

THE LIABILITY INSURER'S DUTY TO SETTLE UNCERTAIN AND MIXED CLAIMS

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What does it mean to say that an individual or organization is “insured” against liability?

Being insured turns out not to be a simple notion, but a bundle of rights whose composition may vary with the setting. Particularly in connection with possible settlements, what it means to be insured is under-theorized. When there is no question that a liability insurance policy would cover liability imposed in a suit brought against the insured, then, as the Restatement of the Law of Liability Insurance (“RLLI”) indicates, the liability insurer’s duty to settle is well established and reasonably clear. An insured party is entitled to have its liability insurer accept reasonable offers to settle suits against it.¹ An important issue on which the case law is far from fully developed, however, is the liability insurer’s duty to settle uncertain and mixed suits or claims—which together I will simply call “claims”—against the insured. What it means to be insured in these settings is more complicated and less settled.

The RLLI briefly proposes an approach to the duty to settle uncertain and mixed claims.² It is virtually inevitable, however, that a restatement will leave some issues unexplored and some problems incompletely solved. That is especially the case in this area, where the issues are

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1. As the RLLI puts it, the insurer is required to make “reasonable settlement decisions.” RESTATEMENT OF THE LAW OF LIAB. INS. § 24 (AM. LAW INST., Discussion Draft 2015). In addition, anyone studying this subject is indebted to the extraordinarily systematic and insightful analysis of Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113 (1990).

2. RESTATEMENT OF THE LAW OF LIAB. INS. § 25 cmts. a–c (AM. LAW INST., Discussion Draft 2015).

diverse, the possible approaches are intricate, and the implications of different approaches sometimes require extended analysis. This Article therefore takes up the task of more fully examining the duty to settle uncertain and mixed claims.

In the sections that follow, I first define a conceptual baseline by analyzing the functions of the duty to settle in “conventional” cases—that is, the cases in which the claim is definitely covered and there is therefore no coverage issue. Then, by reference to the functions of the duty to settle in these conventional cases, I address the duty to settle uncertain and mixed claims. Although I do not refrain from recommending what I regard as the best solution when there is one, my aim throughout is principally analytical. I want to describe the conceptual terrain on which the issues arise, identify the advantages and disadvantages of possible approaches to the liability insurer’s duty to settle uncertain and mixed claims, and explain how these advantages and disadvantages interact.

Before proceeding, it will be useful to define the terms that I will use throughout the Article. A *certain claim* is a claim against a party covered by a liability insurance policy about which there is no coverage question. Certain claims fall into two categories. A *covered claim* is one that definitely would fall within the coverage of the policy if the allegations contained in the claim were true. An *uncovered claim* is one that definitely would not be covered even if the allegations of the claim were true.

In contrast, an *uncertain claim* is one containing allegations against an insured under a liability insurance policy that might or might not fall within coverage if the allegations of the claim were true, because that depends on disputed facts or on unsettled law. For example, a complaint may allege that the defendant-insured is liable for the discharge of a pollutant that harmed the plaintiff, without alleging whether the discharge involved waste or a marketed product. Here there is factual uncertainty, because the former, but not the latter, ordinarily would be excluded. Or the complaint may allege that the defendant-insured discharged a substance that harmed the plaintiff. Whether the substance constitutes a “pollutant” within the meaning of a pollution exclusion may be legally uncertain.

To be distinguished from uncertain claims are two different kinds of “mixed” claims. A *covered-uncovered claim* contains some allegations that, if the claim were successful, definitely would fall within the terms of coverage, and some allegations that definitely would not be covered even if the claim were successful. For example, a claim alleging both

negligently-caused bodily injury and battery would contain both a covered claim (negligence) and an uncovered claim (battery).³ On the other hand, a *covered-uncertain claim* contains some allegations that definitely would fall within the terms of coverage if the claim were successful, and some allegations that are uncertain. A claim alleging both negligently-caused bodily injury and negligently-inflicted emotional distress with accompanying physical symptoms would fall into this category in jurisdictions that have not yet decided whether this form of emotional distress constitutes “bodily injury” within the meaning of a liability insurance policy.

There is no approach that can completely reconcile the interests of insureds and insurers in these situations. The tensions between these sets of interests, and the issues that the tensions pose, are too complex for that ideal to be achievable. But there are solutions that recognize these interests and give them the weight that makes the most sense. The critical move, I think, is to treat liability insurance as what I will call “judgment insurance” and not also as “settlement insurance.”⁴ That is, if the duty to settle is designed primarily as insurance against the risk of incurring covered judgments, then workable rules governing the duty to settle uncertain and mixed claims can be devised. The alternative is to formulate the duty to settle also to protect directly against the other emotional and financial risks and costs associated with litigation, including the understandable desire of some insureds that their liability insurer pay the plaintiff in order to make harassing suits just go away. But it turns out that such an expansion of the duty to settle, regardless of whether it would otherwise be desirable, would not be workable in most settings.⁵ If the duty to settle is to provide what amounts to settlement insurance, it will only be able to do that indirectly, as a side effect of its direct provision of judgment insurance.

I. FUNCTIONS OF THE DUTY TO SETTLE IN CONVENTIONAL CASES

Most liability insurance policies do not expressly impose a duty to settle on the insurer. On the contrary, policies typically provide that the insurer may settle at its discretion. But as is well known, this discretion whether to settle creates a potential conflict between the interests of the

3. See, e.g., *Gray v. Zurich Ins. Co.*, 419 P.2d 168 (Cal. 1966).

4. For what may be the origin of this distinction, see Syverud, *supra* note 1, at 1151, which states that the purpose of the duty to settle is to protect insureds from excess judgments, not make litigants behave as though liability insurance does not exist.

5. See *infra* Section I.B.

insured and the insurer. As a consequence, the courts have created a “duty to settle” that requires the insurer to accept some, but not all, offers to settle claims against its insured.

This duty to settle is so well established as a matter of common law that, in my experience, the duty is informally understood to be a feature of liability insurance policies themselves. Thus, the common law duty to settle has a quasi-mandatory character. Although including express language in liability insurance policies that limit the duty would be permissible in principle, in practice such a change could face strong headwinds. Insurance regulators would probably be reluctant to approve such provisions, the market would be reluctant to accept them, and the courts would likely look on them with disfavor.

For this reason, the duty to settle in conventional cases can be treated as much more firmly-rooted than a mere default rule, even if it is something less than an absolutely mandatory rule. Because the rules the courts develop regarding the duty to settle uncertain and mixed claims are, and will be, part of the duty to settle, there is every reason to believe that these rules will acquire the same sort of quasi-mandatory character.

A. *The Source and Contours of the Duty*

The principal source of the conflict between the insured and the liability insurer is the universal presence of a “limit of liability” on the monetary amount of coverage provided by liability insurance policies.⁶ The insurer is liable to pay covered claims up to a policy’s limit of liability, or “policy limits,” whereas, by virtue of this limit, the insured has responsibility for—in effect, is self-insured for—liabilities in excess of the policy’s limit. As a consequence, it is always in the interest of the insured for the insurer to settle a claim against the insured.⁷ This is because whenever a claim is not settled, there is a risk that liability for an amount exceeding the limit of liability will be imposed when the claim is tried. In the absence of a duty to settle, the insurer would always pay only the amount of its limit of liability and the insured would always pay the amount of any judgment in excess of that limit.

6. There are other potential conflicts as well. See Syverud, *supra* note 1, at 1127 (citing allocation of defense costs, differences in levels of risk aversion, strategic bargaining by insurers, and the additional stakes beyond the amount of the judgment or settlement that the parties may have in the outcome).

7. I am speaking here of the short-term financial interest of the insured. It might be that the insured’s reputation would be better served if a case were not settled, or that settlement would not serve the insured’s long-term financial interest in some other way—for example, by jeopardizing the availability of future insurance to the insured or causing premiums for future insurance to be increased.

Although it is always in the insured's interest for the liability insurer to settle claims for an amount within the policy limits, doing so is not always in the insurer's interest. This is the case even for covered claims, for various reasons. The claim may be groundless and therefore extremely unlikely to result in a judgment against the insured. For instance, the amount for which the plaintiff would be willing to settle could exceed the expected value of the claim plus the insurer's cost of defending against the claim, or the insurer may wish to establish a reputation for toughness by declining to settle some claims that it would otherwise make economic sense for the insurer to settle and pay. In these situations, the insurer would be better off declining to settle such claims. This is because its payouts would be smaller in the long run if the claims were tried to a verdict rather than settled, or if the insurer held out for a smaller settlement.

These conflicting interests can be accommodated by imposing a conditional duty to settle on the insurer, and that is what the common law of insurance has done. Notwithstanding policy language affording the insurer discretion whether to settle, in various formulations, the case law requires the insurer to accept certain offers of settlement that it would not accept if it considered its own interests exclusively.⁸ The most sensible and understandable formulation of the duty is that the insurer must disregard the limits ("DTL") of liability of its policy in deciding whether to settle.⁹ In effect, the insurer must accept offers to settle for an amount within the policy limits if it would be reasonable for a party who would be liable for the entire judgment that would result if the offer were not accepted to accept the offer.

8. Some courts require not only that the insurer accept reasonable offers, but also that it initiate settlement discussions. See Syverud, *supra* note 1, at 1167. Others reject this approach. See, e.g., *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 859 (Tex. 1994). The RLLI takes the position that the failure to initiate settlement discussions may be evidence of unreasonable behavior, but that initiating settlement discussions or making the first offer is not necessarily a breach of the duty to settle. RESTATEMENT OF THE LAW OF LIAB. INS. § 24 cmt. e (AM. LAW INST., Discussion Draft 2015).

9. RESTATEMENT OF THE LAW OF LIAB. INS. § 24 cmt. c (AM. LAW INST., Discussion Draft 2015). The DTL conception seems to have originated with Robert E. Keeton's article, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1148 (1954) ("With respect to the decision whether to settle or try the case, the insurance company must . . . view the situation as it would if there were no policy limit applicable to the claim."). The DTL test found its most prominent early acceptance in *Crisci v. Sec. Ins. Co. of New Haven*, 426 P.2d 173 (Cal. 1967) (in bank). As Syverud observed in 1990, "*Crisci* so dominates case law on duty-to-settle doctrine that some commentators tacitly assume the 'disregard the limits' standard is universally accepted." Syverud, *supra* note 1, at 1122 n.23. The RLLI makes it clear that this is not the case, but nonetheless adopts the DTL test.

By disregarding its policy limits, the insurer compares the expected value of the claim against its insured with the offer of settlement. If the former is greater than the latter and the offer is less than the policy limit, then the offer is reasonable and the insurer has a duty to accept it.¹⁰ Conversely, if the latter is greater than the former, then the offer is not reasonable and the insurer does not have a duty to accept it.

The key to ensuring that the insurer follows the DTL rule is to impose above-limits liability on the insurer when it breaches the duty to accept reasonable offers to settle. If the insurer rejects a reasonable offer, the suit against the insured goes to trial, and there is a judgment against the insured in excess of the policy limits, then the insurer owes the full amount of the judgment, including the amount that is excess of the policy limits. On the other hand, if the insurer rejects an unreasonable offer, it has not breached its duty to settle. When the suit against the insured goes to trial, the insurer is liable only for the amount of any judgment that falls within the policy limits. The insured is liable for the portion of any judgment that exceeds the policy limits.

The DTL test and its allied formulations accommodate the conflicting interests of the insurer and the insured, but do not completely reconcile them. Under the DTL test, the interests of both the insured and the insurer are given weight. How the interests are weighed, however, depends on the interaction of the expected value of the claim and the particular limit of liability to which a policy is subject. Suppose that the insured has a liability insurance policy with a \$500,000 limit of liability, that a claim against the insured has a 60 percent chance of success, and that the plaintiff's damages are \$600,000. The expected value of the claim is \$360,000—60 percent of \$600,000.¹¹

In this scenario, the insured's interest is for the insurer to accept any offer to settle by the plaintiff that is less than \$500,000. This would leave the insured with no liability and no monetary obligation. In contrast, the insurer's interest is to reject any offer above \$300,000—60 percent of \$500,000—leaving the insured exposed to the risk that rejecting the offer will result in an above-policy-limits judgment. Under the DTL rule, however, any offer below \$360,000 is reasonable and must be accepted, whereas any offer above \$360,000 is unreasonable and may be rejected by the insurer. So the insurer must accept offers that are up to \$60,000 more

10. Although anticipated defense costs do not figure into the test, a rational insurer will inevitably take them into account. See RESTATEMENT OF THE LAW OF LIAB. INS. § 24 cmt. h (AM. LAW INST., Discussion Draft 2015).

11. Although—as I indicate below—expected values typically run over a broad range rather than converging on a particular monetary point, *id.* § 24 cmt. d, in order to illustrate the way the DTL test accommodates conflicting interests, we can assume otherwise.

than it is in the insurer's interest to accept, and the insured has a right to have offers below \$360,000 accepted, but no right to have offers between \$360,000 and \$500,000 accepted, although it would be in the insured's interest for the insurer to accept such offers.

In short, under the DTL test, an insurer may reject an unreasonably high offer even though rejection risks a judgment that the insured will be obligated to pay in part, and an insurer must pay the amount of a reasonable offer or bear the consequence of rejecting it when, in the absence of the duty, the insurer could reject the offer with impunity.

For insurers and risk-neutral insureds with unlimited assets, arguably this duty to settle is optimal. The duty minimizes the sum of premiums plus the total of the insurer's and the insured's share of judgments in excess of the policy limits. In the long run, both insurers and insureds as a group save money if reasonable offers are accepted and unreasonable offers are rejected. It would therefore be rational for such parties to agree to this arrangement as part of their contract. The common law duty to settle simply adopts as a rule what the parties would rationally agree to if they were both perfectly informed and there were no costs to contracting. Arguably, if the rule had not long ago been adopted, standard-form contracts would have been modified to adopt it expressly.¹²

Most insureds, however, are not risk-neutral and do not have effectively unlimited assets.

For risk-averse insureds, the DTL test provides under-protection. For such insureds, the risk of incurring an above-limits judgment is of greater concern than the additional cost of insurance that would include an insurer's duty to accept at least some unreasonably high offers to settle. A natural response is that such insureds should purchase insurance with higher limits of liability.

But even sophisticated insureds are unlikely to fully understand the interaction between the amount of insurance they purchase and the insurer's duty regarding the acceptance and rejection of offers to settle. And in any event, the risk of an above-limits judgment is always present as long as liability insurance is subject to some monetary limit of liability.

12. This is not to say that the package of insurance the insured has purchased is optimal. The protection provided by the duty to settle declines as the amount of insurance purchased by an insured increases, unless the amount of insurance purchased increases in direct and precise proportion to the expected value of suits that may be brought against the insured. But assuming that the amount of insurance the insured has purchased is optimal, the duty to settle provides optimal protection to such insureds.

Conversely, for insureds with limited assets, the duty to settle provides over-protection.¹³ An insured with a net worth of \$500,000 does not need protection against the risk of a \$5,000,000 judgment. Yet the duty to settle provides that amount of protection, because claims against the insured with an expected value of more than \$500,000 may require acceptance of offers to settle that exceed this sum. In the majority of jurisdictions, the duty to settle takes no account of the amount of the insured's net worth.¹⁴ Consequently, the portion of any liability insurance premium that takes into account the insurer's risk of liability for breach of the duty to settle is the same, regardless of the differences in net worth of the insureds paying the premium. Insureds with comparatively low net worth therefore subsidize those with comparatively high net worth, because the former gets less advantage from the protection provided by the duty to settle than the latter.

In short, the duty to settle probably provides less asset protection than some insureds would like to have, and more asset protection than is necessary for other insureds. The duty to settle uncertain and mixed claims inevitably will have similar imperfections.

B. Judgment Insurance Versus Settlement Insurance

The scope of the duty to settle is determined by reference to the risk that there will be a judgment against the insured in excess of the policy limits. The duty to settle, however, provides the insured with no direct protection of the other interests the insured may have in having a claim settled. Insureds have interests that extend beyond protecting themselves against covered judgments. Even apart from eliminating the risk of facing an above-policy-limits judgment, insureds usually have something to gain from settlement, not merely nothing to lose.

The interest of the insured is therefore often that a case be settled in order to make a claim go away. Involvement in litigation is emotionally aggravating for individuals and disruptive for businesses. In addition, even for insureds without significant assets, judgments of record can affect credit ratings and ultimately can lead to bankruptcy. And, trial rather than settlement may allow matters that an insured would prefer be kept out of the public eye to be exposed to scrutiny—for example, intoxication, infidelity, sharp-dealing, or addiction.¹⁵

13. See Alan O. Sykes, "Bad Faith" Refusal to Settle by Liability Insurers: Some Implications of the Judgment-Proof Problem, 23 J. LEGAL STUD. 77, 100 (1994).

14. See RESTATEMENT OF THE LAW OF LIAB. INS. § 27 cmt. d (AM. LAW INST., Discussion Draft 2015).

15. Syverud, *supra* note 1, at 1159.

There is no duty on the part of the insurer, however, even to consider these interests, let alone liability for failing to take them into account in deciding whether to settle. Whether an offer to settle is reasonable does not turn in any way on these considerations. The duty to settle protects the insured's interest in avoiding liability for an above-limits judgment, not the interest in avoiding or terminating litigation.

Obviously, the duty to settle nonetheless promotes settlement. In this respect the duty provides what could be considered indirect settlement insurance, by giving the insurer an added incentive to settle claims against the insured. But in fact even this indirect effect is limited. The duty to settle protects against the risk of only some above-limits judgments, and therefore helps to make only some claims go away. If an offer to settle is unreasonably high or there is no risk of an above-limits judgment, then there is no duty to settle, notwithstanding the insured's possible interest in having the claim settled.

The great problem here is that, although many insureds would prefer to have some settlement insurance accompany the judgment insurance that the duty to settle provides, there is no practical way to build such protection into the duty to accept reasonable offers of settlement without defining which economically unreasonable offers must be accepted. Fashioning a duty that required insurers to settle nuisance suits under limited circumstances would have to specify the scope and limits on that limited duty, yet not unduly encourage the filing of nuisance suits solely in order to take advantage of the new duty. That does not seem feasible, whether the duty would apply to conventional claims or also, as we will see below, to uncertain and mixed claims.

It may be that in practice, however, the DTL test actually does provide some such settlement insurance in two ways, though unsystematically and indirectly. First, what makes an offer reasonable is not fully objectifiable. A reasonable offer to settle is not a point but two ranges: the range reflecting the probability that the claim will succeed if tried, and the range of damages that might be awarded. These ranges are likely to depend on expert judgments by attorneys and insurance personnel that cannot be justified or fully explained, objectively. And, a jury's assessment of reasonableness may be subject to a hindsight bias. Imposition of liability in excess of a policy limit may appear after the fact to have been more likely than it actually was, merely by virtue of the fact that such liability was imposed. The prospect that this will occur probably inclines liability insurers to err on the side of accepting offers to settle that are on the high side of reasonable or even a bit over that ceiling on reasonableness.

Second, although the courts do not require insurers to take their anticipated defense costs into account in determining whether offers to

settle are reasonable, insurers surely do exactly that. They cannot always settle merely because of their anticipated defense costs, or they would attract more lawsuits against their insureds seeking to take advantage of this fact. But it seems highly likely that the prospect of saving defense costs inclines insurers to settle some suits that they would not otherwise settle. The result is that insurers accept certain otherwise-unreasonable offers to settle and thereby make certain suits go away.

Despite these positive side effects for insureds, if the duty to accept reasonable offers of settlement cannot feasibly be configured to provide settlement insurance directly, there is an alternative: strict liability. In fact, it might be thought that one of the implications of imposing strict liability for rejecting an offer to settle within policy limits would be that the duty to settle should provide even broader settlement protection. But as the next section demonstrates, strict liability is on balance undesirable and in any event would provide little, if any, additional settlement insurance.

C. *The Strict Liability Alternative*

Under strict liability, the insurer would be liable for any otherwise-covered judgment in excess of the policy limits that ensued after rejection of an offer to settle within the policy limits, regardless of whether the offer was reasonable as defined by the DTL test.¹⁶ In my view, strict liability is on balance not a sensible approach. But it is worth briefly canvassing its advantages and disadvantages.

1. Advantages

Three aspects of strict liability would be positive. First, although the duty to accept only reasonable offers to settle in order to protect the insured against above-limits judgments may be optimal for risk-neutral parties, insureds are not risk-neutral; typically they are risk-averse.¹⁷ They buy insurance precisely because they are averse to the risk of incurring liability. It follows that insureds are more averse to the risk of suffering a judgment in excess of the limits of liability of their liability insurance policies than are insurers to the risk of being held liable for

16. For discussions of strict liability for rejecting offers to settle, see KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 194–95 (1986), Syverud, *supra* note 1, at 1168–72, and Victor E. Schwartz, *Statutory Strict Liability for an Insurer's Failure to Settle: A Balanced Plan for an Unresolved Problem*, 1975 *DUKE L.J.* 901 (1975).

17. Syverud, *supra* note 1, at 1145.

more than these limits of liability. Insurers can diversify this risk across a large number of cases and, at least with respect to judgments resulting from their rejecting reasonable offers to settle, that is exactly what insurers already do. Because premiums for liability insurance are based in part on past claims and loss experience, which include liability imposed for breach of the duty to settle, premiums necessarily include a component that corresponds to anticipated liability for breach of the duty to settle. Adopting strict liability would increase premiums, but this cost would be spread among all insureds—the majority of whom would want the additional judgment protection that strict liability would provide.

Second, most insureds would probably prefer additional protection against groundless, or near-groundless suits—what I earlier called “settlement insurance.” They would prefer, that is, for the duty to settle to include an obligation on the part of the insurer to make certain claims go away, even if the claims are groundless, or nearly so, and even if this expansion of the duty to settle results in somewhat higher premiums.

Finally, proving that an offer to settle within policy limits was reasonable is difficult.¹⁸ Strict liability would save the cost of litigating whether a settlement was reasonable. Moreover, the DTL test places a burden on an insured who has suffered an above-limits judgment. The expected value of the case of the plaintiff against the insured is a function of both the probability that the plaintiff would obtain a verdict and the distribution of possible awards that would be made if there were a plaintiff’s verdict. But just as there is no objective way to quantify these matters in advance of trial of the underlying action against the insured, there is no objective way to do so after a judgment has been obtained. A suit for breach of the insurer’s duty to settle will therefore hinge on testimony that rests on the expert opinions of lawyers, which will be difficult for a jury to assess. As a consequence, some suits for breach of the duty to settle will fail, insurers will not always be threatened with sufficient liability for breach of the duty, and certain reasonable offers to settle will be rejected.

2. Disadvantages

A plausible response to the risk-aversion argument for strict liability is that insureds—who are risk-averse—should purchase or should have purchased liability insurance with higher limits of liability. But this is not a complete solution. Insurers are probably reluctant to insure those with limited assets against hundreds of thousands or millions of dollars

18. See *id.* at 1165.

of liability. Second, even insureds who purchased somewhat higher limits of liability as a result of their risk-aversion—for example, auto insurance with a \$50,000 per accident limit of liability instead of a \$20,000 limit—would still be at risk from groundless or near-groundless suits that their insurers would be under no duty to make go away if accepting an unreasonably high offer to settle was required. So insureds' risk-aversion might in theory support at least some minimal duty to settle groundless or near-groundless suits that the existing duty to settle does not require.

A number of problems, however, would be posed by this approach. First, the effect of strict liability would be to make policy limits irrelevant in any case in which the plaintiff made an offer to settle, no matter how unreasonable. This would result in increased premiums across the board, because occasionally the rejection of even unreasonable offers would result in above-limits judgments for which insurers would be liable, and this exposure would be built into premiums. This pass-through would affect premiums for low-limits coverage the most, because these would be the policies most at risk of a judgment exceeding their limits. The purchasers of such policies tend to disproportionately be ordinary individuals with comparatively low incomes, particularly purchasers of auto liability insurance. The resulting increase in premiums could add to the temptation not to purchase such insurance, despite the fact that the auto liability insurance is legally mandated.¹⁹ The percentage of uninsured drivers would therefore increase, along with all the accompanying ripple effects, including undercompensation of the victims of auto accidents and increased premiums for uninsured motorists' coverage.

Second, strict liability would discourage the purchase of insurance with above-minimum limits of liability, because the amount of a limit would be relevant only in cases in which no offer to settle was made. And those insureds who did prudently purchase insurance with substantial limits of liability would in effect be partially cross-subsidizing those who did not purchase insurance with higher limits.

Third, strict liability could encourage groundless or near-groundless “nuisance” suits, because occasionally, such a suit in which the insurer rejected an offer to settle, would result in an above-limits judgment. Filing such a suit would be akin to buying a lottery ticket.

Fourth, strict liability would provoke strategic behavior by plaintiffs. Even now, when comparatively low-limits liability insurance is a defendant's principal asset, plaintiff's counsel sometimes makes a “set-

19. See KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 656 (6th ed. 2015).

up” offer to settle for an amount just below the policy limits, in the hope that the offer will be rejected.²⁰ If the offer is rejected, then the case is tried, and the plaintiff seeks a recovery in excess of the policy limits. If the plaintiff is successful, then the insurer is liable for the full judgment if there is proof that the “set-up” offer was reasonable. If strict liability were adopted, the plaintiff’s incentive to make genuine, arguably reasonable offers to settle would be diminished, and the incentive to make disingenuous, higher set-up offers would be increased. There would be more disingenuous offers to settle for a dollar less than the policy limit, for example. The result might well be fewer settlements for a reasonable, or more-nearly-reasonable, amount.

Finally, despite the increased incidence of liability for above-limits judgments that would entail, strict liability would not provide any more actual settlement insurance than is provided by the conventional duty. As I noted earlier, insureds justifiably want many suits to go away, even if they are groundless or near-groundless. The way to make such suits go away would be for the insurer to settle them, even if for an unreasonably high sum in light of the groundlessness of the suit. Imposing strict liability on insurers for rejecting even unreasonable offers, however, would not cause insurers to make groundless suits go away by settling them. In the long run, rejecting unreasonable offers would still result in lower payouts by insurers than accepting such offers. The result of strict liability, therefore, will not be more settlements. It will simply be the same number of trials and the imposition of more liability on insurers—for the occasional above-limits judgment that follows the insurer’s rejection of an unreasonable offer to settle within limits.

In short, even when there was no question that a liability insurance policy covered the claim in question, the additional judgment protection that strict liability for rejecting unreasonable offers to settle provided would be accompanied by a number of undesirable effects, and would not include any additional settlement protection. It would simply provide more insurance against the risk of incurring a covered judgment, part of which exceeded the insured’s policy limits.

II. UNCERTAIN CLAIMS

Uncertain claims pose a number of problems that are absent when coverage is certain. The key to the duty to settle in conventional cases,

20. See William T. Barker & Ronald D. Kent, *Bad Faith in Liability Insurance*, in 3 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 23.02[8][a] (Jeffrey E. Thomas & Francis J. Mootz III eds., 2014); Syverud, *supra* note 1, at 1169–70.

when coverage is certain, is that it requires the insurer to internalize the cost of rejecting reasonable offers. When there is no question that the claim against the insured is covered, the insurer knows that, if it accepts an offer to settle, it is avoiding the risk of incurring greater liability—at the least, liability for a judgment within the policy limits, and if the offer to settle was reasonable, liability for the full amount of any judgment, even if it exceeds the policy limits. The insurer therefore has a strong incentive to accept reasonable offers to settle.

In contrast, if the insurer's coverage obligation is uncertain, then—unless a legal rule provides otherwise—the insurer will not necessarily have to internalize the full cost of rejecting offers to settle because the claim in question may not be covered at all. And if the insurer will not necessarily have to internalize the full cost of rejecting reasonable offers, more such offers may be rejected. So the question is: what should be the liability insurer's obligations and rights when its coverage obligation is uncertain?

There are two general situations in which this issue arises: when the insurer rejects an offer to settle, and when the insurer accepts an offer to settle.

A. *When the Insurer Rejects a Reasonable Offer to Settle*

If the insurer in an uncertain claim rejects a reasonable offer and the suit against the insured results in a judgment for the plaintiff, the rights of insured and insurer will be resolved in a subsequent coverage suit. If in that subsequent suit it is determined that the claim was not covered, then the insurer is not liable, either for the amount of the judgment within the policy limits or for any amount in excess of the limits. Because the claim was not covered, the insurer had no duty to settle.²¹

In contrast, when the insurer in an uncertain claim rejects a reasonable offer and in a subsequent coverage suit it is determined that the claim was covered, there is a division of authority. Some jurisdictions—probably the majority—apply the reasonable-offer rule.²² They hold that the insurer has breached its duty to settle. In these jurisdictions, and under the RLLI, the insurer in an uncertain claim takes its chances in rejecting a reasonable offer to settle.²³ Any coverage

21. Barker & Kent, *supra* note 20, § 23.02[6][c][iii][B].

22. *Id.*

23. RESTATEMENT OF THE LAW OF LIAB. INS. § 25(1) (AM. LAW INST., Discussion Draft 2015); *see, e.g.*, *Johansen v. Cal. State Auto. Ass'n Inter-Ins. Bureau*, 538 P.2d 744, 748 (Cal. 1975) ("An insurer who denies coverage [d]oes 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

uncertainty is irrelevant to its duty to settle. The insurer can avoid responsibility altogether by rejecting the offer and later proving that the claim was not covered. But if the insurer attempts to avoid responsibility altogether by rejecting a reasonable offer, and it turns out that the claim was covered, then the insurer has breached its duty to settle, regardless of the fact that the insurer was legitimately uncertain about the scope of its coverage obligation.

Courts that adopt this approach sometimes consider the question to be whether the insurer may take coverage uncertainty into account in deciding whether to accept an offer to settle.²⁴ But of course this is not really what the approach provides. The insurer may take whatever it wishes into account, and surely will take the likely outcome of the coverage dispute into account in deciding whether to accept an offer to settle. Other things being equal, the more likely that the claim is covered, the more likely the insurer will be to accept the offer, because by doing so the insurer will avoid risking liability for an above-limits judgment. Conversely, the less likely it is that the claim is covered, the less likely the insurer is to accept an offer to settle, because rejecting even a reasonable offer is not likely to lead to any liability on the part of the insurer.

Consequently, what the courts must mean when they say that the insurer may not take coverage uncertainty into account in evaluating offers to settle is that coverage uncertainty is irrelevant to the subsequent determination of whether the insurer breached the duty to settle. If the claim is later determined to be covered, then the insurer is liable for rejecting a reasonable offer to settle; if the claim is later determined not to be covered, the insurer had no duty to settle and cannot have breached it. Neither of these outcomes depends on or is affected by the fact that, at the time the offer to settle was rejected, coverage was uncertain.

In contrast, other jurisdictions seem to hold that the insurer is entitled to take coverage uncertainty into account and therefore is not

full amount which will compensate the insured for all the detriment caused by the insurer[]" (emphasis added) (quoting *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 202 (Cal. 1958)); *Eskridge v. Educator & Exec. Insurers, Inc.*, 677 S.W.2d 887, 889 (Ky. 1984).

24. See *Eskridge*, 677 S.W.2d at 889 ("Some [courts] hold that an insurance company in determining whether it should settle a claim within its policy limits is entitled to consider all factors that may affect its ultimate liability, including the factor of whether coverage is afforded by the policy"); see also Michael F. Aylward, *Other People's Money: Insurer Liability for Failing to Settle Within Policy Limits*, 54 FED'N DEF. & CORP. COUNS. Q. 267, 277 (2004) (stating that "[c]ourts are also divided with respect to whether an insurer may consider the partial or total absence of coverage in responding to an opportunity to settle a claim against its policyholder").

always liable—that is, has not necessarily breached its duty to settle—if it has otherwise behaved in good faith. In these jurisdictions, it appears that the duty in question is not a duty to accept reasonable offers to settle, but a duty to behave reasonably in handling offers to settle. In these jurisdictions, for example, the insurer's rejection of a reasonable offer while making a good-faith but unsuccessful effort to have the coverage issue adjudicated before trial of the underlying action against the insured might be regarded as reasonable conduct.²⁵ As a consequence, under this rule the insurer is not necessarily liable for breach of the duty to settle even when it has rejected a reasonable offer to settle and it is later determined that the claim was covered. Such an insurer is of course liable for the amount of any subsequent judgment against the insured falling within its policy limits, but is not liable for the amount of a judgment in excess of policy limits.

It is important to understand that these are the insurer's incentives when considering only the consequences to the insurer of rejecting an offer to settle. The insurer's incentives in considering an offer to settle, however, are influenced not only by the scope of the insurer's liability in the event that the insurer *rejects* a settlement offer. These incentives are also affected by the rules governing the insurer's rights in the event that it *accepts* an offer, because the choice the insurer actually makes is between the consequences of rejecting and the consequences of accepting an offer to settle. Therefore, I now turn to the rules that govern when an insurer accepts an offer to settle when coverage is uncertain.

B. *When the Insurer Accepts an Offer to Settle*

Understandably and unavoidably, the above-stated rules governing the insurer's duty to settle when coverage is uncertain reduce the incentive of the insurer to accept reasonable offers to settle. When coverage is certain, the insurer knows that if it rejects a reasonable offer, it will be liable for the full amount of any judgment that ensues. In contrast, we have just seen that when coverage is uncertain, the insurer will not necessarily be liable for rejecting such offers. And that reduced incentive on the part of the insurer puts the insured in a position of greater vulnerability to having to pay a judgment. The insurer still will tend to accept some reasonable offers, however, because of the prospect that the underlying suit may turn out to be covered.

Beyond this tendency, the pivotal question concerns the way that different rules affect whether an insurer facing coverage uncertainty will

25. See, e.g., *Mowry v. Badger State Mut. Cas. Co.*, 385 N.W.2d 171, 180 (Wis. 1986).

accept an offer of settlement. That is, whether the insurer has a right to reimbursement from the insured if it is later determined that the claim was not covered will affect the insurer's conduct. There are two basic approaches, with subsidiary rules that may accompany them.

Under the first approach, the insurer that accepts a reasonable offer to settle has an automatic right to reimbursement from its insured if the underlying suit turns out not to be covered. I will call this automatic-reimbursement, or "AR." Under the second approach, the insurer is entitled to reimbursement for settlement of non-covered claims only if the insured has consented to paying reimbursement in the event the suit—and therefore the settlement payment—is determined not to be covered. That consent may be reflected in a pre-existing policy provision or in an agreement reached during the pendency of the claim but before the insurer accepts the offer to settle. I will call this approach no-reimbursement-without-consent, or "NRWC."

AR is the California approach;²⁶ NRWC is the Texas approach.²⁷ The RLLI endorses NRWC.²⁸ This is a serious division of respectable authority. But there are only a handful of decisions from other states addressing the issue; the results in these cases are also split.²⁹ As time goes on, the states will align themselves with one of the two approaches.

I want to make what may appear, in light of this division of authority, to be a surprising contention: in many cases, and perhaps even in most cases, it does not matter which approach is adopted. The reason is that both approaches will have the same effect.³⁰ I must qualify this assertion only slightly: the two approaches will have the same effect as long as certain subsidiary rules that accompany each approach are set correctly, and as long as the insurer has a rough idea of the order of magnitude of the insured's assets. These are not, however, highly demanding conditions. The task, therefore, is to explain my contention.

26. See *Blue Ridge Ins. Co. v. Jacobsen*, 22 P.3d 313, 322 (Cal. 2001).

27. See *Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 43–44 (Tex. 2008); *Tex. Ass'n of Ctys. Cty. Gov't Risk Mgmt. Pool v. Matagorda Cty.*, 52 S.W.3d 128, 129 (Tex. 2000).

28. RESTATEMENT OF THE LAW OF LIAB. INS. § 25(2) (AM. LAW INST., Discussion Draft 2015).

29. Outside of California, the only case adopting AR that I have identified is *Phillips & Assocs., P.C. v. Navigators Ins. Co.*, 764 F. Supp. 2d 1174 (D. Ariz. 2011). Cases outside of Texas adopting NRWC include *Mount Airy Ins. Co. v. Doe Law Firm*, 668 So. 2d 534 (Ala. 1995), *Med. Malpractice Joint Underwriting Ass'n v. Goldberg*, 680 N.E.2d 1121 (Mass. 1997), and *Steadfast Ins. Co. v. Sheridan Children's Healthcare Servs., Inc.*, 34 F. Supp. 2d 1364 (S.D. Fla. 1998).

30. A similar point is made, less directly, in *Barker & Kent*, *supra* note 20, § 23.02[6][c][ii][D].

Ideally, the insurer's rights and the insured's obligations in this situation should be structured to capture as many of the benefits of the conventional duty to settle as is possible, yet recognize that an insurer whose coverage obligations are uncertain is in a different position from the insurer in the conventional situation. And it turns out that both approaches can do that, to the extent that doing that is possible.

1. Settlement When the Insured Has Sufficient Assets to Reimburse the Insurer

Under AR, even when the insurer is uncertain whether it will ultimately have a coverage obligation, if the insurer knows that the insured has sufficient assets to pay reimbursement, the insurer has nothing to lose and everything to gain by accepting reasonable offers. If the underlying suit turns out to be covered, then the insurer will have avoided the potential for incurring greater, covered liability, as well as above-limits liability. In settling, the insurer also will have achieved the purpose of the conditional duty to settle: it will have eliminated the risk to the insured of an above-limits judgment. On the other hand, if the underlying suit turns out not to be covered, the insurer will be reimbursed by the insured for the amount of the settlement, and the insured will have avoided liability for a potentially greater judgment.

For practical purposes, however, the same result is likely to occur under NRWC as long as the insurer knows that the insured has sufficient assets to reimburse the insurer for the amount of the settlement. This is because an insured, with sufficient assets to pay reimbursement, can always agree to reimburse the insurer for a settlement if it is later determined that the suit was not covered, if that is a condition of the insurer's accepting a reasonable offer to settle. An insured with sufficient assets to pay reimbursement would be foolish not to agree to reimburse the insurer if the claim turns out not to be covered, whenever the amount of the settlement offer is reasonable. Similarly, an insurer who has concluded that the offer to settle is reasonable would be foolish not to attempt to protect itself by requesting the insured's consent to reimburse. So an agreement to reimburse will be requested and, in most instances, accepted by the insured.

It is true that, under NRWC, insureds with assets could play "chicken" with the insurer by refusing consent to reimburse, in the hope that the insurer will accept the offer to settle anyway, thereby assuring that the insured has no reimbursement obligation even if the claim is not covered. In general, however, insureds are more risk-averse than insurers. An insured will play "chicken" with the insurer only when its coverage claim is strong, and, when the coverage claim is strong, the

insurer is likely to accept a reasonable offer even without the insured's consent to reimburse because the odds of the insurer having to pay any ensuing judgment against the insured are high.

It is true that, if the policyholder has a strong coverage claim, it may be tempted to play "chicken" with the insurer by refusing consent to reimbursement, since the policyholder has a strong interest in ending the entire dispute, and agreeing to defer the coverage dispute by consenting to reimbursement will do just the opposite: continue the coverage litigation. However, in playing "chicken" in this way, the insured will subject itself to the risk that the insurer will not accept the offer, the case will go to trial, there will be a judgment in excess of the policy limits, the claim will turn out not to be covered, and the insured will be liable for the entire judgment. A risk-averse insured is not very likely to follow such a course. To put it another way, in a game of "chicken" the party who is more risk-averse is likely to lose, and that party will typically be the insured. Anticipating loss in a possible game of "chicken," most insureds will decide not to play at all and agree to reimbursement.

In the few reported cases that squarely address the AR versus NRWC issue, there are a couple of examples of what looks like insureds playing "chicken" with their insurers, but these are cases in which there was not yet a rule about whether AR or NRWC applied.³¹ In this situation, the insureds may have refused consent to reimbursement because of their prediction that NRWC and not AR would be adopted. This is a confounding factor that will not be present in cases that arise after a rule is adopted. In such subsequent cases, the odds that an insured will play "chicken" with the insurer when NRWC applies seem low.³²

All this applies only to the situation in which the insured's coverage claim is strong.

When the insured's coverage claim is weak, the insured is much less likely to play "chicken" with the insurer. This is because the insurer is even more likely to reject a reasonable offer in the absence of an agreement to reimburse, since the odds that the insurer will have to pay

31. This appears to have occurred, for example, in both of the two leading cases where the governing rule was not yet established in either California or Texas. See *Blue Ridge Ins. Co.*, 22 P.3d at 317; *Excess Underwriters at Lloyd's*, 246 S.W.3d at 43.

32. However, in cases involving factual rather than legal uncertainty, where an insurer had or might have had a right to reimbursement of non-covered settlement costs but not of defense costs, because there was in fact a duty to defend, the insurer might actually have an incentive to accept settlements for sums that are marginally higher than reasonable in order to avoid incurring additional defense costs. The insured might have more leverage in such a situation, and therefore be a bit more inclined to play "chicken" with the insurer. But such cases are not likely to be the norm.

any ensuing judgment are low. The insured is therefore even more likely in this situation to agree to reimbursement.

In any event, when the insured does refuse consent to reimbursement and the claim is not settled, the insurer should be liable not only for any covered liability within the policy limits, but for any excess-of-limits liability that would otherwise be covered. In this situation, by refusing consent to reimbursement, the insured has risked its own money because of the possibility of a non-covered judgment, and the insurer has concluded that the probability of non-coverage is great enough to warrant not settling. Under these circumstances, because both parties have assumed a risk, there is no reason to impose the consequences of non-settlement on the insured because the insurer has made the actual decision not to settle. It is true that the insured is in some sense enriched by this approach because it obtains coverage in excess of its policy limits, but this enrichment is not unjust because the insurer risked the excess-of-limits judgment in order to give itself the possibility of avoiding all liability.

2. Settlement When the Insured Has Insufficient Assets to Reimburse the Insurer

In contrast, when the insurer knows that the insured does not have sufficient assets to pay reimbursement for uncovered settlements, the result will be different than when the insured has such assets. This result, however, is likely to be the same under both AR and NRWC because a right to reimbursement under AR provides the insurer no benefit if the insured cannot comply with its obligation to reimburse. Similarly, the insured's consent or refusal to consent to reimbursement under NRWC will have the same impact as under AR, because either way the insurer cannot expect actual reimbursement.

Consequently, when the insurer knows that the insured does not have sufficient assets to pay reimbursement, the insurer is less likely to accept reasonable offers to settle because, even if the claim turns out not to have been covered and the insured owes the insurer reimbursement, the insured will be unable to pay. The insured in this situation is therefore placed at greater risk of incurring liability for a judgment in excess of the amount of the offer, and being unable to pay it, with all the collateral consequences that accompany unpayable debts. But it remains the case that, the stronger the insured's coverage claim, the more likely the insurer will settle even without the prospect of reimbursement. In contrast, the weaker the coverage claim, the less likely the insurer is to settle, whether under AR or NRWC.

Up to this point, I have oversimplified by not taking into account the possibility that the *amount* of an insured's assets that are in excess of, or less than, a proposed settlement may affect the analysis of any differences between AR and NRWC. However, adding this consideration changes the analysis only in a minor way. Under AR, unless the insured has substantially more assets than the amount of an offer to settle, the insurer is likely to behave as if it had no right to reimbursement because insurers are reluctant to effectively bankrupt their own insureds, especially if the insured is an individual.³³ It is individuals, not corporations and other insured organizations, who are most likely to be bankrupted by a reimbursement obligation. The insurer that accepts a reasonable offer to settle, which is later determined not to be covered, is unlikely to seek reimbursement for that settlement if doing so would exhaust the insured's net worth.

Similarly, under NRWC, the insured with the same or lower assets than the amount of a proposed settlement is unlikely to agree to reimbursement because it has nothing to lose by risking a judgment in excess of the amount of the offer. A large judgment that bankrupts the insured is no worse than a smaller reimbursement obligation that would bankrupt the insured if the insurer chose to enforce it. Since reimbursing the insurer for a settlement would effectively bankrupt the insured, it may as well "roll the dice" in the hope that either the underlying suit will be unsuccessful or that, if the suit is successful, it will be covered. In short, when the insured has the same or lower assets than the amount of a proposed settlement, the *insured* may behave differently under NRWC than it would if it had sufficient assets to pay reimbursement. But the conduct of the *insurer* when the insured has insufficient assets will be the same, whether AR or NRWC applies.

C. *Settlement by the Insured When the Insurer Rejects an Offer to Settle*

Although the offers the insurer accepts will tend not to vary under AR and NRWC, the insurer will not accept all reasonable offers. Rather, it will accept reasonable offers when, in the event that the claim is not covered, reimbursement is assured but, in other situations, will accept only offers that are less than the value of its potential coverage obligation, discounted by the probability that it has no such obligation. Because the insurer will not accept all reasonable offers, the question

33. *Excess Underwriters at Lloyds*, 246 S.W.3d at 65 (Hecht, J., dissenting) (stating that "an insurer who pursues its insured into bankruptcy does so at a business cost paid in bad customer relations and lower premiums").

that then arises concerns the circumstances under which the insured should be permitted to accept a reasonable offer to settle over the objection or without the consent of the insurer.

The insured may wish to accept an offer under such circumstances for one or more of several reasons. First, the insured may have sophisticated legal counsel whose assessment differs with the insurer's assessment of the reasonableness of an offer. Second, the insured may know that its coverage claim is weak, and therefore have more at stake than the insurer in avoiding the risk that if the offer to settle is rejected, a judgment in excess of the policy limits will ensue. Finally, the insured may simply be more risk-averse than the insurer. This is typically the case, because the risk of incurring substantial liability is a rare event for most insureds, whereas insurers face such risks continually, because they are in the business of diversifying just such risks.

All jurisdictions permit the insured to accept a reasonable offer to settle whenever the insurer has denied coverage of the claim against the insured. Once the insurer has denied coverage, there can be no expectation that it will accept any offers to settle. There would therefore be no justification for protecting the insurer's discretion to settle by precluding the insured from settling in such a situation, given that the insurer has denied its coverage obligation and has left the insured to fend wholly for itself.

In contrast, when the insurer defends subject to a reservation of its right to deny coverage or, when the policy does not provide for a duty to defend, the insurer has neither denied coverage nor unconditionally agreed that the claim is covered, instead reserving its right to deny coverage. The RLLI takes the position that, once the insurer has reserved its rights, the insured is permitted to accept reasonable offers.³⁴ But there is a division of authority regarding the right of the insured to settle without the consent or over the insurer's objection in this situation that reflects the different emphases placed on the interest of insurers and insureds.³⁵ Insurers that have merely reserved the right to contest

34. RESTATEMENT OF THE LAW OF LIAB. INS. § 25(3) (AM. LAW INST., Discussion Draft 2015).

35. See, e.g., *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982); see also *Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co.*, 445 F.3d 381, 385–86 (5th Cir. 2006) (holding that settlement restrictions apply even when insurer has reserved its rights); *Parking Concepts, Inc. v. Tenney*, 83 P.3d 19, 23 (Ariz. 2004) (finding that insured may settle when insurer has reserved its rights); *Patrons Oxford Ins. Co. v. Harris*, 905 A.2d 819, 828 (Me. 2006) (same); *Vigilant Ins. Co. v. Bear Stearns Cos.*, 884 N.E.2d 1044, 1048 (N.Y. 2008) (explaining that insured violates policy by settling when insurer has reserved its rights); Benjamin A. Kahn & Ronald Nemirow, *Unauthorized Settlement Agreements in a Reservation of Rights Context*, 34 TORT & INS. L.J. 799, 799–800 (1999).

coverage, and therefore face potential coverage obligations, still understandably want to control settlement so as to minimize payouts and premiums, because they may ultimately be held liable for coverage. This may lead an insurer to rationally prefer litigating to settling. Conversely, insureds want to avoid the risk that, if a reasonable offer is not accepted, there will be a judgment in excess of the amount of the offer and the claim will turn out not to be covered. The issue arises in two different situations.

1. Settlement by the Insured with Payment Actually Made to the Plaintiff

First, the insured may settle and actually pay the amount of the settlement to the plaintiff. The argument against permitting the insured to do this is that an insurer that defends the insured controls the litigation and should be permitted to decide whether to settle it.

Whatever the merits of this argument, however, it has no application to insurers who are not defending the insured because their policies do not contain a duty to defend.

The argument for permitting the insured in either situation to settle without the insurer's consent or over the insurer's objection—that is, for holding that the insured has not breached any no-settlement-without-the-insurer's-consent clause in the policy—seems stronger. Whether an offer will later be held to have been reasonable is not always clear at the time an offer is made. An insurer may therefore be inclined to reject offers whose reasonableness is in doubt. But risk-averse insureds would probably be willing to pay the marginal increase in premiums that would result if insureds could accept such offers over the insurer's objection.

2. Settlement by the Insured with the Plaintiff's Covenant Not to Sue

The arguments regarding the second situation in which the issue arises are more nearly balanced but still favor the insured. An insured with insufficient assets to pay a settlement may agree to settle, subject to the plaintiff's agreement not to collect the settlement from the insured. This is often referred to as a covenant not to sue. The plaintiff is then subrogated to or assigned the insured's coverage rights against the insurer, and seeks to collect from the insurer upon proof that the suit was covered and that the amount of the settlement was reasonable. The difference here is that, because the insured does not actually pay the plaintiff, the insured has a heightened incentive to accept unduly high offers of settlement. The argument against permitting the plaintiff to

recover from the insurer in this situation is therefore stronger than when the insured has actually paid the plaintiff.

The widespread judicial acceptance of covenants not to sue, however, makes sense.³⁶ Even if an insured cannot pay the amount of a settlement, often insureds have some assets worth protecting and other interests in avoiding trial. Permitting such insureds, who are highly likely to be risk-averse, to enter into settlements that involve the plaintiff's agreement not to collect from the insured is a sensible way to protect the insured against collection by the plaintiff under circumstances in which the insurer probably would not seek to collect reimbursement from the insured anyway, because collection would bankrupt the insured.

Moreover, the alternatives to this approach are less attractive. One approach is too harsh to the insured: simply deny the insured the right to settle if it does not actually pay the plaintiff, but nonetheless absolve the insurer of liability for an above-limits judgment if the underlying suit turns out not to have been covered. This poses a Hobson's choice for the insured: risking potentially enormous liability for an above-limits judgment or foregoing its potential right to coverage.

The other alternative, which disadvantages the insurer, might also be considered harsh, though perhaps less harsh to the insurer than the first alternative is to the insured. This is to deny the insured the right to settle without the insurer's consent, but—regardless of whether the claim would later have been determined not to be covered—hold the insurer liable for the amount of any judgment in excess of a reasonable offer that results after the insurer refuses the insured's permission to settle. This approach ignores the coverage issue, holding the insurer liable for a judgment that is not only in excess of its policy limits, but one that might not be covered at all. And it precludes the insured from minimizing its potential financial exposure.

Both alternatives seem more extreme than necessary. Permitting the insured to minimize its exposure through a covenant not to sue, even at the cost of denying the insurer the chance to avoid all liability by defeating the claim outright, is the more sensible approach. The approach admittedly will result in more settlements for more money, perhaps raising average per claim costs, but there is every reason to believe that the vast majority of insureds would be willing to pay for the increased cost of this approach.

36. RESTATEMENT OF THE LAW OF LIAB. INS. § 31 cmt. e (AM. LAW INST., Discussion Draft 2015).

3. Prerequisites to Recovery from the Insurer

When an insured is permitted to settle without the insurer's consent, it—or the plaintiff suing as the insured's subrogee—typically is required to prove both that the claim was covered³⁷ and that the amount of the settlement was reasonable under the circumstances.³⁸ Exactly what is involved in satisfying these requirements poses a number of issues.

Proving that the claim was covered is sometimes straightforward, but other cases may involve facts that have not yet been determined, and perhaps cannot be determined. For example, if a claim is settled but the insurer takes the position that coverage is excluded because the insured “expected or intended” the harm in question, this may have to be litigated in the insured's coverage suit. Paradoxically, if the bodily injury or property damage alleged in the underlying action did not actually occur, there is no way for the insured to prove which liability insurance policy or policies were triggered to cover liability for that injury or damage, and therefore no way, literally, to prove that the claim was covered. Unless there is to be no coverage in such a situation and settlements thereby heavily discouraged, some counterfactual proxy for the events triggering coverage must be adopted. In one case, for example, the court held that the dates on which injury was alleged to have occurred would govern.³⁹

Even after the insured proves that the claim was covered, it must also prove that the amount of the settlement was reasonable in light of the probability that the claim against the insured would succeed and the amount of likely damages. If the settlement was unreasonably high, the question becomes whether the insured recovers nothing or is still entitled to the portion of the settlement that it would have been reasonable to pay. One way to prevent unreasonably high settlements would be to preclude the insured from recovering anything if the amount of the settlement is unreasonably high; however, they would then err by settling on the low side of reasonableness. The alternative—permitting the insured to recover the amount of the settlement that was reasonable—would encourage excessively high settlements and would

37. See, e.g., *Servidone Constr. Corp. v. Sec. Ins. Co. of Hartford*, 477 N.E.2d 441, 444 (N.Y. 1985). This is the rule when the insurer has not breached its duty to defend. When the duty to defend has been breached, some jurisdictions hold that the insurer is estopped to deny coverage, but others hold that it is not. The RLLI adopts the estoppel approach. RESTATEMENT OF THE LAW OF LIAB. INS. § 19(1) (AM. LAW INST., Discussion Draft 2015).

38. See, e.g., *Luria Bros. & Co. v. Allstate Assurance Co.*, 780 F.2d 1082, 1091 (2d Cir. 1986).

39. *In re Silicon Gel Implant Ins. Coverage Litig.*, 667 N.W.2d 405, 416–17 (Minn. 2003).

generate otherwise unnecessary disputes over whether the amount of the settlement was reasonable.

Since the insured and the insurer are likely to be litigating already whether there is coverage at all, however, it is not clear that the incremental cost of resolving this additional issue would be excessive.

What appears to be the majority rule governing cases in which settlements are permitted is that “collusive” settlements are not covered.⁴⁰ This appears to mean that, if the amount of the settlement was unreasonable, then the insured gets nothing, although it is not well established whether the insured is entitled to recover the reasonable portion of a settlement when the settlement was unreasonably high, but not collusive. Perhaps this is because, in practice, there are few settlements that are found to fall in this category.

III. MIXED CLAIMS

A mixed claim is an underlying action against the insured that contains some allegations that would clearly fall within the terms of coverage if proved, and other allegations that would clearly fall outside coverage even if proved, or about which coverage is uncertain. In each instance, the insurer clearly has a duty to settle with regard to the covered claim. The question then becomes how to accommodate this duty with the different duty the insurer may have regarding the accompanying uncertain or uncovered claim.

The solution is a duty of the insurer to contribute toward settlement. What must be worked out is the scope of this duty to contribute. In my view, the appropriate duty is to contribute what would be a reasonable amount, all things considered, to settle the covered claim, and to permit the insured to contribute whatever additional sum it wishes in order to accomplish settlement.⁴¹ In the following sections, I discuss the two types of mixed claims separately. I then address what makes an offer to contribute reasonable, all things considered. I also discuss remedies for breach of the duty to contribute.

The logic of the duty-to-contribute solution, however, should not obscure its unavoidable but disadvantageous feature. A risk-averse insured—and almost all insureds are more risk-averse than their insurers—will be willing to contribute more to a proposed settlement than a risk-neutral party would be willing to contribute. Consequently,

40. See, e.g., *Shugart*, 316 N.W.2d at 734.

41. The RLLI adopts this position. RESTATEMENT OF THE LAW OF LIAB. INS. § 25 cmt. b (AM. LAW INST., Discussion Draft 2015).

whenever insured defendants have at least some assets, plaintiffs in underlying actions may be able to secure disproportionately larger settlements by adding uncovered or uncertain allegations to their complaints. The insurer will offer to contribute a sum that a risk-neutral evaluation of a stand-alone covered claim would warrant. However, knowing that the insured is likely to be risk-averse, the plaintiff may add an uncovered count—thus being able to extract a greater contribution to settlement by the insured than a risk-neutral evaluation of the uncovered claim alone would warrant.⁴²

It is true that, because this same state of affairs would exist if an uncovered or uncertain count in a mixed claim were the sole basis of a separate lawsuit, it can be argued that the insured's risk-aversion in this situation is not an artifact of the fact that there are both covered and uncovered counts in the same, mixed claim. However, it is worth noting that there is more inertia working against filing a freestanding suit alleging the uncovered count than there is in simply adding an uncovered count to a complaint alleging a covered claim.

For example, plaintiff's counsel typically works on a contingent-fee basis.⁴³ In situations where there is little prospect of recovery of more than nuisance value for an uncovered claim, there would be little point to filing suit if it were not also possible to make a covered allegation that had plausible strength on the merits. If it makes sense for plaintiff's counsel to file suit alleging a covered count, however, then there is much less inertia working against adding another, uncovered count, and doing so may give the plaintiff additional settlement leverage. Moreover, as a practical matter, the threat of sanctions under Rule 11 or its state equivalent may well be greater for filing a separate suit than for adding a count to an otherwise lawful complaint. Nonetheless, because no ready way of gauging the effect of the insured's risk aversion regarding the uncovered claim seems to be available, imposing a duty on the insurer to contribute a reasonable sum to settlement of the covered claim, all things considered, is the most feasible and appropriate test.

A. *Mixed Covered-Uncovered Claims*

It is common for complaints in tort and other civil actions to allege more than one cause of action, in multiple counts. For example, a complaint against the insured might contain one count alleging garden-

42. See Ellen S. Pryor, *The Stories We Tell: Intentional Harm and the Quest for Insurance Funding*, 75 TEX. L. REV. 1721 (1997), for a discussion of the influence of liability insurance on overpleading and underpleading.

43. KENNETH S. ABRAHAM, *THE FORMS AND FUNCTIONS OF TORT LAW* 4 (4th ed. 2012).

variety negligence, and another alleging battery arising out of the same set of facts. Garden-variety negligence claims are covered by liability insurance policies absent special circumstance, but liability for battery typically falls outside the coverage of most liability insurance policies. A claim will fall into this mixed category if the insurer denies coverage of the battery claim, admits coverage of the negligence claim, and there is no dispute between the parties as to the insurer's position. Whenever there is an ongoing dispute between the parties—for example, because the insurer has reserved its rights—then all or part of the claim is uncertain, and is the subject of discussion in the next section. Here, I address suits in which one claim clearly is covered and the other clearly is not.

In such cases, the liability insurer should have a duty to contribute a reasonable amount (up to its policy limits) toward settlement of the covered claim.⁴⁴ If the insurer complies with this duty and the claim is settled, then there is no further issue to be resolved. If the insurer offers to contribute an unreasonably low amount or does not offer to contribute, but the insured is able to settle the case anyway, then the insurer is liable for breach and owes the insured the amount it should have contributed. And if the insurer offers to contribute a reasonable amount but the claim is not settled, the insurer should have no liability for the amount of any ensuing judgment that is in excess of the policy limits because the insurer has complied with its duty to settle by offering to contribute as it was required to do. Whether the insurer's actual or proposed contribution was in fact reasonable in these situations may have to be the subject of a subsequent coverage action if the issue is in dispute. In that case, it would be governed by the rules applicable to breach of the duty to settle, including the rules governing valuation of the insurer's contribution, that I discuss below in Section C.

On the other hand, the insurer has no duty to the insured to settle or contribute to settlement of the uncovered claim. Consequently, if the whole claim is not settled, the fact that the amount of any ensuing judgment for the covered claim is greater than the liability the insured would have faced if the claim had been settled has no bearing on the insurer's liability for the covered claim.

However, one important issue remains. If the claim is not settled—even after the insurer has complied with its duty to contribute—and there is a judgment against the insured, then there must be some allocation of the amount of the judgment, up to the amount of the policy limits, as between the covered and uncovered claim. Strictly speaking,

44. See Barker & Kent, *supra* note 20, § 23.02[6][c][ii][A].

allocation of the amount of the insurer's liability in such a situation is not a function of the rules governing the duty to settle. The same problem arises in a mixed claim in which there has been no offer by the plaintiff to settle. Nonetheless, it is worth considering how allocation might occur, since the same issue arises in connection with breach of the duty to contribute.

The ideal way to accomplish the necessary allocation would be to have the jury in the underlying action bring in a special verdict that indicates the amount of its award for each of the causes of action or counts in question. When this has not occurred, then allocation will have to be performed in the subsequent coverage action.⁴⁵ The allocation would either rely on expert testimony about the comparative value of the covered and uncovered claims against the insured, or be the result of a trial-within-a-trial in which the strength of those claims is determined independently by the trier of fact. The former would be more efficient; the latter may or may not be more accurate, depending on how extensively the trial-within-a-trial replicates the original trial.

B. Mixed Covered-Uncertain Claims

Because the insurer and insured often will not agree on the insurer's assessment of the coverage status of the various allegations in a complaint against the insured, this category is likely to appear more frequently than the covered-uncovered category discussed above. In cases such as these, the uncertain claim or claims will subsequently be determined to be covered or not covered. The application of the insurer's duty to settle clearly should depend on the outcome of this coverage determination. If the uncertain claim turns out not to be covered, then the insurer's duty should be the same as when it is certain that a claim is not covered: the insurer's duty should be to contribute a reasonable sum toward settlement of the covered claim, all things considered.

On the other hand, if the uncertain claim turns out to be covered, then the insurer's duty should be what it is in cases in which all claims are uncertain: the insurer's duty should be to make a reasonable offer to settle the entire claim. These tests give the insurer an incentive to make a coverage evaluation and gauge its offers accordingly, and they provide the insured with the amount of protection that its coverage rights turn

45. See, e.g., *Raychem Corp. v. Fed. Ins. Co.*, 853 F. Supp. 1170, 1175-76 (N.D. Cal. 1994) (noting that the insured bears the burden of showing that settlement was for a covered claim).

out to have required, once the scope of these coverage rights is adjudicated.

Of course, if the insurer has complied with its duty to contribute, the insured contributes, the case settles, and it is later determined that the uncertain claim was covered, then the insurer has made the requisite payment and there is no further issue to be determined. However, in the event that the insurer complies with its duty to contribute, the insured also contributes, the case settles, and it is later determined that the uncertain claim was not covered, then there is a question whether the insurer has a right to be reimbursed and, if so, for what amount. As I indicated earlier, in cases in which all claims against the insured are uncertain, there are two approaches: automatic reimbursement (“AR”), under which the insurer is entitled to reimbursement from the insured whenever it has paid to settle a claim that is later determined not to be covered; and no reimbursement without consent (“NRWC”), under which the insurer is only entitled to reimbursement if the insured has consented to it. As in the case of uncertain claims generally, in my view, the outcomes will be the same under both AR and NRWC.

C. Assessing the Reasonableness of the Insurer’s Contribution and the Measure of Damages for Breach

The amount that is reasonable for an insurer to contribute toward settlement of a mixed claim may or may not depend on the interaction of the covered and uncovered or uncertain claims. The covered and uncovered or uncertain allegations may be *independent* of each other, in the sense that the allegations in the uncovered claim do not have the potential to influence the value of the covered claim. For example, the insured may be sued for the cost of pollution cleanup on its own property, in a jurisdiction in which the portion of the cost of cleanup on owned property, which is incurred to prevent further damage to non-owned property, is not excluded by an owned-property exclusion in a commercial general liability or homeowners policy. The portion of the cost of remedying contamination of owned property that benefits the owned property is not covered. It is extremely unlikely that anything about the claim against the insured for this cost will influence the value of the claim for the other, covered costs.

Alternatively, the covered and uncovered or uncertain allegations may be *dependent* on each other, in the sense that the allegations in the uncovered claims have the potential to influence the value-covered claims. For example, the insured may be sued for both battery and negligence, or the insured may be sued for both punitive and compensatory damages. Even if the insured is not held liable for battery

or for punitive damages, the evidence of blameworthiness admitted in support of the uncovered claims could influence the amount of covered damages awarded by the jury.

Although different factors will be at work in these two types of claims, the same duty to contribute a reasonable amount, all things considered, can be applied to each. In the case of independent allegations, the duty is to contribute an amount that would be reasonable if the suit alleged that the insured was liable for the covered obligation only. This approach treats covered and uncovered claims as if they were made in separate suits, rather than in the same suit.

In contrast, because a dependent, uncovered claim has the potential to enhance the strength or value of a covered claim, the duty to contribute in cases involving such claims cannot ignore them. This is no different, however, than any other factor that increases the insured's vulnerability to a covered claim—the insured's lack of confidence on the witness stand, or the skill of plaintiff's counsel, for example. Consequently, in determining whether an offer to contribute to settlement of a mixed claim is reasonable, one should take into account, among other things, the effect that the uncovered allegations may have on the likely judgment if the case is not settled. When the covered claim is, in effect, a lesser tort—as is the relation between negligence and battery—and the plaintiff is successful on the uncovered claim, then the covered claim is rendered moot. That is, if the plaintiff prevails on battery, it does not matter whether the defendant-insured was negligent. Because there is ultimately no coverage at all in such cases, the value of the covered claim, all things considered, should take into account the probability that the plaintiff will succeed on the uncovered claim and thereby render both sets of claims uncovered.

Thus, to the extent that factors associated with an uncovered or uncertain claim may affect the value of the covered claim, the test requires that this effect be taken into account. If a covered and uncovered or uncertain claim are wholly independent, however, then the covered claim will logically have the same expected value regardless of whether there is an uncovered claim in the same suit. Whether the covered claim is affected by the uncovered claim may sometimes be a difficult question of fact, but it is no more difficult than many such questions that affect the settlement value of a covered claim.

Whether claims are independent or dependent, and whether some claims clearly are not covered or are merely uncertain, suppose that the insurer fails to contribute or make available for settlement a reasonable amount, all things considered. What measure of damages should apply?

1. The Remedy for Breach When the Insured Was Sufficiently Solvent to Contribute Its Share

In the easier scenario to handle, if the insurer had contributed a reasonable sum toward settlement, the insured could have or would have contributed the additional amount necessary to achieve settlement. The case then proceeds to trial, and there is a judgment against the insured. In my view, the insurer in this situation should be liable for the entire amount of the judgment, including any amount that is in excess of the policy limits, minus the amount that the insured would have contributed. This is because, but for the insurer's failure to comply with its duty to contribute, the case would have settled. Consequently, the insurer's breach caused the insured to suffer a judgment that it would not otherwise have suffered, including the awards for both covered and uncovered or uncertain claims.

On the other hand, if there is a judgment for less than the amount of the plaintiff's offer, it cannot be said that the insurer's breach caused a loss to the insured. Under these circumstances, in theory there should be an allocation of this judgment as between covered and uncovered counts, as I describe in the following paragraph. In practice, this would often be a cumbersome and time-consuming task, for the reasons I describe. A practical if not entirely logical way to avoid this task would be to hold the insurer liable for the entire amount of any below-limits judgment, as long as the expected value of the uncovered claim was not disproportionate to the amount of the judgment.

The alternative—and in my view, less satisfactory—approach would be to impose liability on the insurer for only that portion of the judgment that was awarded for covered claims. The problem with this approach is that it fails to recognize that the insurer's breach resulted in a judgment not only for covered, but also for uncovered claims. In addition, the approach would create cumbersome fact-finding challenges. Under this approach, it would be necessary to perform an allocation of the award as between covered and uncovered claims. The ideal version of this approach would be for the court in the underlying case to ask for a special verdict, indicating how much of the award was for the different—covered and uncovered—counts. If there was no such special verdict, then some form of allocation would have to be performed in the subsequent coverage case. Because the insurer's breach of its duty to contribute was a but-for cause of the entry of the judgment for (at the least) the covered claim, the insurer should be liable for the portion of the judgment allocated to that claim, including the portion of any judgment in excess of the policy limits that was so allocated.

2. The Remedy for Breach When the Insured Was Not Sufficiently Solvent to Contribute Its Share

The more difficult scenario arises when the insured could not have contributed the difference between the reasonable amount the insurer should have contributed and the plaintiff's offer. In this situation, it cannot be said that the insurer's breach of its duty to contribute was a but-for cause of the judgment subsequently entered against the insured. Neither the insurer's breach nor the insured's insufficient solvency were but-for causes, but together they were the cause of the judgment.

Therefore, the only way to handle this scenario is to perform the kind of allocation as between the covered and uncovered portions of the judgment that I describe above, either at the trial of the underlying suit against the insured or in the subsequent coverage dispute. Both parties caused the entry of that judgment, and since causal responsibility cannot be pinpointed, each should be responsible for the portion that is properly its share.

These shares should include the amount of any judgment in excess of the policy limits, based in part on the foregoing logic and in part on the idea that, if such liability is not imposed, the insurer will always be in a position to decline to contribute enough. This is because the insurer will never be held liable for an above-limits judgment against an impecunious insured, even if it fails to contribute a reasonable amount to settlement.

IV. CONCLUSION

My goal in this Article has been to identify, elaborate, and suggest possible resolutions of the issues that arise in connection with the duty to settle uncertain and mixed claims. It is evidence of the complexity of these issues that so little law has thus far developed regarding them. The RLLI has taken an important step in addressing the issues. I hope that I have pushed the quest to understand the issues even further, and that scholarly discussion of them will thereby be enhanced and continued.