Good Faith: Some Things Change, Some Stay the Same

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As any insurer knows, handling third-party claims is fraught with danger. The ever-present looming danger of a bad faith claim hangs like a sword of Damocles over every claim professional seeking to protect his or her insured from liability. Make one arguable misstep and the potential exposure to the insurer can go from minimum policy limits of $10,000 to a multiple of many hundreds of times that amount. Therefore, claim professionals must be ever wary of the possibility of stepping into a bad faith trap.

This article discusses several versions of bad faith set-ups attempted by plaintiffs' counsel over the years. The final set-up, that of the consent judgment, is treated in more depth due to the potential for extreme exposure.

The Early Full Limits Set-Up

The original set-up is familiar. Plaintiff is severely injured by an insured holding a minimum-limits liability policy. Plaintiff's counsel offers to settle his client's claim upon payment of the policy limits in a short time frame (a time-limited demand, often with numerous conditions). The plaintiff later claims the insurer either rejected the demand or made a counter-offer, following which the plaintiff proceeds to obtain a large judgment and claims the insurer is liable, due to its failure to protect its insured's interests by settling the claim. This scenario is easy to detect and most insurers have taken measures to ensure that claims with this fact pattern are found early and given close scrutiny.

The case of *Harvey v. Geico*, 259 So. 3d 1 (Fla. 2018) is a particularly troubling decision from the Florida Supreme Court. In *Harvey*, the insurer attempted to offer the full $100k limits to the claimant within days, but the claimant wanted a statement of assets and other available insurance from the insured. The insured delayed in providing the information, but the court found it significant that the claim handler did not inform the claimant's attorney that a statement would be forthcoming. A verdict in excess of $9 million was entered against the insured. The jury found that GEICO had acted in bad faith and entered judgment for the full excess verdict. The appellate court reversed, and entered judgment in favor of GEICO, holding that the conduct did not amount to bad faith and that the conduct did not cause the excess verdict. Over strong dissent, a majority of the Florida Supreme Court found that the evidence supported the jury's verdict both on bad faith and causation and reinstated the jury's verdict.

Fortunately, recent cases in the wake of *Harvey* have reached more logical conclusions and courts seem reluctant to find that mere negligent or deficient conduct amounts to bad faith *or* is

capable of causing an excess verdict when nothing about the case has changed in an material way to warrant the claimant's refusal to settle. *See Eres v. Progressive Ins. Co.* 2021 U.S. App. LEXIS 16277 (11th Cir.)(where insurer included objectionable terms in release but offered to remove them, this did not constitute a bad faith rejection of the claimant's limits demand); *Ilias v. USAA*, 2021 U.S. Dist. LEXIS 117879 (M.D. Fla)(technical non-compliance with insurance disclosure statute did not constitute bad faith and was not cause of excess verdict). *But see, Aldana v. Progressive American Insurance Company,* 828 Fed.Appx. 663 (2020)(discussed infra).

Florida is not the only state that presents difficulty in these types of situations. Cases in Georgia and California are also concerning for insurers who provide insufficient limits in a clear liability case. *See Whiteside v. GEICO*, 2021 U.S. App. LEXIS 13893 (11th Cir.)(certifying questions to the Georgia Supreme Court which held that early attempt to negotiate settlement below limits caused excess default verdict, even where neither insured nor claimant informed insurer that suit was filed); *Pinto v. Farmers Ins. Exchg.*, 61 Cal. App. 5th 676 (Cal. Ct. App. 2021)(failure to settle clear liability promptly or attempting to settle for less than a reasonable amount is evidence of bad faith that can be considered by a jury).

The Multiple-Claimant Set-Up

The multiple-claimant set-up is very similar to the classic set-up. The insured, covered by a single limit policy, causes an accident and in the process injures more than one person. As a result, both claimants demand the single limit of coverage. The insurer is thus presented with a "Catch-22." to-wit, pay the limits to one claimant, leaving the other claimant with nothing (and face resulting bad-faith liability), or attempt to divide the limits between the claimants, also creating potential bad faith liability if settlement discussions are not conducted properly.

Fortunately, courts have recognized the unfairness of imposing bad-faith liability on an insurer in this situation, and generally allowed the insurer the discretion to settle claims among multiple claimants as it sees fit without incurring bad-faith liability. *See Farinas v. Fla. Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555 (Fla. 4th DCA 2003); *DeMarco v. Travelers Ins. Co.*, 26 A.3d 585 (R.I. 2011); *Mesa v. Clarenden Nat'l Ins. Co.*, 799 F.3d 1353 (11th Cir. 2015). However, an insurer walks a fine line when attempting to settle as many claims as possible with low limits, as many courts view the question of whether the insurer indiscriminately settled cases in order to exhaust its limits (and thereby terminate its duty to defend) as one of fact for a jury. The moment the question of bad faith is deemed one of fact, bad faith liability looms large. So long as a plaintiff can survive a motion to dismiss a bad-faith claim, the chances of obtaining a settlement in excess of policy limits is significantly raised. Thus, the multiple-claimant set-up requires special attention and must be handled as carefully as the original bad faith set-up.

The Multiple Claimants With Varying Damages Set-Up

This set-up is really a variation on the multiple-claimant set-up. In this scenario, the insured causes an accident which results in injuries to several claimants, but the extent of their injuries varies greatly. One claimant's damages clearly exceed the "per person" limit of liability, but the other claimants' do not. Therefore, the plaintiffs' attorney makes a demand for the full "per accident" or "per occurrence" limits of liability in return for a release of claims of all claimants.

To illustrate, presume that the policy provides limits of $100,000 per person/$300,000 per accident. Claimant A's injuries are valued at $300,000, but claimant B and C's injuries are valued at only $50,000 each. Does the insurer have a duty to accept the offer, in essence overpaying for two claims, in order to avoid an excess exposure on the third claim?

A recent case out of the 11th Circuit is very troubling. *See, Aldana v. Progressive American Insurance Company,* 828 Fed.Appx. 663 (2020). *Aldana* presented a clear liability case, one claimant with very serious injuries, and another claimant with far less serious injuries. The insurer attempted multiple times to offer its $500,000 limit in a global settlement. These efforts went nowhere, and there was a $50 million verdict against the insured in respect of the serious injury case. The lower court granted summary judgment in favor of the insurer, but the 11th Circuit reversed, finding that the fact that the insurer did not advise the insured that they should settle the serious case alone could be considered bad faith and the cause of the excess verdict, even though there was never any indication that the limits would have been accepted. The court vacated summary judgment and remanded for further proceedings.

Few other courts have addressed this issue. However, it has generally been rejected as a means of creating bad faith liability. *See Redcross v. Aetna Casualty & Surety Co.*, 260 A.D.2d 908 (N.Y. Ct. App. 1999). The *Redcross* court rejected that attempted set-up outright, stating:

> [A]n insurer confronted with multiple claims arising out of the same accident is not required - in order to forestall a bad-faith settlement claim - to accept a "package deal" within the overall policy limits if, in doing so, it would be overpaying on some of the claims in order that in the other claims, as to which the insurer is ready to pay the full policy limit, the insured not be exposed to liability that exceeds the policy limit.

Redcross, 260 A.D.2d at 911.

Both the Texas and Tennessee appellate courts which ruled on the issue also rejected this attempted set-up. See *Rosell v. Farmers Texas County Mut. Ins. Co.,* 642 S.W.2d 278 (Tex. Ct. App. 1982) (abrogated on other grounds, *PPG Indus., Inc. v. JMB/Houston Ctrs. Ptrs. Ltd. Ptrship.*, 146 S.W.3d 79 (Tex. 2004); *Clark v. Hartford Accident & Indemnity Co.*, 457 S.W.2d 36 (Tenn. Ct. App. 1970). Thus, the opinion of the majority of courts on this issue is that it fails.

Damages Are Unclear Or Coverage is Disputed

When damages are unclear or coverage is disputed, courts will typically look at the totality of the circumstances and the reasonableness to determine if the insurer acted in bad faith. For example, in *Deary v. Progressive Am. Ins. Co*, No. 20-80279-CV, 2021 U.S. Dist. LEXIS 83657 (S.D. Fla. Apr. 30, 2021) the insurer used Liability Navigator to determine the appropriate settlement amount would be between $8,000 to $12,7000 when the insured was 100% liable for the accident. However, the claimant rejected any offer that was less than the policy limit. The insurer tirelessly worked to settle despite the claimant's unresponsiveness nature. Notably, an insurer does not have an affirmative duty to continue settlement negotiations when a claimant unequivocally communicated that a settlement was off the table. Similarly, in *Rau v. Allstate Fire & Cas. Ins. Co.*, 793 F. App'x 84 (3d Cir. 2019), the insurer did not act in bad faith when they

refused to pay the full $200,000 uninsured motorist policy limit. Here, the insured had already settled with the other driver, so the UIM insurer was only potentially liable if damages were in excess of $100,000. Since the insured recovered from the other driver and the majority of her claim stemmed from a possible future surgery, the court held the insurer had a reasonable basis for contesting it. Also, in *Columbia Ins. v. Waymar*, Nos. 20-1265, 20-1266, 20-1267, 2021 U.S. App. LEXIS 18568 (4th Cir. June 22, 2021) the insurer did not act in bad faith when it lacked the requisite medical information and had no duty to comply with the settlement offer. A reasonable jury could not fault an insurer for waiting to review medical documents before agreeing to settle.

In addition to reasonable basis, coverage disputes also focus on the insurer's intent: did the insurer have knowledge, reckless disregard, or a dishonest purpose in denying a claim? To illustrate, in *Hallmark Specialty Ins. Co. v. Phx. C & D Recycling, Inc.*, 999 F.3d 563 (8th Cir. 2021) the insurer had a reasonable basis for initially paying $28,000 instead of the full $200,000 policy limit, because of a prior Iowa Supreme Court case; it held payment for replacement cost are not required until the associated equipment is replaced or repaired. Further, coverage disputes are not enough for a bad faith claim. Instead, there needs to be a showing of a dishonest purpose. In *Mazzarella v. Amica Mut. Ins. Co.*, 774 F. App'x 14 (2d Cir. 2019), the insured could not prove the insurer acted in dishonesty when they denied her claim for direct physical loss. On the other hand, Washington law specifies an insurer must ask if there is any conceivable way that one or more of the claims asserted in the lawsuit is covered. For example, in *Webb v. USAA Casualty Insurance Company*, 12 Wash. App. 2d 433, 457 P.3d 1258 (2020) the insurer's coverage position was in bad faith despite the lower court holding otherwise. One would think that a lower court agreeing with the insurer's position would make that position *per se* reasonable; however, the court found that the insurer went out of its way to find any "conceivable way its policy did not provide coverage."

The Punitive Damages Set-Up

The punitive damages set-up really involves a manufacturing of coverage which does not exist. In this scenario, the severely injured plaintiff is hurt by an insured with plenty of coverage, enough in fact to satisfy the full value of the claim. Once the case is filed, the plaintiff adds a claim for punitive damages (in a state in which such damages are uninsurable or where the policy itself excludes such coverage). Presume, for example, that the insured has $1,000,000 in coverage and the "full value" of the plaintiff's compensatory claim is $500,000. So the plaintiff adds a claim for punitive damages. Ordinarily, the insurer would be safe in assuming that it need not concern itself with protecting its insured against the punitive-damage claim, since it is not covered in the first place. Unfortunately, that assumption may prove dangerous.

Savvy plaintiffs' attorneys recognize that the insurer is usually required to defend both covered and non-covered claims when they are asserted in the same lawsuit. Therefore, the insurer still must provide a defense against punitive damages despite the fact that they are clearly excluded from coverage. So far, so good. But this duty can be distorted to the point that, in order to avoid a finding of bad faith, the insurer must consider paying more than the full compensatory value of the claim in order to protect its insured against an excess judgment notwithstanding that the punitive claim is inarguably not covered.

A prime example of this set-up is *Ging v. American Liberty Insurance Co.*, 423 F.2d 115 (5th Cir. 1970), a federal case interpreting Florida law. Ging held that, even though a claim for punitive damages is not covered under a liability policy, the insurer has a duty to act in good faith *vis a vis* the insured with regard to those damages. The language of the opinion is loose, leaving much to later interpretation:

> It is not necessary for us to decide - and we do not decide - whether the policy imposed a duty on the insurer to defend against a claim for punitive damages when it was joined with a claim for compensatory damages. It is sufficient for the purposes of the case at bar to hold that once having undertaken the defense of a non-covered claim, the insurance company is under an obligation to act in good faith toward its insured to the entire extent of its undertaking.

Ging, 423 F.2d at 121. This raises the obvious question: does the duty of good faith extend to actually paying too much on the compensatory claim in order to protect the insured from the punitive claim? If the answer is "Yes," the plaintiff has manufactured coverage which never existed.

The *Ging* rationale, however, has not met with much success in Florida, and for good reason. *See, e.g., Rodriguez v. Am. Ambassador Cas. Co.*, 4 F.Supp. 2d 1153 (M.D. Fla. 1998) (rejecting argument that Ging required insurer to accept offer of inflated property damage claim to protect insured against substantial bodily injury claim where policy provided no bodily injury coverage); *Calhoon v. Leader Specialty Ins. Co.*, 2007 WL 4098840 (M.D. Fla. Nov. 15, 2007) (same); *but see Allstate Indemnity Co. v. Oser*, 893 So. 2d 675 (Fla. 1st DCA 2005) (relying on *Ging* to find insurer undertook duty to protect insured against bodily injury claim by accepting demand for limits of property damage coverage despite fact that policy provided no bodily injury coverage). If the insurer's duty to defend encompasses a duty to pay on an uncovered claim, then the duty to defend must be equated with the duty to indemnify, a proposition that has never seen the light of day. It is generally held that an insurer's duty to defend is far broader than the duty to indemnify. *See, e.g., Jones v. Fla. Ins. Guaranty Ass'n*, 908 So. 2d 435, 443 (Fla. 2003). If any of the claims in the complaint allege covered damages, then the insurer must defend the entire complaint. If the duty to indemnify is extended as broadly as the duty to defend, then exclusions are meaningless and all claims are covered. That bedrock principle is what has likely kept the punitive damages set-up in check. Thus, what appeared to be a clever way to manufacture coverage has simply not materialized as the plaintiff's bar hoped it would.

In other states, however, Ging has generally been embraced. See, e.g., *Brochstein v. Nationwide Mut. Ins. Co.*, 448 F.2d 987 (2d Cir. 1971) (question of bad faith where uninsured claim is presented is a question of fact); *Homestead Ins. Co., Inc. v. Cornish & Carey Residential, Inc.*, 1993 WL 255486 (N.D. Cal. June 30, 1993) (following *Ging*); *Magnum Foods, Inc. v. Continental Cas. Co.*, 36 F.3d 1491 (10th Cir. 1994) (same). It is therefore critical to know whether your jurisdiction permits this form of set-up.

The Multiple-Insureds Set-Up

The multiple-insured set-up is similar to the multiple-claimant set-up. In this scenario, however, there is only one claimant, but more than one insured who is potentially liable for the claimant's injuries. The classic example is where the claimant is injured by a permissive user of the named insured's automobile. In that situation, most auto policies confer omnibus insured status on the permissive user. Alternatively, the named insured can be an employee and the employer is an "omnibus insured." Either way, the insurer must attempt to extinguish the liability of both of its insureds in order to avoid bad-faith liability.

An excellent example of this situation is *Contreras v. U.S. Security Insurance Co.*, 927 So. 2d 16 (Fla. 4th DCA 2006). In *Contreras*, the claimant offered to provide a full release of liability to one insured in exchange for the full policy limit, but refused to release the other insured. This scenario is not uncommon, particularly where one insured appears to have assets beyond coverage or where the active tortfeasor's negligence was egregious, i.e., a D.U.I. Thus, another "Catch-22" is presented: should the insurer do what it can to protect one insured and face a bad faith claim from the other insured who is left exposed, or insist on a release of both insureds and face a bad faith suit by both insureds?[1]

The *Contreras* court recognized the unfairness of allowing this kind of set-up to result in bad faith liability, explaining:

> Having attempted to secure a release for Dale without success, U.S. Security fulfilled its obligation of good faith towards Dale. Once it became clear that Contreras was unwilling to settle with Dale and give him a complete release, U.S. Security had no further opportunity to give fair consideration to a reasonable settlement offer for Dale. Since U.S. Security could not force Contreras to settle and release Dale, it did all it could do to avoid excess exposure to Dale.

Id., 927 So. 2d at 21. Here, the insurer refused to settle if it could not release both insureds and that decision backfired.

This attempted set-up has generally been rejected in other jurisdictions as well. See, e.g., *Kemp v. Hudgins,* 133 F.Supp. 3d 1271 (D. Kan. 2015) (finding insurer acted in good faith by rejecting settlement demand that only included release of one insured); *Pride Transp. v. Continental Cas. Co.*, 511 Fed. Appx. 347 (5th Cir. 2013) (same); *Williams v. GEICO Cas. Co.*, 301 P.3d 1220 (Alaska 2013) (same); *Kauffman v. Cal. State Auto. Ass'n Interinsurance Bureau*, 2009 WL 4049153 (Cal. Ct. App. Nov. 24, 2009) (unpublished) (same). Thus, the multiple-insured set-up finds no purchase and fizzles as a means of manufacturing coverage.

The Consent Judgment Set-Up

This set-up is all too familiar: an insured, disenchanted with its insurer's refusal to defend an action the insured believes is within coverage, decides to stipulate to a "consent judgment" with the plaintiff, in return for which the plaintiff agrees only to pursue satisfaction of the "judgment"

[1] Technically, in many states, the bad faith suit could be brought by the claimant, and/or the insureds.

against the insurer. Some form of this type of judgment is recognized in almost every jurisdiction in the United States. A small minority of jurisdictions refuse to recognize such agreements, instead requiring that the claimant and insured actually litigate the claim to judgment. See, e.g., State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696 (Tex. 1996) (and cases cited therein). The judgment is generally referred to by any number of monikers, generally based upon the "seminal" case in that jurisdiction. See, e.g., *Tidyman's Mgmt. Svcs., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 378 P.3d 1182 (Mont. 2016); *Midwestern Indem. Co. v. Laikin*, 119 F.Supp. 2d 831 (S.D. Ind. 2000); *Gulf Ins. Co. v. Noble Broadcast*, 936 S.W.2d 810 (Mo. 1997) (en banc) (authorized by statute and referred to as "section 537.065 Agreement"); *United Svcs. Auto. Ass'n v. Morris*, 741 P.2d 246 (Az. 1987); *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982); *Coblentz v. Am. Surety Co. of New York.*, 416 F.2d 1059 (5th Cir. 1969) (Florida law).

While the names may change, the agreements are unwaveringly uniform. The critical aspects of these judgments are: 1) entry into a judgment purporting to represent a reasonable settlement of the claim; 2) an agreement not to execute on the judgment against the insured; 3) an assignment of any and all claims the insured may have against the insurer under the insurance policy; and 4) an agreement to satisfy the judgment upon conclusion of the contemplated litigation against the insurer.

In addition, every jurisdiction which accepts consent judgments recognizes the inherent potential for fraud and/or collusion in such judgments and, accordingly requires that the judgments be reasonable in amount and entered into in good faith. The question which seems to be left open in virtually every jurisdiction, however, is what happens if the judgment is found either to be unreasonable in amount or entered into in bad faith.

One of the best examples of how consent judgments are treated emanates from a Florida intermediate court. *See Steil v. Fla. Physicians Ins. Reciprocal*, 448 So. 2d 589 (Fla. 2d DCA 1984). Steil involved a medical malpractice case in which the insured physician entered into a consent judgment following a denial of defense by the insurer. The insurer defended the judgment on the ground that entering into the settlement violated the "no action" clause of the policy, prohibiting the insured from entering into settlements without the insurer's consent. The court held that, because the insurer wrongfully refused to defend, its breach precluded reliance on that condition. The court also held that the judgment was only enforceable against the insurer in the event it was entered into in good faith and was reasonable in amount.

From that situation, the court crafted the procedure followed by virtually every state in the nation:

> ... [I]n the instant case or one involving a consent judgment with a covenant not to execute, the settlement figure is more suspect. The conduct of an insured can hardly be characterized as fraudulent simply because he stipulates to a large settlement figure in order to obtain his release from liability. He has little or nothing to lose because he will never be obligated to pay. As a consequence, the settlement of liability and damages may have very little relationship to the strength of the plaintiff's claim. Due to this problem, the ordinary standard of collusion or fraud is inappropriate. ... Thus, we hold that in a case such as this, a settlement may not be enforced against the carrier if it is unreasonable in amount or

> tainted by bad faith. Moreover, because the circumstances surrounding the settlement will be better known to the party seeking to enforce it, he should assume the burden of initially going forward with the production of evidence sufficient to make a prima facia showing of reasonableness and lack of bad faith, even though the ultimate burden of proof will rest upon the carrier.

Steil, 448 So. 2d 589 (Fla. 2d DCA 1984).

This procedure makes logical sense. Proving coverage is uniformly the burden of the insured. Thus, requiring the insured to come forward with evidence that the consent judgment was reasonable in amount and entered into in good faith properly belongs to the insured. However, since the insurer is usually seen to have abandoned its insured, shifting the ultimate burden of persuasion to the insurer to prove that the judgment was unreasonable in amount or entered into in bad faith also makes logical sense. This is, after all, an affirmative defense. But the opinions which address this question all simply state that such judgments can only be enforced against the insurer if they are reasonable in amount and entered into in good faith. Does this mean that the converse is also true, i.e., that consent judgments which are found to be unreasonable in amount or entered into in bad faith leave the plaintiff with no recovery whatsoever? It appears the answer to that question, at least in every state other than Iowa or Missouri, is, “Yes.”

It is frankly surprising that the plaintiffs’ bar has not mounted a better attack on the insurance industry in this area of the law. Considering the fact that an absolute prerequisite to prevailing on a consent judgment is that the claimant prove both that the policy covers the underlying claim and that the insurer wrongfully refused to defend its insured, a procedure which leaves a claimant with no recovery at all despite the existence of coverage seems harsh. But, as the courts have routinely recognized, the potential for collusion and fraud in such situations is so high that requiring good faith and reasonableness is the only way to keep such conduct at bay.

Courts in Iowa and Missouri, however, created a third alternative, namely that the finder of fact can determine what a reasonable amount would have been and impose that figure on the non-defending insurer. A close examination of those opinions reveals the fallacy of allowing such an ex post determination.

The first court to allow the fact finder to determine what amount should be enforced against the insurer was the Missouri Supreme Court. *See Gulf Ins. Co. v. Noble Broadcast*, 936 S.W.2d 810 (Mo. 1997). In *Noble Broadcast*, the insured, a radio station, was sued by a parade bystander who was injured when the station’s van ran over her foot. After the station’s insurer declined to defend the suit, the claimant and the station entered into a consent judgment in the amount of $1,000,000, complete with a covenant not to execute and an assignment of the station’s rights as against the insurer. In a preemptive declaratory judgment action filed by the insurer, the trial court found the agreement unreasonable in amount and therefore refused to enforce it. On review by the Supreme Court, the Court adopted the same test of reasonableness as the Florida court in *Steil*. However, for the first time, it addressed what effect a finding of unreasonableness should have:

> Finally, this Court must determine an appropriate process for disposition of a case in which the settlement agreement is judged to be unreasonable. There are two possibilities. First,

> the court, after holding an agreement unenforceable, could release the insurer from any liability. Alternatively, the trial court, acting as the finder of fact, could determine a reasonable settlement amount for which the insurer should be held liable. This Court concludes that the second of the possibilities is fairer. This requires that the case be remanded. The question of what constitutes a reasonable settlement in this case would have been necessarily addressed, at least in part, by implication in the determination that the settlement amount was unreasonable. The question may, however, require further argument by the parties. Whether such argument is helpful in this case is left to the sound discretion of the trial court to determine on remand before making a finding of a reasonable settlement amount for which the insurer should be held liable.

Noble Broadcast, 936 S.W.2d at 816-17. Since the policy limits at issue in Noble Broadcast were $1,000,000, there was no possibility of a judgment in excess of policy limits.

The following day, the supreme court of Iowa addressed the same question, apparently without any knowledge that the Missouri Supreme Court just addressed it. *See Six v. American Family Mut. Ins. Co.*, 558 N.W.2d 205 (Iowa 1997). *Six* involved a claimant, injured in a motor vehicle accident, who took an assignment of the insured's rights as against its insurer in a typical consent judgment. The judgment was in the amount of $285,000 and the action was to recover that amount from the insurer "to the extent of its policy limits." *Six*, 558 N.W.2d at 206. The trial court submitted the issue of reasonableness to the jury, which found the judgment to be unreasonable in amount. On appeal, the claimant argued that the insurer should still be held liable for the amount of a reasonable settlement. The court sympathized with that position, explaining simply:

> American Family suggests in its argument that the insurance company's liability is extinguished when a negative finding is made concerning whether a settlement is reasonable and prudent. We disagree with that contention. We are convinced that, if coverage exists, an insurer that declines to defend a claim continues to be liable to hold its insured harmless for that portion of the stipulated judgment that represents a reasonable and prudent settlement.

Six, 558 N.W.2d at 207. Thus, in the Six case, the appellate court remanded for the court to determine a reasonable settlement and enforce that amount against the insurer, within the limits of the policy.

Noble Broadcast has been followed in Missouri. *See, e.g., Auto Owners Ins. Co. v. Ennulat.*, 231 S.W.3d 297 (Ct. App. Mo. 2007). By contrast, the *Six* opinion has been both followed and rejected by other courts. See *Bird v. Best Plbg. Group, LLC*, 260 P.3d 209 (Ct. App. Wash. 2011) (declining to follow *Six*); *Nunn v. Mid-Century Ins. Co.*, 244 P.3d 116 (Colo. 2010) (en banc) (following *Six*). Due to the fact that the decisions were released within twenty-four hours of each other, their silence each as to the other is no mystery. Given the twelve years which passed since the decisions were released, the likelihood that they might open the floodgates to collusive settlements, at least outside Missouri or Iowa, is low. Perhaps the best explanation for why these decisions represent such a minority approach comes from the enigmatic logic on which they appear to be based. When an insurer denies coverage and refuses to defend its insured (whether based on a valid or invalid

reason), the alignment of the parties changes. No longer is the defendant adversarial to the claimant. Rather, both the claimant and the defendant become adversarial to the insurer. Even the most honorable insured will be tempted to consent to a much larger number than he would if he were to remain responsible for satisfying the judgment.

Another approach taken by courts to this problem is that adopted by the Court of Appeals of California in *Pruyn v. Agricultural Ins. Co.*, 42 Cal. Rptr. 2d 295 (Ct. App. Cal. 1995). *Pruyn* crafted an elaborate procedure by which the claimant seeking to impose the consent judgment on the insurer must prove the amount of a settlement to which the insured would agree had he remained personally liable for the judgment. While that procedure is superficially appealing, it suffers from the same lack of true adversarial conflict which any consent judgment lacks. As the Texas supreme court explained when it criticized the *Pruyn* decision:

> The procedure required by Pruyn to enforce an agreed judgment against an insurer is, to be generous, complicated. Its goal is to determine what judgment would have been rendered against an insured, or what settlement he would have agreed to, had he remained personally liable to plaintiff. Put another way, the inquiry is what result would plaintiff and defendant have reached had they remained fully adversarial to the end. The validity of the holdings in *Griggs*, 443 A.2d at 163 (New Jersey), *Red Giant*, 528 N.W.2d at 524 (Iowa), and other cases that uphold prejudgment assignments of claims against insurers is based on the premise that this inquiry is answerable. We think it is not, and that *Pruyn* shows why. It is one thing to say that a defendant's liability must be determined as if he had not settled with the plaintiff; it is quite another thing to do it. We think *Pruyn's* listing of factors to be considered in the process of assessing a defendant's liability after he has settled shows that the undertaking is virtually impossible. Once the parties have changed positions, their views are altered, and it is very difficult to determine what might have been.

State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696 (Tex. 1996). Thus, in Texas, even if the insurer wrongfully refuses to defend its insured, the only liability which can be imposed on the insurer is that which is reached after a truly adversarial adjudication of liability. Given the recognition of the parties' altered motives after a denial of defense, this may be the only approach that makes true logical sense.

The Texas approach recognizes that, even if the parties litigate the case, in the event there is any agreement by the claimant not to seek satisfaction of the judgment from the insured, the insured is insulated from further liability and therefore has no incentive to defend the case vigorously. Thus, the possibility of a sham trial is as real as the possibility of a sham settlement. In short, it is not the fact that the parties have resolved the claim between themselves which raises the specter of fraud and collusion; rather it is the fact that once the claimant agrees to pursue only the insurer, the insured loses all incentive to defend. In the event the liability proves to be catastrophic and the insurer has indeed wrongfully refused to defend, in most cases the judgment will be recoverable in full from the insurer under bad faith principles, if, or especially if, the insured gives the insurer another chance to settle within limits following the determination that coverage was owed in the first place.

It is therefore clear that the Iowa and Missouri approaches to consent judgments cannot be justified logically. If the insured and the claimant know that the only consequence for colluding to create an inflated judgment to be recovered from the insurer is the possibility of a remittitur of the judgment to a "reasonable" sum, there will be no limit on the amount to which insureds will confess judgment. The risk of agreeing to too little would be far more costly than the risk of agreeing to too much. Thus, in every case, "settlement" of the case accomplishes nothing. It is merely one more step to recovering from the insurer, something which will require presentation of all the evidence necessary to prove the case in the first instance against the defendant. If the courts' goals were to encourage settlement (and they are notably silent as to the true rationale of their decisions), they failed miserably. As the old adage goes, the road to Hell is paved with good intentions.

The final approach is that taken by Arizona and Minnesota courts. See *United Svcs. Auto. Ass'n v. Morris*, 741 P.2d 246 (Az. 1987) (en banc); *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982). In *Morris*, the insured entered into a consent judgment notwithstanding the fact that the insurer, USAA, was defending the insured under a reservation of rights. The insured was sued for shooting the claimant at the insured's house during a heated argument. USAA raised as a defense the policy's intentional acts exclusion, but nevertheless defended the insured. During the litigation, the insured entered into a consent judgment with the claimant for the USAA policy's limit of $100,000. The trial court entered a declaratory judgment in favor of USAA, finding that the insured breached the policy's cooperation clause by entering into the consent judgment.

The case made it to the Arizona Supreme Court, which ultimately considered the issue *en banc*. The Court found in favor of the insured, rejecting the contention that entering into the consent judgment breached the cooperation clause. It aligned itself with the Supreme Court of Minnesota, which paved the way for insureds to enter into consent judgments notwithstanding the insurer's defense under a reservation of rights. See Miller, supra. The Court concluded:

> The law distinguishes between an insurer's duties to defend and to pay. … An insurer that performs the duty to defend but reserves the right to deny the duty to pay should not be allowed to control the conditions of payment. The insurer's insertion of a policy defense by way of reservation or nonwaiver agreement narrows the reach of the cooperation clause and permits the insured to take reasonable measures to protect himself against the danger of personal liability. Accordingly, we hold that the cooperation clause prohibition against settling without the insurer's consent forbids an insured from settling only claims for which the insurer unconditionally assumes liability under the policy.

Morris, 741 P.2d at 252, *citing Continental Cas. Co. v. Signal Ins. Co.*, 580 P.2d 372, 376 (Az. Ct. App. 1978); 7C J. Appleman, Insurance Law and Practice § 4682 (1979). Thus, in Arizona and Minnesota, defending under a reservation of rights is tantamount to failing to defend.

As for consent judgments, the conclusion is clear: where a jury finds that the insured and a claimant conspired to enter into an inflated or unreasonable judgment to recover from the insurer, the judgment should not be enforced, period. Insurers have long been forced to exercise the utmost "good faith" toward their insureds. Imposing that reciprocal obligation upon insureds makes perfect sense in that scenario.

The Multiple-Coverage Set-Up

The multiple-coverage set-up appears to be the newest and least-tested theory. It involves a policy which provides both bodily injury and property damage coverage, both with minimal limits. The insured causes an accident which results in significant bodily injury damages, but property damage slightly below the limit for that coverage. For example, each coverage has a limit of $10,000 and the bodily injury claim is valued at $200,000, but the property damage claim is initially valued at $9,000. The insurer tenders the bodily injury limit immediately, but negotiates the property damage claim rather than accepting a demand for the limits of both coverages. When later evidence shows the property damage claim to be worth more than $10,000, the insurer then tenders the limit of property damage coverage which the claimant refuses, claiming the insurer is in bad faith.

The question is whether the insurer's bad faith in connection with the property damage claim opens the limit of liability for the bodily injury claim, since both coverages are found in the same policy. Under Florida law, the answer is "No." See *Rodriguez v. Am. Ambassador Cas. Co.*, 4 F.Supp. 2d 1153 (M.D. Fla. 1998) (rejecting argument that *Ging v. American Liberty Insurance Co.*, 423 F.2d 115 (5th Cir. 1970) required insurer to accept offer of inflated property damage claim to protect insured against substantial bodily injury claim where policy provided no bodily injury coverage). See also Calhoon v. Leader Specialty Ins. Co., 2007 WL 4098840 (M.D. Fla. Nov. 15, 2007) (same).

However, in California, the rule may be otherwise. See *Hutton v. Mercury Casualty Co.*, 2004 WL 1467442 (Cal. Ct. App. 4th Dist. June 30, 2004) (unpublished). In *Hutton*, the insured caused an accident which resulted in the total loss of Hutton's 1968 Volkswagen, as well as severe bodily injuries. In adjusting the claim, the insurer's claim professional refused a combined demand for $17,600, consisting of the limits of the insured's bodily injury coverage ($15,000) and $2,600 for the Volkswagen. The insured had a $10,000 limit for property damage. The claim professional refused the offer because the Volkswagen was only worth $2,400.

The claimant then sued the insured and obtained a verdict of $3,500,000. The insurer paid $500,000 and agreed to pay the remainder in the event Hutton succeeded on a bad faith claim. The California court rejected the insurer's contention that tying the settlement of the bodily injury claim to acceptance of an inflated property damage demand made the demand unreasonable as a matter of law (thereby vitiating bad faith). The court instead upheld the jury's finding that the insurer's rejection of the demand was unreasonable. Curiously, the court did not explicitly consider the question of whether the bad faith in connection with the property damage coverage resulted in a waiver of the bodily injury limits. Rather, the court appears simply to assume that it did.

Hutton is very difficult to reconcile with the decisions concerning the multiple-claimant set-up. Those opinions clearly reject the idea that "per person" limits are irrelevant in the context of multiple claimants within the same coverage. If an insurer is not required to overpay on one claim in order to settle a separate claim under the same coverage, it is difficult if not impossible to justify tying the bodily injury and property damage coverages to a single act of bad faith. Perhaps

that explains why Hutton has not gained any widespread acceptance (California and Florida appear to be the only jurisdictions where this particular set-up received scrutiny).

From a logical standpoint, the rationale of *Hutton* also runs contrary to other well-established principles of law. For example, each coverage for which a separate premium is charged generally constitutes a separate contract of insurance, the breach of which gives rise to a separate cause of action. *See State Farm Mut. Auto. Ins. Co. v. Yenke*, 804 So. 2d 429 (Fla. 5th DCA 2002); *Bryant v. Allstate Ins. Co.*, 584 So. 2d 194 (Fla. 5th DCA 1991); *Almeroth v. Gov't Employees Ins. Co.*, 587 So. 2d 550 (Fla. 4th DCA 1991). Therefore, logically, bad faith in connection with a property damage claim should have no impact on the separate contract of insurance for bodily injury.

Similarly, where the insured commits fraud in connection with one coverage under a policy, that fraud may not vitiate other coverages under the policy. *See Flores v. Allstate Ins. Co.*, 819 So. 2d 740 (Fla. 2002); *Cf. Bosem v. Commerce & Industry Ins. Co.*, 35 So. 3d 944 (Fla. 3d DCA 2010) (holding that fraud in connection with PIP claim for lost wages voided all coverage under policy for PIP claim for medical bills; these coverages all fall within PIP coverage). Thus, where the insured's actions result in a loss of coverage, that act has no effect on a separately stated coverage in the same policy. Justice demands that the insurer receive comparable treatment. There is no logical reason why the separate coverage rule should not apply regardless of which party has breached the separate coverage. If the coverages are separate contracts, bad faith in connection with one could not possibly have any effect on the other.

The *Hutton* court, whether by design or omission, simply got it wrong. However, in the fifteen years since the opinion was released, it has not been followed. Therefore, *Hutton* will likely gather dust and take its rightful place on the shelf with the other unsuccessful versions of the bad faith set-up.

<u>The Failure to Disclose Policy Limits to a Claimant Upon Request</u>

In some states, courts even favorably sanction Plaintiffs who make a request for disclosure of policy limits of coverage where the insurer either refuses or cannot timely obtain their insureds' permission to do so. Based on an interpretation that the request for a disclosure was needed for an inevitable settlement opportunity within policy limits, an insurance carrier's failure to timely respond caused a loss of that settlement opportunity, opening up the policy limits. *See Metropolitan Prop. & Cas. Ins. Co. v. Hedlund*, 218 F. Supp. 1075 (E.D. Cal. 2016). Although (fortunately) the findings of fact and conclusions of law were vacated in 2017 (presumably based on a settlement), this opinion goes to far lengths to demonstrate how evidence presented in a one (1) day bench trial can result in a finding of open coverage for a seriously injured claimant. *See also, Smith v. Safeco Ins. Co.*, 150 Wash. 2d 478 (Wash. 2003) (prior to the claimant providing any documentation in support of a claim, insurer's failure to disclose the applicable limits of coverage to the claimant, which allegedly caused the inability to settle, created a question of fact for the jury on whether the insurer acted in bad faith and opened up the policy limits; summary judgment for the insurer reversed).

Fortunately, life in California is not so bleak. A California state court very recently ruled in favor of the insurer, in *Pinto v. Farmers Ins. Exchg.*, 61 Cal. App. 5th (Cal. Ct. App. 2021). Although a pinto bean is small, this Pinto decision was huge for the insurance industry. Following catastrophic injuries and aggravated liability, the claimant made a demand to the insurer to settle the claim and conditioned the demand on execution by "the insured" of a not-in-the-course-and-scope affidavit and a copy of the insurance policy. Not knowing which of two people were driving the insured's car at the time of the accident, the insurer attempted to obtain the affidavit from both persons. It was successful in obtaining it from one, but not from the other. Of course, plaintiff then claimed a lack of compliance with the terms of the demand and filed suit.

Finding that the jury never found that the insurer unreasonably failed to accept a settlement offer, and unreasonableness is a required element of a bad faith claim, it reversed the judgment entered against the insurer. *See also, Marin v. Interinsurance Exchange of the Auto Club*, 2021 WL 2885757 Cal. Ct. App. Jul. 9, 2021) (unpublished) (no bad faith as a matter of law where demand was conditioned on multiple factors, most of which could not be accomplished within the time frame given, and delivery of the insurance disclosure was not specified).

Conclusion

Where the attempts to settle claims or investigate coverage and damages are reasonable and appropriate, insurers should feel some level of confidence that they will not be liable for bad faith. Although accusations of bad faith are frequently lobbed at insurers for any position short of an unqualified confirmation of coverage, and there are certainly some curious decisions out there, generally the courts seem to get it right. Creative attempts at manufacturing coverage are often met with disfavor as evidenced by the general rejection of the other bad faith set-ups as evidenced by the recent decision in *Ilias.* The only question left is "what is the next set-up?" and will the courts be persuaded by it.