CHALLENGING AN INSURED'S SETTLEMENT

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I.
INTRODUCTION

In those cases in which an insured settles a third-party claim without its insurer's consent as, for example, when the insurer has wrongfully denied the insured a defense, public policy that encourages settlements often conflicts with the contractual rights of the insurer. Equally conflicting are the interest of the insured (or as is often the case the insured and the claimant as its assignee) and the insurer. The insured or claimant seeks to obtain prompt payment or indemnification for the settlement. The insurer, on the other hand, wishes to avoid: (1) a collusive settlement that attempts to shift the cost of an uncovered loss to the insurer, (2) an unreasonably large settlement followed by a consent judgment for which the insured has no personal financial exposure because the claimant has agreed to seek satisfaction solely out of any recovery from the insurer, or (3) an unallocated settlement by which uninsured claims, persons or entities are released at the insurer's expense.

There are surprisingly few reported decisions that deal with the many substantive and procedural issues that arise when an unconsented to settlement is challenged by the insurer. In this article we will examine:

- (1) what it is that the insured must prove (its "actual liability" or something less) to be presumptively entitled to an indemnity from the insurer;
- (2) the standard to be applied when the amount of the settlement is challenged as unreasonable;
- (3) the allocation of a settlement to be made when both insured and uninsured parties benefit therefrom, or whereby uninsured causes of action are released; and,
- (4) the effect of a finding that the settlement was unreasonable. In such a case, does the insured recover nothing or is it nevertheless entitled to some lesser amount? If the latter, how and by whom is that amount determined?

We assume for the purpose of this article a situation in which there is no question about coverage for the loss. If there was such a question, it would be "the insured's burden to establish the existence of coverage," while the "insurer has the burden of establishing that the occurrence comes within [an] exclusionary clause and that its own construction is the only one that fairly could be placed on it."
II.

THE "ACTUAL LIABILITY" AND INSURER CONSENT TO SETTLEMENT REQUIREMENTS

As a general rule, to recover indemnity from its insurer under a liability policy, an insured must prove: (1) its actual liability for damages to a third party claimant; (2) that the cause of action comes under the terms of the insurance policy's grant of coverage (the "Insuring Agreements"); and, (3) that it has complied with all conditions to coverage.

The insured's actual liability may be shown in two ways. It may be established by an "agreed settlement," that is, one entered into with the written consent of the insurer, or a final judgment awarding damages against the insured entered in favor of the claimant after an actual trial on the merits.

When the insured settles a claim without the insurer's consent, the settlement does not bind the insurer. This is true even when the settlement is incorporated in a consent judgment. Furthermore, there is no coverage for the settlement because it was entered into in violation of an express policy condition. A policy condition requiring the insurer's consent to any settlement is generally upheld.

III.

WHEN THE GENERAL RULE DOES NOT APPLY

There are situations in which the general rule does not apply, and an insured is entitled to settle without the insurer's written consent. This is the case when the insured has settled a third party claim after having complied with the policy condition requiring prompt and adequate notice to the insurer of the claim or suit, afforded the insurer the opportunity of assuming the defense of the suit and of participating in the settlement negotiations, and the insurer wrongfully declined to defend or participate in the settlement. Or, sharing the insured's desire to limit its exposure, the insurer may provide written consent to the settlement, subject to an agreement to disagree with the insured regarding the reasonableness of the settlement amount or allocation. The insured may also settle without the insurer's consent when the insurer has wrongfully denied coverage to the insured, leaving the insured, as any prudent uninsured, to defend or compromise the claim against it.

In these circumstances, the insurer may not claim lack of consent as a defense to coverage, and the insured is relieved of the obligation to prove its "actual liability" to the third party. However, in order to recover the settlement amount from its insurer, the insured must prove:

- (1) that, on the basis of the actual facts known to it at the time of settlement, it had a real potential liability (more than a mere possibility of liability on the pleadings) to the third party claimant;
(2) that the settlement of that potential liability was reasonable in view of the size of possible recovery by the third party against it, and the degree of probability of success of the third party’s claim against it; and,

(3) that the actual basis of its potential liability to the third party fell within the coverage provided to it by the insurer under the terms of the policy.

Even then, the insurer may:

- (1) if there is an uncovered claim or party being released by or otherwise benefitting from the settlement, challenge any allocation of liability agreed by those benefitting from the settlement, or with the third-party claimant; and

- (2) assert and prove that there is no coverage by reason of an exclusion clause in the policy.

IV.

REASONABLENESS IS A QUESTION OF FACT

The reasonableness of a settlement is a question of fact, and courts have recognized that "[t]he determination of what constitutes a `reasonable' settlement is not susceptible of a mathematical equation yielding a particularized sum." In every case, "there is a range of reasonableness with respect to a settlement - a range which recognizes the uncertainties of law and fact in any particular case and the concomitant risks and costs necessarily inherent in taking any litigation to completion. . . ."

V.

THE TEST OF REASONABLENESS OF THE SETTLEMENT AMOUNT

Various courts have expressed the test for determining the reasonableness of the amount of a settlement in slightly different ways. However, each has recognized that what is required is an evaluation of the insured's potential exposure in view of (1) the degree of probability that the claimant will succeed, and (2) the likely size of the recovery if it does succeed. The following are examples of how courts have formulated the test of reasonableness:

In Luria Bros. & Co. v. Alliance Assurance Co. the court concluded that:
In order to recover the amount of the settlement from the insurer, the insured need not establish actual liability to the party with whom it has settled "so long as . . . a potential liability on the facts known to the [insured is] shown to exist, culminating in a settlement in an amount reasonable in view of the size of possible recovery and degree of probability of claimant's success against the [insured]."

In Valloric v. Dravo Corp., the court used "risk of exposure" in the test of reasonableness:

- The reasonableness of the settlement consists of two components which are interrelated. The fact finder must look at the amount paid in settlement of the claim in light of the risk of exposure. The risk of exposure is the probable amount of a judgment if the original plaintiff were to prevail at trial, balanced against the possibility that the original defendant would have prevailed.

In Alton M. Johnson Co. v. M.A.I. Co., the court said:

- The test as to whether the settlement is reasonable and prudent is what a reasonably prudent person in the position of the defendant would have settled for on the merits of plaintiff’s claim. This involves a consideration of the facts bearing on the liability and damage aspects of plaintiff’s claim, as well as the risks of going to trial.

Finally, in Uniroyal, Inc. v. Home Insurance Co., the court stated:

- In order to recover the amount of the settlement from the insurer, the insured need not establish actual liability to the party with whom it has settled "so long as . . . a potential liability on the facts known to the [insured is] shown to exist, culminating in an amount reasonable in view of the size of possible recovery and degree of probability of claimant's success against the [insured]."

Thus, although the four courts employed differing language, the substance of the evaluations of each is the same.

VI.

SETTLEMENTS BY JOINT TORTFEASORS
It is unreasonable for several defendants to settle a case on a joint and several liability basis without first allocating the damages among themselves. This is true because, "[w]ithout knowing what each defendant has agreed to pay as its share, there is no way of judging the reasonableness or prudence of the agreement from the standpoint of each defendant."

When an insured faces joint and several liability and settles the injured party's claim, that insured's right to seek contribution may be enforced by its insurer by way of subrogation, provided the settlement preserves the right to contribution from other wrongdoers.

Even when the right to contribution is neither agreed to nor preserved, the insurer remains entitled to require an allocation of the settlement amount between its insured and the non-insured parties. The insurer may agree that the total amount of the settlement is reasonable, yet dispute its obligation to pay that entire amount on behalf of its insured. Otherwise, the uninsured defendants who were released by and benefitted from the settlement will have received a free ride at the expense of the insurer, as the insured would receive by creating coverage for any uncovered claims. The question then becomes how much of the settlement amount should be allocated to covered claims against the insured, and on what basis is the allocation to be made.

One of the earliest and still leading cases upholding an insurer's right to allocation in these circumstances is *PepsiCo, Inc. v. Continental Casualty Co.* In *PepsiCo*, neither the reasonableness of the overall settlement, the insureds' responsibility for some portion of the settlement amount, nor the existence of coverage in respect of that responsibility were matters of contention as between the insurer and its insured directors and officers. Rather, the issue was the proper extent of the insureds' liability when non-insureds had benefitted from the settlement or were responsible for some portion of the settlement amount.

Continental Casualty had issued a policy insuring PepsiCo's directors and officers. PepsiCo subsequently announced that it had discovered certain "accounting irregularities." Thereafter, several lawsuits were filed against PepsiCo, its directors and officers, its accounting firm, and a former officer. The suits alleged a "fraud on the market" under United States securities laws. PepsiCo and its directors reached a tentative settlement agreement with plaintiffs in the underlying securities lawsuits and approached Continental seeking approval of the proposed settlement. They were unable to reach an accord on the settlement. Instead, they entered into a non-waiver agreement which preserved Continental's rights to assert that the settlement was unreasonable and that the amount of the settlement was not properly allocable to the insured directors and officers. Under the terms of the settlement agreement PepsiCo paid the plaintiffs $22,067,754 and the plaintiffs dismissed all claims against all defendants and released them from liability.

Thereafter, PepsiCo brought an action against Continental to recover the amount it paid to settle on behalf of the insured directors and officers. Continental asserted that it had the right to pro rate payment under its insurance policy according to the relative degrees of liability of those defendants it insured and those it did not insure, including PepsiCo itself. PepsiCo, in response, moved for partial summary judgment seeking a declaration that Continental could not pro rate its payments. PepsiCo argued that Continental should reimburse the corporation for the full amount of the settlement because the directors and officers insured by Continental were jointly and severally liable for the entire amount of the settlement. Continental asserted that the directors' and officers' risk of liability was minimal relative to the risk facing PepsiCo and its accounting firm, Arthur Young & Co. It contended that some allocation must be made among the defendants or, alternatively, that it should be permitted to amend its answer to include a claim for contribution against PepsiCo and Arthur Young. Continental argued that it would be unfair for PepsiCo and Arthur Young, neither of which were insured by Continental, to "free ride" on the directors' and officers' insurance policy.

The court found that the insurance policy "clearly provides that it covers only the directors and officers of PepsiCo, not the corporation and not its accounting firm. The policy provides for payments to PepsiCo only for the amount it indemnifies the defendant directors and officers." The court also determined that under New York law insurers have the right to apportion payments on a lump sum settlement according to who was an insured
under the policy. The court held that these same principles applied to the claims of joint and several liability asserted against PepsiCo's directors and officers and the other defendants:

- Continental has not insured the Corporation or Arthur Young, both of which benefitted from the settlement. It is extremely unlikely that the directors and officers would have agreed to a settlement, the costs of which they would be expected to pay in toto. It is unlikely that [the insurer] would have approved such a settlement. Allocation of responsibility according to the relative exposures of the respective parties to the class action litigation is therefore appropriate.

... These allocations are often made, albeit only as approximations, according to some notion of relative fault. ...

This court concludes, therefore, that the Policy requires the parties to allocate the settlement costs between those amounts attributable to the directors and officers and those attributable to PepsiCo and its accountants.

VII.

WHAT EVIDENCE IS CONSIDERED TO DETERMINE REASONABLENESS OF SETTLEMENT AMOUNT AND ALLOCATION?

What evidence is to be considered by a court or jury deciding whether a settlement was reasonable under the Luria, Valloric and Alton tests, or when making an allocation under PepsiCo? Is the determination made on the basis of (1) all the facts known to the parties to the insurance coverage action at the time of the trial or hearing of that action, or (2) only by reference to those facts that were known or should have been known by the parties in the underlying action at the time of the settlement?

In Servidone Construction Corp. v. Security Insurance Co., the New York Court of Appeals addressed the post-settlement reasonableness issue by stating that [w]hile further proceedings are required to determine the basis for [the insured's] liability to [the claimant] -- not from the pleadings but from the actual facts -- the burden of proof will rest with the insurer to demonstrate that the loss compromised by the insured was not within policy coverage." The court rejected the insured's argument that it is "impossible to determine how a New Jersey court would have decided the [settled] underlying action" and that it would be unfair to require a "mock trial," stating "[w]hat the insured refers to as a `mock trial,' or a trial within a trial, is hardly new in the law. In malpractice actions, for example, a client cannot recover against an errant attorney without demonstrating that it would otherwise have succeeded on the merits."

Unfortunately, the court did not address the evidentiary question. It merely held that in a coverage dispute over indemnity for settled claims, a "mock trial" of the plaintiffs' underlying case is appropriate to allocate the settlement among covered and noncovered claims (or persons), and that such allocation is to be made on the basis of the insured's liability as determined "from the actual facts." This begs the question -- what are the "actual facts," and at what point in time are those facts to be examined?
The "actual facts" might broadly include "facts" learned by the insurer after the settlement and during the course of discovery in the coverage litigation. They might also be defined narrowly as those facts that were known or should have been known to the insured at the time it settled the underlying case. However, had the Court of Appeals meant to limit the proof in the allocation proceeding to only that which was known to the parties at the time of settlement, it could easily have said so. It can be argued, therefore, that in the absence of such a limitation, any and all evidence of the "actual facts" available at the time of the trial of the coverage action is relevant and should be considered.

In *Enserch Corp. v. Shand Morahan & Co.*, the court, applying Texas law, held that after settlement of an underlying action against the architect-engineer, the "retrial" of the insurance coverage case for purposes of allocation between covered and excluded claims should proceed as follows:

- If the apportionment cannot be made as a matter of legal interpretation of either the allegations in the complaint or the settlement agreement itself, then the trial court will have to call a jury to allocate damages through the most limited trial it considers necessary. Unfortunately, no cases cited by either party, nor any case we can find, gives us or the trial court specific guidance on how to proceed. The jury can consider any facts that would have been considered in the [underlying] lawsuit itself.

In *Alton M. Johnson Co. v. M.A.I. Co.*, the court noted that issue of reasonableness should not be decided by having the actual trial made unnecessary by the settlement.

- Consequently, the decision maker receives not only the customary evidence on liability and damages but also other evidence, such as expert opinion of trial lawyers evaluating the "customary" evidence. This "other evidence" may include verdicts in comparable cases, the likelihood of favorable or unfavorable rulings on legal defenses and evidentiary issues if the tort action had been tried, and other factors of forensic significance.

*Caterpillar Inc. v. Great American Insurance Co.* involved a coverage dispute under a directors and officers policy in which the issue was whether any amount of settled securities fraud claims was allocable to noninsured directors and officers. The court held that the insurer "will be allowed to attempt to prove that all or part of the activities attributed to [Caterpillar] and its board in the [underlying complaint] were performed by uninsured persons or persons against whom no claims were made."

- Great American relies on evidence of misconduct of persons other than individual defendants found by the SEC in its Opinion and Order . . . . Great American will not be allowed to allocate a portion of the settlement amount to [Caterpillar] based solely on the SEC's findings. *However, to the extent that Great American can prove after discovery that references in the [underlying] complaint to actions by [Caterpillar] and its board include persons named in the SEC Opinion and Order, an allocation would be allowed if such person's actions increased the [underlying] settlement amount.*
In *H.S. Equities, Inc. v. Hartford Accident & Indemnity Co.*, ("H.S. Equities II"), the facts known at the time of the trial were held to govern the allocation between covered and non-covered claims. After a settlement reached during trial, Hartford argued that "plaintiffs must now produce all the evidence that the [plaintiffs] would have presented in their trial, including the four days of trial that had already gone forward . . ." In addressing the issue of allocation, the court stated:

- It is clear that the settlement embraced not only issues going to [the employee's] misconduct, but also issues going solely to HS's misconduct. Plaintiff would have the court look at the complaint in the [underlying] case which on its face charges both defendants with all the misconduct. However, a reading of that complaint shows that it alleged everything but the kitchen sink . . . . A better understanding is found in the analysis by trial counsel of what they were facing at the time of trial after depositions and discovery had refined the issues.

Thus, the court allocated the covered and non-covered claims according to the views held by trial counsel during the underlying trial. The Second Circuit Court of Appeals affirmed the amount of the allocation, but reversed and remanded because the lower court erroneously held a good faith settlement following a wrongful refusal to defend creates a conclusive presumption (not merely a rebuttable one) as to the truth of the facts in the underlying complaint and the basis for the settlement.

- [W]hen an indemnitor has been accorded a reasonable opportunity to defend a third-party action against the indemnitee and declines, the good-faith settlement of the third-party claim by the indemnitee is presumptive evidence of the facts alleged in the third-party complaint. Thereafter, the indemnitor has the burden to successfully contest this presumptive evidence in the action for indemnification.

In *American Home Assurance Co. v. Libbey-Owens-Ford Co.*, as in *HS Equities II*, a settlement was reached after trial had begun. However, in *American Home* the insurer undertook the defense of the underlying claim. The insured, Libbey-Owens-Ford, sought reimbursement for monies paid to settle claims arising out of the plaintiff's need to remove and replace defective windows Libbey had installed. The plaintiff demanded $89 million, $25.9 million of which was for loss of use. Libbey paid $26 million of the $30 million settlement. Under an umbrella policy issued by American Home to Libbey, loss of use and consequential damages flowing therefrom were covered.

In allocating the portion of the settlement constituting the covered portion of loss of use, the District Court used a pro rata apportionment of the damages sought for all the claims in the complaint. Since the $25.9 million claim for loss of use was twenty-nine percent of plaintiff’s total claim of $89 million, the court concluded that only twenty-nine percent of the total settlement constituted settlement of the loss of use claim. The First Circuit Court of Appeals reversed, stating:
We do not believe . . . it was appropriate to make this allocation without accepting any evidence from the parties. It may not be correct to assume that [Libbey] considered the $26 million to be allocated equally to each of the [underlying] claims. As [Libbey] pointed out . . . it may have felt that the loss of use claim was one that could be more easily proven at trial, given the availability and exactness of figures for lost rents, than could, for example the $50 million claim for increased operating costs. Thus, despite the problems that are inherent in any post facto analysis of settlement claims, if the district court is to make an allocation of the settlement amount, it should accept whatever evidence is available regarding the intent behind the settlement decision.

Similarly, the decision in Pruyn v. Agricultural Insurance Co., supports the consideration of a broad range of evidence in assessing the reasonableness of a settlement. To determine whether an insured has made out a prima facia case of a good faith settlement, a number of factors should be considered by the trial court:

- "including a rough approximation of plaintiffs' total recovery and the settlor's proportionate liability, the amount paid in settlement, the allocation of settlement proceeds among plaintiffs, and a recognition that a settlor should pay less in settlement that he would if he were found liable after a trial. Other relevant considerations include the financial conditions and insurance policy limits of settling defendants, as well as the existence of collusion, fraud, or tortious conduct aimed to injure the interests of nonsettling defendants."

Once the insured has made out a prima facia case of a good faith settlement, the insurer is entitled to present evidence:

- that the settlement was the product of fraud and collusion. The principles of fraud and collusion are self evident and require no extended discussion. The facts and circumstances which will lead a court to conclude that either are present are limited only by the imagination of those who would cheat and deceive.

Several directors' and officers' liability cases in which allocation was at issue support the proposition that only facts known at the time of settlement should be considered in making the allocation. In Nordstrom, Inc. v. Chubb & Son, Inc., the insurers argued that there were grounds for uninsured corporate liability other than wrongdoing by its insured directors and officers, and that post-settlement "discovery may reveal other circumstances by which Nordstrom could have been found liable independent of its officers and directors. Defendants intend to show this possibility of liability played a part in the settlement." The district court denied the insurers' request for "further discovery," and the Ninth Circuit Court of Appeals affirmed. The lower court offered the following rationale for its denial of further discovery:
Defendants contend . . . they are entitled to pursue discovery that may reveal that uninsured Nordstrom employees, such as Nordstrom's attorneys or accountants, were actually responsible for the wrongful conduct attributed to Nordstrom's officers and directors in the class actions. These uninsured Nordstrom employees who, according to Federal and Chubb, are potentially liable, were not named as defendants in the underlying class actions, had no direct allegations made against them, were not involved in any settlement negotiations, and were not part of any final settlement. If Federal and Chubb do prove liability with respect to these uninsured employees, defendants' remedy would not be allocation, but rather remedies pursuant to the D & O insurance's subrogation clause.

In Safeway Stores, Inc. v. National Union Fire Insurance Co., the court, applying California law, noted that "[t]he parties also agree that relative exposure means 'the probable percentage of exposure of each of the defendants, as of the date of settlement, based upon claims made as to each defendant and other relevant factors.'" The court concluded that the relevant factors for allocating the settlement sum among the beneficiaries of the settlement include:

- (1) the identity, as an individual, an entity, or as a member of a group, of each beneficiary and the likelihood of an adverse judgment against each in the underlying action;
- (2) the risks and hazards to which each beneficiary of the settlement was exposed;
- (3) the ability of each beneficiary to respond to an adverse judgment;
- (4) the burden of litigation on each beneficiary;
- (5) the 'deep pocket' factor and its potential effect on the liability of each beneficiary;
- (6) the funding of the defense activity in the litigation and the burden of such funding;
- (7) the motivations and intentions of those who negotiated the settlement, as shown by their statements, the settlement documents and any other relevant evidence;
- (8) the benefits sought to be accomplished and accomplished by the settlement as to each beneficiary, as shown by the statements of the negotiators, the settlement documents and any other relevant evidence;
- (9) the source of the funds that paid the settlement sum;
- (10) the extent to which any individual defendants are exempted from liability by state statutes or corporate charter provisions; and
- (11) such other and similar matters as are peculiar to the particular litigation and settlement.

The process a court engages in when making an allocation on the basis of the actual facts is similar to the trial of a contribution claim when asserted in a separate action after the underlying action has been concluded. A party
seeking contribution from a joint tortfeasor in a plenary action is not limited to only those facts known to its counsel at the conclusion of the underlying action. There appears to be no reason why a party should be subject to such a restriction in a subsequent trial or hearing to determine reasonableness of a settlement or allocation of responsibility. The "actual facts" are what they are; they do not change according to when they become known to the parties.

VIII.

RECOVERY WHEN THERE IS AN UNREASONABLE SETTLEMENT

If the insured seeks indemnity for a settlement made under circumstances in which the insurer's consent is not required, and the settlement is challenged and found to be unreasonable, there are four possible outcomes to the coverage litigation:

1. The insured, having entered into an unreasonable settlement, can recover nothing from its insurer and its case is dismissed.

2. The unreasonable settlement is ignored and the insured must prove, on a balance of probabilities and by a preponderance of the evidence, the extent of its liability in the underlying action.

3. The court proceeds with the same type of allocation it would have undertaken had the settlement amount been found reasonable, with the insured entitled to recover so much of the settlement as equals the share that would have been allocated to it had the settlement been found to have been reasonable.

4. The court or jury, subjectively, substitutes for the unreasonable settlement the amount found to be a reasonable settlement.

In one of the very few reported decisions to discuss the issue, Hennings v. State Farm Fire & Casualty Co., the jury had concluded that the insured's settlement of a personal injury action with the claimant for $180,000 was unreasonable, and that $135,000 would have been a reasonable settlement amount. The trial court adopted that finding as its own, and entered judgment against the insured's excess carrier for $35,000 (the difference between the $100,000 primary policy limit and the amount found reasonable in settlement).

The Minnesota Court of Appeals concluded that the trial court correctly submitted to the jury the question of whether the settlement was reasonable. However, it decided that once the jury had determined that the settlement amount was unreasonable, it should not have been instructed to determine what amount would have been reasonable. Rather, the jury should have been instructed to determine claimant's actual damages from the evidence. Thus, the appellate court stated: "The jury has determined that the settlement was unreasonable. Following that decision, the settlement was irrelevant and the question then became the extent of plaintiff's damages."

The insurer argued that it should have been released of all liability once the settlement was determined unreasonable. The court, however, rejected the insurer's argument, explaining that (a) forfeitures are not favored in the law, (b) the insurance policy creates a contractual obligation on the part of the insurer to pay for the
claimant's damages suffered at the hands of the insured, and (c) foreclosing recovery from an insurer when the settlement has been found to be unreasonable would "greatly discourage . . . settlements." *Hennings* adopts outcome "2" above.

A decision which adopts the outcome in "1" above is *State Farm Fire & Casualty Co. v. Gandy*. The action underlying *Gandy* was a suit by a plaintiff against her stepfather for sexually abusing her as a child. The settlement of the underlying action consisted of the assignment of the insured's rights to the plaintiff; a covenant by the plaintiff not to sue the insured in return for consideration of $10; and a consent judgment, entered into two days later, for $4,062,500 plus interest in actual damages, and for $2,000,000 plus interest in exemplary damages.

The district court granted summary judgment for the insurer finding no coverage on the basis that sexual abuse was intentional conduct. The court further held, however, that since State Farm voluntarily undertook the insured's defense, it had a duty to conduct the defense properly. The court thus rendered judgment on a jury verdict in favor of the judgment creditor's claims for negligent defense and violations of the Texas Deceptive Trade Practices Act. The Court of Appeals affirmed.

The Supreme Court of Texas reversed, concluding that the Court of Appeals did not exaggerate when it called the agreed judgment against the insured "a sham," or when it stated that the judgment "perpetuates a fraud" and "an untruth." The supreme court had "no hesitation in holding that the assignment was invalid."

The supreme court also refused to follow the procedure set forth in *Pruyn* for determining what portion of the settlement could be enforceable against the insurer. The court held that the judgment creditor should take nothing:

- *[Pruyn's] 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 . . . 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.

 IX.

BURDEN OF PROOF

There is no one rule as to which party must bear the burden of proving that a settlement was reasonable. Cases can be found in which the initial burden of proving that a settlement was reasonable was placed on the insurer, the insured, and the claimant as assignee of the insured's rights against the insurer.

Insureds assert that the burden should be placed on the insurer, arguing that otherwise they would be placed in an untenable position. They would first have to advocate their freedom from fault in the underlying action up to the
moment of settlement, and then do an about-face in the coverage action and attempt to establish their culpability in order to show the reasonableness of the settlement.

On the other hand, when an insurer has denied coverage and refuses to defend the action, it is usually not in a position to learn very much about the facts of the underlying case. Rather, the insured and its defense counsel possess the information needed to evaluate the insured's exposure to liability and damages. Thus, insurers may argue that it is not unfair to place the burden of establishing the reasonableness of the settlement on the insured.

The insured may counter by saying that since it was the insurer's wrongful denial of coverage that disabled it from acquiring the requisite knowledge of the facts, the insurer should not benefit from its wrongful act.

Many courts have decided that when the insurer has wrongfully refused to defend and the insured reaches a settlement with the injured party, the settlement is presumptively reasonable.

In *PepsiCo*, where the total settlement was acknowledged by the insurer to be reasonable, and the dispute was over how much of that settlement amount should be allocated to the insured on the basis of its relative exposure, the court placed the burden of proof on the insurer to establish that allocation. It is possible to read too much into *PepsiCo* on this point. The burden of proof appears to have been placed on the insurer in *PepsiCo* because there was evidence of a good faith settlement and the insurer was attempting to exclude coverage. As the *PepsiCo* court stated on reconsideration: "once an insured has presented a claim under the policy based on a good faith settlement, the insurer bears the burden of proving that all or a portion of the total paid in settlement is excluded from the policy coverage."

In a growing line of cases, other courts have held that the insured bears at least a minimal, initial burden of demonstrating that the settlement was reasonable and entered into in good faith. Reasons for leaving the initial burden with the insured include the fact that the insured will be the party in possession of the information regarding the settlement and it was the insured's voluntary decision to settle. When settlement of the underlying action involves the assignment of the insured's rights against the carrier to the claimant, some courts have shifted the burden of demonstrating that the settlement was reasonable to the claimant.

Once it has been determined that the settlement is unreasonable, the insurer has met its burden. Under the Minnesota authorities (*Hennings* and *Alton*), the burden shifts to the insured who, having reached an unreasonable settlement, must then prove, on a balance of probabilities and "without further reference to reasonableness and prudence of the settlement," that it was legally liable and the extent of its liability. Under *Wolff*, the insured would recover nothing after an unreasonable settlement.

In the absence of any proof to counter the insured's evidence of a good faith and reasonable settlement, the insurer has failed to meet its burden and the settlement made during trial of the underlying action will be binding on it.

X.

CONCLUSION

SUMMARIZING THE PRINCIPLES
(1) If the insured cannot show potential liability on the actual facts known to it at the time of settlement, the settlement cannot be relied upon by the insured, and is irrelevant in a subsequent action against the insurer for indemnity.

(2) If the original third party claim against the insured, although well pleaded so as to withstand a motion to dismiss, had no real prospects of success, then the settlement amount, if more than nominal, will be treated as unreasonable.

(3) If the insured does show a real potential liability on the actual facts known to it at the time of settlement, it must also be shown that the settlement of that potential liability was reasonable in view of the degree of probability of success of the third party's claim and the size of the likely recovery against it. There is no hard and fast rule as to which party bears the burden of proof on this issue.

(4) If there is an uninsured person, entity or claim being released by or otherwise benefitting from the settlement, the insurer may challenge any allocation of liability agreed to by the parties or with the third-party claimant.

(5) The insurer may always show that there is no coverage by reason of an exclusion clause in the policy or because the settlement is a fraudulent or collusive one.