

Nebraska Law Review

Volume 61 | Issue 2

Article 4

1982

Resolution of Settlement Conflicts among Insureds, Primary Insurers, and Excess Insurers: Analysis of the Current State of the Law and Suggested Guidelines for the Future

Michael D. Gallagher
German, Gallagher & Murtagh

Edward C. German
German, Gallagher & Murtagh

Follow this and additional works at: <https://digitalcommons.unl.edu/nlr>

Recommended Citation

Michael D. Gallagher and Edward C. German, *Resolution of Settlement Conflicts among Insureds, Primary Insurers, and Excess Insurers: Analysis of the Current State of the Law and Suggested Guidelines for the Future*, 61 Neb. L. Rev. (1982)
Available at: <https://digitalcommons.unl.edu/nlr/vol61/iss2/4>

This Article is brought to you for free and open access by the Law, College of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Nebraska Law Review by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

Michael D. Gallagher*
Edward C. German**

Resolution of Settlement Conflicts Among Insureds, Primary Insurers, and Excess Insurers: Analysis of the Current State of the Law and Suggested Guidelines for the Future

Table of Contents

	<u>Page</u>
I. Introduction	285
II. The Right of One Party to a Settlement Dispute to Settle Over the Objections of the Other and Obtain Financial Contribution from the Objector: Seeking Refuge Before the Storm.	290
A. Insured's Right to Settle the Claim and Force the Objecting Carrier to Pay its Share of the Settlement.	290
1. Insurer's Refusal to Defend as Empowering the Insured to Settle.	292
2. Insurer's Bad Faith as Determinant of the Insured's Power to Settle.	294
3. Insurer's Conditional Defense as Empowering the Insured to Settle.	302
B. Excess Insurer's Right to Settle the Claim Against the Insured and Obtain Reimbursement of the Objecting Primary Carrier's Limits of Coverage....	308
C. Insurer's Right to Settle and Sue the Insured for	

* B.A., 1971, St. Joseph's College; J.D. *magna cum laude*, 1974, Dickinson School of Law; Member, German, Gallagher & Murtagh, Philadelphia, Pennsylvania.

** J.D., 1950, Temple University; Member, German, Gallagher & Murtagh, Philadelphia, Pennsylvania.

1982]	RESOLUTION OF SETTLEMENT CONFLICTS	285
	its Deductible, Self-Insured Retention, or Participation.....	312
III.	Imposition of Excess Liability For Failure to Settle: Allocating Liability for the Damage Done by the Storm.....	318
A.	Insurer's Excess Liability in Action Brought by Insured Following Insurer's Refusal to Settle Within Policy Limits.....	318
1.	Fraud as the Standard for Imposition of Excess Liability.....	320
2.	Good Faith as the Standard for Imposition of Excess Liability.....	320
3.	Negligence as the Standard for Imposition of Excess Liability.....	326
4.	Strict Liability as the Suggested Standard for Imposition of Excess Liability.....	329
B.	Excess Carrier's Right to Recover Excess of Adverse Verdict Over Settlement Demand from Primary Carrier Which Refused to Settle Claim Against Their Joint Insured.....	333
1.	Equitable Subrogation.....	335
2.	Contractual Subrogation.....	338
3.	Direct Duty Owed by Primary Carrier to Excess Carrier.....	339
4.	Triangular Reciprocity.....	340
5.	Cases Disallowing Recovery.....	342
C.	Insurer's Right to Recover Excess of Verdict Over Settlement Demand from Insured Which Refused to Give Required Consent or to Post Necessary Sums Under Deductible, Self-Insured Retention, or Participation Provisions of its Coverage.....	343
IV.	Conclusion.....	356

I. INTRODUCTION

Liability insurance may be described as the means by which one party (the "insured") purchases from one or more other parties (the "insurers") financial protection in the form of defense and indemnity against potential claims which all parties hope are never actually filed.¹ Thus, at the inception of the policy, the best interests of the insured and the insurer are identical: each would be best served if no claims were asserted against the insured during the term of the policy. Once a claim has been asserted against

1. For a more detailed definition of "insurance," see R. KEETON, INSURANCE LAW §§ 1-2 (1971).

the insured, however, there is a real possibility that the interests of the insured and insurer may diverge. Thus, while both the insured and the insurer would be best protected if the claim were defeated, in the event this is not possible, the insured will usually be best served by having the claim covered by and satisfied under the policy, whereas the insurer's interests usually would be better served if the claim were beyond the coverage of the policy and satisfied by the insured himself.²

This possible conflict between the interests of the insured and the insurer, of course, may be exacerbated by a difference between them as to whether a claim against the insured should be settled or litigated to judgment. In fact, much of the case law dealing with insurance issues in the last twenty-five years has evolved from situations in which the insured and insurer have been unable to agree on whether a claim should be settled or litigated to judgment. In addressing these disputes, the courts³ and commentators⁴ have focused almost entirely on the rights of the insured and the liabilities of the insurer and have virtually ignored the converse issues of the rights of the insurer, either *inter se* or *vis-a-vis* the insured, and the liabilities of the insured.

Two factors are repeatedly cited as justification for this emphasis on the rights of the insured and the liabilities of the insurer: (1) the vast disparity between the relative sophistication, bargaining power, and economic strength of the insured and the insurer;⁵ and (2) the almost total control of the litigation which is vested in the insurer by the terms of the policy, which typically empower the insurer to settle or litigate claims in its discretion.⁶

Based upon these factors, the courts have developed two principal rules for the protection of the insured against the damage which may result from the insurer's refusal to settle a claim which the insured wants settled. First, in virtually every jurisdiction, the insured is empowered to settle the litigation himself, either by actual payment to the claimant which the insured can recover from

-
2. The interests of the insured and insurer may be reversed where the insured has a large deductible, self-insured retention, or participation. See sections II.C. & III.C. of the text *infra*.
 3. See, e.g., *Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975). For a discussion of this case, see notes 159-66 & accompanying text *infra*.
 4. See, e.g., 7C J. APPLEMAN, INSURANCE LAW AND PRACTICE §§ 4711-4715 (Berdal ed. 1979).
 5. See, e.g., *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967) (court, in upholding excess liability of insurer, also awarded damages for mental suffering caused to insured by company's bad faith).
 6. See, e.g., *Traders & General Ins. Co. v. Rudeo Oil & Gas Co.*, 129 F.2d 621 (10th Cir. 1942).

the insurer upon a showing that settlement was reasonable and not collusive⁷ or by entering into a covenant not to execute, consent to judgment, or loan receipt arrangement with the claimant which limits the claimant's recovery to the proceeds of the insurance policy.⁸ Most jurisdictions, however, limit this power to situations in which the insurer has disclaimed coverage and refused to defend.⁹ Second, most jurisdictions will hold the insurer liable for the entire amount of a judgment rendered against its insured, without regard to policy limits, where such judgment followed a wrongful refusal by the insurer to settle the claim within policy limits.¹⁰ The standard for the imposition of such liability ranges from negligence,¹¹ to bad faith,¹² and even approaches strict liability.¹³

-
7. See *id.*
 8. E.g., *Continental Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 681 (Alaska 1980) (consent to judgment binding on insurer); *Globe Indem. Co. v. Blomfeld*, 115 Ariz. 5, 562 P.2d 1372 (Ct. App. 1977) (under a covenant not to execute, the insurer was liable after the covenant was rescinded); *Hand v. Northwestern Nat'l Ins. Co.*, 255 Ark. 802, 502 S.W.2d 474 (1973) (loan receipt arrangement in settlement of claim not even brought to suit held binding on insurer).
 9. Compare *Fireman's Fund Ins. Co. v. Security Ins. Co.*, 72 N.J. 63, 367 A.2d 864 (1976) (insured can settle claim and recover sums thus spent from insurer who had refused to settle even though insurer was defending insured against such claim) with *Sargent v. Johnson*, 551 F.2d 221 (8th Cir. 1977) (insured who settled claim which was being defended by insurer in spite of dispute as to amount of coverage breached policy and settlement was not binding on insurer).
 10. See Section III.A. of the text *infra*. For a general review of the varying standards, see 7C J. APPLEMAN, *supra* note 4, §§ 4711-4713; Comment, *Liability in Excess of Insurance Policy Limits: Who Bears the Risk of Litigation?*, 12 U. TOL. L. REV. 101 (1980) (author reviewed varying standards and urged that Ohio adopt strict liability standard, a recommendation with which the authors hereof do not concur, see notes 290-92 & accompanying text *infra*).
 11. See *Dumas v. Hartford Accident & Indem. Co.* 94 N.H. 484, 56 A.2d 57 (1941). See also *Allstate Ins. Co. v. Reserve Ins. Co.*, 116 N.H. 806, 373 A.2d 339 (1977) (excess carrier could maintain action, assigned to it by insured, for primary carrier's negligent failure to settle). In addition, the insured has been allowed to proceed on alternative theories of negligence or bad faith. See, e.g., *Bollinger v. Nuss*, 202 Kan. 326, 449 P.2d 502 (1969).
 12. It should be noted, however, that there is considerable difference among the various jurisdictions as to what constitutes bad faith rendering the insurer liable for the excess verdict. Compare *Olson v. Union Fire Ins. Co.*, 174 Neb. 375, 118 N.W.2d 318 (1962) (mere mistake in judgment not equivalent to bad faith) with *Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975) (insurer's "good faith" but mistaken belief that there was no coverage will not insulate it from excess liability).
 13. Compare *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967) (court discussed at length the benefits of a strict liability standard but ultimately based its holding on the insurer's bad faith) and *Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal.

The vast majority of cases in which these rules developed have arisen from fairly simple factual situations involving only one insured, usually an individual, and one policy, usually an automobile liability policy with a relatively nominal deductible and virtually complete control of settlement vested in the insurer.¹⁴ Under such circumstances, it is not surprising that the trend in the law has been toward expanding both the insured's right to settle a claim over the objection of the insurer, which may then be required to fund the settlement up to the applicable limits of the policy, and the insurer's liability for wrongful refusal to settle.¹⁵

Unfortunately, this simple fact pattern and the rules developed under it are no longer adequate to cover all of the disputes which may arise between and among insurers and insureds today. Due in large part to the increasing needs for greater amounts of insurance, the increased variety in the types of coverage available, and the increased bargaining power of large commercial and professional insureds, an insured, itself consisting of myriad subsidiaries and affiliates, may purchase several layers of insurance in varying amounts from dozens, if not hundreds of insurers.¹⁶ Moreover, these policies may give the insured significant control over the handling and settlement of any litigation covered thereunder, either by requiring the insured's consent to any settlement or by vesting in the insured a significant financial involvement in the claims asserted against it through such devices as a large deductible, self-insured retention, or participation in one or more layers of coverage.¹⁷

The possible permutations and combinations of potential conflict among the parties to such an insurance structure seem almost infinite. Analysis of these potential conflicts in terms of the increased exposure to which one party may be subjected by an-

Rptr. 288 (1975) (court noted argument for strict liability and fact that New Jersey Supreme Court had adopted rule in *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 65 N.J. 474, 323 A.2d 495 (1974), but again nominally based its holding on insurer's bad faith) *with* *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 65 N.J. 474, 323 A.2d 495 (1974) (interpreted by the California Supreme Court as adopting strict liability standard) *with* *Fireman's Fund Ins. Co. v. Security Ins. Co.*, 72 N.J. 63, 367 A.2d 864 (1976) (New Jersey Supreme Court rejected argument that Rova Farms established strict liability as standard, but did not rule out possibility of future adoption).

14. *See, e.g., Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975) and cases cited therein.

15. *See* notes 126-33 & accompanying text *infra*.

16. This complex picture does not even take into account the possibility that each of these "direct" insurers, *i.e.*, insurers having a direct contractual relationship with the insured, will in turn place part of the risk with reinsurers, whose only contract will be with the direct insurer, not the insured.

17. *See* Section II.C. of the text *infra*.

other's refusal to settle a claim against the insured reveals three basic types of conflict which may arise during the course of settlement negotiations:

- (1) the insured, in order to avoid exposure beyond policy limits, wants the claim settled but the insurer refuses to fund the proposed settlement;
- (2) the excess carrier, in order to avoid increased exposure within its limits, wants the claim against the insured settled but the primary carrier refuses to contribute the sums necessary within its limits to fund the proposed settlement; and
- (3) the insurer with exposure above the settlement demand wants the claim settled to eliminate such exposure but the insured refuses to post the sums necessary within its deductible, self-insured retention, or participation to fund the proposed settlement.¹⁸

Not every settlement dispute, however, will necessitate litigation between the parties to resolve their respective rights and liabilities. Rather, a failure to effect settlement because of a dispute may be followed by a verdict or other determination in the third party litigation either in favor of the insured or, if adverse to the insured, for an amount less than the proposed settlement figure.¹⁹ In either event, of course, the failure to settle has not caused any real damage and no further litigation would be required between or among insured and insurers.

However, in two situations, a dispute over settlement may require litigation to establish the rights and liabilities of the insured and insurers:

- (1) where the party desiring settlement enters into a settlement agreement with the claimant and then attempts to force the party who refused to settle to bear the same financial burden as would have been required of him under the policy provisions had he consented to the settlement; and
- (2) where the claim against the insured is not settled and results in a verdict against the insured in an amount higher than that for which the claim could have been settled and the party who wanted to settle seeks to have this excess amount paid, not in strict accordance with policy provisions and limits, but entirely by the party who refused to settle.

This Article will examine the current state of the law concerning the relative rights and liabilities of the insured, primary insurer, and excess insurers in these types of settlement disputes

-
18. Of course, there are other types of conflicts. For example, a dispute may arise when the insured and the excess carrier wish to settle the claim and the primary carrier refuses to post its limits. In most respects, other disputes are basically combinations of or minor variations from the three basic types of conflicts listed in the text and do not require detailed separate analysis. Any significant legal difference in the less basic types of conflicts will be noted in the discussion which follows.
 19. For a more detailed catalog of the possible results of a failure to settle, see the dissenting opinion in *Fireman's Fund Ins. Co. v. Security Ins. Co.*, 72 N.J. 63, 367 A.2d 864 (1976) (Clifford, J., dissenting).

and suggest appropriate guidelines for the resolution of such issues in the future.

**II. THE RIGHT OF ONE PARTY TO A SETTLEMENT
DISPUTE TO SETTLE OVER THE OBJECTIONS OF
THE OTHER AND OBTAIN FINANCIAL
CONTRIBUTION FROM THE OBJECTOR:
SEEKING REFUGE BEFORE THE STORM**

In the event the parties are unable to resolve their dispute over whether a claim against the insured should be settled, they may choose to simply let the claim go to verdict on the chance that a verdict may be in favor of the insured or, if adverse to the insured, may be in an amount less than the settlement demand. Such a gamble obviously involves the risk that the verdict may be adverse to the insured or in an amount far greater than the settlement demand. When an excess verdict results, the effort to establish the liability of the party who blocked settlement has been aptly likened to "seek[ing] shelter after the storm"²⁰ and will be examined in a succeeding section of this Article. This section will examine the related issue of whether the party who desires settlement of the claim against the insured may eliminate the possibility of an adverse verdict in excess of the settlement demand and, in effect, "seek shelter *before* the storm," by settling the claim and then forcing the party who opposed settlement to fund its share thereof in accordance with the terms of its policy as though it had consented to the settlement.

A. Insured's Right to Settle the Claim and Force the Objecting Carrier to Pay its Share of the Settlement

As a practical matter, and because it is in their best interests to do so, most insurers will settle a case within policy limits where it appears that the insured's liability in the event of an adverse verdict will exceed the amount for which the case may be settled. This is especially true where such liability may exceed policy limits. Where an insurer refuses to post all or part of its limits to settle a case, however, the insured confronts two obstacles in his efforts to settle the case with the third party claimant and force the insurer to bear its share of such settlement:

(1) *Policy language.* Virtually every policy contains three clauses which pose formidable obstacles to any effort by the insured to force the carrier to fund a settlement arranged by the insured over the insurer's objections: (a) the defense clause, which

20. *Traders & General Ins. Co. v. Rudeo Oil & Gas Co.*, 129 F.2d 621, 627 (10th Cir. 1942).

vests almost total discretion over settlement decisions in the insurer, typically providing that "the company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient";²¹ (b) the cooperation clause, which is much broader than its name suggests requiring not only that the insured "assist . . . in the conduct of suits,"²² but also proscribing voluntary payments by the insured, typically by providing that "the insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense";²³ and (c) the no-action clause, which typically precludes any action by the insured against the insurer "until after full compliance with all the terms of [the] policy [or] until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and [the insurer]."²⁴

(2) *Financial ability.* The amount required to settle most claims is usually beyond the ability of the insured to pay immediately, and the claimant is usually unwilling or unable to accept a long term payout.²⁵

The attitude expressed in early cases toward attempts by the insured to get around these obstacles is reflected in the following language of the Pennsylvania Supreme Court in *C. Schmidt & Sons Brewing Co. v. Travelers Insurance Co.*:²⁶

The rights of the parties are to be determined by the agreement into which they entered. By the provisions of the policy the insurance company was obliged to defend at its own cost any action against the insured, and the entire management of the defense was expressly intrusted to it, and the insured was forbidden to settle any claim, or to interfere in any negotiations for settlement, or in any legal proceeding against it. The insurer was under no obligation to pay in advance of trial, and the decision whether to settle or to try was committed to it. The plain words of the policy have no other meaning.²⁷

A review of the more modern case law reveals, however, that these obstacles are no longer viewed as insurmountable and that, in appropriate circumstances and under varying standards, the courts will force an insurer to pay its share of a settlement entered

21. *Sargent v. Johnson*, 551 F.2d 221, 230 n.12 (8th Cir. 1977) (quoting policy at issue).

22. *Taylor v. Safeco Ins. Co.*, 361 So. 2d 743, 745 (Fla. Dist. Ct. App. 1978) (quoting policy at issue).

23. *Id.*

24. *Id.*

25. See, e.g., *Hoagland Wagon Co. v. London Guarantee & Accident Co.*, 202 Mo. App. 490, 212 S.W. 393 (1919) (insured forced into corporate dissolution by insurer's refusal to indemnify).

26. 244 Pa. 286, 90 A. 653 (1914).

27. *Id.* at 287, 90 A. at 654.

into between the insured and the claimant, even where such settlement not only is over the insurer's objections but also has been specifically arranged to shift the ultimate financial obligation to the insurer.

1. Insurer's Refusal to Defend as Empowering the Insured to Settle

In the typical liability policy, both the insurer's duty to defend and its control over settlement are set forth in the same provision:

"As respects the insurance afforded by the other terms of this policy the company shall:

(a) defend any proceeding against the insured seeking such benefits in any suit against the insured alleging such injury and seeking damages on account thereof, even if such proceeding or suit is groundless, false or fraudulent; but the company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient"²⁸

Inasmuch as the insurer's power to control settlements arises from its duty to defend claims, it is not surprising to find universal recognition of the principle that abandonment by the insurer of the duty to defend will deprive it of control over settlements and empower the insured to enter into settlements which may bind the insurer in certain circumstances.²⁹ Indeed, this rule was succinctly set forth almost forty years ago in *Traders & General Insurance Co. v. Rudeo Oil & Gas Co.*³⁰

It is well settled that if the potential loss is within the limits and coverage of the policy and the insurer accepts liability therefor, by agreeing to defend the claims or suits against its assured, and to pay the losses when established, the insurer is accorded the absolute control of the litigation. It may elect to compromise and settle the claims before suit is filed or after, or it may elect to defend in the name of the assured, and the exercise of its discretion is not subject to challenge of the assured. The assured may not do more than cooperate with the insurer in the defense of the claim or suit. . . . If, however, the insurer denies liability for the asserted claims and refuses to defend in the name of the assured or to acknowledge any duty or obligation arising under the contract of insurance, the assured is released from the covenant against settlement or interference and may assume control of the litigation, defend in his own name, or effect a reasonable and prudent settlement of the claims, or suits, and thereafter assert his rights under the policy; in which event, his right to

28. *Sargent v. Johnson*, 551 F.2d 221, 230 n.12 (8th Cir. 1977) (quoting policy at issue).

29. *See Traders & General Ins. Co. v. Rudeo Oil & Gas Co.*, 129 F.2d 621 (10th Cir. 1942) and cases cited therein.

30. 129 F.2d 621 (10th Cir. 1942). Although the issue rarely arises, it should be noted that there are cases which hold that an insured and his primary carrier have the right to settle with the third party claimant and leave the excess carrier who has refused to settle or participate in defense open to further liability. *See Elas v. State Farm Mut. Auto. Ins. Co.*, 39 Ill. App. 3d 944, 352 N.E.2d 60 (1976); *Deblon v. Beaton*, 103 N.J. Super. 345, 247 A.2d 172 (1968).

recover against the insurer is generally measured by the coverage under the policy and the reasonableness of the settlement.³¹

Although in the past forty years there has been substantial erosion of the unfettered discretion of the insurer to settle or litigate, especially in the development of liability for an excess verdict following wrongful refusal to settle,³² the rules stated above in *Traders & General* prevail in the majority of jurisdictions today.³³ Two important points of clarification must be noted, however. First, transfer of the power to settle the litigation to the insured does not require an absolute refusal to defend by the insurer and cannot be avoided by the insurer simply by failing to do anything in response to a notice of claim. Rather, the insurer is required to act promptly in response to a notice of claim. Failure to respond may be regarded as a disclaimer of coverage and refusal to defend, entitling the insured to effect a settlement and seek reimbursement from the insurer. This point was made in *Hand v. Northwestern National Insurance Co.*,³⁴ in which the court upheld the insured's right to settle a claim *prior* to suit where the insured notified his insurer of a potential claim for which he believed he was liable, and the insurer responded only by advising the insured that he had no liability and should institute suit to vindicate that position.

The second point of clarification is that the mere refusal of an insurer to defend does not vest the insured with an absolute right to enter into a settlement with the claimant which will be binding on the insurer. For the insured to shift the burden of funding the settlement to the insurer, he must establish that the settlement was reasonable and not collusive,³⁵ and that the claim settled was covered under the insurer's policy.³⁶ Even if both of these points are established by the insured, the insurer's liability will normally be no greater than its policy limits³⁷ and any costs incurred by the insured in defense and settlement of the claim.³⁸ In some cases, however, the insured also has been allowed to recover his costs

31. 129 F.2d at 626.

32. See Sections III.A & III.B. of the text *infra*.

33. See 7C J. APPLEMAN, *supra* note 4, §§ 4712-4715.

34. 255 Ark. 802, 502 S.W.2d 474 (1973). However, the insurer must be given some reasonable opportunity to act upon the claim. *Dairyland Ins. Co. v. Hughes*, 317 F. Supp. 928 (W.D. Va. 1970) (settlement reached before insurer even notified of claim not binding on insurer).

35. See, e.g., *First Nat'l Indem. Co. v. Mercado*, 511 S.W.2d 354 (Tex. Civ. App. 1974).

36. *Id.*

37. See *Elas v. State Farm Mut. Auto. Ins. Co.*, 39 Ill. App. 3d 944, 352 N.E.2d 60 (1976).

38. See, e.g., *Alderman v. Hanover Ins. Group*, 169 Conn. 603, 363 A.2d 1102 (1975).

and attorney's fees in the action against his insurer.³⁹

2. *Insurer's Bad Faith as Determinant of the Insured's Power to Settle*

Although there is universal agreement that an insurer's disclaimer of coverage coupled with a refusal to defend will empower the insured to effect a settlement which may be binding on the insurer, there is a split of authority as to what conduct, if any,⁴⁰ will give such power to an insured who is offered a defense by the insurer. In some jurisdictions, an insured who is offered a conditional defense may reject such defense and effect a settlement which will be binding on the insurer, at least up to its limits, upon a showing that the settlement was reasonable and the claim was covered.⁴¹ In other jurisdictions, however, if the insurer offers a conditional defense, the insured will not be able to effect a settlement which is binding on the insurer unless he can establish that the settlement was reasonable, that the claim was covered, and that the insurer was acting in bad faith in its defense and/or refusal to settle. This rule is perhaps best illustrated by a comparison of the landmark case of *Traders & General Insurance Co. v. Rudco Oil & Gas Co.*,⁴² in which the bad faith exception was most clearly delineated, with *Sargent v. Johnson*,⁴³ decided thirty-five years later by the Eighth Circuit Court of Appeals.

In *Traders & General*, the insured, Rudco, purchased a liability insurance policy from Traders & General which had bodily injury limits of \$5,000 per person and \$10,000 per accident. During the term of the policy, a claim for \$63,000 was filed against Rudco by Carl H. Nelson and several members of his family as a result of an explosion which destroyed the house in which the family lived, killing some family members and injuring others. Although the Nelsons owned the house, Rudco held an oil and gas lease on the land by assignment from the Carter Oil Company, which retained the surface rights to the land. The explosion apparently resulted from a defect in a gas line system used by Rudco to fuel the engines which pumped oil from the wells. Upon notification of the claim, Traders & General denied coverage on the grounds that the injuries were incurred away from or off the premises owned by

39. See, e.g., *Otteman v. Interstate Fire & Cas. Co.*, 172 Neb. 574, 111 N.W.2d 97 (1961).

40. Some jurisdictions will not allow an insured to settle a claim against which he is being defended by the insurer, even under a conditional defense. See, e.g., *Sargent v. Johnson*, 551 F.2d 221 (8th Cir. 1977). Whether such rule would obtain if the defense were being conducted in bad faith is unclear.

41. See notes 66-84 & accompanying text *infra*.

42. 129 F.2d 621 (10th Cir. 1942).

43. 551 F.2d 221 (8th Cir. 1977).

Rudco and arose from the delivery, sale, or distribution of natural gas.

Following this disclaimer, Traders & General and Rudco entered into a non-waiver agreement which provided that Traders & General would defend Rudco but that such defense would not be regarded as a waiver by Traders & General of its disclaimer. Shortly thereafter, Traders & General instituted a declaratory judgment action against both Rudco and the Nelsons. Traders & General refused Rudco's request that it refrain from pressing the declaratory judgment action until after the personal injury actions were tried and settled, stating it would refrain only if Rudco agreed to pay certain attorney's fees incurred in defense of the personal injury claims in the event that Traders & General's non-coverage position was vindicated.

Rudco was convinced it would be legally liable in the personal injury actions and "morally certain"⁴⁴ that the anticipated adverse verdict therein would far exceed the policy limits. With the full knowledge of Traders & General, Rudco obtained a settlement demand from the Nelsons of \$17,000 and an offer of Carter Oil Company to contribute one-half thereof. Rudco then demanded that Traders & General agree to the settlement and contribute to it, with the ultimate burden of funding the settlement to be decided in the declaratory judgment action. Traders & General refused, but offered "purely as a matter of policy"⁴⁵ to contribute \$2,000 to any settlement made. Following several more unsuccessful attempts to persuade Traders & General to participate in the settlement, Rudco effected settlement on its own and thereafter sued Traders & General to recover the settlement amount.

The trial court found that the claims were covered under the policy, that the settlement amount was reasonable, and that Traders & General acted in bad faith toward its insured in the handling and settlement of the Nelsons' claims and in filing and pressing the suit for declaratory judgment. Thus, Traders & General was estopped from invoking the policy provision against voluntary settlement. The Tenth Circuit affirmed the judgment in a well-reasoned opinion clearly setting forth the limited circumstances in which an insured can settle a claim over its insurer's objections.

After reviewing the general rule vesting complete control of the defense and settlement of claims in the insurer and the exception allowing the insured to settle where the insurer has refused to defend, the court noted other exceptions to the rule:

The rule is again modified if the loss asserted against the assured exceeds

44. *Traders & General Ins. Co. v. Rudco Oil & Gas Co.*, 129 F.2d 621, 623 (10th Cir. 1942).

45. *Id.* at 624.

the limits of the policy, liability for which is admitted by the insurer to the extent of the policy limits. In these circumstances, both the insured and the insurer have a pecuniary interest in the ultimate liability to the third party and each of them become vested with the right to protect that interest, commensurate with the extent of its potential liability. . . .

Where, as here, each has a potential liability, the insurer is obligated by contract to defend the suits or claims in the name of assured and to pay the losses incurred to the extent of the limits of its policy. Its obligation to defend and to pay is primary and paramount; consequently, its right to control the litigation is first and paramount, an essential part of which is the right to insist upon the cooperation of the assured, and the assured may not interfere by voluntary assumption of liability or by arbitrarily insisting upon settlement of the claims or suits. But, the rights of the insurer in these circumstances are not absolute, they are subject to moderation by the rule of right and justice. Exclusive authority to act does not necessarily mean the right to act arbitrarily. . . . The right to control the litigation in all of its aspects carries with it the correlative duty to exercise diligence, intelligence, good faith, honest and conscientious fidelity to the common interest of the parties. . . . When the insurer undertakes the defense of the claim or suit, it acts as the agent of its assured in virtue of the contract of insurance between the parties, and when a conflict of interest arises between the insurer, as agent, and assured, as principal, the insurer's conduct will be subject to closer scrutiny than that of the ordinary agent, because of his adverse interest.⁴⁶

The court then reviewed the varying standards in different jurisdictions for imposition of excess liability on insurers for failure to settle a claim against the insured. The court noted a key distinction between cases where the insured waited for the final outcome before asserting his rights under the policy, and the matter before it, but nonetheless extended the bad faith rationale to uphold Rudco's right to settle the claim and force Traders & General to fund the settlement. The court stated:

We think, however, the rule applies with equal force to a prudent settlement made by the assured in the face of a potential judgment far in excess of the limits of the policy. Why should the assured be required to wait until after the storm before seeking refuge.

[B]efore Traders & General may interpose the voluntary settlement made by Rudco as a bar to recovery upon the policy, it must be shown that it acted, not alone in furtherance of its own interest, but it must also appear that it acted in good faith and dealt fairly with the assured. Its manifest attitude and course of conduct must have some legal justification and factual basis.⁴⁷

Although the court acknowledged the right of Traders & General to adjudicate its liability under the policy, it agreed with the trial court that the insurer's filing of the declaratory judgment action, pressing same over the objections of the insured, and refusing to participate in the settlement, subject to reallocation of the burden of funding in accordance with the outcome of the declaratory

46. *Id.* at 626.

47. *Id.* at 627-28.

judgment action, was clear evidence of bad faith. While recognizing "the evils inherent in any rule which permits, or justifies, a compromise or settlement by the assured without the consent of the insurer,"⁴⁸ the court found that such bad faith was sufficient to justify an exception to the rule that a voluntary settlement by the insured will not be binding on the insurer.

The limitations imposed on the bad faith exception to the rule that the insurer has control over settlement are perhaps best illustrated by the decision of the Eighth Circuit Court of Appeals in *Sargent v. Johnson*.⁴⁹ In that case, the insured, Preston Haglin Company, was joined as a third-party defendant in an action brought by one of its employees, Paul F. Sargent, as a result of a construction accident. It was joined by the defendant architect and a subcontractor on theories of contribution and indemnity for failing to provide a safe place for the employee to work and contractual indemnity. Liberty Mutual Insurance Company insured Haglin with limits of \$100,000 for employers' liability and \$500,000 for comprehensive general liability, including contractual indemnity but excluding coverage for claims arising out of injury to Haglin's employees.

Liberty provided a defense in the action but notified Haglin that its liability was limited to \$100,000 with respect to the indemnity claim for failure to provide a safe place to work and \$500,000 with respect to the architect's contractual indemnity claim. Liberty further advised Haglin that its coverage might not apply to the contractual indemnity claim because such claim appeared to arise out of the architect's professional duties, including supervision and inspection, which type of claim was specifically excluded under the Liberty policy. Following this notification, Haglin instituted a fourth-party claim against Liberty, alleging, among other things, that Liberty should be liable for up to \$2 million of any third-party claims against Haglin because Liberty had negligently failed to recommend that Haglin purchase insurance in such amount.

At the trial of the personal injury action, in which Haglin was defended by counsel Liberty selected, the trial judge directed a verdict in favor of plaintiff and against defendants and third-party defendant, leaving to the jury assessment of damages and apportionment of liability. The jury entered an award of \$1.6 million in favor of the plaintiff and apportioned Haglin's liability at 30%. Haglin then dismissed its counsel and entered into a settlement agreement which provided that Haglin would pay \$700,000 plus interest as its share of the damage award and that these sums would

48. *Id.* at 628.

49. 551 F.2d 221 (8th Cir. 1977).

only be paid from the proceeds of Haglin's insurance policy with Liberty. The district court formally approved the settlement agreement and entered a judgment accordingly. In addition, the district court entered judgment on the fourth-party action, holding Liberty liable for the sums agreed to by Haglin.

Liberty appealed to the Eighth Circuit Court of Appeals, which framed the central issues as follows:

[D]oes a liability insurer which is affording its insured a defense to a pending action for damages breach its contract of insurance by disputing with its insured the amount of coverage that is available for the claim? The converse of the question is whether or not an insured, disputing the amount of coverage with its insurer, breaches the defense and settlement provisions of the policy, the assistance and cooperation provisions of the policy and the "no action" clause of the policy, by unilaterally discharging the insurer's attorney defending the case and thereafter entering into a settlement with the claimant.⁵⁰

In resolving these issues, the court focused on the dual nature of the insurer's undertakings in its policy: the duty to defend and the duty to pay or settle. The court found that Liberty was providing a defense for Haglin.⁵¹ In regard to the duty to pay or settle, the court found that "[b]ecause the time for Liberty's payment performance had not been reached through a final judgment or a demand for settlement within policy limits[,] Liberty had not breached any policy obligation to its insured, whether the coverage was \$100,000, \$500,000, or \$2,500,000."⁵²

The court distinguished all the cases Haglin relied upon to support its contention that Liberty breached its insurance contract by failing to accede to Haglin's demands for additional coverage. It noted that all of the cases in which an insured had been allowed to settle involved either the insurer's refusal to defend or its denial of all liability, neither of which were present in the case before it.⁵³ The court then stated:

The theory of the appellees would stand insurance law on its head by requiring an insurance carrier to perform under the terms of a contract not in writing and not yet determined to exist. . . . Here, the demand of the insured was for additional coverage which the insurance company at that point was not obligated to provide by any contract, by any judicial decision, or otherwise. Under these circumstances, the obligations of the insurer must be measured by the then-established insurance coverages.⁵⁴

The court concluded that the *insured* was guilty of bad faith, which effectively severed the insurer-insured relationship and relieved the insurer of its duty to pay under the policy:

50. *Id.* at 230.

51. *Id.* at 231.

52. *Id.*

53. *Id.*

54. *Id.*

[The] standard of good faith and mutual respect applies to both parties to the insurance contract. In this case, under the circumstances previously related, we must conclude that the insured's conduct in discharging defense counsel provided by the insurance carrier and entering into a settlement of the pending litigation without the insurer's consent even with court approval, constituted a violation of terms of the existing policies. Moreover, the insured not only breached its contract, but acted in bad faith. Counsel for the insured did not enter into a bargain to settle its liability claims for a fair price, but entered into a questionable collaboration by which the parties maneuvered through terms of a settlement agreement to impose an uncompromised full balance of a judgment upon the insurer, while the insured incurred no real detriment. In light of the questionable validity of the judgment on its face, and the substantial sum obtained outright by Sargent from [defendant] Ohman, this seems particularly unreasonable. This kind of bargain represents the antithesis of mutual respect for rights.⁵⁵

The potential for abuse of the bad faith exception to the rule that the control over settlement is vested in the insurer, which was vaguely foreshadowed in the reluctant nature of the court's holding in *Traders & General* and formed the basis for the court's holding in *Sargent v. Johnson*, was discussed at length by Justice Clifford of the New Jersey Supreme Court in a dissenting opinion in *Fireman's Fund Insurance Co. v. Security Insurance Co.*⁵⁶ In *Fireman's Fund*, the New Jersey Supreme Court upheld, by a vote of four to three, a lower court ruling that Security Insurance Company, the primary carrier, was obligated to pay its full primary limits of \$50,000 toward a \$135,000 settlement which had been arranged by its insured and the insured's excess carrier, Fireman's Fund. The primary carrier had refused to approve that settlement in spite of a request by the insured and the recommendation of both the trial attorney and the excess carrier that it do so.

The majority based the right of the insured to arrange the settlement squarely on the bad faith of Security as the primary carrier. The court held that the insurer's breach of its implied covenant to exercise good faith in considering a settlement in excess of its policy limits allowed the insured "to protect his own interest in minimizing a potential liability in excess of the policy limits by agreeing to a reasonable good faith settlement of the negligence actions and then, on proof of the insurer's default, to re-

55. *Id.* at 232.

56. 72 N.J. 63, 367 A.2d 864 (1976). It should be noted that, in *Fireman's Fund*, the excess insurer, Fireman's Fund, actually assisted in the payment of the settlement and then, as assignee of the insured, brought the action against the primary insurer. The opinion made clear, however, that the insured's rights, *not* the excess insurer's rights, were at issue: "The parties agree that plaintiff's status is no different than that of the insured and that no additional rights flow to it because it was an excess insurer." *Id.* at 68 n.1, 367 A.2d at 866 n.1.

cover from it the amount of its policy limits."⁵⁷

However, the majority limited the right of the insured to settle over the objections of the insurer to those situations in which the insurer was acting in bad faith *and* the potential loss exceeded the recalcitrant insurer's policy limits.⁵⁸ Where the potential loss was within policy limits, the insured had no right to settle even though it believed the insurer was acting in bad faith; the sole recourse was to await the verdict and then sue the insurer for the amount, if any, by which the verdict exceeded the settlement demand.⁵⁹

Justice Clifford vigorously dissented on grounds of "both sound public policy and the efficient operation of the liability industry"⁶⁰ to empowering the insured to settle claims in the absence of a breach of an *express* provision of the policy and thereafter recover from the insurer the full amount of the policy. He pointed out a significant difference between the breach of the implied duty of good faith and breach of the express duties to defend or indemnify:

[W]hen an insurer refuses to defend, substantial damage is almost certain to result unless the assured acts, while if the insurer defends but merely decides to gamble by not settling, his gamble may pay off in a judgment for the insured at trial. In the latter situation, then, the insured receives protection under existing law: if the gamble was unreasonable and loses, the insurer and not the insured is liable for any excess. If the gamble wins, both are absolved from liability.⁶¹

Justice Clifford noted that the insurer's right to gamble, with full acceptance of the consequences, was destroyed by plaintiff's decision to settle, which eliminated any possibility that the claim would result in a verdict favorable to the insured or at least in a verdict less than the amount of settlement.⁶² The insured's precipitous settlement was criticized as turning a *potential* risk, which could have ranged from zero to an amount in excess of policy limits, to a *certain* loss of the primary limits.

The dissent cited public policy and sound business reasons for favoring control over settlement by the insurer:

In order for an insurance carrier effectively to discharge its duty to defend, its control over the negotiation and litigation must be complete, not undercut by the separate undertakings of the insured. By purchasing insurance, the insured acquires the expertise and competence of the carrier in claims proceedings. This in turn necessitates a turning over of complete

57. *Id.* at 72-73, 367 A.2d at 869.

58. *Id.* at 75-76, 367 A.2d at 870-71.

59. *Id.*

60. *Id.* at 79, 367 A.2d at 873 (Clifford, J., dissenting).

61. *Id.* at 82, 367 A.2d at 875 (Clifford, J., dissenting) (citing R. Keeton, *Liability Insurance and Responsibility for Settlement*; 67 HARV. L. REV. 1136, 1162 (1954)).

62. *Id.* at 85-86, 367 A.2d at 877 (Clifford, J., dissenting).

control to the insurer. Likewise, the insured is under the obligation to cooperate with the insurer, and to refrain from negotiating independently. "Giving the insured the power to control the settlement of his own case would raise the possibility that the insured, inexperienced in evaluating claims and desiring to avoid potential excess liability, would settle in cases in which litigation would result in no liability." Note, 41 S. Cal. L. Rev. 120, 126 (1968). The efficient disposition of claims dictates that the one party with the expertise, the carrier, be in sole control. If it be otherwise, there is created the risk of claimants playing off the insurer against the insured, holding out for the higher stakes the insured will pay if the insurer does not because of the threat of excess liability. The adverse cost effects would of course end up being borne by the insured public.⁶³

The dissent also noted that the majority decision was anomalous in that, as a supposed extension of the insurer's duty of good faith and fair dealing, it deprived the insurer of the very exclusive control over settlements which gave rise to that duty.⁶⁴

Justice Clifford concluded with a sharp criticism of the majority decision: "I see today's decision as fraught with the potentiality for mischievous consequences, as an unwarranted intrusion upon the insurance carrier's contracted-for right to control its own destiny, and as contrary to established law and sound public policy."⁶⁵

This warning by Justice Clifford aptly summarizes the potential problems with the bad faith exception to the general rule vesting complete control over settlements in the insurer. Although, as pointed out in *Traders & General*, the exception seems to afford greater protection to the insured by allowing it to reduce its exposure through settlement in spite of the insurer's objections, a serious question remains as to whether such seeming additional protection is real or warranted. On balance, it is clear that the bad faith exception does not provide any real additional protection to the insured. Rather, such protection of the insured is already provided by the now well-established body of case law holding that liability for the entire amount of an excess verdict will be imposed upon an insurer who has acted in bad faith in refusing to settle. This does not mean, however, that the bad faith exception has no impact upon the relationship between the insured and insurer. Rather, as pointed out in *Sargent* and in Justice Clifford's dissent in *Fireman's Fund*, the bad faith exception virtually turns that relationship upside down, stripping the insurer of its control over settlements and placing such power in the hands of the insured.

63. *Id.* at 84, 367 A.2d at 876 (Clifford, J., dissenting).

64. *Id.*

65. *Id.* at 87, 367 A.2d at 877 (Clifford, J. dissenting). The bad faith exception was also applied by the Arkansas Supreme Court in *Home Indem. Co. v. Snowden*, 223 Ark. 64, 264 S.W.2d 642 (1954) and provoked an equally critical dissent by Justice Robinson.

Any new rule of law, such as the bad faith exception, which drastically reduces the contractual rights of the insurer without any real increase in the protection afforded to the insured is, we submit, subject to severe criticism and should be applied sparingly, if at all.

3. Insurer's Conditional Defense as Empowering the Insured to Settle

In the cases thus far examined, the insurer will be deprived of its exclusive control over settlement only upon a showing of some culpable conduct on its part, either in the form of wrongful refusal to defend or undue delay in investigating and defending, or in the form of bad faith refusal to settle. Some jurisdictions, however, deprive the insurer of its control over settlement without any showing of wrongdoing, by allowing an insured who has been offered a conditional defense to reject such defense and assume control over the defense and settlement of the litigation. This rule was stated more than sixty years ago by the Kansas City (Missouri) Court of Appeals in *Rieger v. London Guarantee & Accident Co.*⁶⁶ In that case, Rieger, the insured, was sued for injuries to an employee, Miss Miller, and was initially defended by its insurer, London Guarantee & Accident Company. During the course of the litigation, however, a dispute arose as to whether Miss Miller was within the category of employees insured under the policy, and London disclaimed liability. The insured then demanded that the company either admit liability under the policy or turn over control of his defense to him. This demand was rejected and the counsel selected by the insurer withdrew their appearance. Advised by his own attorneys of the probability of an adverse judgment against him, the insured settled the suit and instituted an action to recover the settlement amount from his insurers.

The court of appeals, reversing the trial court's grant of a demurrer in favor of the insurer, specifically rejected the insurer's contentions that the insured's demand for an unconditional defense, which allegedly forced the insurer's attorneys to withdraw, breached the policy and that the insurer was not liable for the settlement because it was a voluntary payment by the insured in contravention of the policy terms. The court stated:

Nor did plaintiff [insured] force defendant [insurer] from the further defense of the Miller suit and thereby disable the plaintiff to claim against it the payments made in settlement of the Miller suit. The answer pleaded that such payments were voluntary. The facts show that they clearly were not. Besides, the company had breached its contract, and, under these circumstances, the insured had the right to, in good faith, make the best

66. 202 Mo. App. 184, 215 S.W. 920 (1919).

compromise he could and is not bound to submit to an adverse judgment. . . . In addition to this, the evidence does not show that defendant was forced out of the defense. It had been allowed to take charge and had continued therein, under the idea that it was doing so in recognition of its liability under the policy. It was only for that reason that plaintiff surrendered his right to control his defense in his own way and through his attorneys. This is an important right; one that plaintiff could not be expected to surrender to the insurance company if there was no liability upon it involved in the outcome of the suit defended, in order to spur them on to do their best. The plaintiff had the right to insist that, if the company was not going to recognize his liability under the policy, it had no right to control his defense, which right they could claim only by virtue of that policy.⁶⁷

The rationale underlying the conditional defense exception to the insurer's exclusive control over settlement was clearly set forth by the Florida District Court of Appeal in *Taylor v. Safeco Insurance Co.*⁶⁸ In that case, Earl Taylor was driving a car owned by Robert Henry, Safeco's named insured, when it was involved in an accident which killed Earl's brother, William, who was a passenger. William's widow then sued Earl Taylor and joined Safeco, which undertook his defense but pleaded non-coverage in its own defense to the widow's claim. After obtaining summary judgment declaring that Earl was not an insured under its policy because he did not have the owner's permission to drive the car at the time of the accident, Safeco withdrew its conditional defense. Earl thereupon filed a notice of appeal and Safeco again offered to defend him, subject to a reservation of its right to contest coverage. Earl refused this tender of a conditional defense and proceeded to negotiate a \$730,000 settlement with the widow and her attorney. This settlement was formalized by the entry of a consent judgment.

The court of appeal reversed Safeco's summary judgment and remanded the coverage issue for trial.⁶⁹ The widow, as assignee of the unsatisfied consent judgment, filed a separate action against Safeco. A consolidated trial of both the coverage issue and the action to recover the judgment resulted in summary judgment for Safeco on the grounds that Safeco was released from any coverage by Earl's action in refusing the re-tendered conditional defense and settling the widow's claim. This ruling was in turn reversed and remanded by the Florida District Court of Appeal,⁷⁰ in an opinion which explored the reasons for, and limits to, the conditional

67. *Id.* at 211, 215 S.W. at 930.

68. 361 So. 2d 743 (Fla. Dist. Ct. App. 1978). See also *Evans v. Continental Cas. Co.*, 40 Wash. 614, 245 P.2d 470 (1952) (court allowed recovery by insured of amounts paid by him in settlement but limited such recovery to a reasonable amount within policy limits).

69. *Taylor v. Safeco Ins. Co.*, 324 So. 2d 645 (Fla. Dist. Ct. App. 1976).

70. *Taylor v. Safeco Ins. Co.*, 361 So. 2d 743 (Fla. Dist. Ct. App. 1978).

defense exception to the exclusive control of the insurer over settlement.

At the outset of its opinion, the court conceded the validity of reservation of rights agreements but noted that they were merely permissive and not mandatory:

Safeco was entitled to [defend under Reservation of Rights Agreement] for the law distinguishes between the insurer's duties to defend and to pay . . . and does not forbid agreement between insurer and a putative insured which resolves the urgent question of who shall defend and postpones resolution of the contingent question of who shall pay any judgment.

Similarly, Earl Taylor was not obliged to surrender control of his personal defense to an insurer which disclaimed responsibility for any judgment within the policy limits that might result from the litigation. Without affecting the question of Safeco's liability to pay any judgment within policy limits, Earl was privileged at the outset to deny Safeco control of his defense which is exemplified by Safeco's selection and payment of a lawyer to represent Earl. Just as the insurer is not required to abandon its contest of a duty to pay as a condition of fulfilling an assumed or admitted duty to defend, the insured is not required to abandon control of his own defense as the price of preserving his claim, disputed by the insurer, that the insurer pay any judgment. The law respects, but does not require, such agreements.⁷¹

Nowhere in its opinion did the court even suggest that the insurer was acting in bad faith in its refusal to defend Earl without reservation of its rights to disclaim coverage. Rather, the court labeled Safeco's reservation of rights position "legitimate" but nonetheless held that such a reservation shifted to the insured the power to defend and settle the claim.⁷² The court extended the insured's right to settle claims beyond cases involving the insurer's unjustified refusal to defend to situations where, "as a result of the parties' failure to agree upon a conditional defense, the putative insured chooses to control the litigation and to effect a reasonable settlement."⁷³

The appellate court, however, refused to enter judgment against Safeco for the full amount of the settlement. Rather, it held that the issues of whether Earl actually was an insured of Safeco and whether the settlement was negotiated in good faith and not collusively remained for resolution by the trial court.⁷⁴ The question of the insured's good faith in settling the claim against him was seen as the key to imposing *any* liability on the insurer for the settlement. The fact that the insurer did not abandon the insured altogether, but merely reserved its rights to contest coverage while defending, was seen as limiting its *maximum*

71. *Id.* at 745.

72. *Id.* at 746.

73. *Id.*

74. *Id.* at 746-47.

liability to the amount of a reasonable settlement up to its policy limits. Thus, the court remanded the action to the trial court for resolution of these factual issues.

Some jurisdictions which uphold the conditional defense exception to the insurer's exclusive control draw a distinction between cases in which the reservation of rights was based on a *coverage* defense, *i.e.*, a defense that the claim was not covered under the policy, and those in which the reservation of rights was based on a *policy* defense, *i.e.*, a defense that the policy was unenforceable because the insured breached a condition of the policy. This approach is illustrated in *Continental Insurance Co. v. Bayless & Roberts, Inc.*⁷⁵ In that case, the insurer, Continental, initially undertook the defense of its insured, Bayless & Roberts, Inc., in a personal injury action, without any reservation of rights. After trial of the action had commenced, the insurer sought to continue the defense under a reservation of its rights to disclaim coverage for breach of the cooperation clause. This breach was alleged to have occurred because an officer of the insured knowingly gave conflicting testimony regarding the facts giving rise to the litigation.

The insured refused to accept this conditional defense and replaced the attorney retained by the insurer with counsel of its own choosing. The insured's new attorney notified Continental that the other two defendants had settled for approximately \$458,000 and requested that Continental accept the current demand against Bayless & Roberts for \$160,000. Following Continental's refusal, the insured's new attorney entered into a consent judgment in favor of the claimant for \$618,000 and entered into an agreement with the claimant whereby the claimant agreed not to execute on the judgment against any assets of Bayless & Roberts except its claim against Continental. The insured, in turn, agreed to prosecute its claim against the insurer, and to assign any proceeds thereof to the plaintiff in the personal injury action.

Pursuant to this agreement, Bayless & Roberts then instituted an action against Continental alleging that the insurer's refusal to defend except under a reservation of rights agreement constituted a breach of its fiduciary duty to its insured. Continental counterclaimed, charging that Bayless & Roberts had breached its duty to cooperate with its insurer. The court dismissed the counterclaim upon a motion for directed verdict, and the jury found that Continental had acted negligently and had breached its duty to defend Bayless & Roberts. Continental appealed to the Alaska Supreme Court.

The central issue on appeal, of course, was whether the insured

75. 608 P.2d 281 (Alaska 1980).

breached the cooperation clause by refusing to accept the reservation of rights which Continental attempted to impose on its defense during the course of the trial. The court noted that there were two different views on this issue. The general rule required that "if an insured refuses to accede to the insurer's reservation of rights, the carrier must either accept liability under the policy and defend unconditionally, or surrender control of the defense and be held liable if it guessed wrong on the coverage issue."⁷⁶ The alternative approach allowed the insurer to defend in the action and, if judgment were entered against its insured, it would not be estopped from contesting coverage in a later action.⁷⁷

The court noted, however, that these divergent views had developed from cases in which the insurer attempted to condition the defense on reservation of its right to assert a *coverage* defense, whereas the matter before it developed from the insurer's attempt to condition its defense on reservation of its right to assert a *policy* defense, *i.e.*, breach of the cooperation clause. The court specifically declined to state whether an insured was obligated to accept a conditional defense from an insurer who wished to reserve its right to assert a *coverage* defense.⁷⁸ The court did, however, clearly state that an insured would not be required to accept a defense conditioned upon reservation of the right to assert a *policy* defense: "[T]he insurance company must either affirm the policy and defend unconditionally or repudiate the policy and withdraw from the defense. The insurer may not reserve its right to repudiate the policy, unless the insured consents to a reservation of that right."⁷⁹

This "all or nothing" approach by the court was, however, tempered in a footnote suggestion that the insurer could retain its right to later litigate a policy defense, provided it allowed the "insured the right to retain independent counsel" and agreed to pay the necessary costs of such counsel.⁸⁰

76. *Id.* at 288.

77. *Id.*

78. *Id.* at 291.

79. *Id.*

80. *Id.* at 291 n.17(dictum). The use of the word "independent" seems both confusing and unfortunate. In view of the fact that the original counsel for Bayless & Roberts in the personal injury action, although presumably paid by Continental, was not house counsel but rather was a member of a private firm, the suggestion that he lacked independence smacks of impropriety in dealing with his client, Bayless & Roberts, for the benefit of his principal, Continental. In view of the general practice in the insurance industry that defense counsel is chosen by the insurer, perhaps the court meant to indicate that the insured should be offered the right to select counsel to represent him in the personal injury action. The use of the expression "of its own choosing" would certainly have more clearly expressed this intent than the word "in-

In its actual holding, however, the court seemed to go out of its way to punish the insurer for its attempt to defend the insured while reserving a right to assert a policy defense to coverage. The court held that the insurer's failure to notify the insured of its intention to deny coverage until after the trial had begun "waived this alleged breach of its cooperation clause as a matter of law,"⁸¹ and, further, that the failure of the attorney retained by the insurer to correct the conflict in testimony constituted a negligent defense of the insured and rendered Continental liable for the entire amount of the settlement without regard to its policy limits.⁸² Moreover, even though the settlement was specifically arranged to provide credit for the amounts already paid in settlement by the other defendants,⁸³ the court held that Continental was not entitled to any such credit and would be required to pay the entire amount of the settlement agreed to by its insured, plus interest and costs.⁸⁴ This represented a total payment of more than eight times the insurer's policy limits and five times greater than the final settlement demand of plaintiff's decedent.

In summary, then, it may be noted that the pendulum between the rights of the insured and insurer seems to have swung full cycle in development of the conditional defense exception to the rule vesting complete control of defense and settlement in the insurer. Thus, while in the earlier cases it was the *insured* which had to decide at the outset to accept a conditional defense or forego coverage, in the *Continental Insurance* case the court seems to have gone out of its way to punish the *insurer* for having the temerity to attach a condition to its defense. Perhaps the best balance between these two polar extremes and the view most likely to be followed in other jurisdictions is the rule set forth in *Taylor*, which allows the insured to reject a conditional defense and effect a settlement which may be binding upon the insurer but does not strip the insurer of any meaningful right to condition its defense. Rather, the insurer is still protected by the court's requirement of a tripartite showing that the claim was covered, the settlement was in good faith and not collusive, and the amount thereof was reasonable.

dependent" and would not gratuitously cast aspersions on the propriety and ethics of counsel chosen by the insurer.

81. *Id.* at 292.

82. *Id.* at 293-94.

83. *Id.* at 297 (Boochever, C.J., dissenting in part).

84. *Id.* at 295-96.

B. Excess Insurer's Right to Settle the Claim Against the Insured and Obtain Reimbursement of the Objecting Primary Carrier's Limits of Coverage

In contrast to the cases just discussed, where the key obstacle to recovery of sums paid in settlement by the insured was the *presence* of policy language vesting control over settlements in the insurer, the key obstacle to recovery of sums spent in settlement by an excess carrier from a primary or lower level excess carrier is the *absence* of any policy language justifying such reimbursement. Indeed, in the ordinary situation, there is *no* contract between the primary and excess carriers. Rather, each carrier has a contract only with the insured. Thus, reimbursement cannot be justified on the grounds of any explicit contractual duty owed by the primary or lower level carrier to the excess carrier.

An additional obstacle to recovery by the excess carrier may be found in the Guiding Principles for Primary and Excess Insurers,⁸⁵ to which many insurance companies subscribe. Under ordinary principles of contribution and indemnity, an excess insurer seeking reimbursement of sums spent in settlement from a primary insurer would need to show that it made demand upon the primary insurer to settle the claim, but that such demand was rejected. The Guiding Principles, however, specifically preclude such a formal demand by the excess insurer: "The excess insurer shall refrain from coercive or collusive conduct designed to force a settlement. It shall never make formal demand upon a primary insurer that the latter settle a claim within its policy limit."⁸⁶

In apparent recognition of the fact that failure to make a formal demand could be deemed a waiver by the excess carrier in a subsequent action against the primary carrier for wrongful refusal to settle, the Guiding Principles further provide: "In any subsequent proceeding between excess insurer and primary insurer, the failure of the excess insurer to make formal demand that the claim be settled shall not be considered as having any bearing on the excess insurer's claim against the primary insured."⁸⁷

Extensive research revealed only one case which specifically dealt with the rights of an excess insurer which settled a claim

85. Claims Executives Council of the American Ins. Ass'n & the American Mut. Ins. Alliance, *Guiding Principles for Insurers of Primary and Excess Coverages* (1974) (on file at the Nebraska Law Review). *See generally* P. MAGARICK, *EXCESS LIABILITY: DUTIES AND RESPONSIBILITIES OF THE INSURERS* 216-18 (1976).

86. Claims Executives Council of the American Ins. Ass'n & the American Mut. Ins. Alliance, *Guiding Principles for Insurers of Primary and Excess Coverages* (1974).

87. *Id.*

over the primary insurer's objections and then instituted an action to recover the primary carrier's limits.⁸⁸ In view of excess insurers' increasing tendency to become involved in the settlement of claims and the potential for future litigation of this type, detailed consideration of the court's opinion in *Continental Casualty Co. v. Reserve Insurance Co.*⁸⁹ is appropriate.

In that case, plaintiff, Continental, provided excess liquor liability insurance for the city of Marshall, Minnesota, with limits of \$900,000 in excess of the \$50,000 primary coverage provided by defendant Reserve. The city of Marshall was joined as a third-party defendant in an action brought by Lucille Christianson and her husband against Edward DeLange for injuries sustained in an automobile accident. The defendant joined the city on the ground that it was liable under the Dramshop Act for an illegal sale of liquor to him by the municipal liquor store. On the second day of trial, at which the city was represented by counsel provided by both Reserve and Continental, a settlement in the amount of \$750,000 was reached among plaintiffs, DeLange's insurers, and Continental. The settlement agreement provided that DeLange's insurers would contribute \$550,000 and Continental would contribute the remaining \$200,000. Prior to this settlement, Continental had made demand upon Reserve that it tender its full \$50,000 primary limits toward settlement, but this demand was refused. Continental paid the entire \$200,000 on behalf of the city and reserved its rights against Reserve.

Continental sued Reserve, seeking to recover the amount of the primary limits on the theory that Reserve's failure to contribute its limits in settlement breached its contract with the city and constituted bad faith. The district court granted Reserve's motion for judgment on the pleadings on the ground that Reserve could not be held liable for refusing to contribute any part of its policy limits toward settlement because there had been no judicial determination of the city's liability. Continental appealed to the Minnesota Supreme Court, which reversed the trial court in a well-reasoned opinion by Justice Kelly.

After stating the threshold question as "whether a primary insurer owes any duty to an excess insurer in the settlement negotiation process,"⁹⁰ and noting the duty of good faith which an insurer owes an insured, the court bridged the contractual gap between the excess and primary insurers by applying principles of subrogation. The court stated:

88. *Continental Cas. Co. v. Reserve Ins. Co.*, 307 Minn. 5, 238 N.W.2d 862 (1976).
See note 56 *supra*.

89. 307 Minn. 5, 238 N.W.2d 862 (1976).

90. *Id.* at 8, 238 N.W.2d at 864.

We hold that an excess insurer is subrogated to the insured's rights against a primary insurer for breach of the primary insurer's good-faith duty to settle. . . . When there is no excess insurer, the insured becomes his own excess insurer, and his single primary insurer owes him a duty of good faith in protecting him from an excess judgment and personal liability. 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.⁹¹

In support of its holding, the court noted that extension of the primary insurer's duty to the excess insurer as well as to the insured was consistent with the bulk of the well-reasoned authority from other jurisdictions and with the views of several leading commentators.⁹² In addition, the court cited two crucial policy considerations: society's interest in fair and reasonable settlement of lawsuits and the fair distribution of losses among insurers. In regard to the first consideration, the court found that in the absence of a duty between the primary and excess insurers, the incentives were against settlement.⁹³ If the excess insurer elected to settle despite the primary insurer's objections, it risked being forced to pay the entire settlement itself. However, if the case were allowed to go to trial, resulting in a judgment in excess of the primary's policy limits, the primary insurer would be forced to pay at least up to those limits. As to the second policy consideration, the court found that forcing the excess insurer to make a reasonable settlement covering both primary and excess liability would thwart the purposes for having the different coverages.⁹⁴ The court concluded that "[w]hether on insurance-economics principles or general equitable principles, a party should not be made to bear a loss that rightfully belongs to another party."⁹⁵

The court summarily rejected Reserve's argument that Continental had acted as a "gratuitous volunteer" and was "entitled to no equitable consideration," noting that Continental had acted in good faith and that there would be "no equity in penalizing an excess insurer who performs its duty in contrast to a primary insurer who does not."⁹⁶ The court gave similar short shrift to the argument that the excess carrier should have merely made a record of its good faith and then sought to impose upon the primary liability for the entire amount of whatever judgment might result from its failure to settle. The court noted: "We think it better to avoid unnecessary litigation by encouraging fulfillment of the good faith

91. *Id.*

92. *Id.* at 10 & n.7, 238 N.W.2d at 865 & n.7.

93. *Id.* at 9, 238 N.W.2d at 864-65.

94. *Id.* at 9-10, 238 N.W.2d at 865.

95. *Id.* at 10, 238 N.W.2d at 865.

96. *Id.* at 9 n.4, 238 N.W.2d at 865 n.4.

duty by all insurers in the settlement process."⁹⁷

Reserve offered additional arguments against imposing liability on it for the settlement: (1) the power to settle and seek reimbursement could be used as a bludgeon by the excess insurer to force the primary insurer to settle cases of doubtful liability; (2) there was an absence of any judgment against its insured; and (3) it would be deprived of due process if Continental's right to recovery were upheld.

The court rejected all three arguments. In cases of doubtful liability, the court imposed a duty on the primary insurer "to exercise only good faith, not omniscient powers, in predicting litigation results."⁹⁸ Only in the absence of good faith could the excess insurer effect a settlement and seek reimbursement. In regard to the absence of any judgment, despite the lack of any case law directly on point, the court found no difficulty in allowing a suit by the excess insurer against the primary insurer. The court noted that the insured could protect himself against the primary insurer's bad faith refusal to settle by settling a claim and instituting a suit for reimbursement, and therefore, by virtue of subrogation, the excess insurer also obtained these rights.⁹⁹ Furthermore, the primary insurer was protected against an improper settlement since in the subsequent lawsuit it "could claim that the insured was not liable or [was] liable for less than its policy limits and those questions could be tried by the jury along with the general issue of bad faith."¹⁰⁰ Finally, the court rejected Reserve's constitutional argument since it would be able to challenge in court the issue of its bad faith and, if liable, the extent of its insured's liability.¹⁰¹

The court, in a footnote, emphasized that its holding was limited to situations involving bad faith and rejected the possibility that the primary carrier should be held strictly liable for its failure to settle.¹⁰² Thus, the *Continental Casualty* case must be viewed as allowing recovery by the excess insurer only upon a showing that the primary carrier's refusal to settle was in bad faith; a mere showing that the claim settled by the excess carrier was covered by the policy and that the amount of the settlement was reasonable will be insufficient to warrant recovery by the excess carrier.¹⁰³

97. *Id.* at 9 n.5, 238 N.W.2d at 865 n.5.

98. *Id.* at 12, 238 N.W.2d at 866.

99. *Id.* at 13-14, 238 N.W.2d at 867.

100. *Id.*

101. *Id.* at 14, 238 N.W.2d at 867-68.

102. *Id.* at 14 n.10, 238 N.W.2d at 868 n.10.

103. Because the *Continental* decision was not based on the primary's duty to defend the insured, its rationale would also seem to support recovery by a higher level excess carrier of sums spent by it in settlement of a claim against

C. Insurer's Right to Settle and Sue the Insured for its Deductible, Self-Insured Retention, or Participation

Extensive research has failed to reveal a single case in which an insurer, prior to the entry of any judgment against its insured, settled a claim and then sued the insured for reimbursement of its deductible, self-insured retention, or participation. This should not be read as an indication, however, that the issue is merely an academic one. Rather, this absence of case law is attributable to past practices in the insurance industry which are undergoing a radical transformation.

The vast majority of insurance policies which have given rise to litigation over the duty to settle have been automobile policies.¹⁰⁴ In these policies, the insured has had little or no financial involvement in the coverage below the limits of the policy and little or no control over defense and settlement of the claim. This pattern was generally followed even with respect to larger commercial policies. Thus, the focus of insurance litigation has been upon the insured's efforts to force the insurer to live up to its obligations of defense and settlement. The ever-increasing size of jury verdicts and settlements, coupled with the concomitant upward spiral of premiums and the evolution of novel theories of recovery, have led to certain basic changes in the insurance industry which may effectuate a shift in this focus.

The first such change concerns a policy requirement of the insured's consent to settlement. As discussed above,¹⁰⁵ insurance policies have traditionally vested almost complete control over settlement in the insurer, typically empowering it to settle claims not only without the consent of the insured but also over the objection of the insured. Increasing concern for the damage which settlement of doubtful litigation might do to their reputations and the desire to protect their own financial interests (especially the availability of their limits of coverage for other claims, premium ratings, and future insurability) have led insureds to insist upon and obtain policy language requiring their consent to any settlement. Thus, it is not uncommon today for an insurance policy, especially one of professional liability, to provide that the insurer "shall not

its insured over the objections of a lower level excess carrier. Even though such lower level excess carrier would ordinarily have no duty to defend the insured, defense of the insured was not the key to liability in *Continental*. Thus, recovery might be allowed if it can be shown that the claim was covered, the amount of the settlement was reasonable, and the lower level excess carrier's refusal to settle constituted bad faith.

104. See note 14 & accompanying text *supra*.

105. *Id.*

settle any claim without the written consent of the insured,' "¹⁰⁶ rather than providing that the insurer may settle claims in its discretion. Two issues are raised by the presence of such a clause in a policy when there is a dispute between an insurer who wishes to settle a claim and an insured who prefers litigation to judgment: (1) whether, if the objections of the insured are valid, the insurer will be liable for damage to the insured's reputation or financial interests by settling over such objections;¹⁰⁷ and (2) whether, if the objections of the insured are unreasonable, the lack of the insured's consent will preclude the insurer's recovery of any sums spent by it in settlement which the insured should have posted under the deductible, self-insured retention, or participation provisions of the policy.

An additional change in the insurance industry is the amount of financial involvement which the insured has in its coverage. Traditionally, the insured purchased insurance with the aim of protecting himself against virtually all liability below the limits of coverage. Thus, the typical policy which gave rise to litigation between the insured and insurer concerning settlement contained only a very limited deductible which was not at issue in such litigation. Recently, however, the reluctance of insurers to provide coverage from "dollar one" and the desire of insureds to reduce their premiums has led to insureds' increasing financial involvement in their own coverage. This financial involvement may take one or more of the following three forms: (1) a substantial deductible, which may be as high as \$500,000 or \$1 million in some of the larger professional and products liability policies; (2) a large self-insured retention, which may be applicable either before any coverage or between layers of coverage; and (3) a participation by the insured in one or more layers of coverage whereby the insured provides a percentage of the layer.

The final significant change in the insurance industry is the recent trend toward imposition of an express duty to settle upon the insured.¹⁰⁸ As noted above,¹⁰⁹ earlier policies either vested control of settlement in the insurer or merely required the consent of the insured to settlement without imposing any affirmative duty upon the insured to effect settlement. The recent trend toward greater financial involvement by the insured in its own coverage raises the

106. *Transit Cas. Corp. v. Spink Corp.*, 94 Cal. App. 3d 124, 129 n.1, 156 Cal. Rptr. 360, 365 n.1, (1979) (quoting primary policy), *disapproved in part*, *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980).

107. Discussion of this issue is beyond the scope of this Article.

108. See Section III.C. of the text *infra*.

109. See note 14 & accompanying text *supra*.

issue of whether the insured has an affirmative duty to settle a claim within its financial limits when it has the opportunity to do so and failure to effect such settlement may lead to an adverse judgment, satisfaction of which will require increased payments by the insurers. Although many policies are silent on this point and, therefore, the insured's duty to settle thereunder must be bottomed on an implied duty of good faith and fair dealing, some policies specifically impose upon the insured an affirmative duty to settle claims within its deductible, self-insured retention, or participation where it is reasonable and appropriate to do so.

The cumulative effect of these changes in the insurance industry is to virtually turn upside down the very nature of the basic conflict of interest between insured and insurer. Thus, under a policy which provides for the insured's substantial financial involvement in the coverage and vests control over settlement in the insured, it is not necessarily in the insured's best interest to settle, nor is it always in the insurer's best interest not to settle. Rather, especially in cases where the claim cannot be settled for less than the total amount of the insured's financial involvement in the coverage, the insured may well wish to litigate the claim in the hopes of obtaining a verdict which is either favorable or, if adverse, at least in an amount less than the insured's financial involvement. The insurer, on the other hand, may wish to settle in order to eliminate or reduce the increased exposure which it will have if the case is not settled.

The authors submit that, in an appropriate case, the insurer should have the right to settle the claim and sue the insured for the amount due toward such settlement under its deductible, self-insured retention, or participation. Where the policy specifically imposes a duty to settle upon the insured, the insurer may attempt to seek specific enforcement of such duty,¹¹⁰ or may choose to settle and sue to recover the sums thus spent on a theory of breach of that express contractual agreement. As we have seen, however, the absence of language specifically imposing a duty to settle has not barred the courts from imposing such a duty by implication upon insurers.¹¹¹ Accordingly, it seems that such an implied duty might also be imposed on an insured in an appropriate case.¹¹²

110. It should be noted, however, that filing and prosecuting such a suit prior to satisfaction of the claim against the insured might well increase the insured's exposure. Such a result would not only be harmful to the insurer bringing the action but might also be regarded as indicative of bad faith towards the insured. *See Traders & General Ins. Co. v. Rudco Oil & Gas Co.*, 129 F.2d 621 (10th Cir. 1942).

111. *See Sections II.A. & II.B. of the text supra.*

112. An appropriate case would be where the insured is refusing to settle, not out of any genuine belief that the case is defensible or can be brought to verdict

Irrespective of whether the insurer's suit is based on an express or implied duty on the part of the insured, its right of recovery should not be without limit. Rather, the insurer's right should be judged by a mirror of the standard which determines the insured's rights to settle and sue as discussed above.¹¹³ Thus, in jurisdictions where good faith is the standard,¹¹⁴ the insurer should be allowed to settle and obtain reimbursement from the insured upon a showing that its refusal to settle constituted bad faith as that standard is interpreted in such jurisdictions. In jurisdictions where the insured's right to settle and shift the burden of settlement to the insurer is limited to situations where the insurer disclaimed coverage and refused to defend,¹¹⁵ the insurer's right to settle and sue the insured for reimbursement should be limited to situations where the insured refused to assist and cooperate in its own defense.¹¹⁶

The concept of an insurer suing its insured for sums spent in settlement is not entirely novel. The California Supreme Court, which is noted for its protective attitude toward the insured, suggested that there are instances in which the insurer may settle and sue the insured for reimbursement of the sums thus spent. In *Johansen v. California State Automobile Association Inter-Insurance*

lower than the self-insured retention or deductible, but solely in order to save its deductible or retention and in an effort to force the insurer to put up all sums without regard to the financial involvement of the insured in its own coverage. In other words, we would suggest that the standards and factors considered in determining whether liability should be imposed upon an insured for bad faith refusal to settle should mirror the standards and factors used in determining whether to impose such liability upon an insurer.

113. See Section II.A. of the text *supra*.

114. But see notes 290-92 & accompanying text *infra*, in which the authors suggest that good faith is an inappropriate standard for determining the right of one party to settle over the objections of the other and still obtain reimbursement therefrom. In good faith jurisdictions, the efforts of an insurer to persuade an insured with a large deductible, retention, or participation to contribute its share to an appropriate settlement should be likened to an effort to persuade or force a primary carrier to contribute its limits. The legitimacy of this effort was recognized in *Continental Cas. Co. v. Reserve Ins. Co.*, 307 Minn. 5, 238 N.W.2d 862 (1976), and distinguished from an effort to persuade an insured without such a large financial involvement to contribute to settlement below primary limits, an effort which may be regarded as bad faith. *Netzley v. Nationwide Ins. Co.*, 63 Ohio Op. 2d 127, 34 Ohio App. 2d 65, 296 N.E.2d 550 (1971).

115. See notes 28-39 & accompanying text *supra*.

116. An alternative method of proceeding for an insurer faced with such an uncooperative insured is to declare a breach of the cooperation clause and disclaim coverage. Such a response may not only be unsuccessful, but may also lead to disastrous results. See, e.g., *Continental Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281 (Alaska 1980), and text accompanying notes 66-84 *supra*.

Bureau,¹¹⁷ the court suggested that an insurer who contests coverage of the claim asserted against the insured has the right to settle the claim and obtain reimbursement upon vindication of its coverage position. If the insurer can obtain reimbursement of sums spent in settlement of claims for which there is *no coverage*, then, *a fortiori*, it should have the right to settle claims which are *covered* and obtain reimbursement from the insured's financial involvement in such coverage.

Moreover, there are sound legal, public policy, and business reasons supporting the allowance of such a suit by the insurer. First, it may be noted that the duty to settle has been imposed upon an insurer as a logical concomitant of its implied duty of good faith and fair dealing.¹¹⁸ If that duty is to be truly reciprocal,¹¹⁹ then the duty to settle in good faith should logically be imposed upon the insured in appropriate cases, binding both the insured and insurer so that "neither party will do anything which will injure the right of the other to receive the benefits of the agreement."¹²⁰

Support for this proposition may also be derived by analogy to the reasoning of the court in *Continental Casualty Co. v. Reserve Insurance Co.*¹²¹ In that case, the court equated the position of the excess carrier to that of the insured in certain instances:

When there is no excess insurer, the insured becomes his own excess insurer, and his single primary insurer owes him a duty of good faith in protecting him from an excess judgment and personal liability. 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.¹²²

Similarly, when the insured deliberately purchases insurance which provides for a large deductible, self-insured retention, or

117. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975). For a discussion of the suggestion mentioned in the text, see text accompanying notes 139-66 *infra*.

118. *E.g.*, *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958).

119. Some courts have suggested in other contexts, that the implied duty of good faith and fair dealing is or should be reciprocal. *See, e.g.*, *Sargent v. Johnson*, 551 F.2d 221, (8th Cir. 1977); *Kaiser Found. Hosps. v. North Star Reinsurance Corp.*, 90 Cal. App. 3d 786, 153 Cal. Rptr. 678 (1979) (insured's duty of good faith prohibited its collusion with primary to artificially set dates of loss in manner maximizing excess carrier's liability); *Liberty Mut. Ins. Co. v. Altfilissen Constr. Co.*, 70 Cal. App. 2d 789, 139 Cal. Rptr. 91 (1977) (insured breached duty of good faith when it destroyed insurer's subrogation rights against third parties).

120. *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 658, 328 P.2d 198, 200 (1958) (citing *Brown v. Superior Court*, 34 Cal. 2d 559, 564, 212 P.2d 878, 881 (1944)).

121. 307 Minn. 5, 238 N.W.2d 862 (1976).

122. *Id.* at 8, 238 N.W.2d at 864.

participation, it in effect substitutes itself for the primary insurer. Paraphrasing the language of *Continental Casualty* and extending that case's reasoning, "it follows that the [insured] should assume the rights as well as the obligations of the [primary insurer] in that position." Thus, the insurer would be entitled to settle the claim against the insured and obtain reimbursement in the same manner and to the same extent as the excess carrier was allowed to settle and sue the primary in *Continental Casualty*.

A balancing of benefits and burdens also mandates the conclusion that the insurer should be allowed to settle and seek reimbursement from the insured in appropriate cases. Clearly, when an insured purchases a policy which has a substantial deductible, retention, or participation provision, its premiums are significantly lower than they would be if the insured had purchased a policy without such provisions. The benefit of such lower premiums must carry with it the burden of settling cases within such provisions where possible and appropriate.¹²³

Finally, allowing a cause of action by the insurer against the insured serves two important public interests. The first is obviously that of extrajudicial settlement of litigation.¹²⁴ The second, perhaps less obvious, interest is in having the greatest amount of insurance available at the lowest price.¹²⁵ If the insured is free to block settlement and the insurers are precluded from settling and suing to recover the insured's deductible, retention, or participation, policies offering such provisions obviously will become either less available, because such provisions will have substantially lost their meaning, or more expensive. Either of these events would clearly be against the general public interest.

123. A benefit and burden analysis has been suggested in other contexts involving the resolution of settlement disputes. See, e.g., Crisci v. Security Ins. Co., 66 Cal. 2d 425, 431, 426 P.2d 173, 177, 58 Cal. Rptr. 13, 17 (1967), discussed in text accompanying notes 187-92 *infra*, in which the California Supreme Court suggested that a strict liability standard would serve "elementary justice" because it would place the *burden* of an incorrect decision not to settle on the carrier, who would receive the *benefit* of any correct decision not to settle.

124. E.g., Valentine v. Aetna Ins. Co., 564 F.2d 292 (9th Cir. 1977).

125. The increase in excess premiums which would inevitably result from a rule that the excess carrier could not sue the primary carrier for bad faith refusal to settle has been cited in support of the rejection of such a prohibition. Valentine v. Aetna Ins. Co., 564 F.2d 292, 297 (9th Cir. 1977). Accord, Continental Cas. Co. v. United States Fid. & Guar. Co., 516 F. Supp. 384, 393 (N.D. Cal. 1981); Peter v. Travelers Ins. Co., 375 F. Supp. 1347, 1351 (C.D. Cal. 1974).

III. IMPOSITION OF EXCESS LIABILITY FOR FAILURE TO SETTLE: ALLOCATING LIABILITY FOR THE DAMAGE DONE BY THE STORM

Not every failure to settle a claim against the insured, of course, will result in the type of verdict which will necessitate further litigation between the party pressing for settlement and the party opposing settlement. There are, however, two types of verdicts which may require such litigation. The first is a verdict which, although within the limits of the insured's coverage (primary or excess), is higher than the amount for which the case could have been settled. The insurer, who pressed for settlement and whose required payment has been increased, will seek to impose liability for such excess of the verdict over the settlement demand upon the party opposing settlement. The second is a verdict which is in excess of the insured's policy limits and the insured demanded that the case be settled for or within the policy limits. The insured will attempt to hold the recalcitrant insurer liable for the entire amount of the verdict without regard to policy limits.

The vast majority of so-called excess liability cases have been brought by insureds against their insurers after verdicts of the second type. Recently, however, there have been several cases brought either by excess insurers against primary insurers or by insurers against their insureds seeking to impose excess liability as a result of verdicts of the first type. This section of the Article will review the standards which have been developed in the more traditional "excess liability" suits brought by insureds against insurers as well as the developing standards for imposition of excess liability in suits brought by excess carriers against primary or lower level excess carriers and in suits brought by insurers against their insureds.

A. Insurer's Excess Liability in Action Brought by Insured Following Insurer's Refusal to Settle Within Policy Limits

The typical insurance policy does not specifically impose a *duty* upon the insurer to settle claims against the insured. Rather, as has been noted,¹²⁶ the policy usually speaks in terms of the *power* of the insurer to settle claims in its discretion. Based upon this absence of language, early decisions uniformly held that an insurer would not be liable for refusing to settle.¹²⁷ Rather, in the event of an adverse verdict in excess of policy limits following the insurer's refusal of a demand for settlement within policy limits,

126. See text accompanying notes 28-39 *supra*.

127. E.g., *Georgia Cas. Co. v. Cotton Mills Prod. Co.*, 159 Miss. 396, 132 So. 73 (1931); *McDonald v. Royal Indem. Co.*, 109 N.J.L. 308, 162 A. 620 (1932).

the insurer could fulfill its obligations under the policy merely by paying its limits in satisfaction of the judgment.¹²⁸ The insured was then required to satisfy the excess of the verdict over the limits from its own assets.

The trend in the law today is clearly away from this immunity of insurers for refusal to settle and toward imposition of excess liability upon insurers. Thus, in virtually every jurisdiction today an insurer may be held liable for the excess of an adverse verdict over policy limits where it is shown that the insurer's refusal to settle the claim within the policy limits violated a certain standard of conduct.¹²⁹ There is no general agreement among the jurisdictions, however, as to the appropriate standard by which the refusal should be measured. At least four separate standards have been either adopted or suggested:

1. At least one jurisdiction still adheres to the rule that excess liability may not be imposed upon an insurer unless its refusal to settle was so arbitrary and capricious as to constitute fraud.¹³⁰
2. The majority of jurisdictions hold that excess liability may be imposed upon an insurer if it is shown that the refusal to settle was made in bad faith, but there is substantial disagreement among those jurisdictions as to what type of conduct by the insurer will be sufficient to constitute bad faith.¹³¹
3. Some jurisdictions have adopted a negligence standard, allowing the imposition of excess liability upon an insurer if it is shown that the refusal to settle was the result of the insurer's failure to use due care.¹³²
4. A few jurisdictions have suggested a strict liability standard under which excess liability would be imposed upon an insurer, without regard to fault, whenever an adverse verdict in excess of policy limits follows a refusal to settle within or for policy limits.¹³³

Each of these standards for the imposition of excess liability in suits brought by insureds against insurers will be discussed in some detail as a prelude to a more detailed discussion of the standards which are, or may be, imposed in excess liability suits brought between insurers at different levels of coverage or by insurers against their insureds.

128. See, e.g., McDonald v. Royal Indem. Co., 109 N.J.L. 308, 162 A. 620 (1932).

129. 7C J. APPLEMAN, *supra* note 4, §§ 4711-4715. In *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 658, 328 P.2d 198, 200 (1958), the court set forth the rationale for allowing recovery beyond the policy limits, reasoning that the limits govern only the carrier's obligation for performance of its duty to settle and are inapplicable to a suit based upon breach of that duty.

130. *Martin v. Travelers Indem. Co.*, 450 F.2d 542 (5th Cir. 1971) (applying Mississippi law).

131. See text accompanying notes 139-66 *infra*.

132. See text accompanying 167-84 *infra*.

133. See text accompanying 185-202 *infra*.

1. Fraud as the Standard for Imposition of Excess Liability

The rule that an insurer cannot be liable beyond its policy limits for refusing to settle a claim against its insured absent a showing of fraud was stated more than forty years ago by the Mississippi Supreme Court in *Farmers Gin Co. v. St. Paul Indemnity Co.*.¹³⁴

In the absence of proof of a refusal to properly investigate the case, or conduct defense of it fairly, without willful oppression, or arbitrary action in refusing to settle the case [which] was so unreasonable as to constitute fraud, there can be no liability on the policy beyond the limits therein agreed to by the parties thereto.¹³⁵

Although at one time a majority of jurisdictions might have employed the fraud standard, only a small minority of jurisdictions use this standard today. Most jurisdictions have replaced fraud with either good faith or negligence as the appropriate standard for the imposition of excess liability.¹³⁶ Under the more modern standards, of course, proof of fraud will suffice for the imposition of excess liability but failure to establish fraud is not necessarily fatal.¹³⁷ It should be noted, however, that this trend away from the fraud standard is not universal. Indeed, the continued validity of the fraud standard in Mississippi was reaffirmed by the Fifth Circuit Court of Appeals in *Martin v. Travelers Indemnity Co.*¹³⁸ as recently as 1971.

2. Good Faith as the Standard for Imposition of Excess Liability

Although a majority of jurisdictions use "good faith" as the standard to impose excess liability upon an insurer for refusal to settle,¹³⁹ these jurisdictions are not in agreement as to the meaning of "good faith". Rather, there is substantial disagreement among these so-called "good faith" jurisdictions with respect to two crucial issues. First, there is disagreement as to whether the duty to exercise good faith in attempting to settle claims within policy limits is an *affirmative* one, requiring the insurer to actively

134. 186 Miss. 747, 191 So. 415 (1939).

135. *Id.* at 754, 191 So. at 417.

136. 7C J. APPLEMAN, *supra* note 4, §§ 4711-4714. Some jurisdictions which have nominally shifted to a good faith standard define that standard in a way which is not significantly different from a fraud standard. *See, e.g., Netzley v. Nationwide Ins. Co.*, 63 Ohio Op. 2d 127, 34 Ohio App. 2d 65, 72, 296 N.E.2d 550, 556 (1971), in which the court equated bad faith under Ohio law with moral obliquity and conscious wrongdoing.

137. *See e.g., Alt v. American Family Mut. Ins. Co.*, 71 Wis. 340, 237 N.W.2d 706 (1976).

138. 450 F.2d 542 (5th Cir. 1971).

139. *But see* discussion in note 169 *infra*.

seek out opportunities for such settlement, or merely a *responsive* one, triggered only by a demand for settlement for or within the policy limits.¹⁴⁰ Second, there is disagreement as to the appropriate test by which to determine whether the insurer has fulfilled its duty to settle in good faith.¹⁴¹

With regard to the first issue, some courts hold that proof of an offer to settle within or for policy limits is an absolute prerequisite to imposition of excess liability upon an insurer for its bad faith refusal to settle. Thus, in *Baton v. Transamerica Insurance Co.*,¹⁴² the Ninth Circuit Court of Appeals reversed a district court holding that an insurance company was liable for bad faith refusal to settle, when there was no clear proof of an unequivocal offer to settle for or within policy limits. Even in such jurisdictions, however, an insurer is not totally relieved of responsibility to settle by the mere fact that the claimant's demand is for an amount in excess of policy limits. The insurer may still be held liable if the insured can demonstrate that it would have contributed the necessary amount above policy limits or if it can be shown that further negotiation by the insurer would have resulted in reduction of the demand to one within the policy limits. As one court stated:

Where an insurer receives an offer of settlement in excess of the coverage of its policy it acts in bad faith if it fails to make any attempt to engage the injured plaintiff's counsel in discussions seeking a reduction in the initial settlement demand and if it fails to inform its insured of the opportunity to settle. The initial demand of plaintiff's counsel often will be as far removed from the actual figure acceptable in settlement as the *ad damnum* in the Complaint is removed from the initial settlement demand, especially in a personal injury action. It is a matter of common knowledge that it is a rare case where exploration of the possibilities of settlement, beyond the mere receipt of the plaintiff's demand, will not result in some substantial reduction of the amount.¹⁴³

Other jurisdictions, especially those imposing high standards of good faith upon insurers, do not require proof of an offer to settle within policy limits as a prerequisite to the imposition of excess liability upon the insurer. Rather, the insurer is under an affirmative duty to pursue settlement. This view is exemplified by the opinion of the New Jersey Supreme Court in *Rova Farms Resort v. Investors Insurance Co.*,¹⁴⁴ in which the insurer's defense that

140. Compare *Baton v. Transamerica Ins. Co.*, 584 F.2d 907 (9th Cir. 1978) (firm offer required) with *Rova Farms Resort v. Investors Ins. Co.*, 65 N.J. 474, 323 A.2d 495 (1974) (offer not prerequisite to bad faith liability).

141. See cases discussed in text accompanying notes 147-66 *infra*.

142. 584 F.2d 903 (9th Cir. 1978).

143. *Young v. American Cas. Co.*, 416 F.2d 906, 910-11 (2d Cir. 1969).

144. 65 N.J. 474, 323 A.2d 495 (1974).

there was no offer to settle within policy limits was rejected. The court stated:

It would be unrealistic to believe that such an offer [to settle within policy limits] is a prerequisite for finding the insurer to have acted other than in good faith. . . . The better view is that the insurer has an affirmative duty to explore settlement possibilities. . . . At most, the absence of a formal request to settle within the policy is merely one factor to be considered in light of the surrounding circumstances, on the issue of good faith.¹⁴⁵

In support of its holding, the court cited *State Automobile Insurance Co. v. Rowland*,¹⁴⁶ in which the Tennessee Supreme Court had also held that proof of an offer to settle within policy limits was not absolutely necessary to impose excess liability upon an insurer for bad faith refusal to settle.

There is also wide disagreement among the jurisdictions as to the appropriate definitional test of "good faith". The more conservative view was perhaps best expressed by the Nebraska Supreme Court in *Olson v. Union Fire Insurance Co.*,¹⁴⁷ in which good faith was equated with honesty:

If the insurer has exercised good faith in all of its dealings under its policy, if the settlement which it has rejected has been fully and fairly considered and has been based on an honest belief that the insurer could defeat the action or keep the judgment within the limits of the policy, and if its determination is based on a fair review of the evidence after reasonable diligence in ascertaining the facts, accompanied by competent legal advice, a court will not subject the insurer to liability in excess of policy limits if it ultimately turns out that its determination is a mistaken one.¹⁴⁸

A more stringent test followed in some jurisdictions may be referred to as the "equal consideration" test. The rationale underlying this test was set forth in *McChristian v. State Farm Mutual Automobile Insurance Co.*:¹⁴⁹

The determination by the Court as to the insurer's good faith necessarily involves considerable second-guessing. The decision not to settle must be an honest one, resulting from a fair weighing of probabilities. The officers of any large insurance company have a great deal of experience in handling claims arising out of automobile accidents and are entitled to use that experience in reaching a decision. A good faith decision is, therefore, simply an honest and intelligent one, giving equal consideration to the interest of the insured, made in light of the company's expertise in the field. The requirement is satisfied if reasonable settlement possibilities are exhausted by the company.¹⁵⁰

The *McChristian* opinion made it quite clear that "where reasonable cause appear[ed], in the form of a clearly litigable issue as to damages or liability, for rejecting a settlement offer and defending

145. *Id.* at 493, 323 A.2d at 505.

146. 221 Tenn. 421, 435, 427 S.W.2d 30, 36 (1968).

147. 174 Neb. 375, 118 N.W.2d 318 (1962).

148. *Id.* at 380, 118 N.W.2d at 323.

149. 304 F. Supp. 748 (W.D. Ark. 1969).

150. *Id.* at 753 (emphasis in original).

the action,"¹⁵¹ the insurer would be justified in refusing to settle.

Some courts have stated this test in a slightly different fashion, holding that "the insurance company must give at least equal consideration to the insured's interests as to its own when making settlement decisions,"¹⁵² or that "the insurer is generally required to weigh the interests of the insured at least equally with its own."¹⁵³ In view of the fact that the insurer clearly has an interest in not paying claims which are not covered under its policy, it would seem that an honest belief that the claim was not covered, coupled with an attempt to have the coverage issue resolved in a declaratory judgment action, would be a sufficient reason for an insurer to reject settlement pending such resolution. Indeed, this has been suggested in at least one case.¹⁵⁴

Other cases nominally applying the "equal consideration test" have come to a contrary conclusion. Thus, in *Communale v. Traders & General Insurance Co.*,¹⁵⁵ the California Supreme Court, after stating that "[t]he insurer, in deciding whether a claim should be compromised, must take into account the interest of the insured and give it at least as much consideration as it does to its own interest,"¹⁵⁶ summarily precluded the insurer's consideration of its interest in not paying claims which are not covered under its policy. The court stated:

We do not agree with the cases that hold there is no liability in excess of the policy limits where the insurer, believing there is no coverage, wrongfully refuses to defend and without justification refuses to settle the claim. An insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, 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.¹⁵⁷

151. *Id.* In another recent case, it was also held that the insured's demand that the insurer not settle the claim against him because it might weaken his counterclaim precluded a later bad faith claim against the insurer. *Boston Old Colony Ins. Co. v. Gutierrez*, 386 So. 2d 783 (Fla. 1980).

152. *Peterson v. All City Ins. Co.*, 472 F.2d 71, 77 (2d Cir. 1972) (applying New York law).

153. *Sobus v. Lumberman's Mut. Cas. Co.*, 393 F. Supp. 661, 672 (D. Md. 1975).

154. *Landie v. Century Indem. Co.*, 390 S.W.2d 558 (Mo. App. 1965). The declaratory judgment action must be conducted in good faith. *Traders & General Ins. Co. v. Rudco Oil & Gas Co.*, 129 F.2d 621 (10th Cir. 1951). See also *Beck v. Pennsylvania Nat'l Mut. Cas. Ins. Co.*, 429 F.2d 813 (5th Cir. 1970) (applying Pennsylvania law, court affirmed holding that carrier could not be liable for excess of verdict over policy limits where its declination of coverage, albeit mistaken, was made in good faith). For a further discussion of this issue, see the various opinions in *Luke v. American Family Mut. Ins. Co.*, 476 F.2d 1015 (8th Cir. 1972).

155. 50 Cal. 2d 654, 328 P.2d 198 (1958).

156. *Id.* at 659, 328 P.2d at 201.

157. *Id.* at 660, 328 P.2d at 201-02.

The continuing search for a working definition of good faith by which to determine the excess liability of an insurer for wrongful refusal to settle has led some courts to adopt what may be referred to as the "no limits" test. This test has been expressed as follows:

When it is probable that an adverse verdict will exceed the policy limit, the propriety of an insurer's refusal to accept a settlement offer which is within the coverage requires a resolution of conflicting interests. In our judgment, in view of the duty of the insurer to act in good faith, the resolution can lead to but one fair result: both interests can be served justly only if the insurer treats any settlement offer as if it had full coverage for whatever verdict might be recovered, regardless of policy limits, and makes its decision to settle or go to trial on that basis.¹⁵⁸

Careful review of the cases applying the "no limits test" indicates that it does not allow for even remotely equal consideration of the insurer's and insured's interests. Rather, the test simply requires the insurer to sacrifice its interest for the protection of the insured wherever it appears possible that an adverse verdict may exceed policy limits. This point may be seen from an examination of the decision of the California Supreme Court in *Johansen v. California State Automobile Association Inter-Insurance Bureau*.¹⁵⁹

In *Johansen*, plaintiff was an injured tort claimant who sued as assignee of the insureds' rights against the defendant, their insurer, for excess liability following refusal to settle for policy limits. At the beginning of the personal injury litigation, the insurer asserted that its policy did not provide coverage and instituted a declaratory judgment action, seeking to vindicate its position. However, the insurer continued to defend its insureds under a reservation of rights. When the plaintiff in the personal injury action offered to settle for policy limits, the insurer did not flatly reject this demand, but offered to place its entire policy limits in an interest-bearing escrow account with the agreement that the entire amount would be paid to the plaintiff in the event the declaratory judgment action resulted in a determination of coverage. This offer was rejected, and the subsequent trial of the personal injury action resulted in a verdict against the insureds substantially in excess of policy limits.

At the trial of the excess liability action, the court rendered judgment in favor of the defendant insurer on the basis that the insurer's bona fide belief that coverage did not exist, coupled with the manner in which it both defended its insureds and attempted to resolve the coverage issue, negated any finding of bad faith.

158. *Bowers v. Camden Fire Ins. Ass'n*, 51 N.J. 62, 71-72, 237 A.2d 857, 862 (1968). Other cases have tempered this rule by suggesting that the duty to settle does not arise where an excess verdict is not reasonably foreseeable. *Fulton v. Woodford*, 26 Ariz. App. 17, 545 P.2d 979 (1976).

159. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).

This verdict was upheld by the court of appeal,¹⁶⁰ which cited repeated instances of the insurer's good faith and criticized the collusion between the insureds and the tort claimant. The court of appeal noted that the bad faith rule is, and must be, limited in its application:

The bad faith rule—consistently followed in California—is a sound, salutary principle. It permits an excess recovery against those insurance carriers which refuse to acknowledge their obligations . . . and at the same time recognizes that every refusal to settle on the demand of others whose interests may not be parallel with—but in fact may well be adverse to—those of the insurer is not asserted in bad faith.¹⁶¹

The California Supreme Court reversed the holding of the court of appeal.¹⁶² The supreme court made it clear that it was concerned only with the interests of the insureds and not with any interests of the insurer:

[I]n deciding whether or not to compromise the claim, the insurer must conduct itself as though it alone were liable for the entire amount of the judgment. Thus, the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer. 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 a decision as to whether the settlement offer in question is a reasonable one.¹⁶³

The court ended its opinion with the somewhat sophististic suggestion that its decision did not leave the insurer entirely without protection:

Finally, we cannot accept defendant's complaint that the *Comunale* [good faith] rule requires an insurer to settle in all cases irrespective of whether the policy provides coverage. Clearly, if defendant's belief that the policy did not provide coverage in the instant case had been vindicated, it would not be liable for damages flowing from its refusal to settle; all that *Comunale* establishes is that an insurer who fails to settle does so "at its own risk." Moreover, contrary to defendant's assertion, an insurer in defendant's position retains the ability to enter an agreement with the insured reserving its right to assert a defense of noncoverage even if it accepts a settlement offer. If, having reserved such rights and having accepted a reasonable offer, the insurer subsequently establishes the noncoverage of its policy, it would be free to seek reimbursement of the settlement payment from its insured.¹⁶⁴

Such professed solicitude for the interests of the insurer ignored the fact that the insurer did attempt to vindicate its beliefs

160. 41 Cal. App. 3d 974, 116 Cal. Rptr. 546 (1974), *rev'd and remanded*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).

161. 41 Cal. App. 3d at ___, 116 Cal. Rptr. at 553.

162. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).

163. *Id.* at 16, 538 P.2d at 748-49, 123 Cal. Rptr. at 292-93.

164. *Id.* at 19, 538 P.2d at 750, 123 Cal. Rptr. at 294.

concerning coverage in a fashion which would have protected the insureds and allowed for a conditional settlement, but was thwarted in this effort by the collusion of the insureds and the tort plaintiff. In addition, the court ignored the fact that the insurer would have virtually no realistic chance of recovering any substantial sums of money from its insureds if the procedure suggested by the court were followed and coverage were determined to be lacking.¹⁶⁵ Indeed, the California approach to good faith in *Johansen* has been severely criticized in a leading authority on insurance law:

Remarkable good faith was shown [by the insurer in *Johansen*]. A belief coverage does not exist should not be an excuse not to try to settle a claim but here the insurer did all it could reasonably be expected to do—good faith offer, attempt to expedite determination of coverage and proper direction of trial tactics. Unfortunately, the California Supreme Court in its overwhelming generosity to injured parties (at the ultimate expense, of course, of insureds who must pay higher premiums) no longer does more than give lip service to the good faith test.¹⁶⁶

3. Negligence as the Standard for Imposition of Excess Liability

Although negligence has been rejected as a standard of liability in many cases,¹⁶⁷ some jurisdictions allow the imposition of excess liability on an insurer upon a showing that it failed to use due care in weighing an offer for settlement within policy limits. Unfortunately, the distinction between good faith and negligence is often blurred in the cases discussing the appropriate standard for the imposition of excess liability. This confusion is perhaps best illustrated by the opinion of the New Jersey Supreme Court in *Radio Taxi Service, Inc. v. Lincoln Mutual Insurance Co.*¹⁶⁸ In that case, the court noted that the confusion in the law was so great that two leading authorities on insurance law had taken opposite positions as to whether negligence or good faith was the standard applied in

165. It must be noted that, in following this suggestion, the insurer would have had to pay its limits to the third-party claimant but would have had to seek reimbursement from the insureds. There is no suggestion in the case that the insureds had such a large sum available for repayment to the insurer if coverage were determined to be lacking. In fact, the insureds' refusal to settle and then sue the insurer suggests that they did not have such funds. Indeed, most individual insureds would not have such sums available, and this is one of the reasons why they purchase insurance. Similar considerations may not apply in the large commercial and professional policies and, accordingly, this settle and sue approach may be workable in those cases. See discussion in text at sections II.C. *supra* and III.C. *infra*.

166. 7C J. APPLEMAN, *supra* note 4, § 4712 n.41.

167. *See, e.g., Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 110 Cal. Rptr. 511 (1973).

168. 31 N.J. 299, 157 A.2d 319 (1960).

the majority of jurisdictions.¹⁶⁹ The court opted for the good faith test but injected language more appropriate for a negligence standard:

[W]e hold that the obligation assumed by the insurer with respect to settlement is to exercise good faith in dealing with offers of compromise, having both its own and the insured's interests in mind. And it may be said also that a reasonably diligent effort must be made to ascertain the facts upon which a good faith judgment as to settlement can be formulated.¹⁷⁰

Similarly, the Wisconsin Supreme Court, in the landmark case of *Hilker v. Western Automobile Insurance Co.*,¹⁷¹ defined good faith in negligence terms:

[T]he good-faith performance of the obligation [to consider fairly settlement demands against its insured] which the insurance company assumed when it took to itself the complete and exclusive control of all matters that determine the liability of the insured, requires that it be held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business were he investigating and adjusting such claims.¹⁷²

A number of jurisdictions have attempted to avoid this semantic wrangle by adopting the negligence standard as alternative or additional to the bad faith standard. Thus, the Oregon Court of Appeals, in *Kriz v. Government Employees Insurance Co.*,¹⁷³ stated that excess liability may be imposed upon an insurer "if the insurer has failed, negligently or in bad faith, to settle the claim against the insured." Similarly, the Seventh Circuit Court of Appeals, in *General Casualty Co. v. Wipple*,¹⁷⁴ stated that "negligence or bad faith is the Illinois standard of conduct to be applied to the facts"¹⁷⁵ to determine excess liability.

Other courts, however, in rejecting negligence as a standard for imposition of excess liability have sought to distinguish negligence from bad faith in terms of culpability. Thus, in upholding the dismissal of a claim for negligent failure to settle within policy limits, a California court of appeal, in *Merritt v. Reserve Insurance Co.*¹⁷⁶ stated:

169. *Id.* at 303, 157 A.2d at 322 (court noted that Appleman had taken the position that good faith was giving way to negligence as the majority standard but an annotation at 40 A.L.R.2d 168, 178 had taken the position that good faith was the standard used "[i]n the great majority of the cases.") Our research convinces us that the view stated in the annotation is the correct one.

170. 31 N.J. at 304, 157 A.2d at 322.

171. 204 Wis. 1, 231 N.W. 257 (1931).

172. *Id.* at 10, 231 N.W. at 261.

173. 42 Or. App. 339, 343, 600 P.2d 496, 500. The court remanded the case for consideration of the factual issue of whether the insurer had a reasonable opportunity to settle.

174. 328 F.2d 353 (7th Cir. 1964).

175. *Id.* at 355.

176. 34 Cal. App. 3d 858, 110 Cal. Rptr. 511 (1973).

With respect to the first charge, negligent failure to initiate settlement discussions, we have seen from our review of the California cases that actionable failure to settle must encompass bad faith, that negligence alone is insufficient to support the charge. As the court said in rejecting the negligence test in *Brown v. Guarantee Ins. Co.*, 155 Cal. App. 2d 679, 688, 319 P.2d 69, 74, “[t]o justify such a result [liability in excess of policy limits] requires substantial culpability on the part of the insurer—bad faith rather than mere negligence . . . negligence alone is insufficient to render the insurer liable.”¹⁷⁷

Even in those jurisdictions which reject negligence as the appropriate standard, it may be considered in connection with the issue of whether the insurer's refusal to settle was a breach of its duty of good faith and fair dealing. Thus, the Florida Supreme Court recently noted: “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.”¹⁷⁸ Indeed, where the negligence has been repeated or pervasive, the court may find that such slipshod handling of the insured's case constituted bad faith on the part of the insurer.¹⁷⁹

Courts which have adopted negligence as the appropriate standard for imposition of excess liability have relied on the theory that the insurer, having contractually reserved the right to defend and settle cases against the insured, has a duty to exercise its right to settle and perform its duty to defend with due care. As one court stated:

[The insurer] contracted to take charge of the defense of this claim. That contract created a relation out of which grew the duty to use care when action was taken. The insurer entered upon the conduct of the affair in question. It had and exercised authority over the matter in every respect, even to negotiating for a settlement. It is difficult to see upon what ground it could escape responsibility when its negligence resulted in damage to the party it had contracted to serve.¹⁸⁰

The negligence standard has long been criticized because, in many cases, it would penalize the insurer for an inaccurate prediction on an inherently unpredictable topic—a likely jury verdict. This point was rather colorfully made by the Kentucky Supreme Court in *Georgia Casualty Co. v. Mann*:¹⁸¹

The gift of prophecy has never been bestowed on ordinary mortals, and as yet their vision has not reached such a state of perfection that they have the power to predict what will be the verdict of the jury on disputed facts in a personal injury case. . . . Calling it negligence for an agent not to divine what would be the result of a jury trial on disputed evidence, per-

177. *Id.* at 880, 110 Cal. Rptr. at 526.

178. *Boston Old Colony Ins. Co. v. Gutierrez*, 386 So. 2d 783, 785 (Fla. 1980).

179. *Yeomans v. Allstate Ins. Co.*, 121 N.J. Super. 96, 296 A.2d 96 (1972).

180. *Douglas v. United States Fid. & Guar. Co.*, 81 N.H. 371, 376, 127 A. 708, 711 (1924).

181. 242 Ky. 447, 46 S.W.2d 777 (1932).

mitting a jury to determine the question not solely on the facts as presented to him, but in the light of the subsequent verdict of the jury, would carry his responsibility beyond the bounds of reason and further than the demands of justice require.¹⁸²

Two further points should be noted with respect to the negligence standard for the imposition of excess liability. First, in most jurisdictions applying this standard, the test is not whether the insurer acted as a reasonable average man would have done in the face of the settlement demand. Rather, most jurisdictions take into account the expertise of the insurer in handling and settling claims and, accordingly, hold the insurer to a higher standard of care consistent with this expertise.¹⁸³ Second, some jurisdictions have tempered the effect of the negligence rule by imposing a higher burden of proof upon the claimant or the insured, stating that "the breach of the insurer's duty must be proved by clear and convincing evidence."¹⁸⁴

4. Strict Liability as the Suggested Standard for Imposition of Excess Liability

Several cases¹⁸⁵ and numerous commentators¹⁸⁶ have suggested that strict liability should be imposed upon an insurer who refuses a demand that the claim against its insured be settled within policy limits. Under such a standard, the insurer would be liable for whatever verdict might be returned against its insured following such a refusal, without regard to its due care or good faith in the handling and defense of the claim against its insured.

182. *Id.* at 451-52, 46 S.W.2d at 779-80.

183. See 7C J. APPLEMAN, *supra* note 4, § 4713 and cases cited therein at note 1. The expertise of an insurer may even be considered in good faith jurisdictions. See, e.g., *Bowers v. Camden Fire Ins. Ass'n*, 51 N.J. 62, 237 A.2d 857 (1968). Other factors to be considered in negligence cases are set forth in *Globe Indem. Co. v. Gen-Aero, Inc.*, 459 S.W.2d 205 (Tex. Civ. App. 1970).

184. *Alt v. American Family Mut. Ins. Co.*, 71 Wis. 340, 354, 237 N.W.2d 706, 714-15 (1976). In addition, at least one court has held that liability for negligence cannot be imposed without proof of an unconditional offer to settle by the third-party claimant. *Danner v. Iowa Mut. Ins. Co.*, 340 F.2d 427 (5th Cir. 1964). In *Danner*, the court held that the insurer was not negligent in failing to accept a conditional settlement offer.

185. *Johansen v. California State Auto. Inter-Ins. Bureau*, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975); *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967); *Rova Farms Resort, Inc. v. Investors Ins. Co.*, 65 N.J. 474, 323 A.2d 495 (1974); *Alt v. American Family Mut. Ins. Co.*, 71 Wis. 2d 340, 237 N.W. 2d 706 (1976).

186. See Comment, *supra* note 10; Comment, *Approaching Strict Liability of Insurer for Refusing To Settle Within Policy Limits*, 47 NEB. L. REV. 705 (1968). Such approval is not universal, however, and strict liability has been regarded unfavorably by some leading commentators. See Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136 (1954).

Three jurisdictions, California, New Jersey, and Wisconsin, are generally cited as having either suggested or actually adopted a strict liability standard. Careful review of the cases in those jurisdictions reveals, however, that none of them have actually adopted the proposed strict liability standard.

The strict liability standard seems to have first been suggested by the California Supreme Court in *Crisci v. Security Insurance Co.*¹⁸⁷ In that case, the insurer's arbitrary and unreasonable refusal to settle resulted not only in an excess verdict against its insured, but also in the forced sale of her house to satisfy the judgment. The supreme court upheld the trial court's determination that the insurer was liable for the entire amount of the verdict against the insured because it failed to give as much consideration to the financial interests of its insured as it gave to its own, even though the insurer knew that there was considerable risk of substantial recovery beyond the policy limits. In addition, the court upheld an award of substantial damages to the insured for her mental suffering occasioned by the forced sale of her house.

Amicus curiae argued that a strict liability standard should be

187. 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967). The theory appears to have been most recently considered in *Shearer v. Reed*, — Pa. Super. —, 428 A.2d 635 (1981) in which the Pennsylvania Superior Court upheld a determination that an insurer was liable for the excess of an adverse verdict over its policy limits because it had acted in bad faith in refusing an offer to settle for policy limits. In so holding, however, the court considered adoption of a strict liability standard:

In reaching our decision, we have not overlooked the possibility that we should reexamine the good faith standard. We recognize, as others have before us, that there is an inherent conflict of interest between an insurance company and its insured once an offer to settle within policy limits has been received. Whenever the insurance company decides not to settle, it has, in effect, chosen its interests over that of its insured's—and by terms of virtually all liability insurance policies, including the one in this case, that decision is made solely by the insurance company. If the company's guess is wrong, but nevertheless satisfies the good faith standard, it is not the company, which made the decision, but the insured who suffers. We need not discuss this peculiar situation at any length because others have already done so very well. [citations omitted] In some of the cases the courts have indicated that in a proper case they would consider resolving the conflict between an insurance company and its insured by adopting an automatic liability rule, that whenever the company refused to offer its policy limit toward a settlement, it would be liable for any excess verdict. [citations omitted] However, in each of these cases the insurance company was found liable for the excess verdict by application of the existing good faith standard, and the court chose to leave any change in the law to a future day.

We shall do the same.

Id. at —, 428 A.2d at 639-40. The court in *Shearer* also noted, as our research has disclosed, that no appellate decision has actually adopted the strict liability rule.

adopted by California and, indeed, the proposed rule was discussed at length, and favorably, in the opinion. Three reasons supporting adoption of the rule were advanced by Justice Peters. First, the rule was seen as consistent with the reasonable expectations of the insured that "a sum of money equal to the limits is available and will be used so as to avoid liability on his part with regard to any covered accident."¹⁸⁸

Second, strict liability was viewed as far simpler to apply than the good faith test since it "avoids the burdens of a determination whether a settlement offer within policy limits was reasonable."¹⁸⁹ The third reason proposed by the supreme court focused on a balancing of the benefits and burdens involved in the decision to litigate rather than settle. The court stated: "[T]here 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 detriment of its decision."¹⁹⁰

Although noting that a number of commentators had urged adoption of the strict liability standard and in spite of its own favorable comments concerning the rule,¹⁹¹ the court decided that in view of the clear bad faith of the insurer, it was unnecessary to decide whether to adopt such a standard in the case before it.¹⁹²

The proposed strict liability rule was discussed by the New Jersey Supreme Court in *Rova Farms Resort, Inc. v. Investors Insurance Co.*¹⁹³ In that case, Chief Justice Hughes discussed the strict liability standard at length and quoted extensively from the *Crisci* opinion. Again, however, the court stopped just short of actually adopting a strict liability standard, stating: "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."¹⁹⁴

Apparently ignoring this paragraph of the *Rova Farms* opinion, the California Supreme Court in *Johansen v. California State Automobile Association Inter-Insurance Bureau*,¹⁹⁵ interpreted *Rova*

188. 66 Cal. 2d at 431, 426 P.2d at 177, 58 Cal. Rptr. at 17.

189. *Id.*

190. *Id.*

191. See comments and notes cited by the court at 66 Cal. 2d at 431, 426 P.2d at 177, 58 Cal. Rptr. at 17.

192. *Id.* at 431-32, 426 P.2d at 177-78, 58 Cal. Rptr. at 17-18.

193. 65 N.J. 474, 323 A.2d 495 (1974).

194. *Id.* at 502, 323 A.2d at 503.

195. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975). The court, in a footnote, stated:

Farms as adopting strict liability, but found it unnecessary to adopt such a standard in the matter before it.

The New Jersey Supreme Court had an opportunity to further clarify its stand on the strict liability issue in *Fireman's Fund Insurance Co. v. Security Insurance Co.*,¹⁹⁶ discussed at length above.¹⁹⁷ In that case, the insurer argued rather ingeniously that the insured should not have been allowed to settle the claim over the insurer's objections because, under the strict liability standard supposedly adopted in *Rova Farms*, the insurer would have been liable for whatever verdict resulted from the insurer's refusal to settle. This argument was flatly rejected:

Security's argument is bottomed on an erroneous interpretation of our opinion in *Rova Farms*, *supra*. Contrary to what Security contends, *Rova* did not eliminate "bad faith" as one of the factors to be proven where an action is instituted by an insured against his insurer based on its refusal to settle. Nor did we in *Rova* adopt a rule making the insurer "automatically liable to the insured for the over the limit judgment." While the opinion in *Rova* did suggest that it might be desirable "one day" to adopt such a rule, it concluded that "it is unnecessary in the instant case to embrace such an extended rule", (65 N.J. at 502), and such a rule has never been adopted.¹⁹⁸

The final case which is sometimes cited as having adopted a strict liability standard is the opinion of the Supreme Court of Wisconsin in *Alt v. American Family Mutual Insurance Co.*¹⁹⁹ Although that case did set forth an unusually high standard of good faith, and posited negligence as an alternative ground of recovery, it did not adopt a strict liability standard. The court held that there was "an affirmative duty on the part of the insurance company to compromise claims,"²⁰⁰ but did not hold that the insurer had a

Both plaintiff and amicus curiae on behalf of plaintiff urge that we hold that whenever an insurer receives an offer to settle within policy limits and rejects it, the insurer should be held liable in *every case* for the amount of any final judgment. We note that the New Jersey Supreme Court in a well reasoned opinion has adopted this rule. (*Rova Farms Resort, Inc. v. Investors Ins. Co. of America* (1974) 65 N.J. 474 [323 A.2d 495].) In light of our conclusion that defendant's liability for the excess judgment may be predicated on its rejection of a reasonable settlement offer, we need not resolve this issue.

196. *Id.* at 17 n.6, 538 P.2d at 749 n.6, 123 Cal. Rptr. at 293 n.6 (emphasis added).

196. 72 N.J. 63, 367 A.2d 864 (1976).

197. See notes 56-65 & accompanying text *supra*.

198. 72 N.J. at 70-71, 367 A.2d at 868.

199. 71 Wis. 2d 340, 237 N.W.2d 706 (1976).

200. *Id.* at 349, 237 N.W.2d at 712. The court cited *Baker v. Northwestern Cas. Co.*, 26 Wis. 2d 306, 132 N.W.2d 493 (1965), as imposing "at least" three other affirmative duties upon the insurer with respect to its insured:

It must make a diligent effort to ascertain the facts upon which only an intelligent and good-faith judgment may be predicated. In addition, the insurance company has a duty to determine the probability that recovery will exceed the indemnity and to make a full disclosure

duty to settle a claim within its policy limits whenever possible. Rather, the court's holding was of a more limited nature:

We hold . . . that in all cases involving a probable overage, an insurance carrier must be circumspect in respect to all settlement overtures which are not patently frivolous, whether they be legally binding offers or not, at least in situations where it would be apparent to a reasonable insurer that excess liability was probable and liability almost certain.²⁰¹

Indeed, this holding was tempered by the court's further comment that although the insurer was liable for negligence, it was negligence of a rather unique sort, "the breach of ordinary care in a fiduciary relationship,"²⁰² and, accordingly, the plaintiff would be held to a higher burden of proof.

Thus, each court which has discussed possible adoption of a strict liability standard for imposition of excess liability upon an insurer which has refused to settle has stepped back from the brink and has required some showing of fault as a condition to imposition of such liability. Moreover, this approach of refusing to adopt strict liability but punishing culpable conduct by the insurer is followed by all jurisdictions. While *no* standard may be said to be universal or even the clear majority standard, it is clear that *all* jurisdictions will impose excess liability upon a showing of some fault; no jurisdiction leaves an insurer free to refuse settlement of a claim within its policy limits solely to further its own interests at the expense of the insured.

B. Excess Carrier's Right to Recover Excess of Adverse Verdict Over Settlement Demand from Primary Carrier Which Refused to Settle Claim Against Their Joint Insured

Two factual situations may give rise to an action by an excess carrier against a primary carrier for wrongful refusal to settle. First, there may be a verdict against the insured in excess of primary limits, which follows a refusal by the primary carrier to settle within such limits. Second, there may be a verdict in excess of a settlement demand which was greater than primary limits, but with respect to which the excess carrier was willing to contribute the necessary amount over the primary limits and the primary carrier was unwilling to contribute its limits. In the event of either type of verdict, of course, the excess carrier may argue that it has

to the insured so that the insured may protect himself to the extent possible. *Baker* added a third duty, not previously stated in Wisconsin cases—the responsibility of keeping the insured timely and adequately informed of any offers of settlement from the claimant and of the progress of any settlement negotiations.

71 Wis. 2d at 346-47, 237 N.W.2d at 711.

201. *Id.* at 353, 237 N.W.2d at 714.

202. *Id.* at 354, 237 N.W.2d at 714.

been damaged by the refusal of the primary carrier to settle. In the first type of verdict, the measure of damages will be the entire excess of the verdict over the primary limits. In the second type of verdict, the appropriate measure of damages would seem to be the excess of the verdict over the amount for which the claim could have been settled.

An excess carrier which brings suit against the primary carrier to recover the damages allegedly occasioned by the primary's wrongful refusal to settle will face the same basic hurdle as an excess carrier which attempts to settle the claim and then sue the primary carrier for reimbursement—the lack of any contractual relationship between excess and primary carriers.²⁰³ The right of an excess carrier to recover its damages from a primary carrier which has wrongfully refused to settle a claim against their joint insured has been considered in several cases. A review of those cases reveals a number of theories upon which recovery has been allowed: (1) the theory that the excess carrier is equitably subrogated to the rights of the insured against the primary carrier;²⁰⁴ (2) the theory that the primary carrier owes a direct duty to the excess carrier;²⁰⁵ (3) the theory that the excess carrier may proceed by contractual subrogation;²⁰⁶ and (4) the theory that the primary carrier, the excess carrier, and the insured owe to each other a triangular reciprocal duty to use due care in the handling and settlement of claims against the insured.²⁰⁷

However, the liability of the primary carrier to the excess carrier for wrongful refusal to settle within primary limits is not universally accepted. Rather, some courts have specifically held that the primary carrier owes no duty to the excess carrier which would require it to settle within primary limits, and accordingly, cannot be liable for failure to do so.²⁰⁸

With this general overview in mind, it is appropriate now to examine the various theories which have been adopted by jurisdictions in allowing or disallowing recovery by an excess carrier against a primary carrier for the damage occasioned by the latter's wrongful refusal to settle.

203. See Section II.B. of the text *supra*.

204. See, e.g., *American Fid. & Cas. Co. v. All Am. Bus Lines, Inc.*, 190 F.2d 234 (10th Cir. 1951).

205. See, e.g., *Estate of Penn v. Amalgamated Gen. Agencies*, 148 N.J. Super. 419, 372 A.2d 1124 (1977).

206. See, e.g., *Allstate Ins. Co. v. Reserve Ins. Co.*, 116 N.H. 806, 373 A.2d 339 (1976).

207. See, e.g., *Transit Cas. Co. v. Spink Corp.*, 94 Cal. App. 3d 124, 156 Cal. Rptr. 360 (1979), *disapproved in part*, *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980).

208. See, e.g., *Universal Underwriters Ins. Co. v. Dairyland Mut. Ins. Co.*, 102 Ariz. 518, 433 P.2d 966 (1967).

1. Equitable Subrogation

Equitable subrogation was first employed as the means to bridge the contractual gap between primary and excess carriers in the landmark case of *American Fidelity & Casualty Co. v. All American Bus Lines, Inc.*.²⁰⁹ In that case, the primary insurer, American Fidelity, refused to settle within its policy limits a claim arising out of an accident involving its insured, All American Bus Lines. A verdict at trial resulted in a judgment in excess of the primary limits. The case was settled, pending appeal of the action, with the primary carrier contributing the limits of its policy, and the excess carrier, Security Mutual Casualty Company, contributing the balance.

The excess insurer instituted an action against the primary insurer and obtained a judgment for the full amount it spent, indirectly, in settling the action against the insured. This judgment was upheld by the Tenth Circuit Court of Appeals, which rejected the primary carrier's arguments that it owed no contractual duty to the excess carrier and that a subrogation theory could not be used by an insurance company discharging a debt in the performance of its own obligation.²¹⁰ Although not using the term directly, the court clearly based its decision on the theory of equitable subrogation:

[T]he equities between the two companies were not equal . . . American was allegedly guilty of bad faith [refusal to settle] while Security was at most guilty of breach of contract [by reimbursing the insured for satisfaction of the settlement rather than directly funding same] . . . and . . . as between the two, it would be just and equitable for American to bear the loss occasioned by its own misconduct.²¹¹

The equitable subrogation theory first espoused in *American Fidelity & Casualty Co.* has since been followed in other Tenth Circuit decisions.²¹² In addition, this theory has gained widespread acceptance and is now the theory employed by the majority of jurisdictions allowing recovery by the excess carrier from the primary carrier for wrongful refusal to settle within primary limits.²¹³ The rationale underlying the employment of equitable sub-

209. 190 F.2d 234 (10th Cir. 1951).

210. *Id.* at 238.

211. *Id.*

212. *United States Fid. & Guar. Co. v. Tri-State Ins. Co.*, 285 F.2d 579 (10th Cir. 1960); *St. Paul-Mercury Indem. Co. v. Martin*, 190 F.2d 455 (10th Cir. 1951).

213. *Valentine v. Aetna Ins. Co.*, 564 F.2d 292 (9th Cir. 1977); *Peter v. Travelers Ins. Co.*, 375 F. Supp. 1347 (C.D. Cal. 1974); *Universal Underwriters Ins. Co. v. Dairyland Mut. Ins. Co.*, 102 Ariz. 518, 433 P.2d 966 (1967); *Continental Cas. Co. v. Reserve Ins. Co.* 307 Minn. 5, 238 N.W.2d 862 (1976); *Estate of Penn v. Amalgamated Gen. Agencies*, 148 N.J. Super. 419, 372 A.2d 1124 (1977); *Western Pac. Ins. Co. v. Farmers Ins. Exch.*, 69 Wash. 2d 11, 416 P.2d 468 (1966).

rogation as the means for allowing such recovery was perhaps best set forth in *Peter v. Travelers Insurance Co.*²¹⁴ The court cited a number of "strong equitable and economic considerations"²¹⁵ supporting its decision that the primary carrier was liable for the entire judgment because of its wrongful refusal to settle within policy limits. First, the primary carrier owed a contractual duty to its insured to settle in good faith, and "this duty is not reduced merely because of another contract between the insured and its excess insurer."²¹⁶ Second, the court found that allowing the excess carrier to recover against the primary carrier was consistent with insurance industry practice and did not impose an undue burden upon the primary carrier. The court stated:

An insurance company's duty to act in good faith in settling claims within its policy limits is well established and is reflected in its premiums. That an excess insurer may recover from the primary for breach of duty does not increase the duty or the liability of the primary. Under the doctrine of equitable subrogation, the duty owed an excess insurer is identical to that owed 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.²¹⁷

Finally, the court cited the control which the primary carrier alone maintains over defense and settlement as an additional factor in support of its holding. The court found that the actions of the primary insurer had a significant impact on the excess insurer,

214. 375 F. Supp. 1347 (C.D. Cal. 1974). The court quoted the following list of elements for a cause of action for equitable subrogation:

"The elements of an insurer's cause of action based upon equitable subrogation are these: (1) The insured has suffered a loss for which the party to be charged is liable, either because the latter is a wrongdoer whose act or omission caused the loss or because he is legally responsible to the insured for the loss caused by the wrongdoer; (2) the insurer, in whole or in part, has compensated the insured for the same loss for which the party to be charged is liable; (3) the insured has an existing, assignable cause of action against the party to be charged, which action the insured could have asserted for his own benefit had he not been compensated for his loss by the insurer; (4) the insurer has suffered damages caused by the act or omission upon which the liability of the party to be charged depends; (5) justice requires that the loss should be entirely shifted from the insurer to the party to be charged, whose equitable position is inferior to that of the insurer; and (6) the insurer's damages are in a stated sum, usually the amount it has paid to its insured, assuming the payment was not voluntary and was reasonable."

Id. at 1350 (quoting *Patent Scaffolding Co. v. William Simpson Constr. Co.*, 256 Cal. App. 2d 506, 509, 64 Cal. Rptr. 187, 190 (1967)).

215. 375 F. Supp. at 1350.

216. *Id.*

217. *Id.*

and if the primary insurer were relieved of its duty to accept reasonable settlement offers because of the existence of excess insurance, it would result in higher premiums by the excess insurer and would reduce the incentive of the primary insurer to settle.²¹⁸

A number of defenses commonly offered by primary carriers to suits by excess carriers have been rejected by those jurisdictions which follow the equitable subrogation theory of *All American Bus Lines* and *Peter*. Thus, the defense that there is no contractual relationship between the primary and excess carrier has been rejected. As one court stated:

This argument ignores equitable subrogation. Under that doctrine, it is the duty of the insurer to the insured that is enforced, not an independent duty to the excess insurer. . . . "This right of the insurer against the wrongdoer does not rest upon any relation of contract or of privity of them, but arises out of the nature of a contract of insurance as a contract of indemnity."²¹⁹

The defense that subrogation cannot lie because the insured, having been insulated from the excess judgment by the excess insurer, has suffered no damage, also has been rejected: "It is not a prerequisite to equitable subrogation that the subrogor suffered actual loss; it is required only that he would have suffered loss had the subrogee not discharged the liability or paid the loss."²²⁰

Finally, the contention that the excess carrier's right of recovery is barred by its own contributory negligence in failing to settle the liability above primary limits has also been found wanting. This defense was forwarded by the primary carrier in *Vencill v. Continental Casualty Co.*,²²¹ but was rejected on the ground that the excess carrier had no duty to defend the insured and no duty to contribute any sums under its policy until the primary carrier had posted its full limits. The failure of the primary carrier to post its full limits in settlement, then, is seen as preventing the duty of the excess carrier to contribute to such settlement from ever arising.

One important point should be noted with respect to those cases which approve the use of equitable subrogation in this area. The cases are in general agreement that this mode of recovery does not establish a *separate* duty owed by the primary carrier to the excess carrier. Rather, equitable subrogation is employed as a

218. *Id.* at 1350-51.

219. *Northwestern Mut. Ins. Co. v. Farmers' Ins. Group*, 76 Cal. App. 3d 1031, 1050, 143 Cal. Rptr. 415, 426 (1978) (quoting *Offer v. Superior Court*, 194 Cal. 114, 118, 228 P. 11, 13 (1924)).

220. 76 Cal. App. 3d at 1044, 143 Cal. Rptr. at 423.

221. 433 F. Supp. 1371 (S.D. W. Va. 1977). The similar defense of failure to mitigate damages has also been rejected. *Continental Cas. Co. v. United States Fid. & Guar. Co.*, 516 F. Supp. 384 (N.D. Cal. 1981).

means to allow the excess insurer to succeed to the duty owed by the primary insurer to the insured. Thus, whether excess liability will actually be imposed upon the primary carrier will depend upon whether its conduct in refusing to settle violates the standard established in the particular jurisdiction for imposition of excess liability in a suit brought by the insured against its insurer.

2. *Contractual Subrogation*

The Supreme Court of New Hampshire, in *Allstate Insurance Co. v. Reserve Insurance Co.*,²²² held that the excess carrier's right of recovery against the primary carrier for wrongful refusal to settle may be based upon the standard subrogation clause contained in most insurance contracts. In that case, Allstate based its cause of action against the primary carrier, Reserve, on alternative theories of contractual subrogation and negligence, arguing that Reserve owed a direct duty to use due care to protect Allstate's interest as an excess carrier. Reserve's motion to dismiss was denied by the trial court, and this ruling was upheld by the supreme court. The supreme court rejected Allstate's direct duty theory, and, although it noted that many other jurisdictions employed equitable subrogation in such matters, it approved Allstate's contractual subrogation theory as the appropriate means of recovery. The court stated:

We perceive no relationship between the two insurers which would impose directly upon Reserve a duty to exercise due care in regard to Allstate. We agree, however, that Allstate is entitled to bring an action against Reserve on the basis of [the insured's] assignment clause. Other courts have sustained the right of excess insurers to maintain an action against the primary carrier under a theory of equitable subrogation. We find it unnecessary to utilize a subrogation analysis in view of our rule that tort claims of this sort are assignable as choses in action.²²³

It should be noted that the assignment in *Allstate* was not a specific and separate assignment to the excess insurer by the insured of his rights against the primary carrier for wrongful refusal to settle. Rather, the court viewed the standard subrogation clause in the policy as automatically effecting an assignment of the insured's cause of action to the excess insurer.

The court in *Allstate*, like the courts which have accepted the equitable subrogation theory, rejected the argument that an action by subrogation cannot lie because the insured has suffered no damage. The court based its rejection of this argument on the fact that, under New Hampshire law, the insured's cause of action against the insurer for negligent failure to settle "is not dependent

222. 116 N.H. 806, 373 A.2d 339 (1976).

223. *Id.* at 808, 373 A.2d at 340.

upon the insured's prior payment or the certainty of his future payment of the judgment against him."²²⁴

3. Direct Duty Owed by Primary Carrier to Excess Carrier

The decision in *Estate of Penn v. Amalgamated General Agencies*,²²⁵ may be interpreted as upholding the right of the excess carrier to recover from the primary carrier upon the basis of a *direct* duty owed by the primary to the excess. Indeed, the court specifically held: "[T]he 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."²²⁶ The clarity of this holding is somewhat blurred, however, by the fact that it was preceded by a lengthy quote from *Peter v. Travelers Insurance Co.*²²⁷ concerning the doctrine of equitable subrogation.

An important distinction exists between the theories of equitable subrogation and a direct duty owed by the primary to the excess. Under the theory of equitable subrogation, the excess insurer succeeds to whatever rights the insured has against the primary insurer. Unfortunately, under this theory, the rights of the subrogee can never be greater than those of the subrogor. Applying that principle to an action by an excess carrier against a primary carrier may produce inequitable results. Thus, if the primary carrier and the insured have acted in collusion to improperly reject settlement within the primary limits, such wrongful conduct on the part of the insured would seem to bar the right of the excess carrier to recover from the primary carrier by way of equitable subrogation. If, on the other hand, a direct duty is owed by the primary to the excess, the insured's conduct would seem to present no obstacle to the excess carrier's cause of action against the primary carrier.²²⁸ This weakness in the equitable subrogation doctrine led directly to the adoption of "triangular reciprocity" as the means of allowing recovery by the excess carrier against the primary carrier in *Transit Casualty Co. v. Spink Corp.*²²⁹

224. *Id.*

225. 148 N.J. Super. 419, 372 A.2d 1124 (1977).

226. *Id.* at 424, 372 A.2d at 1127.

227. 375 F. Supp. 1347 (C.D. Cal. 1974). For a discussion of *Peter*, see notes 214-18 & accompanying text *supra*.

228. See, e.g., *Kaiser Found. Hosps. v. North Star Reinsurance Corp.*, 90 Cal. App. 3d 786, 153 Cal. Rptr. 678 (1979) (collusion between primary insurer and insured will not be allowed to destroy rights of excess carrier).

229. 94 Cal. App. 3d 124, 156 Cal. Rptr. 360 (1979).

4. *Triangular Reciprocity*

The existence of a triangular reciprocal duty of due care owing between and among the insured, the primary carrier, and the excess carrier, was posited by the court of appeal in California in *Transit Casualty Co. v. Spink Corp.*²³⁰ as a basis for the excess carrier's recovery against the primary carrier for wrongful refusal to settle. Whether *Transit Casualty* has any continuing validity is somewhat in doubt, however, in view of the express disapproval of that opinion by the California Supreme Court insofar as it allowed recovery against the insured and insofar as it allowed recovery for negligent failure to settle.²³¹

In *Transit Casualty*, the excess carrier, Transit Casualty, sued both the insured engineering firm, Spink Corporation, and the primary carrier, American Reserve, for their allegedly wrongful refusal to settle a claim within the substantial deductible of the insured and the primary limits. At trial, the excess carrier was awarded all of the sums it had spent in satisfaction of the excess judgment and settlement of related claims, which sums were allegedly inflated by the excess verdict in the trial of the first claim. This judgment was appealed by both the insured and the primary insurer.

In support of its appeal, the primary carrier argued that the excess carrier's right of recovery was defeated by the bad faith of the insured in refusing to settle within the deductible and primary limits. This argument was flatly rejected:

American's contention rests on the assumption that equitable subrogation is a *sine qua non* of the excess insurer's suit. The assumption will not survive analysis. Equitable subrogation is a descendant of historic equity

230. *Id.*

231. In *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 921, 610 P.2d 1038, 1043, 164 Cal. Rptr. 709, 714 (1980), the California Supreme Court, in rejecting the imposition of liability upon an insured for bad faith refusal to settle, stated:

We observe that an apparently contrary conclusion has been reached by the Third District in the recent case of *Transit Casualty Co. v. Spink Corp.* . . . [W]e disapprove that case] insofar as it holds that an insured's duty of good faith and fair dealing to his excess carrier compels him to accept a settlement offer or proceed at his peril where there is a substantial likelihood that an adverse judgment will bring excess insurance coverage into play.

For a discussion of *Commercial Union*, see notes 249-81 & accompanying text *infra*.

However, in a more recent case, *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 365, 612 P.2d 889, 892-93, 165 Cal. Rptr. 799, 802-03 (1980), the California Supreme Court quoted *Transit Casualty* at length, stating that Justice Paras had "summarized very well, within the context of an action alleging a wrongful refusal to settle, the relationship between excess and primary coverages" and cited *Transit Casualty* as "disapproved in part in *Commercial Union*".

practice; it is utilized as a device to achieve a just result by clothing a party with a right of recovery when he would otherwise be defeated by lack of privity. Tested as an indispensable element of the excess carrier's claim, equitable subrogation fails to achieve even handed justice. . . . [The primary and excess carriers] [u]sually . . . have no contractual privity *inter se*. They are however, fully aware of their respective roles and of the significant differences in their obligations to the insured. . . . When an accident occurs, they become totally aware of each other. When the settlement value of the injury hovers over the upper limit of primary coverage, the two carriers face interacting problems of claim adjustment, settlement and defense. Each has a choice of mutual support or naked self-interest. The law, then, would be unrealistic in demanding that either carrier use the policyholder as its stepping stone to the assertion of a mutual obligation to each other. Triangular reciprocity is far more rational.²³²

The triangular reciprocal duty of due care was also seen as promoting the "sharing of the loss according to the measure of each party's comparative fault."²³³ The court analyzed the relationship among insured, primary insurer, and excess insurer and saw imposition of triangular reciprocity as consistent with the nature of that relationship in a settlement context. The court stated:

The three-way duty concept harmonizes with settlement realities. The policyholder pays for two kinds of liability coverage, each at a different rate. The premium charged by the primary insurer supports more localized claims adjustment facilities than those of the excess carrier. It takes into account costs of defense, including legal fees, which the primary insurer normally provides. The excess carrier is less frequently confronted with loss possibilities and, when it is, may employ local adjusters. The primary insurer is assisted, not impeded, by the active participation of another carrier with a stake in the negotiations. Self-interest will impel the primary carrier to take the lead when settlement value is well within its policy limits, the excess carrier when the claim invades its own policy exposure. When settlement value hovers over the fringes of both policies, both carriers may collaborate. Each may disagree with the settlement sentiments of the other; agreement is more likely when each knows that a jury may ultimately pass upon the reasonableness of its conduct. The primary carrier's conflict of interest with the excess carrier is no more acute than its conflict with the policyholder without excess coverage. Either may sue it for a bad faith refusal to settle. Neither carrier is likely to be intransigent if both know that intransigence will be a factor for consideration in a later refusal-to-settle lawsuit. Triangular reciprocity advances the public interest in extrajudicial settlement.²³⁴

Finally, the court rejected the primary carrier's arguments that the requirement that the insured consent to settle relieved the insurer of any obligation to settle and that the insured's refusal to settle precluded settlement by the primary carrier. The court noted that the settlement clause provided that the insured would be liable for the excess of any verdict over a settlement amount

232. *Transit Cas. Co. v. Spink Corp.*, 94 Cal. App. 3d 124, 132-33, 156 Cal. Rptr. 360, 365 (1979).

233. *Id.* at 134, 156 Cal. Rptr. at 366-67.

234. *Id.* at 135, 156 Cal. Rptr. at 367.

recommended by the insurer and opposed by the insured and viewed this clause as giving the insurer substantial power to pressure the insured into settlement.²³⁵ In addition, the court rejected the argument that the insured's refusal to consent to settlement was the sole cause of the excess carrier's loss. Such an argument, the court stated, "ignores the elementary proposition that a tortious injury may result from two independently concurring causes."²³⁶

5. Cases Disallowing Recovery

The trend toward allowing the excess carrier to recover the damages occasioned by the primary carrier's refusal to settle within its limits is not universal. Rather, two cases applying Arizona law clearly and specifically rejected such a cause of action. In *Universal Underwriters Insurance Co. v. Dairyland Mutual Insurance Co.*,²³⁷ the Arizona Supreme Court, in a six paragraph opinion, summarily rejected the argument of the excess carrier, Universal, that it should be entitled to recover its damages occasioned by the wrongful refusal of the primary carrier, Dairyland, to settle the claim against their joint insured within primary limits. The court stated:

Without doubt Dairyland owed good faith to its insured, which may or may not have been here exercised, a question we find unnecessary to answer. There is no privity of contract between these two insurance companies nor is there any principle of law of which we are aware that would give Universal such a windfall because of Dairyland's mistreatment of its assured.²³⁸

Thus, the court limited recovery by the excess carrier, which had defended the insured and settled the judgment against it following the refusal of the primary carrier to do so, to the primary carrier's limits of coverage.

In a more recent case involving an excess insurer against the same primary carrier, *Rocky Mountain Fire & Casualty Co. v. Dairyland Insurance Co.*,²³⁹ the Ninth Circuit Court of Appeals held that it was required, under *Universal Underwriters*, to affirm the judgment for the primary carrier because that opinion precluded an action under a theory of either equitable subrogation or breach of a direct duty between primary and excess insurers.

One point should be noted with respect to both the *Universal Underwriters* and the *Rocky Mountain* cases. In each case, the

235. *Id.* at 137, 156 Cal. Rptr. at 368.

236. *Id.*

237. 102 Ariz. 518, 433 P.2d 966 (1967).

238. *Id.* at 520, 433 P.2d at 968.

239. 452 F.2d 603 (9th Cir. 1971).

primary and excess relationship did not arise by the specific design of the insured. Rather, each case involved an automobile accident in which the driver who was a defendant in the personal injury action was driving a borrowed car. In such circumstances, the owner's policy provided the primary coverage and the driver's carrier, by coincidence, provided the excess coverage. Thus, it was sheer happenstance that the two carriers came to enjoy a primary and excess relationship *inter se*. It is not altogether clear whether the Arizona courts would hold that a primary carrier has no duty to the excess carrier when it provided a specific primary coverage and was aware that the insured had also purchased excess coverage from carriers which would be relying on the primary to properly handle, defend, and settle claims below the threshold limits of their coverage.

**C. Insurer's Right to Recover Excess of Verdict Over Settlement
Demand from Insured Which Refused to Give Required
Consent or to Post Necessary Sums Under Deductible,
Self-Insured Retention, or Participation Provisions
of its Coverage.**

As has been noted,²⁴⁰ many of today's policies contain one or more of the four following features which give the insured substantial control over settlement: (1) a clause requiring that the consent of the insured be obtained to any proposed settlement; (2) a substantial deductible; (3) a large self-insured retention; and (4) a participation in one or more layers of coverage. The insured's exercise of the power granted to it by one or more of these clauses to block settlement may, of course, result in an adverse verdict substantially higher than the proposed settlement. The question then arises whether the insurer which is forced to pay a greater amount in satisfaction or settlement of the adverse verdict than it would have had to pay in settlement prior to such verdict may recover the excess from the insured.

Extensive research has revealed only two cases in which this issue has been resolved, and the results therein are diametrically opposed. In *Transit Casualty Co. v. Spink Corp.*,²⁴¹ the court of appeal of California held that the excess carrier could recover damages from the insured for its wrongful refusal to settle. However, in a later case, *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*,²⁴² the California Supreme Court disapproved this as-

240. See text accompanying notes 104-09 *supra*.

241. 94 Cal. App. 3d 124, 156 Cal. Rptr. 360 (1979). See notes 230-36 *supra* for a discussion of the court's holding that the excess carrier could recover damages from the primary carrier for its wrongful refusal to settle.

242. 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980).

pect of *Transit Casualty* and held that, in ordinary circumstances, the insured could not be held to a duty to effect settlement below the threshold limits of excess coverage either under a theory of negligence²⁴³ or under its duty of good faith and fair dealing. An examination and comparison of the two cases suggests, however, that the *Transit Casualty* opinion is better reasoned and that the *Commercial Union* decision is unsound and should not be followed by other jurisdictions.

In *Transit Casualty*, Spink, an engineering company, was sued in connection with the cave-in of a trench upon which it had worked. The cave-in resulted in the death of one workman and injury to several others. The heirs of the deceased worker filed a wrongful death suit against five different defendants, including Spink. Spink maintained a \$100,000 professional liability policy with American Motorists, the primary carrier, which contained a \$15,000 deductible and provided for Spink's consent, in writing, to any settlement proposal. Spink also had an excess policy with Transit Casualty with limits of \$1 million. The plaintiffs offered to settle for \$300,000, to be divided among the five defendants. Spink, concerned about its future insurability, refused to consent to its \$76,000 share of the settlement and refused to post its deductible.

At trial, plaintiffs obtained a \$632,000 verdict against Spink and two other defendants. Spink was also held liable to one of these other defendants on its cross complaint. In order to satisfy Spink's liability, Spink paid \$15,000, American Motorists paid \$100,000, and Transit Casualty paid \$175,000. Thereafter, Transit Casualty contributed an additional \$285,000 toward settlement of the other personal injuries claims resulting from the trench collapse.

Transit Casualty then brought an action against Spink and American Motorists, charging that their unwarranted refusal of settlement had forced the first case to trial, resulting in the excess judgment and escalating the settlement value of the remaining cases. At this trial, the jury was instructed that the implied covenant of good faith and fair dealing bound all three parties, including the policyholder. The jury awarded Transit Casualty all sums which it had to pay, not only in satisfaction of the adverse judgment, but also in settlement of the personal injury claims. Both Spink and American Motorists appealed the verdict.

The jury verdict was affirmed by the court of appeal in a lengthy and well-reasoned opinion in which the court made two fundamen-

243. *Id.* at 921, 610 P.2d at 1043, 164 Cal. Rptr. at 714. The court gave short shrift to Commercial Union's negligence theory, noting that it also depended upon the existence of a duty to settle which was not explicit in the policy and could not be derived from the insured's implied duty of good faith and fair dealing.

tal holdings:²⁴⁴ (1) the insured's duty of good faith and fair dealing requires it, in appropriate cases, to settle claims below the threshold limits of the excess carrier's coverage; and (2) the duty of good faith and fair dealing is not the only duty which exists between insured, primary, and excess carriers; rather, each owes the other a "triangular reciprocal duty of due care" and may be held liable for breach of that duty. With respect to the first holding, the court rejected any notion that the insured did not have any duty of good faith and fair dealing, finding that this implied duty bound both policyholder and insurer.²⁴⁵

The court also rejected Spink's argument that, even if it did have a duty of good faith and fair dealing, such duty could not be extended to include a duty to settle because of the "consent to settlement" clause in its policy.²⁴⁶ The court noted the adverse effect which acceptance of this argument would have on the public interest:

There is however a public interest in extrajudicial settlement of law-suits. . . . The settlement clause tends to defeat that interest and therefore will be narrowly construed so as not to defeat the covenant of good faith and fair dealing which is an implied reciprocal term of the policy. That covenant contemplates that neither party will injure unreasonably, and certainly not arbitrarily, the right of the other to receive the benefit of the agreement or to minimize a loss thereunder. . . .

Thus the settlement clause does not permit unreasonable rejection of settlement by the insured. This circumscription does not divest the clause of meaning. In a suit charging the policyholder with unreasonable refusal to settle, the clause provides him with an opportunity to convince a jury or judge that his refusal to agree to a settlement was reasonable under all the circumstances, including his concern for professional reputation. The settlement clause exhibits no inconsistency with the policyholder's obligation of good faith.²⁴⁷

Thus, the court in *Transit Casualty* based its holding that the insured may be liable for failure to settle claims below the threshold limits of its excess coverage on three fundamental concepts: (1) the triangular reciprocal duty of due care among insureds, primary, and excess insurers;²⁴⁸ (2) the reciprocal nature of the duty

244. 94 Cal. App. 3d at 134-36, 156 Cal. Rptr. at 366-67.

245. *Id.* at 131, 156 Cal. Rptr. at 364. The reciprocal nature of the duty of good faith and fair dealing was recognized by the court in *Commercial Union* and the cases cited therein. See *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 918, 610 P.2d 1038, 1041, 164 Cal. Rptr. 709, 712 (1980). In addition, this rule was similar to that espoused in *Sargent v. Johnson*, 551 F.2d 221, 231-32 (8th Cir. 1977), in which the court stated that the insured and insurer must "maintain a mutual respect for the interests of the other."

246. 94 Cal. App. 3d at 136, 156 Cal. Rptr. at 367.

247. *Id.*

248. For a discussion of this triangular reciprocal duty, see notes 230-36 & accompanying text *supra*.

of good faith and fair dealing; and (3) the public interest in extrajudicial settlement of litigation.

A comparison of the court's consideration of these concepts in *Transit Casualty* with their treatment in *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*²⁴⁹ compels the conclusion that the reasoning and holding of the court in *Transit Casualty* clearly represent the better view. The *Transit Casualty* decision is more consistent with the California courts' interpretation of the duty of good faith and fair dealing as a reciprocal obligation binding both the insured and insurers,²⁵⁰ and with the public policy favoring extrajudicial settlement of litigation.

In *Commercial Union*, Safeway Stores, Inc., the insured, had insurance with limits of \$50,000 with Travelers Insurance Company and Travelers Indemnity Company and was self-insured for liability between the sums of \$50,000 and \$100,000. Commercial Union Assurance Companies and Mission Insurance Company (concurrently referred to as Commercial in the opinion) provided insurance coverage for Safeway's liability in excess of \$100,000 to \$20 million. One Hazel Callies recovered a judgment of \$125,000 against Safeway. Thereafter, Commercial Union brought an action against Safeway and Travelers, alleging negligence and breach of the duty of good faith and fair dealing in their failure to settle the Callies claim for \$60,000 (or possibly even \$50,000), when they had the opportunity to do so and the knowledge that there was a possible and probable liability in excess of \$100,000.

Safeway's demurrer to the complaint for failure to state a cause of action was sustained, and Commercial Union was given twenty days leave to amend. Following Commercial Union's failure to amend the complaint, the action was dismissed as to Safeway. The dismissal was affirmed by the court of appeal²⁵¹ and then by the California Supreme Court, which adopted the court of appeal's opinion, with a few additions and deletions,²⁵² as its own.

249. 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980).

250. See, e.g., *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980); *Kaiser Found. Hosps. v. North Star Reinsurance Corp.*, 90 Cal. App. 3d 786, 153 Cal. Rptr. 678 (1979); *Liberty Mut. Ins. Co. v. Altfilisch Constr. Co.*, 70 Cal. App. 3d 789, 139 Cal. Rptr. 91 (1977).

251. 96 Cal. App. 3d 449, 158 Cal. Rptr. 97 (1979).

252. 26 Cal. 3d at 915, 610 P.2d at 1039, 164 Cal. Rptr. at 710. The California Supreme Court's deletion of the court of appeal's entire discussion of negligence, followed by its rejection of the bad faith cause of action against the insured and its later statement in *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 612 P.2d 889, 165 Cal. Rptr. 799 (1980), that *Transit Casualty* was only "disapproved in part" in *Commercial Union*, *id.* at 365, 612 P.2d at 892, 165 Cal. Rptr. at 802, leads one to wonder just which part of *Transit Casualty* was approved by the supreme court. A plausible interpretation that draws some support both from the supreme court's opinion in *Commercial Union* and *Signal* is that the

It is interesting to note that the court in *Commercial Union*, like the court in *Transit Casualty*, initially acknowledged that the duty of good faith and fair dealing was "a two-way street,"²⁵³ i.e., reciprocal. However, the court immediately set about dividing this duty, leaving the insurer's side of the street considerably wider and more difficult to maintain than the insured's by eliminating any duty to settle on the part of the insured, while acknowledging the insurer's duty to settle.

In discussing whether the insured's duty of good faith and fair dealing included the duty to settle cases below the threshold limits of its excess coverage, the court focused upon two aspects of the relationship between the excess insurer and the insured: (1) the nature of the bargain struck between the insurer and the insured; and (2) the legitimate expectations of the parties which arise from the contract. However, the court seriously misconstrued both aspects of the relationship between the excess insurer and the insured. This misinterpretation led it to a decision which is simply wrong both as a matter of legal reasoning and as a matter of public policy.

Turning first to the nature of the bargain between the excess insurer and the insured, it is interesting to note that the court of appeal in *Commercial Union* based its rejection of the *Transit Casualty* case, in part, on the latter court's supposed failure "to take into account the disparity of bargaining power between insured and insurer."²⁵⁴ Although this specific paragraph was deleted by the supreme court, review of that court's opinion suggests that the deletion was more editorial than philosophical. Thus, the supreme court did not treat the dispute before it as one between two sophisticated corporations of relatively equal bargaining strength. Rather, the tone of the supreme court's opinion suggested that the matter pitted an unsophisticated insured against an overbearing insurer. A more accurate interpretation of the typical fact situation giving rise to suits such as *Commercial Union* suggests that it is the courts in *Commercial Union* which have failed to accurately assess the relative bargaining power of the insurers and insureds in excess insurance situations.

Stated simply, courts dealing with excess insurance actions brought by insurers against their insureds are not handling cases involving simple and unsophisticated individual insureds, such as

supreme court approved only that part of *Transit Casualty* which allowed the excess carrier to proceed, by way of equitable subrogation, against the primary carrier for wrongful refusal to settle. This, of course, is an exceedingly small part of *Transit Casualty*.

253. 26 Cal. 3d at 918, 610 P.2d at 1041, 164 Cal. Rptr. at 712.

254. 96 Cal. App. 3d at 459, 158 Cal. Rptr. at 101-02.

are found in the automobile accident cases giving rise to bad faith claims by the insureds against their insurers. Rather, the courts are faced with very large, powerful, and sophisticated insureds whose bargaining power is at least equal to that of the insurers. This contention is clearly reinforced by a consideration of the two insureds involved in the two cases in which the issue of the insurer's right to recovery against its insured arose. In *Transit Casualty*, the insured, Spink, was a large engineering firm and in *Commercial Union*, the insured, Safeway, was one of the largest supermarket chains in the world.

The contention that the bargaining power of the insureds in excess insurance situations is at least equal to that of the excess insurers is further supported by examination of the excess insurance policies. For example, an excess insurance policy may contain page after page of special endorsements and conditions specifically tailored to the desires and needs of the insured and thus, may be appropriately referred to as a "manuscript policy."²⁵⁵ This situation, of course, is markedly different from the typical automobile insurance situation where the insured has been presented with a form policy which he must either reject or accept *in toto*. The courts are understandably more inclined to view these contracts as virtually contracts of adhesion.²⁵⁶ Although the disparity of bargaining power rationale has some merit in simple individual insured vs. giant insurance company cases, it is simply not applicable to excess insurance cases, such as *Commercial Union*, where the insured's bargaining power is at least equal to if not greater than that of the excess insurer.²⁵⁷

In addressing the "legitimate expectations of the parties which arise from the contract,"²⁵⁸ the court in *Commercial Union* found that, although the insured had a reasonable expectation that the insurer would settle the claim within policy limits, the excess insurers had no such legitimate expectations. The court stated:

The essence of the implied covenant of good faith in insurance policies is that "neither party will do anything which injures the right of the other to receive the benefits of the agreement." (*Murphy v. Allstate Ins. Co.*,

255. See, e.g., the policies at issue in *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 612 P.2d 889, 165 Cal. Rptr. 799 (1980), which are discussed in greater detail in the court of appeal's decision, in 97 Cal. App. 3d 750, 159 Cal. Rptr. 10 (1979).

256. The form nature of such policies has led to the adoption of a number of rules for the protection of the insured, including the rules that coverage is broadly construed, see, e.g., *Mohn v. American Cas. Co.*, 458 Pa. 576, 326 A.2d 346 (1974), and exclusions are narrowly construed. *Middlesex Mut. Ins. Co. v. Wells*, 453 F. Supp. 808 (N.D. Ala. 1978).

257. See, e.g., *Brokers Title Co. v. St. Paul Fire & Marine Ins. Co.*, 610 F.2d 1174 (3d Cir. 1979) (where parties of relatively equal bargaining power enter into insurance contract, it will not be treated as contract of adhesion).

258. 26 Cal. 3d at 918, 610 P.2d at 1041, 164 Cal. Rptr. at 712.

supra, 17 Cal. 3d at 940, quoting from *Brown v. Superior Court* (1949) 34 Cal. 2d 559, 564 [212 P.2d 878]). One of the most important benefits of a maximum limit insurance policy is the assurance that the company will provide the insured with defense and indemnification for the purpose of protecting him from liability. Accordingly, the insured has a legitimate right to expect that the method of settlement within policy limits will be employed in order to give him such protection.

No such expectations can be said to reasonably flow from an excess insurer to its insured. The object of the excess insurance policy is to provide additional resources should the insured's liability surpass a specified sum. The insured owes no duty to defend or indemnify the excess carrier; hence, the carrier can possess no reasonable expectation that the insured will accept a settlement offer as a means of "protecting" the carrier from exposure. The protection of the insurer's pecuniary interest is simply not the subject of the bargain.²⁵⁹

Here the court failed to make the fundamental distinction between a situation where the insured has only one layer of coverage and that in which there is excess coverage, and the court compounded this failure by inaccurately assessing the basic nature of excess insurance. It may be true that where there is only one layer of insurance the insurer has no reasonable right to expect that the insured will settle claims out of its own pocket in order to protect the insurer. However, it does not necessarily and logically follow, as the court in *Commercial Union* seemed to assume, that an excess insurer has no legitimate expectation that the insured will settle claims below the threshold limits of the excess coverage where there is an opportunity to do so.

The fundamental nature of excess insurance is just what the name implies—it is excess to other insurance and to the insured's own deductible, retention, and participation. Viewed from the excess insurer's perspective, one of the most important benefits of an excess policy is the full protection of the primary limits (including any and all deductibles, retentions, and/or participations). Thus, neither the insured nor the insurers expect that the excess carriers will be required to step in and defend, settle, or satisfy judgments of claims which can be settled or defended to judgment below the threshold limits of the excess coverage. This contention is clearly supported by the following facts: (1) premiums for excess insurance are historically significantly lower than premiums for primary insurance,²⁶⁰ (2) the excess policies at issue in *Commercial Union* specifically required, as do all excess policies,²⁶¹ that the insured

259. *Id.* at 918-19, 610 P.2d at 1041-42, 164 Cal. Rptr. at 712-13.

260. For example, review of the court of appeal's opinion and the briefs filed in *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 612 P.2d 889, 165 Cal. Rptr. 799 (1980), revealed that the primary carrier received \$106,000 in premiums for \$25,000 in coverage whereas the excess carriers received approximately \$150,000 for \$10 million in coverage.

261. See, e.g., *Vencill v. Continental Cas. Co.*, 433 F. Supp. 1371 (S.D. W. Va. 1977)

maintain primary insurance in specified amounts; and (3) the limits of liability provisions of excess policies specifically provide that the carrier will pay its limits in settlement or satisfaction of judgments only *after* the primary limits have been exhausted.²⁶² Moreover, under the law of California and other jurisdictions, the excess carrier has no duty to settle claims until the primary carrier has exhausted or posted its entire limits.²⁶³

The failure of the *Commercial Union* court to distinguish between cases involving one layer of coverage and those involving specific excess insurance was highlighted in its focus upon the duties to defend and indemnify as supporting its conclusion that the excess carrier had no reasonable expectation that the insured would accept a settlement offer below the threshold limits of the excess coverage. Again, where there is no excess insurance, only one carrier has the obligation to defend and indemnify. In such a situation, the carrier must protect the insured and cannot reasonably expect the insured to settle cases out of his own pocket to protect the insurer. Where, however, excess insurance is involved, the situation is completely different. In such a case, the excess carrier will usually not have any duty to defend and will have only a limited duty to indemnify. Moreover, the insured and the primary will usually control the defense to the exclusion of the excess carrier. Thus, to a very real extent, the excess carrier is at the mercy of the primary and the insured and *must* depend on their good faith and fair dealing in the defense and settlement of claims.

Although such a duty may not be considered a classic example of a duty to indemnify, the insured *does* have a duty to maintain primary insurance (including any deductible, retention, or participation thereunder) and, thus, to protect the excess carrier from

(court noted existence of such requirement in excess policy and construed primary policy in such a way as to avoid "gap" between primary and excess coverage); *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 612 P.2d 889, 165 Cal. Rptr. 799 (1980) (court noted that excess policies required maintenance of primary coverage but primary policies did not require maintenance of excess coverage).

262. *Vencill v. Continental Cas. Co.*, 433 F. Supp. 1371, 1373 (S.D. W. Va. 1977); *Signal Cos. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 362, 612 P.2d 889, 891, 165 Cal. Rptr. 799, 801 (1980).
263. *Valentine v. Aetna Ins. Co.*, 564 F.2d 292, 296 (9th Cir. 1977) (applying California law). *Cf. Offshore Logistics Servs., Inc. v. Arkwright-Boston Mfg. Mut. Ins. Co.*, 639 F.2d 1142 (5th Cir. 1981) (court refused to reduce excess liability verdict against excess carrier, which had refused to settle, by amount of deductible both because there was not proof that deductible was not paid and because excess carrier received full credit for primary limits, including deductible); *Benroth v. Continental Cas. Co.*, 132 F. Supp. 270 (W.D. La. 1955) (actual payment of limits by primary not required, it may be sufficient that third-party claimant gives full credit for primary limits.)

exposure below its limits. Implication of a duty on the part of the insured to settle cases below the threshold limit of the excess coverage is, then, logically concomitant not only to the insured's general duty of good faith and fair dealing but also to its duty to maintain primary insurance.

The court in *Commercial Union* completely missed the point when it suggested that "[t]he object of the excess insurance policy is to provide additional resources should the insured's liability surpass a specified sum."²⁶⁴ Although this statement, taken in the abstract, may be true, it fails to address the fundamental issue of whether the insured, as part of its duty of good faith and fair dealing, is required to settle cases below the threshold limit of its excess coverage in order to prevent its liability from exceeding that limit. Under the *Commercial Union* decision, the insured is entitled to the *benefit* of the lower premiums which are paid for excess insurance because such insurance does not take effect until a certain threshold limit of liability has been passed, but has no *obligation* to see to it that this limit is not passed. Such a holding is not only inequitable and illogical, but squarely inconsistent with other cases which have suggested that any benefit to be realized under an insurance contract should not be a mere windfall but should be accompanied by some burden undertaken in exchange.²⁶⁵

Amazingly, the court in *Commercial Union* further bolstered its conclusion that the insured had no duty to settle below the threshold limit of excess coverage by describing excess insurance as a carte blanche authorization to the insured to gamble with the insurer's money. The court stated:

"The duty to settle is implied in law to protect the insured from exposure to liability in excess of coverage as a result of the insurer's gamble—on which only the insured might lose." (*Murphy v. Allstate Ins. Co.*, *supra*, 17 Cal. 3d at p. 941). Similar considerations do not apply where the situation is reversed: where the insured is fully covered by primary insurance, the primary insurer is entitled to take control of the settlement negotiations and the insured is precluded from interfering therewith (see *Shapero v. Allstate Ins. Co.*, (1971) 14 Cal. App. 3d 433, 437-438 [92 Cal. Rptr. 244], quoting from *Ivy v. Pacific Automobile Ins. Co.*, (1958) 156 Cal. App. 2d 652, 659-660 [320 P.2d 140]). Where, as here, the policyholder is self-insured for an amount below the beginning of the excess insurance coverage, he is gambling as much with his own money as with that of the carrier. The crucial point is that the carrier has no legitimate expectation that the insured will "give at least as much consideration to the financial well-being" of the insurance company as he does to his "own interests" (*Shapero, supra*, 14 Cal. App. 3d at p. 438), in considering whether to settle for an amount below the excess policy coverage. In fact, the primary reason excess insurance is purchased is to provide an available pool of money

264. 26 Cal. 3d at 919, 610 P.2d at 1041, 164 Cal. Rptr. at 712.

265. See, e.g., *Valentine v. Aetna Ins. Co.*, 564 F.2d 292 (9th Cir. 1977); *Estate of Penn v. Amalgamated Gen. Agencies*, 148 N.J. Super. 419, 372 A.2d 1124 (1977).

in the event that the decision is made to take the gamble of litigating.²⁶⁶

In this single quote, the court misconstrued both the purpose of excess insurance and the purpose of litigation. First, the purpose of excess insurance is not to provide would-be gamblers with "an available pool of money" with which to gamble. Rather, the purpose of excess insurance is to protect the insured in the event of a genuinely catastrophic loss. The catastrophe is the event insured against, not the risk that the insured will take a case that can be settled below the threshold limits of excess coverage and parlay it into a monumental adverse verdict. The court in *Commercial Union* ignored the facts, not only of the case before it, but also those common to most specific excess insurance situations, when it suggested that the insured is "gambling with his own money as much as with that of the carrier." In *Commercial Union*, the total amount of Safeway's self-insured retention was \$50,000—a minimal amount when compared with the \$19.9 million in coverage provided by the excess carriers. Indeed, in almost every case, the amount of excess coverage is vastly greater than both the primary and any self-insured retention. It is simply not true, then, to suggest that the insured is "gambling with his own money as much as with that of the carrier" when the insured refuses an opportunity to settle below the threshold limits of excess coverage.

More importantly, the *Commercial Union* court misconstrued the purpose of litigation. Litigation is not, as the court seemed to suggest, a game of chance to be engaged in by all who can afford the risks (indeed, made all the more easily affordable by the court's decision that the insured should be allowed to gamble with the insurer's money). Rather, litigation is and traditionally has been society's vehicle for the peaceful resolution of disputes. In our current "superlitigious society,"²⁶⁷ courts have been veritably inundated with a flood of litigation and have actively fostered, wherever possible, extrajudicial settlement of claims. The suggestion in *Commercial Union* that insureds should be encouraged to gamble with the excess carrier's money by litigating even cases which can and should be settled runs directly counter to the public interest in reserving the limited resources of the courts for resolution of cases which cannot be settled.²⁶⁸

The court in *Commercial Union* apparently overlooked entirely the adverse effect which its decision would inevitably have on the public interest in minimizing loss and spreading the risks of loss through the means of insurance. If the *Commercial Union* holding

266. 26 Cal. 3d at 919, 610 P.2d at 1042, 164 Cal. Rptr. at 713.

267. Kaiser Found. Hosps. v. North Star Reinsurance Corp., 90 Cal. App. 3d 786, 793 n.11, 153 Cal. Rptr. 678, 682 n.11 (1979).

268. See note 124 & accompanying text *supra*.

were to become the generally accepted rule and thus, insureds were to have no duty to settle below the threshold limits of their excess coverage, not only would there be a greater increase in the number of cases which have to be tried, but also an inevitable increase in verdicts which exceed the primary limits and thus must be paid by excess carriers. In such a situation, as a matter of simple economics, either premiums would have to be increased or excess insurance would become unavailable. Either result would have an adverse effect on the public interest in spreading the risk of loss through reasonably affordable (and available) insurance.²⁶⁹

The final anomaly in *Commercial Union* is that it was decided in a state which upholds the right of an excess carrier to proceed against a primary carrier for bad faith refusal to settle a claim below the threshold of excess coverage.²⁷⁰ If a jurisdiction allows an excess carrier to proceed against a primary carrier absent a contractual relationship²⁷¹ and even absent the primary's knowledge of the excess carrier's existence,²⁷² then *a fortiori*, it ought to allow a suit for bad faith refusal to settle against an insured with which the excess carrier does have a direct contractual relationship. This is especially true where the insured has voluntarily assumed financial obligations under that contract, which make it more akin to a primary insurer than to a normal insured.

While the decision in *Commercial Union* must be interpreted as requiring extraordinary circumstances, beyond the mere existence of the insurer/insured relationship, to justify imposition of a duty to settle upon the insured, it does not absolutely preclude the imposition of such a duty. Rather, there are at least three plausible arguments which may be made for the imposition of such a duty.

First, it may be noted that in *Commercial Union* there was no allegation of any conscious wrongdoing on the part of the insured or any improper collusion between the insured and the primary insurer. The court emphasized the absence of any such allegations in distinguishing *Kaiser Foundation Hospitals v. North Star Rein-*

269. The increase in premiums which would result from a rule which freed a party to an insurance relationship from a duty to settle below the threshold limits of excess coverage has been considered a factor weighing against the adoption of such a rule by courts in the excess versus primary cases cited in note 125 *supra*.

270. See, e.g., *Continental Cas. Co. v. United States Fid. & Guar. Co.*, 516 F. Supp. 384 (N.D. Cal. 1981); *Peter v. Travelers Ins. Co.*, 375 F. Supp. 1347 (C.D. Cal. 1974); *Northwestern Mut. Ins. Co. v. Farmers' Ins. Group*, 76 Cal. App. 3d 1031, 143 Cal. Rptr. 415 (1978).

271. See Sections II.B. & III.B. of the text *supra*.

272. See, e.g., *Western World Ins. Co. v. Allstate Ins. Co.*, 140 N.J. Super. 338, 356 A.2d 83 (1976).

surance Corp.²⁷³ and *Liberty Mutual Insurance Co. v. Altfilisch Construction Co.*²⁷⁴ the two cases principally relied upon by Commercial Union in support of its cause of action for bad faith against Safeway.²⁷⁵ Nevertheless, the court approved the principle set forth in those cases that the insured must act in good faith toward its insurer:

We acknowledge that equity requires fair dealing between the parties to an insurance contract. We view the *Kaiser* and *Liberty* cases as pointing up a recognition in the law that the insured status as such is not a license for the insured to engage in unconscionable acts which would subvert the legitimate rights and expectations of the excess insurance carrier.²⁷⁶

Where the insured has engaged in willful wrongdoing or in collusion with the primary to block settlement at the expense of the excess carrier, it might be argued that such conduct constitutes an attempt by the insured to use his status as "a license . . . to engage in unconscionable acts which would subvert the legitimate rights and expectations of the excess insurance carrier"²⁷⁷ and, accordingly, is actionable even under *Commerical Union*.

Second, it should be noted that the policy at issue in *Commerical Union* did not specifically impose any duty upon the insured to settle below the threshold of the excess coverage. Thus, Commercial Union was forced to base its cause of action upon the implied duty of good faith and fair dealing. Although the court rejected this *implied* duty as a basis for a cause of action, it did not rule out the possibility that an insured could be held liable for breach of an *express* duty to settle:

If an excess carrier wishes to insulate itself from liability for an insured's failure to accept what it deems to be a reasonable settlement offer, it may do so by appropriate language in the policy. We hesitate, however, to read into the policy obligations which are neither sought after nor contemplated by the parties.²⁷⁸

Finally, the court's repeated emphasis upon the "reasonable expectations" and "implied promises" of the parties to an insurance contract suggests that it might impose a duty of settlement upon an insured where it could be shown that the insured, in return for lower premiums or for some other reason, impliedly promised and the insurers reasonably expected that the insured would settle claims below the threshold limits of the excess coverage. Indeed,

273. 90 Cal. App. 3d 786, 153 Cal. Rptr. 678 (1979).

274. 70 Cal. App. 3d 789, 139 Cal. Rptr. 91 (1977).

275. 26 Cal. 3d at 919-20, 610 P.2d at 1042-43, 164 Cal. Rptr. at 713-14.

276. *Id.* at 921, 610 P.2d at 1043, 164 Cal. Rptr. at 714.

277. *Id.*

278. *Id.*

this suggestion arises from the way in which the court stated the central questions which were to be resolved:

In the instant case, whether Commercial could harbor any legitimate expectation that its insured would settle a claim for less than the threshold amount of the policy coverage must be determined in the light of what the parties bargained for. The complaint makes no reference to any language in the policy which would give rise to such expectation. We must therefore ask the question: Did Safeway, when it purchased excess coverage, impliedly promise that it would take all reasonable steps to settle a claim below the limits of Commercial's coverage so as to protect Commercial from possible exposure? Further, did Commercial extend excess coverage with the understanding and expectation that it would receive such favorable treatment from Safeway under the policy?²⁷⁹

It should be noted, however, that the court's own answer to these questions ("We think not")²⁸⁰ and the reasons given in support of that answer seem to severely diminish, if not altogether destroy, any prospect that it would ever uphold a cause of action against the insured for wrongful failure to settle based solely upon an implied promise by the insured and the reasonable expectation of the insurer that the insured would do so. This prognostication is bolstered by the fact that the court explicitly held that the mere existence of a self-insured retention and primary layer of coverage did not imply a promise to settle within such retention and primary limits.²⁸¹

Thus, although *Commercial Union* does not explicitly forever foreclose the possibility that an insurer could successfully sue its insured for wrongful refusal to settle, for all practical purposes it seems to narrow any such suit to one based upon explicit language in the policy of insurance. Such a narrow view of the relationship between an insurer and an insured might be sound and equitable in the context of a low-limit automobile liability policy, where the insured is at a substantial disadvantage in terms of bargaining power and has paid a standard premium in return for virtually no financial involvement in protecting himself against risks up to the limits of his coverage. However, applied to cases involving large, sophisticated insureds who have bargaining power relatively equal to that of the insurers and have received substantial reduction in their premiums in return for retaining a substantial financial involvement in protecting themselves against risk, the approach taken by the court in *Commercial Union* is neither equitable nor

279. *Id.* at 920, 610 P.2d at 1042, 164 Cal. Rptr. at 713.

280. *Id.*

281. *Id.* at 921, 610 P.2d at 1043, 164 Cal. Rptr. at 714. This holding seems to reveal a basic lack of understanding of insurance industry practice and standards, in stark contrast to Justice Paras' explanation of the relationship between insured, primary insurer, and excess insurer in *Transit Casualty*, which was specifically approved in *Commercial Union*.

just. Rather, the approach, analysis, and holding of the court in *Transit Casualty* clearly represents the better view in allocating the liability for an excess verdict in a dispute between a sophisticated insured with a large deductible, retention, or participation and its insurer and, accordingly, should be followed by other jurisdictions.

IV. CONCLUSION

Resolution of settlement disputes among insureds, primary insurers, and excess insurers is perhaps the one field in the law in which there is the greatest internal confusion in, and conflict among, the various jurisdictions. For example: (1) there is a dispute among two leading authorities as to whether negligence or good faith is the majority standard for the imposition of excess liability upon an insurer for wrongful failure to settle a claim within policy limits;²⁸² (2) there are cases which have discussed this split and opted for the good faith standard but then proceeded to discuss the standard in terms more appropriate to a negligence standard;²⁸³ and (3) one jurisdiction cited another jurisdiction as having adopted strict liability, which was promptly followed by a case in which the latter pointed out that it had not adopted such a standard.²⁸⁴

Much of this conflict, of course, may be attributed to the federalism of our common law system. Where close questions are involved and persuasive arguments may be made for different resolutions, as seems to be the case in the resolution of settlement disputes, it is not surprising to find that different jurisdictions have adopted differing standards. However, an additional factor contributing to this confusion in, and conflict among, jurisdictions seems to be a failure of some jurisdictions to recognize the changes in the insurance industry which have rendered inapposite or inappropriate some of the more strongly entrenched principles of insurance law. In particular, of course, we speak of the failure of some jurisdictions to distinguish between two types of insurance disputes: (1) those which pit an unsophisticated individual insured, with no financial involvement in his own protection and no control over the litigation, against a large insurance company, which has issued a standard form policy vesting virtual total control over litigation in the insurer; and (2) those which pit a large, sophisticated insured with substantial bargaining power, control over litigation, and financial involvement in its own protection

282. See note 169 *supra*.

283. See text accompanying notes 168-72 *supra*.

284. See text accompanying notes 195-98 *supra*.

against an insurance company which has issued a policy with endorsements specially tailored to the needs of the insured and has granted a substantial reduction in premiums in return for the protection of an underlying deductible, self-insured, or participation and/or primary limits.

Having reviewed all of these cases and conflicts, and knowing full well that even opinions which have been expressed by noted insurance law scholars have not received universal acceptance,²⁸⁵ the authors nonetheless suggest three proposals which we believe would bring more order and rationality to the resolution of settlement disputes.

First, the duties imposed upon the parties to the insurance contract should be truly reciprocal. When dealing with duties which are imposed under the express terms of the contract and which are not usually the same (such as the insurer's duty to defend and the insured's duty to cooperate), the courts should interpret such terms so as to make the duties of one party mirror or mesh with the duties of the other. Where the duties arise by implication, such as the duty of good faith and fair dealing, they should be truly reciprocal, equally burdening all parties to the insurance relationship. Courts should not nominally hold the duty of good faith and fair dealing to be reciprocal, then place the overwhelming burden of that duty upon the insurers and thus strip the term of all practical meaning as applied to the insured.

This proposal for reciprocity of duties among insureds and insurers, of course, may be expected to engender considerable controversy. Thus, some jurisdictions will reject the proposal on the ground that it places an unbearable and unwarranted burden on the insured. However, that view, while possessing superficial plausibility, simply ignores the realities of the types of situations in which the necessity for its application will arise. The proposed rule of reciprocity would place no additional burden upon simple individual insureds, for which the courts profess appropriate solicitude. Disputes with such insureds, who have little or no control over settlement and little or no financial involvement in settlement or judgments within the upper limits of their coverage, do not require litigation by the insurer to protect its own interest. In the event that a claim can be settled within policy limits, the insurer can do so with or without the consent of the insured. In the event that a claim cannot be settled for policy limits, the insurer, provided it is acting in good faith, can simply offer its limits to the

285. See, e.g., the treatment of Professor Keeton's views concerning unilateral settlement by the New Jersey Supreme Court in *Fireman's Fund Ins. Co. v. Security Ins. Co.*, 72 N.J. 63, 367 A.2d 864 (1976), discussed in text accompanying notes 56-65 & 196-98 *supra*.

third-party claimant and, in the event of an excess verdict, fulfill its obligations by paying those limits.²⁸⁶

Where, however, the insured has retained substantial control over, and financial involvement in, litigation or settlement of claims against it, there is real need and justification for the rule of reciprocity. In such cases, the insurer may well be at the mercy of the insured and, accordingly, must rely on the good faith of the insured. Moreover, imposing upon the insured duties which are reciprocal of those placed upon the insurer is justified by many of the same analyses which have been used to impose such duties upon the insurer. First, the control over settlement analysis which has been applied in some cases to impose the duty of good faith and fair dealing upon insurers would seem equally applicable to impose such a duty upon insureds who have such control. Second, the benefit and burden analysis which has been used by some jurisdictions in support of the imposition of a duty of good faith and fair dealing or in support of the suggested standard of strict liability, would seem equally applicable to an insured who may reap the benefit of his refusal to settle and, therefore, should be burdened with the detriment if such refusal was wrongful. Third, the equal consideration test which has been applied to impose a duty of good faith and fair dealing upon insurers because they are, in essence, gambling with the insured's money when they refuse to settle, would seem equally applicable to impose such a duty upon an insured who is gambling with the insurer's money by refusing to settle.

Our second proposal in the area of settlement dispute resolution concerns the right of one party to a settlement dispute to settle over the objections of another and obtain the financial contribution required from the objector as though it had consented. We believe such a right should subsist only where the objecting party has violated the express terms of the contract. Thus, where the insured refuses to settle, the insurer should have the right to settle and sue the insured for its deductible, self-insured retention, or participation only where the insured's refusal to settle is part of its overall refusal to cooperate and not merely a difference of opinion as to the advisability of settlement. Conversely, where the insurer refuses to settle, the insured's right to sue for reimbursement should be limited to those cases where the insurer has refused to defend. In proposing such a standard, we do not intend to encourage parties to resolve a settlement dispute by unilaterally effecting settlement with the third-party claimant.

286. See, e.g., *Boston Old Colony Ins. Co. v. Gutierrez*, 386 So. 2d 783 (Fla. 1980) (insurer who was prevented from settling claim by insured not liable for excess verdict).

Rather, this suggestion stems from the reluctant realization that there will be situations in which a unilateral settlement is the only way the objecting party can effectively protect itself and limit its exposure. Nonetheless, those circumstances are extremely limited, and the adoption of either a bad faith or a conditional defense standard for determining the propriety of unilateral settlement would be unwarranted and unwise.

With respect to the bad faith standard for unilateral settlement, the authors are in substantial agreement with the opinions expressed by Justice Clifford in his dissent in *Fireman's Fund Insurance Co. v. Security Insurance Co.*²⁸⁷ Thus, we believe that adoption of this standard is unwarranted because it deprives the objecting party of any opportunity to obtain a judgment more favorable than the settlement demand and yet provides no real additional protection to the party seeking settlement. The party seeking settlement is already fully protected by the fact that if the objecting party's refusal to settle is in bad faith (as it would have to be for unilateral settlement to be upheld under the bad faith standard), that party will be liable for the entire excess of the verdict over the settlement amount in any event.

An additional objection to the bad faith standard arises from the amorphous nature of the concept. Courts have had considerable difficulty establishing guidelines for the determination of bad faith, even in cases where the claim against the insured has gone to a verdict. While not conclusive, the verdict is at least some indication of the value of the claim and, hence, the good faith of the party rejecting the settlement demand. The difficulty in determining bad faith can only be compounded where there is no verdict and, accordingly, the likely outcome of a trial against the insured would be a subject of sheer speculation.

The authors disapprove of the conditional defense standard for the right of unilateral settlement because it exacerbates the very problem which it is supposed to resolve. Requiring the insurer at the outset of litigation to either waive any reservation of rights and accept coverage or turn over complete control of defense and settlement to the insured takes a potential conflict concerning coverage, which may never need to be resolved,²⁸⁸ and turns it into a confrontation which must be resolved before many of the facts

287. 72 N.J. 63, 367 A.2d 864 (1976). For a discussion of this case, see text accompanying notes 56-65 *supra*.

288. If the case is settled by the joint agreement of insured and insurer, results in a verdict favorable to the insured, or results in an adverse verdict on a ground clearly within or without coverage, the dispute may become moot. Another way of avoiding immediate confrontation, of course, would be to settle or litigate subject to the outcome of a declaratory judgment.

bearing on its resolution are even discovered. This all or nothing approach is unwarranted. Rather, a better solution would be to allow the insurer to continue to defend under a reservation of rights. In the event that the insured is not satisfied with the counsel selected by the insurance company, it would seem appropriate, as the Alaska Supreme Court suggested in *Continental Insurance Co. v. Bayless & Roberts, Inc.*,²⁸⁹ to allow the insured to choose its own counsel, which would nonetheless be paid by the insurer.

Finally, we propose that good faith ought to be the standard by which imposition of liability for the excess of an adverse verdict over the settlement demand is determined. This recommendation is based as much on the flaws of the negligence and strict liability standards as upon the propriety of the good faith standard. With respect to the negligence standard, the authors agree with the colorful criticism of that standard by the Kentucky Supreme Court²⁹⁰ as requiring gifts of prophecy which mere mortals do not possess, especially when the object of such prophecy is inherently unpredictable. Obviously, taking the element of fault out of such a prediction altogether and imposing a strict liability standard only serves to increase the injustice done to the party whose prediction was incorrect.

The authors realize that in suggesting a good faith standard, we are advocating further use of a term which has already caused considerable confusion. The appropriate definitional test for that standard should be whether the party (insured or insurer) objecting to settlement has made such objections after "equal consideration" of the interests of the other.²⁹¹ Such a test more appropriately carries out the principle of reciprocity and is far superior to the working definition of good faith employed by some jurisdictions, which simply requires the insurer to sacrifice its legitimate interests on behalf of the insured at the altar of good faith.²⁹²

We realize that even the length of this Article has not been sufficient to address every problem which may arise in settlement disputes among insureds, primary insurers, and excess insurers. However, the cases analyzed reflect the current state of the law with respect to the more basic types of disputes. The proposals outlined above, if adopted by the courts in resolving such problems in the future, would lead to greater clarity in the law and a more rational basis for conduct of the relationship between insured and insurer in settlement disputes.

289. 608 P.2d 281 (Alaska 1980).

290. See quote in text accompanying note 182 *supra*.

291. See text accompanying notes 152-54 *supra*.

292. See text accompanying notes 155-66 *supra*.