efforts to fulfill its contractual duty to defend.  Id. at 111-12.

Similarly, in Webb v. Witt, 876 A.2d 858 (N.J. App. Div. 2005), the court stated that a consent to settle provision that allowed the named insured hospital to refuse to consent, but did not give such a right to an individual physician, did not violate public policy.

On the other hand, in Mosely v. Wilson, No. 91-0712, 1991 WL 134285, at *2 (E.D. Pa. July 18, 1991), the court stated that, where the PL policy provided that the insurer “shall not
settle any suit without the INSURED’S consent,” the insurer’s failure to allow the named insured’s employee, a co-defendant to the underlying action, to refuse to consent to settlement “might well have been a breach of [insurer’s] fiduciary duty.”

Thus, insurers and insureds should understand the scope of the PL policy’s consent to settle provision, including which insureds have the right to refuse to consent, in making settlement decisions. Insureds who are hesitant to settle should also factor in that refusal to settle could mean that defense costs will burn through the policy limits, leading to personal exposure, as well as a potentially higher loss run, which could result in higher premiums in the future. Insurers and insureds should also consider whether the PL insurer can invoke the policy’s hammer clause, and the potential effect of invocation of that clause on the insured.

B. Hammer Clauses

Hammer clauses are most common in EPLI policies and physician malpractice policies. A hammer clause may provide:

If the Named Insured refuses to consent to a settlement that the Company recommends and the claimant will accept, then the Company will have the right, but not the duty or obligation, to continue to defend any such Claim or suit. The Company’s liability for any settlement or judgment shall not exceed the amount for which the Company could have settled if the Named Insured had consented less all of the Claims Expense incurred from the date of the Company’s recommendation. This amount constitutes the applicable limits of liability of the policy.

RLI Corp. Form No. MML311 (10/12), available at https://www.rlicorp.com/sites/default/files/downloads/rockbridge/MML311.pdf. The above-quoted provision is informally known as a “hard” hammer clause, because the insured bears the entire risk—both defense costs and indemnity—of rejecting a settlement demand that the insurer would have accepted. A “soft” hammer clause makes an insured that did not consent to settlement responsible for only a percentage of the defense costs and indemnity incurred after its rejection of the settlement.


Where the consent to settle provision contains a reasonableness requirement, courts have held that the PL insurer cannot invoke the hammer clause if the insured acted reasonably in refusing to consent to settlement. Freedman, 2011 WL 781919; Clauson v. New England Ins.
Co., 254 F.3d 331 (1st Cir. 2001) (Rhode Island law). This holds true even where the hammer clause does not expressly reference the reasonableness requirement. Freedman, 2011 WL 781919. These courts have reasoned that “if the insurer could limit its liability even when the insured reasonably refused to settle—the position [the insurer] advances here—that would, in itself, negate the insured’s right to withhold consent.” Id., 2011 WL 781919, at *6 (citing Clauson).

None of the reported cases have held insurers liable for bad faith for invoking hammer clauses. E.g., Scottsdale v. Alabama, 2013 WL 5231928 (holding PL insurer was not liable for bad faith for invoking hammer clause and withdrawing from defense); Scottsdale Ins. Co. v. Alabama Mun. Ins. Co., No. 2:11-CV-0668-MEF, 2012 WL 4477656, at *2 (M.D. Ala. Sept. 28, 2012) (hammer clause at issue in later decision provided: “Should the INSURED refuse consent for such recommended settlement the insurer may withdraw from the defense of the CLAIM.”); McCollough, 2013 WL 823411.

C. Practical Tips

A hammer clause will apply only if the third-party claimant makes a settlement demand, the insurer is willing to accept that demand, and the insured rejects that demand (or, depending on the language of the hammer clause, unreasonably rejects that demand). Where the third-party claimant has made a demand that the insurer wishes to accept, the insurer must request the insured’s consent to settle. The insurer should ideally make that request in writing, unless there is a short acceptance deadline. Cf. J-U-B, 2007 WL 7072001. In addition, the insurer should usually comply with the jurisdiction’s law regarding keeping the insured advised of the status of settlement negotiations.

If the insured refuses to consent, and the PL policy contains a reasonableness requirement, the insurer should evaluate whether the insured’s refusal to consent is reasonable. See Freedman, 2011 WL 781919. If it is, the insurer must continue to defend, but can explore other opportunities to settle. If the refusal to consent is not reasonable, the insurer must inform the insured, preferably in writing, that the insurer will invoke the hammer clause. Such a letter is nicknamed a “hammer letter.” The call to the insured and/or hammer letter should explain the consequences to the insured if it continues to refuse to consent to settlement. As a practical matter, an insured’s principled opposition to settling usually disappears when it faces personal exposure.

Where the jurisdiction and/or the insured allows the insurer to communicate with the third-party claimant, an effective approach for the insurer may be to advise the third-party claimant that the insured refused to consent, and that the insurer has exercised the hammer clause. Wise third-party claimants will often settle for less rather than take the risk that the insured may not be able to fund a settlement by itself. If the third-party claimant makes a subsequent, different settlement demand, which the insured then rejects, the insurer should send another hammer letter. This is especially the case where the hammer clause contains a reasonableness requirement or another restriction on the insurer’s right to hammer the insured,
because, while the insured’s refusal to consent to the first demand could have been reasonable, its refusal to the consent to a second, lower demand might be unreasonable.

If the third-party claimant leaves a rejected demand on the table, the insurer should consider periodically writing to the insured to remind it that there is still a pending demand that the insurer has recommended the insured consent to, and that if the insured continues to refuse to consent, the insurer’s liability will be limited to the amounts set forth in the hammer clause. If the PL policy has burning limits (most PL policies do), the insurer should consider advising the insured of the remaining limits on the policy and the anticipated costs of taking the case through trial. This can be a very effective strategy, as most insureds have little grasp of how quickly defense costs can erode the limits.

As for the insured, when faced with a settlement request to which it does not wish to consent and the insurer’s invocation of a hammer clause, the insured should notify the insurer in writing of its refusal to consent, including its reasons (to establish, if required, the reasonableness of its refusal). If the settlement offer is left on the table, or if a lower offer is forthcoming, the insured should continue to reasonably evaluate such offer, including the likely increasing defense costs and eroding policy limits.

V. CONCLUSION

While a settlement demand presents the possibility of resolution and an end to defense costs, it can also present the risk of bad faith liability for the insurer. Under PL policies, which usually have burning limits, it can present the insured with the risk that the insurer will invoke a hammer clause, resulting in increased potential liability for the insured. Insurers and insureds alike are wise to understand the settlement landscape. Insurers are also wise to avoid bad faith set-up attempts by third-party claimants, who well know how complicated the duty to settle is, and who may be trying to turn a small claim into an excess verdict that they will then seek to enforce against the insurer. Policyholders, on the other hand, should reasonably evaluate settlement offers and the risks associated with continuing to litigate the third-party claim, including, where necessary, by engaging independent coverage counsel.