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Narrative

Policy Limit Demands- Strategies and Pitfalls

While both insurance carriers and their insureds have the same goals in litigation, quickly and economically resolving a case, getting to that point, is not always without obstacles, one of which is settlement negotiations when there is a possibility for an excess judgment. When the potential damages of a case exceed the available limits, negotiating a settlement can present many problems for both the claims handler and the defense attorney and include many competing interest. These competing interests often develop between the carrier and its insured as to whether a matter should be settled, the value of the claim, not overpaying the claim, and protecting the insured's interest but also minimizing the carrier's exposure for extra-contractual damages in the event of an excess judgment. Because of the various competing interest, most if not all states have developed jurisprudence or enacted statutes to ensure the carrier does not put its interest ahead of that of its insured, and in those situations, holding the carrier in bad faith as having breached its duty to its insured, resulting in the carrier being liable for a variety of damages including penalties, attorney fees and in some cases, the amount of the excess judgment. In some jurisdiction, these duties are not limited to the insured but are also extended to excess insurers. These competing obligations become even more complicated when there are multiple claimants competing for those limits. When negotiating policy limit demands, these competing issues must be taken into consideration. These obligations are further complicated in a commercial transportation scenario as there is often prejudices toward commercial and fleet drivers. This narrative will focus on examples from Texas, Florida, and California with regard to the duties of the insurer and unique policy limit demand situations but the panelists will provide their expertise from many different jurisdictions.

1. Duties to the Insured and Excess Carrier

Most if not all states provide for some obligation of an insurance carrier to negotiate and attempt to settle a claim in good faith to avoid excess judgments. What differs between states is the duties imposed on carriers and the damages that are owed due to the breach of those obligations. It is vital when negotiating a policy limit demand that both the claims handler and the defense attorney not only understand the obligations in the state the negotiations are taking place but take those duties into consideration from countering standpoints to the benefit of the defense.

A. Texas

In Texas, the *Stowers* doctrine is the applicable doctrine that all claim handlers and practitioners need to be aware when dealing with policy limit demands. The *Stowers* doctrine shifts the risk of liability for an excess judgment from the insured to the insurer in situations where the insurer was presented with a reasonable opportunity to prevent the excess judgment but failed to settle within the applicable policy limits. *American Physicians Ins. Exch. v. Garcia*, 876 S.W. 2d 842 (Tex. 1994).

An insurer has a duty to act with "that degree of care and diligence which an ordinarily prudent person would exercise in the management of its own business" in responding to settlement demands within policy limits. *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W. 2d 544 (Tex. Comm'n App. 1929). Under *Stowers*, the insurer has a duty to respond properly to an actual settlement demand, but it does not obligate the insurer to initiate, solicit, or engage in give and take settlement negotiations. *Stowers* requires several elements be met by a plaintiff including: (1) that the claim be within the scope of coverage; (2) the demand is within policy limits; (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment; (4) and the proposed settlement fully, completely, and unconditionally releases the insured from liability of all claims, including liens. The insured does not have to demand that the insurer accept the demand for *Stowers* to apply. *Highway Ins. Underwriters v. Lufkin-Beaumont Motor Coaches*, 215 S.W. 2d 904 (Tex. Civ. App. 1948). This obligation also applies in favor of an excess carrier who has the ability in Texas to pressure a primary insurer to accept a policy limit demand. In addition to *Stowers*, The Texas legislature enacted Tex. Ins. Code 541.060(a)(2) establishing obligations of a carrier toward its insured. However, the Texas Supreme Court has found that these statutes are the functional equivalent of the *Stowers* duty. *Rocor Int'l, Inc. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W. 3d 253 (Tex. 2002).

This duty of course is complicated when there are multiple claimants. The Texas Supreme Court has held that an insurer is allowed to fulfill its *Stowers* duty to its insured by settling with one claimant, even though the result is to leave the insured exposed to another claim. *See Texas Farmers Insurance Co. v. Soriano,* 881 S.W.2d 312, 315 (Tex.1994). Under this situation, an insurer can only be liable for settling a claim if (a) they had previously rejected a valid settlement offer within policy limits from the other claimant or (b) the settlement they reached was unreasonable considering solely the merits of the settled claim and the potential liability of its insured on that claim.

The *Stowers* duty is further complicated in a situation where there are more than one insured seeking limits. At least one Texas court has held that a carrier may settle the claims against the insured while refusing to defend an additional insured in a separate suit as its duties to the additional insured terminated based on the terms of the policy when the settlement exhausted the policy limits. See *American States Ins. Co. Of Texas v. Arnold*, 930 S.W.2d 196 (Tex. App.—Dallas 1996.

B. California

California law implies a covenant of good faith and fair dealing. This implied covenant obligates the insurance company, among other things, to make reasonable efforts to settle a third party's lawsuit against the insured. If the insurer breaches the implied covenant by unreasonably refusing to settle the third-party suit, the insured may sue the insurer in tort to recover damages proximately caused by the insurer's breach. *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (1999).

In evaluating whether an insurer acted in bad faith, the critical issues is the reasonableness of the insurer's conduct under the facts of the particular case. To hold an insurer liable for bad faith in failing to settle a third-party claim, the evidence must establish that the failure to settle was unreasonable.

> An insurer's duty to accept a reasonable settlement offer is not absolute. " '[I]n deciding whether or not to settle a claim, the insurer must take into account the interests of the insured, and when there is a great risk of recovery beyond the policy limits, a good faith consideration of the insured's interests *may* require the insurer to settle the claim within the policy limits. An *unreasonable* refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits.

Pinto v. Farmers Ins. Exch., 61 Cal. App. 5th 676, 688, 276 Cal. Rptr. 3d 13, 21 (2021), citing *Comunale v. Traders & General Ins. Co*. (1958) 50 Cal.2d 654, 658-661, 328 P.2d 198 (1958).

In order to establish a claim for bad faith refusal to settle, a plaintiff must prove that the third party made a reasonable offer to settle the claim against the insured for an amount within the policy limits, the claim requires proof the insurer unreasonably failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance. *Graciano v. Mercury Gen. Corp.*, 231 Cal.App.4th 414, 179 Cal. Rptr. 3d 717, 726 (2014).

When multiple insureds are involved, California protects the insureds and does not allow the insurer to settle claims if it would leave an insured exposed. California holds that an insurer has a duty of good faith to all its insured and if an insurer pays the entire policy limit on behalf of one of the insureds without providing coverage to the other, it breaches its duty. *Strauss v. Farmers Ins. Exch.*, 26 Cal. App. 4th 1017, 1021, 31 Cal. Rptr. 2d 811, 813 (1994). An insurer may within the boundaries of good faith, reject a settlement offer that does not include a complete release of all of its insured. *Id*. In such a case, the duty of good faith and fair dealing requires the carrier to make some assessment as to whether it is confronting viable competing claims and to respond to the potential conflict in a timely manner.

C. Florida

Florida has both common law and statutory obligations of bad faith imposed on an insurer that provide for almost identical obligations. *See* Fla. Stat. § 624.155. Florida imposes on an insurer the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. *Boston Old Colony Ins. Co. v. Gutierrez,* 386 So.2d 783 (Fla.1980). The Florida Supreme Court has held that because the insured has relinquished control of all decisions regarding claims to the insurer, the insurer's standard of care requires the insurer to act in good faith and with due regard to the interests of the insured. *Id.* The court defined the standard as follows:

> This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid the same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.

Additionally, when there are multiple claimants and minimal policy limits, "it follows that, insofar as the insureds' interest governs, the fund should not be exhausted without an attempt to settle as many claims as possible." *Liberty Mut. Ins. Co. v. Davis,* 412 F.2d 475 (5th Cir.1969).

> Florida law provides that where multiple claims arise out of one accident the liability insurer may exercise its discretion in how it elects to settle claims, "and may even choose to settle certain claims to the exclusion of others, provided [that] this decision is reasonable and in keeping with its good faith duty." In order to satisfy these requirements the insurer must: (1) fully investigate all claims arising from a multiple claim accident; (2) seek to settle as many claims as possible within the policy limit; (3) minimize the magnitude of possible excess judgments against the insured by reasoned claim settlement; and (4) keep the insured informed of the claim resolution process.

Gen. Sec. Nat. Ins. Co. v. Marsh, 303 F. Supp. 2d 1321, 1325 (M.D. Fla. 2004).

2. Strategies and Pitfalls

The claims hander and defense attorney must keep the insurer's obligations and the insured's interest at the forefront of any negotiation. Other unique areas of concern with regard to policy limit demands are ensuring that a claim is properly valued and such evaluation is ongoing, the insured cooperates in the negotiations, negotiating effectively multiple claims in the same occurrence, and ensuring all potential insureds are dismissed.

A. The Continuing Obligation to Evaluate Valuation

A prime example of how policy limit demands were poorly handled by the claims handler and the defense attorney with regard to valuation is *American Guarantee and Liability Ins. Co. v. Ace American Ins. Co.*, 990 F. 3d 842 (5th Cir. 2021), which is demonstrative of how important it is that the claims handler and defense attorney properly and continually evaluate the value of the case from the inception of the claim through trial taking into consideration not only evolving medical issues but also liability and evidentiary issues.

After Mark Braswell died when his bike collided with a stopped truck, his survivors sued the truck owner the Brickman Group, Ltd., LLC. seeking substantial damages. Brickman was insured by Ace with limits of $2 million and excess coverage with AGLIC with limits of $10 million. There were disputed facts as to how the accident occurred and the amount of comparative fault that should be allocated to the decedent. Based on these issues, the defense attorney valued the case for settlement purposes between $1.25 and $ 2 million. AGLIC's case manager valued the settlement at no more than $500,000. No one on the defense side thought a verdict over $2 million was likely. On the eve of trial, a demand for primary limits was made. Ace counteroffered with $500,000, which was rejected and the matter proceeded to trial. The matter quickly went south for the defense at trial when the judge made unfavorable evidentiary rulings. After plaintiffs' closing argument, the case manager for AGLIC advised that a verdict in excess of primary limits was possible given the adverse rulings. Before the jury reached a verdict, two additional settlement demands were made. The first was a bracket of $1.9 to $2 million with costs, which Ace rejected as outside its settlement valuation as the inclusion of costs would push the final settlement value beyond policy limits. A third demand was made for policy limits, which would stay open until the jury announced it had a verdict. A counteroffer was made resulting in all demands being withdrawn. The next day, a jury verdict was rendered for approximately $40 million which was reduced due to comparative fault of the decedent to approximately $28 million but eventually settled for $10 million to avoid an appeal.

Thereafter, AGLIC sued Ace arguing Ace violated its *Stowers* duty by failing to accept one of the three offered settlement demands for primary policy limits. The trial court found that the third offer triggered a *Stowers* duty and that Ace was liable to AGLIC for the amount of the excess judgment. Specifically, the court found that Ace's evaluation of the case should have changed when the trial court made the adverse evidentiary rulings, which exacerbated the known weaknesses in the defense. A reasonable insurer would have reevaluated the settlement value of the case and accepted the policy limit demand. In Ace's defense on appeal, it argued that while its actions appeared unreasonable, Ace was not negligent because the court's errors on the evidentiary issues would have likely been reversed on appeal, which Ace failed to argue at the trial level, and which was a novel issue in Texas. Finding that an ordinarily prudent insurer in Ace's position would have realized that the likelihood of an excess judgment had materially worsened since the trial's inception and an ordinary, prudent insurer would have accepted the demand for limits, the court found that Ace violated its *Stowers* duty by failing to reevaluate the settlement value and was liable to AGLIC.

B. The Insured as Your Worse Enemy

In attempting to negotiate a settlement with a third party to the benefit of the insured, sometimes the biggest obstacles a claims handler and defense attorney can face is the insured. A prime example is *Pinto v. Farmers Ins. Exch.*, 61 Cal. App. 5th 676, 682, 276 Cal. Rptr. 3d 13, 16–17 (2021), *as modified* (Mar. 18, 2021), *reh'g denied* (Mar. 30, 2021), *review filed* (Apr. 16, 2021). Alaxandrea Martin was a passenger in her pickup truck with Dana Orcutt, Alexander Pinto, and Anthony Williams on the way back from a party where drugs and alcohol had been present. The truck went off the road and flipped, injuring all four occupants. The truck was covered by a policy issued by Farmers Insurance Exchange with liability limits of $50,000 per person and $100,000 per occurrence. The policy covered Martin and any permissive driver. Orcutt was allegedly driving when the truck went off the road but refused to cooperate with the insurer. Statements later revealed, Alaxandrea initially gave her keys to Pinto to drive, but he gave them to Orcutt, who had also been drinking.

During the course of the investigation, the claims adjuster tendered the $100,000 bodily injury policy limits to all injured parties except Orcutt. Thereafter, Pinto's attorney sent a letter to the adjuster offering to settle Pinto's claim against Alaxandrea and did not mention any claim against Orcutt. The letter advised that Pinto had been rendered a quadriplegic in the accident. In the letter, Pinto agreed to accept the liability and medical payment limits in full settlement of the claim in exchange for a release, a declaration that the insured was not in the course and scope of her employment, and a copy of any applicable insurance policy. The offer was to remain valid for 15 days but due to counsel mailing the letter and the Fourth of July, it was received with only eight workdays to respond. The adjuster assumed the demand was directed to both Alaxandrea and Orcutt.

Pinto’s attorney advised that he needed to inspect Martin's truck to evaluate a potential claim against GM. Two days later, the adjuster retained a private investigator to locate Orcutt and obtain information about the accident and any other available insurance. Orcutt was located but did not provide any type of verification even after several requests by the adjuster.

In the meantime, the adjuster requested from Pinto’s counsel an extension of time on the settlement demand but did not receive a response. As such, defense counsel was retained to assist with the claim. The defense attorney thereafter sent a letter to Pinto’s attorney tendering the $50,000 limits to resolve Pinto’s claim against all insureds under the policy. There were issued between counsel as to the type of declaration that was required by Pinto’s counsel and questions whether Pinto planned to pursue a claim against GM that might expose Farmers and the insureds to cross-claims. Additional information was also requested of Pinto’s attorney including information regarding medical liens, martial status, and additional time to respond. Pinto’s attorney provided responses to some of the questions and gave a deadline to 5:00 pm to accept the demand. Farmers hand delivered a letter to Pinto’s counsel accepting the demand and enclosing the settlement check and a release. A declaration of no additional insurance was also sent to counsel for Pinto that day for Alaxandrea but not for Orcutt. Pinto argued that Farmers failed to unconditionally accept the tender claiming:

> "Farmers apparently failed to perform even the most perfunctory investigation and consequently has been unable to provide my client with the most basic and critical information set forth in his offer: reasonable proof of Ms. Orcutt's complete policy limits and course and scope status.... [M]y client, with his astronomical medical bills and devastating injuries, would be a fool to accept Farmers' $50,000.00 without knowing the exhaustive policy limits *or course and scope[ ] status of Ms. Orcutt*. [¶] .... Suit will soon be filed so that my client can discover that information which Farmers failed to provide."

Pinto filed suit against Orcutt and Martin for negligence. The lawsuit settled, with an agreement that: (1) Orcutt and Martin would assign all their rights against Farmers to Pinto; (2) the settlement would be treated as the equivalent of a $10 million judgment; and (3) the insurers (another insurer had been found for Orcutt) would pay Pinto their combined policy limits of $65,000. Pinto then filed this action against Farmers alleging that Farmers acted in bad faith towards its insureds Martin and Orcutt by failing to accept his settlement demand. At trial, the court found in favor of Pinto against Farmers but also found that Orcutt had failed to cooperate with Farmers, which prejudiced Farmers. The jury made no finding that Farmers acted unreasonably in any respect. Following the verdict, the court rejected any arguments that Farmers should not be held liable and entered judgment for Pinto in the amount of $9,935,000. Farmers appealed.

On appeal, the court found that no evidence suggested Farmers' conduct caused the settlement to fail. Farmers attempted to accept Pinto's settlement offer, and timely tendered both the policy limits and Alaxandrea's declaration. Settlement failed only because Pinto rejected the tender on the ground that Farmers failed to include Orcutt's declaration. But no evidence established, and the jury did not find, that Farmers should have done more to obtain that declaration. On the contrary, the jury expressly found that Farmers used reasonable efforts to obtain Orcutt's cooperation and her lack thereof prejudiced Farmers. Based on those grounds, the judgment was reversed and the matter was remanded with directions to enter a judgment in favor of Farmers.

C. Strategically Choosing Which of Multiple Claims to Settle

There are many issues to consider when determining which of several competing claims that an insurer should settle or how limits should be allocated including which of several claims is more advantageous to the insured to settle. In *Aldana v. Progressive Am. Ins. Co.*, 828 F. App'x 663, 664 (11th Cir. 2020) there was an issue of face as to whether the carrier should have focused on the most severe claim to minimize the potential excess judgment. In *Aldana*, plaintiff and her four children sustained severe injuries in a rear-end automobile accident caused by a driver insured by Progressive with limits of $500,000 per occurrence. This was a three-vehicle collision with plaintiffs' vehicle in the middle of two other vehicles. A jury rendered a verdict in favor of the plaintiffs for approximately $52 million and they received an assignment of rights from the driver to pursue Progressive for its alleged bad faith in handling the claim. Judgment was rendered in favor of Progressive on a motion for summary judgment finding that Progressive was not in bad faith for its handling of the matter. The judgment was appealed and was vacated on the basis there

were genuine issues of material fact as to whether Progressive's handling of the case was in bad faith.

After the accident, Progressive investigated the accident and learned that several of the claims more than likely would exceed policy limits. As such, Progressive began attempting a global settlement of the claims and advised that limits would be paid if the claimants could agree to an allocation of the limits. If not, Progressive suggested a settlement conference. Plaintiffs' attorney advised that due to the severe nature of the injuries sustained, he was not in a position to respond in the timeframe suggested by Progressive and wanted to investigate the assets of the negligent driver. Progressive then unilaterally scheduled a settlement conference that had to be postponed because the plaintiffs were still investigating the matter. Progressive also received a letter from the workers' compensation carrier for the driver of the first vehicle seeking reimbursement of amounts expended.

After that point, not much occurred. Progressive would send a letter to the claimants' counsel monthly regarding the claims. Plaintiffs' counsel only responded to one of those letters advising that he was continuing to gather information, medical bills were nearly $1 million, plaintiffs were still treating, and he was still awaiting for a financial affidavit from the driver. In the meantime, Progressive attempted to get a financial affidavit from the driver but was not successful. At no time did Progressive advise the driver that there was a potential for an excess judgment. Thereafter, the attorney for the driver of the first vehicle proposed a settlement of his claim. Progressive still maintained it wanted to attempt a global settlement. Progressive continued to follow up with counsel for plaintiffs but new counsel was retained but Progressive was not informed of the change of counsel. Plaintiffs filed suit and judgment was rendered in their favor for over $50 million.

In connection with the suit for bad faith damages, the plaintiffs hired an expert who offered opinions regarding Progressive's handling of the case. He opined that prior to suit, Progressive failed to independently assess the value of each claim, to advise its insureds of these likely values, and then to make recommendations about how best to minimize their liability going forward. Because the global settlement strategy was not working and driver of the first vehicle was least significant, Progressive should have sought permission from its insured to offer full limits to the plaintiffs or possibly attempt to settle the largest claim. In the expert's opinion, Progressive failed to act with any haste in attempting to get the matter resolved.

In reversing summary judgment in favor of Progressive, the court noted that there was sufficient evidence in the record for a reasonable jury to conclude that Progressive's actions in the month leading up to the lawsuit were not in keeping with its duty to its insured. The inquiry was whether Progressive diligently and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment. The court noted that the need for haste and diligence was heighted because of the "ticking financial time bomb and suit could be filed at any time." Although Progressive did not receive medical records regarding the plaintiffs, a reasonable jury could conclude it knew that the insured was clearly at fault, the plaintiffs had suffered severe injuries, and a judgment well in excess of the policy limits was likely.

The court further noted that Progressive offered policy limits shortly after the collision almost entirely due to injuries suffered by the plaintiffs and knew of the substantial injuries sustained. Based on correspondence from plaintiffs' counsel, they gave no indication to Progressive that they were willing to settle for anything less than full policy limits as such limits was "nothing more than a drop in the bucket." It was also doubtful that the insured would complete the financial affidavits. In the face of these facts, Progressive failed to act with any haste in attempting to settle the matter. Rather, Progressive continued to send the same ineffective letter to counsel for the claimants and failed to fulfill its duties to the insured to advise about the possibility of an excess judgement and steps to avoid same. The expert's testimony, which the district court did not address in its analysis, combined with the facts recounted created a genuine issue of material fact as to whether Progressive "diligently, and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment."

D. Settling Policy Limit Claims Involving the Insured and Additional Insured

Generally, most failure to settle claims deal with an insurer's obligation towards its insured, but there are cases where the insured has competing obligations toward its insured and an additional insured. This issue is illustrated in *Travelers Indem. Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 763 (5th Cir. 1999). Travelers issued three insurance policies to Wright Petroleum: a business auto policy, a catastrophe umbrella policy, and a comprehensive general liability policy. Citgo, which had a franchise agreement with Wright was made an additional insured as to each of these policies by valid endorsement. The business auto and umbrella policies each contained provisions allowing Travelers to settle claims at its discretion, and stated that Travelers' duties under the policy would terminate when the applicable policy limits had been exhausted.

There was a collision between a tanker truck owned by Wright and an automobile driven by Richard Friedrichs, resulting in the death of both drivers. The tanker was transporting products not only for Citgo but other oil companies. Friedrichs' survivors sued Wright but Citgo was not named as a defendant. Plaintiffs made a demand and the matter was eventually settled for $1.5 million, policy limits of the auto and umbrella policies. Citgo who had not been named in the suit and no demand was sent was not included in the release. Several months before a settlement was agreed upon, Travelers was aware that plaintiffs insisted on reserving their rights against Citgo. Suit was eventually amended to name Citgo who demanded defense and indemnity from Travelers. Travelers refused the demand citing exhaustion of two policy limits and that no coverage was provided under the CGL policy. Travelers thereafter filed a declaratory judgment action seeking a determination that it had no duty to Citgo. Citgo counterclaimed for a determination of coverage and also alleged several other causes of action including breach of the duty of good faith and fair dealings. Judgment was rendered in favor of Travelers, which was appealed.

Citgo argued that under Texas law an insurer cannot favor one insured over another in obtaining settlements. Citgo argued that Travelers favored Wright over Citgo and breached its duty to it. The Fifth Circuit found that such argument was without merit, holding:

> Under Texas law, an insurer defending its insured on a covered claim owes that insured a tort law duty to accept a reasonable settlement offer within policy limits rather than unreasonably risk

an adverse judgment substantially over the policy limits. Texas courts have also held that an insurer is free to favor a claim by one claimant over a claim by another claimant in pursuit of this duty. We find that the logic of these positions requires that an insurer be free to settle suits against one of its insureds without being hindered by potential liability to co-insured parties who have not yet been sued. Since we reject Citgo's invitation to create a special duty for insurers when multiple parties are covered under the policy, we also reject its contention that settling a claim in accordance with Texas law is a violation of the insurer's independent contractual duty to perform reasonably.