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Emerging Issues Involving Policies with Burning Limits, SIRs or Deductibles – Careful Considerations for Professional Liability Insurers

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I. Introduction[1]

Commercial insureds continue to look for ways to tighten their corporate belts, cut costs and boost profits. One of the areas where insureds are increasingly taking a second look to determine whether it is possible to reduce costs is their corporate risk management programs, including the insurance products they purchase. As a direct result of such cost-saving efforts, more and more commercial policies are being written with large self-insured retentions ("SIRs") and higher deductibles. As noted by the Wisconsin Supreme Court, as a growing numbers of insureds elect to control their insurance costs by purchasing policies with substantial SIRs and deductibles, a body of case law is beginning to emerge highlighting some of the issues that often accompany an insured's decision to manage its costs, and its exposure, in this way.[2] A number of issues that are implicated by an insured's decision to assume responsibility for a greater portion of its risk in the form of an insurance policy with a significant SIR or deductible.

Furthermore, where policies are written with eroding limits, often times in professional liability policies, insurers face additional challenges in the management of claims and dealing with their insureds. These policies provide that the costs of defense are included within the coverage limit—every dollar spent on defense correspondingly erodes the amount available to resolve the claim. These so-called eroding or burning limits, or defense-within-limits policies become particularly important in heavily litigated cases, where high defense costs can approach, and sometimes surpass, the total limit of liability.

II. Policies with SIRs and Deductibles

In the current economic climate, first-dollar coverage has become a luxury that many commercial insureds can no longer afford. Although policies with large self-insured retentions and deductibles have always been available, they were frequently overlooked in the past when bottom lines were healthier and insurance premium costs were subject to less scrutiny. As more insureds assume greater responsibility for managing the risk of smaller claims while relying on traditional insurance products for catastrophic protection, more policies are being issued with significant SIRs and deductibles.

True "self-insurance" involves a pure risk retention approach under which a company elects to assume full responsibility for any losses that may arise and insures none of its potential liability with a third party.[3] As such, a corporation that truly self insures must pay all judgments and settlements for all claims asserted against it, as well as the related loss adjustment expenses including defense costs. All other forms of self-insurance, including the strategic use of deductibles and SIRs as part of an overall risk management strategy, represent a departure from true self-insurance.

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[1] Substantial portions of this paper originally appeared in the following article: Hamilton and Murphy, *SIRs and Deductibles, Evolving Policies and Their Impact on Carrier Duties*, Defense Counsel Journal, Vol 78, No. 4 (Oct. 2011).

[2] *See Roehl Transport, Inc. v. Liberty Mutual Ins. Co.*, 784 N.W. 542, 546 (Wis. 2010).

[3] *See, e.g., Bordeaux, Inc. v. American Safety Ins. Co.*, 186 P.3d 1188, 1192 (Wash. Ct. App. 2008) (comparing the characteristics of traditional insurance and self-insurance as it relates to the shifting and retention of risk).

SIRs and deductibles are similar in that both require the insured to bear financial responsibility for a portion of a loss and, in this regard, represent an exposure that is not covered by insurance. However, there are important differences in the way they operate and it is a mistake to use these terms interchangeably as inexperienced insureds occasionally do. In *Allianz Ins. Co. v. Guidant Corp*., the Indiana Court of Appeals explained the distinction between a deductible and an SIR was recently explained by one appellate court in this way: "[a] policy with a deductible obliges the insurer to respond to a claim from dollar one (i.e., immediately upon tender), subject to the insurer's right to later recoup the amount of the deductible from the insured. A policy subject to a SIR, in contrast, obliges the policyholder itself to absorb expenses up to the amount of the SIR, at which point the insurer's obligation is triggered."[4]

Insurances policies written with deductibles provide that the insurer will pay the defense and indemnity costs in connection with a covered claim, and then charge or bill back the deductible amount to the insured. In other words, the "deductible" is a sum that is subtracted from the insurer's indemnity and/or defense obligation under the policy. Importantly, the responsibility for the defense and settlement of each claim rests solely with the insurer, and the insurer maintains control of the entire claim process.

Policies written with large self-insured retentions, in contrast, may place responsibility for claims handling, including the investigation, settlement and payment of claims, in the hands of the insured. Under a policy with an SIR, the insured is typically required to pay the defense and other allocated expense costs as well as indemnity payments until the amount of the retention has been exhausted. Once the SIR has been exhausted, the insurer responds to the loss and assumes control of the claim.

As the pressure to contain insurance costs by increasing the portion of the risk retained by the insured grows, larger SIRs and deductibles offer the commercial insured a series of advantages and disadvantages. On the positive side, SIRs allow the policyholder to control the defense and settlement of smaller claims and, depending on the reporting requirement in the specific policy at issue, may allow the insured to keep smaller claims out of its experience rating. On the negative side, administering claims within the SIR may involve more staff and resources than planned or may require the insured to hire a third-party administrator ("TPA") at its own expense to handle claims within the retention amount. Under deductible policies, not only does the insured avoid the indemnity obligations it would have under an SIR, it also avoids the loss adjustment expenses. In addition to lower premium costs, one of the major benefits identified by many commercial insureds whose policies have larger SIRs and deductibles is that they provide the company with an entirely new awareness of loss control which, in turn, can translate into improved loss experience in the long run.

[4] 884 N.E.2d 405, 410, n.2 (Ind. Ct. App. 2008).

III. Whether an Insured Has A Duty of Good Faith to Settle Claims Within the SIR

In addition to enjoying the benefit of reduced policy premiums that come with an SIR, an insured who selects a policy with a substantial SIR also retains greater control over the handling of claims, including the decision as to whether to settle a given claim within the policy's SIR. Where a loss is likely to exceed the amount of the SIR, an issue arises as to whether the insured or its insurer should have control over decisions regarding settlement. Presented with a settlement demand at or near its SIR as the trial date approaches, the insured may be inclined to roll the dice and proceed to trial knowing that its indemnity obligation is capped in an amount equal to the SIR. In such a case, the insurer providing coverage in excess of the SIR would want to settle the case in order to avoid the risk of its own exposure. Under these circumstances, the issue is whether an insured has a duty to accept a settlement offer within the amount of the SIR to avoid exposing the excess insurer to liability.

One of the first reported decisions to address the issue of whether an insured who retains a portion of the risk of loss has a duty to its excess insurer was the California Supreme Court's decision in *Commercial Union Assurance Companies v. Safeway Stores, Inc*.[5] In that case the insured, Safeway, maintained primary insurance through Travelers Insurance Company and Travelers Indemnity Company for the first $50,000 of liability for covered claims. For losses between $50,000 and $100,000, Safeway was self-insured. With respect to liabilities in excess of the self-insured amount, Safeway purchased an excess insurance policy for liability in excess of $100,000 and up to $20 million.

A claimant initiated an action against Safeway and recovered a judgment in the amount of $125,000. In order to discharge its obligations under the policy, the excess insurer was required to pay $25,000 towards the total judgment. After paying its share of the judgment, the excess insurer brought an action against the insured and the primary carrier to recover the $25,000 it had expended based on their failure to settle the claim for less than the amount of the judgment.

The excess insurer argued that the insured and its primary insurance carrier had an opportunity to settle the case for $60,000, or possibly, even $50,000. According to the excess insurer, the insured and the primary knew or should have known that the probable liability for the claim was in excess of $100,000 and, further, that the defendants had an obligation to settle the claim for less than $100,000 when they had an opportunity to do so. The causes of action asserted by the excess insurer against the insured and the primary were for negligence and breach of the duty of good faith and fair dealing.

In ruling against the excess insurer and dismissing the claim against the insured, the court noted that the essence of the implied covenant of good faith in every insurance policy is that "neither party will do anything which injures the right of the other to receive the benefits of the agreement."[6] As explained by the court, 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 purposes of protecting him from liability and, as a result, "the insured has the

[5] 610 P.2d 1038 (Cal. 1980)
[6] *Id*. at 1041.

right to expect that the method of settlement within policy limits will be employed in order to give him such protection."[7] The court concluded its analysis by observing:

> 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 interests is simply not the object of the bargain.[8]

In the absence of such a duty imposed by law, the court opined that "[i]f 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."[9]

In *Employers Mutual Casualty Co. v. Key Pharmaceuticals, Inc*., the United States District Court for the Southern District of New York, applying New Jersey law, reached a similar conclusion and held that that an insured has no common law duty to an excess carrier to settle a lawsuit below the threshold of an excess policy.[10] In ruling that an insured's failure to settle a lawsuit below the limits of an excess insurer's policy was not actionable, the court rejected the excess insurer's argument that just as a primary insurer may be held liable if it acts in bad faith in failing to settle a claim in such a way that spares the excess insurer's coverage layer, a policyholder should face similar liability. The court explained its rationale as follows:

> … we are impressed enough with the differing circumstances of self-insured policyholders and primary carriers to hesitate to assume that New Jersey would create novel tort duties on behalf of excess insurance companies as against their policyholders. The simple fact of the matter is that policyholders, even partially self-insured policyholders, are not primary carriers. Policyholder pay premiums to excess carriers in order to have protection against the risks of litigation (which risks include that of guessing wrong in settlement negotiations); primary carriers do not, and therefore must be careful as to how they balance their own interests with the competing interests of the excess carriers in any given claim instance. We have found no basis in the law, nor have we been pointed to any, for concluding that, apart from the premiums it pays, an insured also assumes a fiduciary duty of care toward its insurer in the context of settlements.[11]

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[7] *Id*.
[8] *Id*. at 1042.
[9] *Id*. at 1043.
[10] 871 F. Supp. 657, 666 (S.D.N.Y. 1994).
[11] *Id*. at 666.

Courts from other jurisdictions have either expressly adopted the California Supreme Court's holding in *Safeway Stores* that an insured does not have a common law duty to an excess insurer to settle a claim below the excess insurer's limits or have cited the decision with approval. [12]

Significantly, while in some jurisdictions an insured may not have a common law duty to its excess insurer to settle a claim within its self-insured retention, as even the *Safeway Stores* Court acknowledged, "equity requires fair dealing between the parties to an insurance contract" and a party's status as an insured "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."[13] To the contrary, the insured must be cognizant at all times of its obligations under the "cooperation" clause standard in most policies which, in a given circumstance, may require it to contribute its SIR to settle a third-party action.[14]

Taking their cues from the California Supreme Court, courts and insurers alike have recognized that if an excess insurer wants to protect itself from the possibility that an insured may refuse to accept a reasonable settlement offer, the way to do so is in the language of the policy itself. In *Twin City Fire Insurance Co. v. Superior Court*, for example, the Arizona Supreme Court offered insurers the following guidance:

> … we believe an excess insurance carrier can protect itself in its contract with the insured. For instance, an excess insurer can provide in its contract that it may control the defense whenever potential for excess liability exists. In addition, an excess insurer can require notice of all lawsuits filed against the insured or at least all lawsuits requesting either no set amount of damages or damages in excess of primary limits. An excess insurer can also reserve to itself the right to approve all settlement offers.[15]

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[12] *See, e.g., International Insurance Co. v. Dresser Industries, Inc*., 841 S.W.2d 437, 444 (Tex. Ct. App. 1992) (adopting *Safeway Stores* holding and noting that ruling otherwise "would require an insured to settle any case, even one in which it believes liability is questionable or nonexistent, if there is any risk of a verdict impacting the excess layer of coverage); *Lexington Insurance Co. v. Sentry Select Insurance Co*., 2009 WL 1586938, *13, No. CV-08-1539 (E.D. Cal. June 5, 2009); *Certain Underwriters of Lloyd's v. General Accident Ins. Co*., 909 F.2d 228, 232 (7th Cir. 1990); *Commercial Union Ins. Co. v. Medical Protective Co*., 393 N.W.2d 479, 482 (Mich. 1986).

[13] 610 P.2d at 921.

[14] *See Harbor Insurance Co. v. City of Ontario*, 231 Cal. App.3d 927, 935 (4th Dist. 1991) (rejecting insured's interpretation of cooperation clause and ruling that it could not refuse to contribute to settlement in excess of SIR on the basis that it "permitted" but did not "agree" to settlement).

[15] 792 P.2d 758, 760 (Ariz. 1990)

Similarly, in *Liberty Mutual Insurance Co. v. Wheelwright Trucking Co., Inc.*, the Alabama Supreme Court considered an insurance policy in a slightly different context that included the following SIR endorsement which effectively illustrates the type of provision that an insurer can include in a policy to protect its interests:

> 4. You [the insured] shall be responsible for the investigation, defense and settlement of any "claim" or "suit" for damages within the Self-Insured retention, and for the payment of all "Allocated Loss Adjustment Expenses." You shall exercise the utmost good faith, diligence and prudence to settle al "claims" and "suits" within the Self-Insured Retention."[16]

Ultimately, an insurer that believes that its insured has unreasonably refused to accept a settlement offer within the SIR may not prevail in an action to hold the insured liable for the amount of any judgment in excess of the settlement offer on the grounds that the insured has a common law duty of good faith to the excess insurer. However, the case law suggests that clear contractual language in the policy setting forth an insured's duties with respect to handling and settling claims within the self-insured retention will be enforced. Accordingly, inserting appropriate, protective language in the policy itself is the surest way for an insurer to protect itself against the possibility that an insured will ignore reasonable offers to settle a claim before the excess insurer's coverage attaches.

IV. Claims Handling and Other Issues Involving Policies with Eroding Limits

Increasingly, policyholders have been filing bad-faith claims against insurers when their policies do not distinguish the costs of defense from the coverage limits. Policyholders have argued that insurers are acting in bad faith by failing to adequately control the costs of defense, both in the rates charged and the activities performed by counsel, resulting in a depletion of the policy limits.

For example, in *Pueblo Country Club v. AXA Corporate Solutions Ins. Co.*,[17] the insured was sued by a former employee and tendered the defense to its insurance carrier. The policy had a $1 million limit that included the costs of defense. The case proceeded to trial and a judgment was entered against the employer for over $1.5 million, which the parties agreed to resolve via a settlement. By the time the case settled, however, the insurer had advanced over $300,000 in legal fees, leaving less than $700,000 to pay towards the settlement. As a result, the employer was left on the hook for over $800,000.

The employer subsequently filed a bad faith claim against the insurer, which included allegations that the insurer caused additional defense costs and placed its interests above the insured. The insurer filed a motion for summary judgment, but the court denied the motion, stating that there was a factual dispute as to whether the carrier's conduct was reasonable. The

[16] 851 So.2d 466, 485 (Ala. 2002)
[17] Civ A No. 05-cv- 01296 (D. Colo. May 31, 2007)

court further observed that there was evidence "[the insurer] was aware that attorneys' fees and costs were reducing the available policy limits, and that [the insured] was exposed to a judgment in excess of the available limits."

In another case, *NIC Insurance Co v PJP Consulting, LLC,* [18]a federal district court judge declining jurisdiction over a declaratory judgment action in favor of a competing suit in state court commented on the issues created by defense-within-limits provisions, noting that some regulators and legislators have limited or barred them because of the conundrum faced by the policyholder that might lose protection against a judgment or settlement due to the costs of defense being applied against the policy coverage. Policyholders are increasingly challenging insurers' erosion of coverage through defense costs, pointing to statutory and regulatory restrictions on the use of burning limits provisions, for example, in Minnesota, Minn. Stat. Ann. § 60A.08 subdiv. 13; New York, NY Comp. Codes R. and Regs. Tit. XI § 71.3; and Oregon, Or. Rev. Stat. § 742.063(1). These new claims seek to alter settled law in which courts have applied defence-within-limits provisions in a straightforward manner, even when they eliminate an obligation to pay for settlement or judgment. For years, the majority of courts have enforced the contract language of eroding limits policies, despite policyholder claims of ambiguity or confusion.

Nevertheless, when dealing with jurisdictions that allow for burning limits policies, an insurer may be caught in a dilemma. It may be accused of failing to settle within limits but also accused of wasting the limits with "profligate spending" during the litigation.[19] In this regard, the Louisiana Supreme Court held that the insurer could not deduct costs to defend itself, as a named defendant in a suit along with its insured, from the insured's limits, and prejudgment interest could not be deducted from the insured's limits.[20]

When the insured assumes control of the defense, it is not axiomatic that the insurer's duty to settle may not be lessened. According to one federal court: "Assuming for purposes of these motions that [insurer] failed in bad faith to settle the underlying suit, [insured] would probably be excused from its concomitant duties to cooperate and allow the insurer to control the defense (and all the more so where the policy is asserted to be cannibalizing)."[21] Likewise, where the wasting limits policy contains a provision allowing for withdrawal of the defense upon exhaustion of the limits by litigation costs or settlement payments, "even under a DWL policy, withdrawal may sometimes be thwarted. Courts may estop insurers from withdrawing even when they have the policy rights to do so in the following categories of cases: (1) where the case is so near trial as to prejudice the insured . . . (2) where the insurer, in the course of defending, has done something that prejudices the insured in its defense, or (3) where the insurer has already defended the insured over a substantial period of time." [22]

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[18] No. 09-0877, 2010 WL 4181767 (ED Pa. 22 October 2010),
[19] *See e.g., NIC Ins. Co. v. PJP Consulting, LLC*, 2010 WL 4181767 *4 (E.D.Pa., Oct. 22, 2010).
[20] *Edwards v. Daugherty*, 883 So.2d 932 (La. 2004).
[21] *Weber v. Indemn. Ins. Co. of N.A.*, 345 F.Supp.2d 1139, 1146 (D.Haw. 2004).
[22] Gregory S. Munro, *Defense Within Limits: The Conflicts of "Wasting" or "Cannibalizing" Insurance Policies,* 62 Mont. L. Rev. 131 (2001).

For insurers defending under eroding limits policies, the presence of a self-eroding policy places a premium on early resolution; accurate budgeting; advance discussion with the insured and the insurer of litigation decisions that will affect the cost of defense; and accurate disclosure of the remaining policy limits at critical points in the suit. The less money spent on defense, the more available to pay settlements and judgments. The cases which present the greatest difficultly in this respect are those in which the plaintiff has substantially overvalued his or her case. Defending the case through trial may erode the limits to a point where an adverse judgment is guaranteed to exceed the remaining policy limits. The insured, should be involved in settlement discussions when there is a risk of an excess judgment, the insurer, and defense counsel need to have a full and frank discussion of the costs, risks and benefits of continuing to defend as opposed to settling. Sometimes that discussion may lead to a decision to pay more to settle early even though a vigorous defense might substantially reduce the settlement value.

Some jurisdictions require the disclosure of liability insurance during discovery, including policy limits. Thus, defense counsel may then be required to disclose the self-eroding nature of the policy. Disclosure of the remaining limits presents a challenge to insurers because defense counsel must disclose not only the amounts already paid by the insurer, but defense counsel's accounts receivable, his or her unbilled time, unbilled disbursements, unbilled expert witness expenses and the future costs of completing any settlement negotiated at that moment.

V. Settling Claims Within an SIR or a Deductible Without the Insured's Consent

Under policies with high SIRs/deductibles, another issue is whether an insurer may agree to a settlement without the consent of the insured where the insured has a substantial deductible or SIR that must be applied to the settlement. As discussed below, the majority rule is that where the policy language gives the insurer the exclusive right to control and settle the claim, courts will enforce such language even where the insured has a direct financial stake in the settlement.

In *American Protection Insurance Co. v. Airborne, Inc*.,[23] a federal court, applying Illinois law, enforced the majority rule and held that where the policy clearly granted the insurer the authority to settle claims, the insurer had the right to settle a personal injury action over the insured's objection even though the settlement implicated the insured's substantial deductible. In *Airborne*, an automobile liability insurer sued its insured, a parcel delivery service company, seeking reimbursement of a $1 million deductible that the insurer had paid as part of a $1.85 million payment to settle a personal injury claim asserted against the insured for alleged injuries as the result of a collision between an automobile and one of the insured's delivery vehicles. The insurance policy at issue provided that the insurer had "the right, but not the duty or obligation to … investigate and settle any 'accident,' claim or suit."[24]

According to the district court, the above policy language "unambiguously gave [the insurer] the right to settle the third party claim involved here without [the insured's] consent."[25] In so ruling, the court rejected arguments by the insured against enforcement of the insurer's clear right to settle over the insured's objections based on estoppel, waiver and a purported

[23] 476 F. Supp.2d 985 (N.D. Ill. 2007)
[24] *Id*. at 990.
[25] *Id*.

course of dealing between the parties. The *Airborne* Court explained its rationale by stating that "an insured cannot complain that such a provision inevitably allows an insurer to commit an insured's funds -- the policy deductible -- without the insured's consent, because that is exactly the bargain that the insured struck under the policy that it bought and paid for."[26]

In *Stan Koch & Sons Trucking, Inc. v. Great West Casualty Co.*,[27] a decision involving an insurer's right to settle a claim triggering a substantial payment of an insured's retention, the United States Court of Appeals for the Eighth Circuit, applying Minnesota law, held that the insurer could settle the claim over the objection of the insured where the policy provided that the insurer had the right to settle any claim under the policy and there was no showing that the amount of the settlement was unreasonable or improper. In that case, an insured trucking company brought a declaratory judgment action against its insurer seeking a determination that, among other things, the insurer breached its fiduciary duty to the insured by settling a personal injury claim against the insured. The insurer settled the matter for $750,000 triggering the insured's obligation to contribute $500,000 towards the settlement pursuant to the policy's retention endorsement.

The policy included a provision giving the insurer the right and the duty to "settle or defend, as we consider appropriate, [any] claim or "suit" asking for damages which are payable under the terms of this Coverage Form."[28] Based on its interpretation of this language, the Eighth Circuit concluded that the insurer had the "unfettered right to settle the claims despite the substantial retention in the policy."[29] The court further noted that (1) the foregoing principle has been affirmed by numerous other courts construing similar policy language, and (2) under Minnesota law, the insurer's unfettered right to settle under the contractual language was balanced by "a duty of good faith in settling claims."[30]

In *United Capitol Insurance Company v. Bartolotta's Fireworks Company, Inc.*,[31] another case involving a settlement by an insurer triggering payment of a self-insured retention exceeding the insurer's *own* contribution to the settlement, the Wisconsin Court of Appeals declined to write a provision into the policy requiring the insured's consent to any settlement where no such provision appeared in the policy. In *Bartolotta*, the policy involved a specially tailored insurance contract between the insured, a company that performed fireworks displays for municipalities and others, and the insurer. The contract included a provision requiring the insured to pay the first $25,000 as "self insurance" as well as a provision giving the insurer the right, in its discretion, to "settle any claim or suit."[32]

A thirteen year old boy suffered burns on his face and legs after an undetonated fireworks shell he found in a public park suddenly exploded. The insured had performed a fireworks display at the very same location where the shell was found four days earlier. The injured boy

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[26] *Id.*
[27] 517 F.3d 1032 (8th Cir. 2007)
[28] *Id.* at 1043.
[29] *Id.*
[30] *Id.* at 1043-44.
[31] 546 N.W.2d 198 (Wis. Ct. App. 1996)
[32] *Id.* at 199.

threatened to sue the insured, alleging that the shell was a remnant from its Fourth of July display. The insurer investigated the claim on the insured's behalf and decided to settle the matter for $35,000.

In ruling that the insurer had no obligation to obtain the insured's consent before settling a claim under the policy language at issue, the court rejected an argument by the insured that the existence of a $25,000 self-insured retention "somehow separates this single policy into two, leaving [the insured] with absolute authority over small claims (those less than $25,000) and [the insurer] with power over the remainder."[33] As explained by the court, the insurer believed that one way to offset the high risk of claims associated with the fireworks industry was to bargain for the power to settle claims quickly which is why it sought, and acquired, the "discretion" under the policy to make settlements without having to consult the insured.[34] The court also rejected the insured's argument that, as a matter of public policy, the insurer should be required to obtain the insured's consent before making any settlement.[35]

The foregoing cases represent the majority view adopted by most courts that have addressed this issue. [36] However, this approach is not universal. A distinct minority of jurisdictions have adopted the view that where the insured has a financial stake in the settlement, including a significant deductible, the law requires the insurer to obtain the insured's consent before settling a claim regardless of the terms of the insurance contract.[37]

Significantly, the fact that an insurer may have a contractual right to control whether to settle a case and to place the insured's significant SIR or deductible at risk does not relieve the insurer of its obligation to act in good faith. Indeed, this very issue has been specifically addressed by several state and federal courts within the last year. In *Roehl Transport, Inc. v. Liberty Mutual Insurance Company*,[38] for example, the Wisconsin Supreme Court ruled, in a

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[33] *Id*. at 201.

[34] *Id.*

[35] *Id*. at 202.

[36] *See also American Home Assurance Co., Inc. v. Hermann's Warehouse Corp*., 563 A.2d 444, 448 (N.J. 1989) (ruling that insurer that settled third-party claim for substantially more than the deductible but within policy limits was entitled to recover deductible where policy clearly stated that insurer had discretion to settle claims as it deemed expedient); *New Plumbing Contractors, Inc. v. Edwards, Sooy & Byron*, 99 Cal. App.4th (4th Dist. 2002) (ruling that under a policy provision giving an insurance company discretion to settle as it sees fit, insurer is entitled to control settlement negotiations without interference from the insured and will not be liable to the insured for settlements within policy limits).; *Casualty Insurance Co. v. Town & Country Pre-School Nursery, Inc.*, 498 N.E.2d 1177 (Ill. Ct. App. 1986) (upholding the right of the insurer to settle the claim fully within the deductible portion of the liability policy where the policy gave insurer the right to settle claim within policy limits without the insured's consent); *Orion Insurance Co., Ltd. v. General Electric Co*., 493 N.Y.S.2d 397, 401 (N.Y. Sup. Ct. 1985), *aff'd*, 509 N.Y.S.2d 778 (2d Dep't 1986) (holding that pursuant to the terms of the policy, the insurer could settle without the insured's consent even where the insured's contribution via the deductible was considerably more than the insurer's contribution);

[37] *See, e.g., St. Paul Fire & Marine Insurance Co. v. Edge Memorial Hospital*, 584 So.2d 1316, 1327 (Ala. 1991) (stating that "the insurer cannot agree to pay money in a settlement which must be repaid by the insured without first obtaining the consent of the insured"); *see also National Service Industries, Inc. v. Hartford Accident & Indemnity Co.*, 661 F.2d 458, 462 (5th Cir. 1981) (stating that, under Georgia law, an insurer is required to give equal consideration to the interests of the insured in making decisions about the settlement of claims under the policy).

[38] 784 N.W.2d 542 (Wis. 2010)

matter of first impression, that an insurer may be liable for the tort of bad faith when it exposes the insured to liability for sums within the deductible amount.

In *Roehl Transport*, the insured, a trucking company, obtained a truckers/auto insurance policy issued by Liberty Mutual that provided $2 million in liability coverage subject to a $500,000 deductible. A personal injury claim was asserted against the insured by a motorist whose vehicle was rear ended by one of the insured's trucks. The matter went to trial, and a jury awarded the injured motorist $830,000 which was well-within the policy limits but which required the insured to pay its entire deductible.

In *Roehl Transport*, the insured brought a bad faith action against its liability insurer, alleging that the insurer mishandled the claim and failed to settle the claim for substantially less than the amount awarded at trial despite the opportunity to do so. Notwithstanding the large deductible, the policy at issue contained a provision giving the insurer control over the claims process including the right to settle any claim or suit. Specifically, the settlement provision stated that "[w]e have the right and duty to defend any 'insured' against a 'suit' for … damages [and] we may investigate or settle any claim or 'suit' as we consider appropriate."[39]

According to the insured, Liberty Mutual's handling of the claim was replete with inadequate investigation, inexperienced and high-turnover staffing, and lacking in good faith efforts to settle the claim for less than the verdict thereby resulting in damages to the insured. Liberty Mutual, in turn, moved for summary judgment on the bad faith claim, arguing that the insured's bad faith claim "is not recognized in Wisconsin law because the judgment entered in the [personal injury] lawsuit against [the insured] was not in excess of the $ 2 million policy limit."[40] The trial court disagreed, and held that Wisconsin law recognized a bad faith claim in this context, and a jury awarded the insured $127,000 in compensatory damages.[41]

On appeal, the insured argued that because Liberty Mutual "wasted" its deductible by conducting a slipshod investigation, ignoring settlement opportunities, and mishandling the insured's legal defense, it should not be permitted to avoid legal responsibility for its alleged bad faith actions "only because the judgment was within policy limits."[42] Liberty Mutual, in turn, argued that the insured could not succeed on its bad faith claim in the absence of a verdict in excess of policy limits "because [the insured] bargained for lower premiums by accepting a high deductible," and, therefore, should not be permitted to complain now that it was required to pay a sum up to the amount of the deductible.[43]

In ruling that an insurer could be liable for bad faith in the absence of an excess liability judgment, the Wisconsin Supreme Court first noted that "[a]n insurance company owes a duty to its insured to settle or compromise a claim made against the insured and to act in good faith in doing so."[44] According to the court, where the insured has a significant deductible, "the

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[39] *Id.* at 548.
[40] *Id*. at 549.
[41] *Id*.
[42] *Id.* at 550.
[43] *Id*.
[44] *Id*. at 552.

insurance company's and the insured's interests might diverge, and the insurance company could make decisions in settling claims that favor its own interests over those of the insured."[45] For example, the insurance company might offer "an unnecessarily high settlement within the deductible to avoid the expenses of diligent investigation or adjustment," or it might expend "insufficient effort to investigate a claim unless of until the insurance company's own money is at risk when the value of the claim approaches or exceeds the deductible." [46]

The *Roehl Transport* Court reasoned that just as in traditional third-party excess judgment cases, the insured with a high deductible needs the protection of a bad faith cause of action to guard against the risk that an insurance company's control over a claim might favor its own financial interests over those of the insured. As explained by the court, in both instances, the "insurance company's bad faith conduct exposes an insured to a set of harms not covered by the policy."[47] Although the Wisconsin Supreme Court determined that the insured was not entitled to punitive damages on the specific facts of the case because the evidence did not show either that the insurer had a "purpose" to disregard the insured's rights or that it was aware that its acts were "substantially certain" to result in such disregard, the court did rule that the insured "was entitled to attorney fees as a matter of law as a result of the jury's finding of bad faith."[48]

In *Windmill Distributing Company v. Hartford Insurance Company*,[49] the Connecticut district court considered whether an insurer's decision to settle an underlying action against the insured arising from a motor vehicle accident was made in bad faith and reached the opposite conclusion, ruling that it was not. In that case, the insured was covered under an automobile liability insurance policy issued by Hartford Insurance Company ("Hartford") which had a limit of $2,000,000 for any one accident or loss "subject to a prefunded deductible of $250,000 and additional fees of up to $25,000 for claim handling."[50] Under the terms of the policy, Hartford had the right to "investigate and settle any claim or 'suit' as [it] consider[s] appropriate."[51]

A pedestrian who sustained serious injuries when she was struck by a motor vehicle asserted a liability claim against the insured. According to the police report, the pedestrian was crossing an intersection when she was struck by a motor vehicle which was cut-off at the intersection by the insured's delivery truck. Over the objection of the insured, the insurer's claim adjuster settled the pedestrian's claim for $325,000 thereby exhausting the insured's entire prepaid deductible.[52] Hartford also charged the insured $25,000 in claims handling fees.

Thereafter, the insured initiated an action against its insurer, alleging that the insurer breached its duty to defend the insured in good faith and, further, that the insurer settled the underlying action in bad faith. According to the insured, Hartford acted in bad faith by settling the case for an amount within the insured's deductible when the insured believed there was a

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[45] *Id*. at 554.
[46] *Id*.
[47] *Id*. at 555.
[48] *Id*. at 575, 577.

[49] 2010 WL 3829128 (D. Conn. Sept. 24, 2010).
[50] *Id*. at *1.
[51] *Id*.
[52] *Id*. at *5.

good likelihood of obtaining a defense verdict at trial.[53] In response, Hartford argued that settling the case was reasonable because a defense verdict was not certain and the settlement was, in fact, in the insured's best interest.[54]

In entering judgment in favor of the insurer, the court first noted that while the authority to settle claims under the clear language of the policy was not conditioned on the insured's consent or approval, Hartford was not excused "from exercising good faith in considering any settlement offers."[55] The court noted that in deciding to settle the case, the insurer's adjuster had considered numerous factors which led him to the conclusion that settlement constituted a fair and reasonable resolution of the case, including the following: (1) the injured party was likely to be a sympathetic and credible witness whereas the witnesses for the defense were not; (2) there was conflicting testimony as to the role of the insured's truck in causing the other motorist to lose control of the vehicle that ultimately struck the pedestrian; (3) an arbitration proceeding had attributed fifty percent of the fault for the accident.[56] In addition, the accident victim incurred more than $58,000 in damages and had suffered a permanent disability as a result of the accident.

The court concluded that based on the facts of the case, "Hartford's decision to enter a settlement within the deductible amount of the insured, rather than exposing its insured and itself to a potentially higher judgment, was not unreasonable."[57] As explained by the court, in deciding to settle the case, Hartford was allowed to consider its own interests "as long as that consideration was not at the expense of [the insured's] interests."[58] Accordingly, the court entered summary judgment in favor of the insurer on the bad faith claim.

It should be noted that several cases seem to suggest that when a liability policy contains a deductible clause along with a clause granting an insurance company an unfettered right to settle claims, the insured has bargained away any rights to protest how the insurance company disposes of the insured's deductible.[59] These decisions, however, represent a distinctly minority view.

Taken together, the foregoing cases stand for the proposition that where the language of the policy clearly provides that the insurer has the right to settle a claim or suit, it may generally do so without the insured's consent (and over its objection) even if the settlement triggers an obligation on the insured's part to pay a substantial SIR or a sizeable deductible. The right to control the settlement does not, of course, relieve the insurer of its obligation to act in good faith.

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[53] *Id*. at * 14.
[54] *Id*.
[55] *Id*. at * 15.
[56] *Id*.
[57] *Id*.
[58] *Id*. at * 16.
[59] *See, e.g., American Protection Insurance Co. v. Airborne, Inc.*, 476 F. Supp.2d 985, 995 (N.D. Ill. 2007) (wherein the court rejected bad faith claim, noting that "[w]hile [the insured] certainly risked significant personal liability in this case because of the large deductible, that risk was exactly what it contracted for"); *see also Methodist Hospital v. Zurich American Insurance Company*, 2009 WL 3003251 (Tex. App. Ct. 14th Dist. July 7, 2009) (unpublished opinion) (noting that right to settle provision in workers' compensation policy precluded imposition of contractual or extra contractual duties on insurer to properly handle and pay claims within the deductible even though policy required insured to reimburse insurer for amounts paid within deductible limits).

On the other hand, to the extent that an insured has the ability to negotiate clear language in a policy reserving unto the insured the right to approve or consent to any settlement on its behalf, that language will also be enforced

VI. Who Pays the SIR and How the SIR Is Paid

As the number of commercial policies written with substantial SIRs continue to increase, issues as to the extent an insurer can dictate the manner in which an SIR may be satisfied are starting to emerge. These issues are particularly prevalent where an insured qualifies as such under more than one policy. In *Forecast Homes, Inc. v. Steadfast Ins. Co.*,[60] for example, housing developers were named as additional insureds under their subcontractors' liability policies. Five lawsuits alleging various construction defects were filed against the developers; however, no subcontractor was named as a defendant in any of the suits. After incurring defense costs and related expenses in excess of the SIRs in the subcontractors' policies, the developers tendered their defense to several of the insurers of the subcontractors.

An insurer who issued policies to several subcontractors denied the developers' tender, arguing that only the "named" insured could satisfy the policies' SIR. The policies provided, in pertinent part, that "it is a condition precedent to our liability that you [i.e., the named insured] make actual payment of all damages and defense costs" and, further, that "[p]ayments by others, including additional insureds or insurers, do not satisfy the self-insured retention."[61] In the developers' coverage suit, they argued that this language was contradicted by other language in the policy that rendered it ambiguous. The developers also argued that the insurers' interpretation rendered coverage illusory and violated public policy. The California Court of Appeal disagreed, holding that the SIR endorsement defining "you" and "your" to mean the "named insured" clearly limited who could satisfy the SIR.[62]

In *Vons Companies, Inc. v. United States Fire Ins. Co.*,[63] the court addressed the related issue as to whether an SIR could only be satisfied by an out-of-pocket payment by the insured or whether it could be satisfied by "other insurance." In that case, Vons was the named insured under a CGL policy with a $1 million limit that was subject to a $1 million SIR. Vons also qualified as an additional insured under a second policy that also had a policy limit of $1 million.

Vons was named a defendant along with several others in a tort action, and the case was settled for approximately $1.5 million. The settlement was funded by the insurer's $1 million payment under a policy where Vons qualified as an additional insured, together with approximately $500,000 of Vons' own funds. Thereafter, Vons sought reimbursement of its settlement contribution from its own insurer.

The insurer filed a declaratory judgment action, and took the position that that the SIR endorsement in its policy required Vons to pay $1 million of its own money, not money coming

[60] 181 Cal. App.4th 1466 (2010)
[61] *Id*. at 1477.
[62] *Id*.
[63] 78 Cal. App.4th 52 (2000).

from other insurance, before the SIR was exhausted and its obligations were triggered.[64] The trial court ruled that the insurer was required to reimburse Vons for the total amount it paid toward the settlement.[65] The California Court of Appeals affirmed, ruling that the SIR endorsement permitted payment through other valid and collectible insurance because (1) the policy was "subject to" the policy's "other insurance" provision which made the policy excess if there was another policy covering the accident, and (2) the policy did not expressly state that the insured had to pay the SIR.[66]

VII. Conclusion

Policies with burning limits or high deductibles/SIRs present new disputes between policyholders and their primary carriers over the rights and obligations of the parties and control over the defense of claims. These disputes are certain to continue, leading to more judicial opinions that will provide guidance on how to resolve these thorny issues.

[64] *Id*. at 56.
[65] *Id*. at 57.
[66] *Id*. at 63-64. *See also Mt. McKinley Ins. Co. v. Swiss Reinsurance America Corp.*, 757 F .Supp. 2d 952, 958, (N.D.Cal. 2010) (There is no requirement absent a contrary contractual provision, that an insured pay an SIR amount out of its own pocket."); *Royal Indemnity Co. v. Wyckoff Heights Hospital*, 953 F. Supp. 460 (E.D.N.Y. 1996) (ruling that insured could not satisfy $1 million SIR by purchasing an annuity with a present value of less than that amount).