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Segmented Settlements Are Not the Answer: A Response to Professor Squire's Article, How Collective Settlements Camouflage the Costs of Shareholder Lawsuits

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SEGMENTED SETTLEMENTS ARE NOT THE ANSWER: A RESPONSE TO PROFESSOR SQUIRE'S ARTICLE, *HOW COLLECTIVE SETTLEMENTS CAMOUFLAGE THE COSTS OF SHAREHOLDER LAWSUITS*

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ABSTRACT

In his recent article, Professor Richard Squire offers a provocative theory in which he claims the underlying claimants in shareholder litigation against corporate policyholders are overcompensated due to what he describes as “cramdown” settlements, under which insurers are forced to settle due to the “duty to contribute” that arises under multi-layered directors and officers (“D&O”) insurance programs. He also offers a novel idea regarding how this problem could be fixed by what he refers to as “segmented” settlements in which each insurer and the policyholder would be allowed to settle separately and consider only its own interests in doing so.

In this Response to that article, I further explore the assumptions underlying Professor Squire’s claims. I also explore the complexities associated with implementing a segmented settlement scheme because such a scheme is not consistent with the existing policy language or common law that has developed. Under the existing policy language, insurers are only contractually obligated to contribute to settlements that are reasonable based upon the policyholder’s expected liability at trial. Consequently, the policy language regarding settlements would need to be rewritten to allow insurers to consider only their own financial interests when deciding whether to settle. In addition, in order to implement a segmented settlement scheme, the exhaustion requirement that currently exists in many excess policies would need to be removed to allow insurers to settle for less than their full policy limits. Such changes would have a dramatic impact on the structure of insurance programs and the risk transferring function of insurance because excess insurers’ exposure would increase while policyholders may be forced to become self-insured and fund significant portions of settlements. Such changes would also create some practical difficulties regarding the trials of cases in which the policyholder settled but some of the insurers had not because such cases would proceed without a defendant, the policyholder. The Response closes by addressing the issue of whether segmented settlements would be appropriate for other lines of corporate insurance.

INTRODUCTION

IN his recent article,¹ Professor Richard Squire offers a provocative theory in which he claims the underlying claimants in shareholder litigation against corporate policyholders are overcompensated under “cramdown” settlements. Cramdown settlements are forced on insurers due to what he calls a “duty to contribute” that arises under multi-layered directors and officers (“D&O”) insurance programs. He also offers a novel idea regarding how this problem could be fixed: “segmented” settlements.

In essence, Professor Squire claims that the existence of multi-layered D&O insurance programs makes policyholders “overeager to settle risky lawsuits.”² Insurers are then forced to settle such lawsuits in “cramdown” settlements for more than the lawsuits are actuarially worth, due to an obligation he names “the duty to contribute.”³ This dynamic, he further claims, causes the overcompensation of the underlying claimants.⁴ As a result, the real costs of lawsuits against corporate policyholders are camouflaged from shareholders in the form of higher premiums charged by insurers in an effort to recoup the excessive settlement amounts they are forced to pay.⁵ Professor Squire then discusses the idea of whether this alleged problem could be solved by allowing insurers and policyholders to each act in their own self-interest and settle individually with the underlying claimants.⁶ Under this segmented approach to settlements, each party could settle for any amount it negotiates. The underlying plaintiffs would then proceed to trial only against the parties that had not settled.⁷

In his article, Professor Squire offers numerous important insights regarding shareholder litigation and collective settlements, such as coining the phrase “duty to contribute” to describe insurers’ obligations to contribute to settlements that implicate their layers of coverage.⁸ He is also the first scholar to identify the risk stemming from financial incentives that certain excess insurers may have to pay more than the actuarial value of cases in certain circumstances in order to settle.⁹ Rather than focus on the contributions

¹ Richard Squire, *How Collective Settlements Camouflage the Costs of Shareholder Lawsuits*, 62 DUKE L.J. 1 (2012).

² *Id.* at 3.

³ *Id.* at 4.

⁴ *Id.*

⁵ *Id.* at 6.

⁶ *Id.* at 5.

⁷ *Id.*

⁸ *Id.* at 4.

⁹ *Id.* at 27–29.

Professor Squire has made to insurance law scholarship in his article, however, this Response addresses the assumptions that underlie Professor Squire's claims and the issues that would arise if a segmented settlement scheme were implemented. This Response counsels against the implementation of a segmented settlement scheme due to the extensive changes to the existing policy language and law that would be required, along with the collateral negative consequences that would flow from such a scheme.

This Response is divided into three parts. Part One addresses the claim that the "duty to contribute" results in "cramdown" settlements in which insurers are forced to settle for unreasonable amounts and the underlying claimants are overcompensated as a result. As noted above, Professor Squire has identified a theoretical situation that could arise in some circumstances where excess insurers may be tempted to pay more than they are contractually obligated in order to settle. I seek to demonstrate that, although it is theoretically a risk in certain circumstances, in practice the situation does not actually occur.

Part Two addresses the complexities and problems that would be created if a segmented settlement scheme were implemented. These problems range from the difficulties of conducting "empty chair" trials to the extensive changes that would need to be made to the existing policy language and law. Part Two also discusses public policy concerns that would be implicated by a segmented settlement scheme. Finally, Part Two considers whether the benefits of a segmented settlement scheme would outweigh the problems such a system would create.

Part Three addresses whether a segmented settlement scheme would be appropriate for other lines of corporate insurance. In discussing this issue, I draw upon my own twenty years of experience litigating and trying insurance disputes, as well as the case law. I use two actual experiences a Fortune 100 company had with its insurers regarding product liability claims under commercial general liability ("CGL") insurance policies to illustrate the settlement dynamic that typically occurs.

I. ANALYSIS OF THE RISK OF "CRAMDOW" SETTLEMENTS AND OVERCOMPENSATION OF PLAINTIFFS UNDER THE EXISTING POLICY LANGUAGE AND LAW

The central premise of Professor Squire's article – that policyholders and excess insurers are allowed under the existing policy language and law to

“cramdown” unreasonable settlements on primary insurers that results in the overcompensation of the underlying claimants – is a completely novel idea that demands discussion and consideration. At its core, Professor Squire's insight involves recognizing that by forcing a primary insurer to make the portion of its limits above its own expected trial liability available for settlement, in effect this “duty to contribute” gives the excess insurer the “benefit” of that amount to use towards settlement. As a result, the excess insurer, acting in its own rational self-interest, may be incentivized to overpay.

This dynamic is, however, a situation that insurers themselves have created under the policy language they drafted. Indeed, the duty to contribute is simply the enforcement of the policy language under the specific facts of each case. With that said, the actual risk of excess insurers overpaying is, as will be shown below, absent as a practical matter and becomes more and more remote as a theoretical matter as the plaintiffs’ chances of success decrease and/or the policyholder’s potential liability increases beyond its coverage limits.

Under the express terms of D&O policies and many other types of excess liability policies, the decision to settle is made by the policyholder.¹⁰ While the policies also require that the policyholder obtain the consent of each insurer that would be required to pay any portion of the settlement, “such consent shall not be unreasonably withheld.”¹¹ This means that insurers are only required to contribute to reasonable settlements. If the policyholder settles for an unreasonable amount, then the insurer is not obligated to

¹⁰ See, e.g., *Fuller-Austin Installation Co. v. Highlands Ins. Co.*, 135 Cal. App. 4th 958, 982 (2006) (considering a policy which allowed the policyholder to decide whether to settle but required the excess insurer’s consent, which means “[a]n excess insurance company has a duty to accept reasonable settlements on its policyholder's behalf; [e]ven if an excess insurance company has not denied coverage or refused to defend, the insurance company has a duty to accept a reasonable settlement”) (quoting *Fuller-Austin Installation Co. v. Fireman’s Fund Ins. Co.*, No. BC116835, 2002 WL 31005090, at *18 (Cal. App. Dep’t Super. Ct. Aug. 6, 2002)); *Taylor v. Gov’t Emps. Ins. Co.*, 978 P.2d 740, 747 (Haw. 1999) (“An insurer may not use [a consent-to-settle] clause to block settlement *unreasonably*”) (quoting *Prudential Prop. & Cas. Ins. Co. v. Nayerahamadi*, 593 F. Supp. 216, 218 (E.D. Pa. 1984)); 14 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 203:37 (3d ed. 2011) (“Liability policies typically contain a consent to settle clause under which the insured is not permitted to enter into settlement with a tortfeasor without the consent of the insurer. Where the policy contains such a clause, the insured’s failure to obtain prior consent from the insurer constitutes a breach of a condition of the insurance contract and thereby forfeits coverage under the policy unless the insured can show that the insurer effectively waived the requirement of consent by the insurer’s . . . unreasonable refusal to consent.”).

¹¹ E.g., *Hilco Capital, LP v. Fed. Ins. Co.*, 978 A.2d 174, 179 (Del. 2009); *Vigilant Ins. Co. v. Bear Stearns Cos.*, 10 N.Y.3d 170, 177 (N.Y. 2008).

contribute to it. The question of whether a settlement is reasonable is based upon the expected exposure of the policyholder at trial, not each individual insurer's expected exposure.¹² With respect to excess insurance and many types of liability insurance, such as D&O insurance, this rule of "reasonableness" is not a judicial creation under which the policyholder defends itself and decides whether to settle.¹³ Rather, it is a contractual obligation set forth in the very policies that the insurers themselves drafted. Thus, by contractually agreeing to consent to settlements that are reasonable, insurers have agreed to consider the policyholder's interests when the settlement decision is made, not solely their own financial self-interest.¹⁴

¹² See Squire, *supra* note 1, at 19; *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 176 (Cal. 1967) (finding that, in determining reasonableness, the question to be answered is whether "a prudent insurer without policy limits would have accepted the settlement offer"); *Wierck v. Grinnell Mut. Reins. Co.*, 456 N.W.2d 191, 195 (Iowa 1990) ("If, but for the policy limits, the insurer would settle for an offered amount, it is obligated to do so . . .").

¹³ Under many types of liability insurance, such as auto insurance and homeowners insurance, the insurer has the right and obligation to defend the policyholder and the insurer has the right to settle cases asserted against the policyholder. Because the insurer controls the defense and settlement decisions under such policies and has the ability to place the policyholder's assets at risk for judgments that exceed the policy's limits, the insurer is in a fiduciary role with respect to the policyholder. Consequently, courts have interpreted the right to settle provisions in such policies to contain an implied duty to act fairly and in good faith, which means the insurer must accept reasonable settlement offers that are within the policy's limits. See, e.g., Alan O. Sykes, *Judicial Limitations on the Discretion of Liability Insurers to Settle or Litigate: An Economic Critique*, 72 TEX. L. REV. 1345, 1349 (1994); Kent D. Syverud, *The Duty To Settle*, 76 VA. L. REV. 1113, 1117–26 (1990); *PPG Indus. Inc. v. Transamerica Ins. Co.*, 975 P.2d 652, 659 (Cal. 1999) (Mosk, J., dissenting) ("Pursuant to the covenant of good faith and fair dealing, which is implied by law in every liability insurance policy, the insurer has a duty to make reasonable efforts to settle a claim against its insured's victim – which accords with the public policy favoring settlement.") (citations omitted); *Birth Ctr. v. St. Paul Cos.*, 787 A.2d 376, 389 (Pa. 2001) ("Today, we hold that where an insurer acts in bad faith, by unreasonably refusing to settle a claim, it breaches its contractual duty to act in good faith and its fiduciary duty to its insured."). That is not the situation at issue in Professor Squire's article or in this Response. Unlike policies in which the insurer defends the case and controls the settlement decision and courts have created a duty to settle as a fiduciary duty and an implied contractual obligation, the obligation to consent to reasonable settlements under many excess policies and some lines of liability insurance, such as D&O insurance, is specifically set forth in the language of the policies. See *Hilco Capital*, 978 A.2d at 179; *Vigilant Ins. Co.*, 10 N.Y.3d at 177; *Crisci*, 426 P.2d at 176; *Wierck*, 456 N.W.2d at 195; Squire, *supra* note 1, at 19.

¹⁴ Professor Squire acknowledges this contractual obligation in his article, but then discounts the power of the requirement that a settlement must be reasonable before an insurer must consent to it in his analysis by claiming insurers nonetheless are somehow forced to settle for presumably unreasonable amounts in what he describes as "cramdown" settlements. See Squire, *supra* note 1, at 19–21, 28. Notably, he does not provide any examples of unreasonable "cramdown" settlements that allegedly have

Does this contractual arrangement allow excess insurers to “cramdown” unreasonable settlements on primary insurers? No, it actually should prevent such occurrences. Does it create a financial incentive for excess insurers to overpay in order to settle? Theoretically, yes, in some limited circumstances, but in practice, no.

To understand these answers, consider the simple hypothetical that Professor Squire uses in his article.¹⁵ A policyholder is facing a claim with \$5 million in damages. The policyholder’s primary insurance has \$2 million in limits. The excess insurer provides \$3 million in limits. There is a 50% chance of a defense verdict on liability. Under this scenario, Professor Squire and I both agree that the policyholder’s expected liability would be \$2.5 million ($0.5 \times \$5M = \$2.5M$).¹⁶ Because the primary insurer has contractually agreed to pay the first \$2 million of the policyholder’s liability, it would be reasonable for it to pay the full \$2 million of its limits if a reasonable settlement demand exceeding \$2 million is made and thus, a “cramdown” situation would not exist. Would the primary insurer nonetheless be economically incentivized to overpay the plaintiff in order to settle? No, its maximum liability is capped at its policy limit of \$2 million so it would have neither a contractual nor an economic reason to pay more than \$2 million.

Due to the fact the primary insurer’s expected trial liability would only be \$1 million ($0.5 \times \$2M$ (the policy limits) = \$1M), but it is required to pay the full \$2 million of its limits if the case can be settled for the reasonable settlement value of \$2.5 million, does this system result in the transfer of wealth, what Professor Squire refers to as “T” in his formulas,¹⁷ from the primary insurer to the excess insurer, as Professor Squire suggests?¹⁸ No. Under the existing policy language and law, the reasonableness of the settlement is based on the overall expected liability of the policyholder, not each individual insurer’s expected trial liability.¹⁹ Indeed, due to the requirement in excess policies that all of the underlying insurance be exhausted before the excess policy has an obligation to pay,²⁰ the primary

occurred despite the contractual limitation that insurers are only required to pay reasonable settlements.

¹⁵ See Squire, *supra* note 1, at 24–25, 28.

¹⁶ *Id.* at 25.

¹⁷ See, e.g., *id.* at 29.

¹⁸ See *id.* at 29.

¹⁹ See *id.* at 19; *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 176 (Cal. 1967); *Wierck v. Grinnell Mut. Reins. Co.*, 456 N.W.2d 191, 195 (Iowa 1990).

²⁰ See, e.g., 2 ALLAN D. WINDT, *INSURANCE CLAIMS AND DISPUTES* § 6:45 (5th ed. 2012) (“An excess insurer is liable only to the extent that the covered portions of a judgment or settlement exceed the primary insurance.”); *Utica Nat’l Ins. Co. of Tex. v. Fid. & Cas. Co.*

insurer is paid a much higher premium in exchange for its promise to pay its full limits if the reasonable settlement value of the case from the policyholder's perspective exceeds the primary policy's limits.²¹ Thus, there is no transfer of wealth from the primary insurer to the excess insurer. The primary insurer contractually agreed to pay more than its expected trial liability in order to settle and was paid a premium commensurate with that agreement.

Does the same analysis apply to the excess insurers? No, they have different contractual obligations and financial incentives than the primary insurer. Under this hypothetical, the excess insurer would contractually be required to pay \$0.5 million to settle because the reasonable settlement value of the case is \$2.5 million and the primary insurer would be required to pay the \$2 million limits of its policy if a settlement for \$2.5 million were possible. Would the excess insurer nonetheless have an economic incentive to pay more than \$0.5 million to settle if the plaintiff is insisting on more than \$2.5 million to settle? Theoretically, yes; Professor Squire has identified this as a problem.²² Because there is a 50% chance that the excess insurer could be required to pay its full limits of \$3 million at trial, the excess insurer has an expected trial liability of \$1.5 million ($0.5 \times \$3M = \$1.5M$). Thus, although the excess insurer would contractually be obligated to pay only \$.5 million to

of N.Y., 812 S.W.2d 656, 659–60 (Tex. App. 1991), *writ denied*, (Oct. 23, 1991) (explaining that excess insurers are not required to pay any amount until primary insurance coverage is exhausted); *Rhone-Poulenc, Inc. v. Int'l Ins. Co.*, 877 F. Supp. 1170, 1175–77, (N.D. Ill. 1995) ("Excess insurance 'kicks in' to provide additional coverage once the policy limits of other available insurance are exhausted. . . . The protections of excess insurance does not begin until those of the primary policy end; all primary insurance must be exhausted before liability is triggered on the excess insurance, regardless of how the excess insurance is created. . . . Excess policies . . . are not automatically triggered by an event; they are not triggered until underlying insurance is exhausted. By the terms of the policy, an insured is not entitled to recover from an excess insurer until underlying insurance is exhausted.").

²¹ See, e.g., ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 976 (5th ed. 2012) ("[P]rimary insurers charge higher premiums than do excess and umbrella carriers. In contrast, relieved of primary insurance burdens and shielded from frequent losses by the presence of underlying primary insurance, excess and umbrella insurers charge relatively low premiums when compared with the amount of risk insured."); Michael M. Marick, *Excess Insurance: An Overview of General Principles and Current Issues*, 24 TORT & INS. L.J. 715, 718 (1989) ("Most major corporations purchase multiple layers of excess insurance to cover losses potentially aggregating in the millions of dollars. The premium paid by the insured for each successive layer of coverage is normally proportionately less expensive than for the immediate underlying layer. The lower premium charged for following form excess insurance is based upon both the decreased risk of a judgment or settlement within higher layers of coverage and the absence of a duty to defend the insured.") (citations omitted).

²² See Squire, *supra* note 1, at 28–29.

accomplish a reasonable settlement, it economically would be incentivized to pay up to \$1.5 million to settle.

This hypothetical reveals both the strengths and weaknesses in Professor Squire's analysis that lead him to the incorrect conclusion that the current rules regarding settlement result in the overcompensation of plaintiffs.²³ Professor Squire is correct that a temptation to overpay may exist in such circumstances;²⁴ however, it is the excess insurer, not the primary insurer, which has the financial incentive to pay more to settle when one considers the reasonableness of the settlement from the perspective of each insurer's expected trial liability and its existing contractual obligations. The reasonable amount for the excess insurer to pay to settle under the current policy language and rules would be \$0.5 million, where the policyholder's expected trial liability is \$2.5 million (\$2 million from the primary insurer plus \$0.5 million from the excess insurer). But the excess insurer's expected trial liability is \$1.5 million ($0.5 \times \$3\text{M} = \1.5M) so it would have an economic incentive, but not a contractual obligation, to pay more than \$0.5 million in order to settle.

With that said, situations in which excess insurers actually would be tempted to overpay are more theoretical than real. In practice, excess insurers are not eager to settle. Instead, they are the most reluctant insurers to settle.²⁵

²³ The assertion that shareholders are overcompensated in shareholder lawsuits is not without controversy. The average settlement for such lawsuits between 2003 and 2008 was \$45.1 million. See TOM BAKER & SEAN J. GRIFFITH, ENSURING CORPORATE MISCONDUCT: HOW LIABILITY INSURANCE UNDERMINES SHAREHOLDER LITIGATION 22 (2010). Although that figure may sound like a lot of money, it represents less than 3% of the average damages actually sought in such cases. *Id.* at 8.

²⁴ See Squire, *supra* note 1, at 25–26.

²⁵ Excess insurers, which receive smaller premiums from the policyholder than the primary insurer and may not have any liability until tens or hundreds of millions of dollars of underlying insurance has been exhausted, typically are the insurers that are most skeptical of the reasonableness of proposed settlements that implicate their policies. Consequently, they often refuse to settle and then become the defendants in subsequent coverage litigation brought by the policyholder or underlying claimants after the underlying case has been settled without the excess insurers' participation. See, e.g., Michael F. Aylward, *Paying to Play: What Does It Mean to Exhaust Underlying Insurance*, 54 DRI FOR THE DEF., no. 5, May 2012, at 27, 28–30 (discussing cases where excess insurers have battled in courtrooms for years in an effort to avoid paying when the underlying insurance arguably has not been exhausted); *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, No. 99C-12-253 JTV, 2006 WL2338045 *1, *4 (Del. Super. Ct. July 31, 2006), *aff'd*, *Travelers Cas. & Sur. Co. v. E.I. du Pont de Nemours & Co.*, 933 A.2d 1250 (Del. 2007) (describing a policyholder who funded over \$239 million of defense and settlement costs associated with underlying litigation where excess insurers refused to settle and then litigated with its excess insurers for over a decade in order to recover the amounts paid in the underlying litigation); *Comerica Inc. v. Zurich Amer. Ins. Co.*, 498 F. Supp. 2d 1019, 1034 (E.D. Mich. 2007)

Indeed, they often either do not pay their full policy limits or must be sued in order to force them to pay anything.²⁶ This happens because they often disagree with the policyholder's and/or underlying plaintiffs' assessment of the plaintiffs' chances of success at trial and because of the requirement that all of the underlying insurance first be exhausted.²⁷ They also simply do not fear the risk of being held liable for more than their policy limits for bad faith refusal to settle if a judgment is entered against the policyholder for more than the limits of the policyholder's insurance program.²⁸ This is because they know the policyholder, which controls settlement, will settle the case before exposing the corporation to an enormous uninsured loss.²⁹ Indeed, due to the enormous financial downside of shareholder trials for the policyholder and the unwanted negative publicity associated with such cases, almost no shareholder cases go to trial.³⁰

Excess insurers also insist on a discount for their coverage defenses based on policy exclusions, such as the fraud and unjust enrichment exclusions, which often potentially apply in shareholder lawsuits and become even stronger defenses if the case goes to trial and the shareholders are able to introduce evidence of the policyholder's deliberate misconduct and obtain a judgment.³¹ Consequently, because of their coverage defenses and knowledge

(exhibiting an instance where an excess insurer successfully argued that it was not required to pay anything where the settlement with the primary insurer was for less than the policy's full limits).

²⁶ *Comerica*, 498 F. Supp. 2d at 1034. *See also* Part III.

²⁷ *See E.I. du Pont de Nemours*, 2006 WL2338045 at *4; *Comerica*, 498 F. Supp. 2d at 1034; *United States Fire Ins. Co. v. Lay*, 577 F.2d 421 (7th Cir. 1978); Aylward, *supra* note 25, at 27, 28–30; BAKER & GRIFFITH, *supra* note 23, at 167–69, 187; *infra* text accompanying note 42.

²⁸ Proving an insurer acted in bad faith is not an easy task. Most of the cases in which the policyholder successfully proves the insurer acted in bad faith involve more insurer misconduct than a simple refusal to accept a reasonable settlement demand within policy limits. *See, e.g.*, *Crisci v. Sec. Ins. Co.*, 426 P.2d 173 (Cal. 1967) (affirming jury verdict of bad faith where the insurer, in addition to refusing to accept a settlement demand within policy limits, refused to settle even though the policyholder, a 70-year old widow, offered to contribute to the settlement and ultimately committed suicide after becoming indigent while attempting to satisfy the judgment in excess of the policy's limits entered against her); *Birth Ctr. v. St. Paul Cos.*, 787 A.2d 376 (Pa. 2001) (affirming jury verdict of bad faith in a medical malpractice case involving an injured baby where the insurer refused to settle within policy limits due to its corporate practice of trying, instead of settling, all “bad baby cases” despite the insurer-appointed defense counsel recommending settlement and the presiding trial judge informing the insurer that it was acting in bad faith by refusing to settle).

²⁹ BAKER & GRIFFITH, *supra* note 23, at 142, 167–69, 187.

³⁰ *Id.* at 160, 167–69, 187.

³¹ *Id.* at 178–79, 186–90, 198.

that policyholders cannot afford to risk an enormous uninsured verdict at trial, excess insurers routinely insist upon receiving discounts off their policy limits and policyholders effectively have to pay a portion of the various excess insurers' layers of coverage to the underlying claimants in order to settle cases.³² Thus, instead of having an incentive to overpay in order to settle under the current policy language and laws,³³ more incentives need to be created to pressure excess insurers to pay reasonable amounts to settle because the existing incentives are inadequate. Awarding the policyholder attorneys' fees if the policyholder is forced to fund a reasonable settlement itself and then sue its excess insurers for reimbursement would be an example of a way that the law could be changed to encourage insurers to settle.³⁴

Moreover, even if an excess insurer theoretically were willing to pay more to settle than they contractually are obligated to do, the only time it would have an incentive to do so is when its expected trial liability plus the limits of

³² *Id.* at 10, 143, 179, 198.

³³ Although Professor Squire discusses some of these facts in Part IV of his article, his discussion does not reconcile how excess insurers that refuse to settle and/or insist on significant discounts off their policy limits based on their coverage defenses and differing assessments of the plaintiffs' chances of success at trial are nonetheless forced to overpay under "cramdown" settlements. Indeed, he offers the Second Circuit case of *Schwartz v. Liberty Mut. Ins. Co.*, 539 F.3d 135 (2d Cir. 2008), as his leading example of a case in which a "cramdown" settlement allegedly occurred and the court allegedly overlooked the overcompensation hazard that he claims exists under the current policy language and law. See Squire, *supra* note 1, at 65. Instead of being a "cramdown" settlement situation, *Schwartz* is actually an example of why more incentives need to be created to force insurers to accept reasonable settlement demands. In *Schwartz*, the policyholder had \$50 million of D&O insurance and the insurers refused to offer more than \$5 million to settle, which forced the policyholder to go to trial. *Schwartz*, 539 F.3d at 139. Just before the end of trial, the policyholder agreed to settle for \$20 million without his insurers' consent. *Id.* The policyholder subsequently sued his insurers for reimbursement and a jury found that the insurers unreasonably refused to consent to the settlement. On appeal, the Second Circuit held that the evidence supported the jury's verdict. *Id.* at 145. In short, *Schwartz* is not a "cramdown" settlement case. The policyholder settled for \$30 million *less* than the limits of the insurance program and the policyholder had to fund the settlement himself. After funding the settlement, the policyholder then had to: 1) sue all of his insurers to seek reimbursement, and 2) convince a jury and the Second Circuit that the insurers acted unreasonably in refusing to consent to the settlement. That is a far cry from a situation where the primary and lower layer insurers were coerced by the excess insurers and policyholder to accept an unreasonably high settlement demand in order to avoid trial.

³⁴ See, e.g., WINDT, *supra* note 20, at § 9:24 ("There are, in short, sound public policy reasons for allowing an insured some type of 'extra' award when an insurance company unreasonably refuses to . . . indemnify the insured, forcing him or her to go to the expense of establishing the company's error by means of litigation The most appropriate relief, therefore, when an insurance company has acted unreasonably, is an award of attorney's fees.").

the underlying insurance are greater than the policyholder's expected trial liability. That scenario could only arise when the alleged damages are within, or do not greatly exceed, the coverage limits and the plaintiffs' chances of success at trial are relatively high. The following formula reveals when the temptation to overpay could arise:

$$(UL + UI) \times P < UL$$

Under this formula, UL represents the underlying policy limits, P represents the probability of the plaintiffs winning at trial, and UI represents the uninsured exposure of the policyholder based on the amount of alleged damages that exceed the policy limits.

Similarly, to put the formula in Professor Squire's terms where he calls the risk of overpayment a "transfer,"³⁵ the formula can simply be stated as follows:

$$(UI \times P) < T$$

Under this alternative formula, UI represents the uninsured portion of the damages, P represents the probability of the plaintiffs winning at trial, and T represents the amount of the potential overpayment.

To illustrate the limited circumstances in which the theoretical temptation to overpay could arise, consider again Professor Squire's example that we have been discussing. If the alleged damages were increased to \$7 million, but all of the other assumptions remained the same, then the excess insurer's temptation to overpay would disappear. This is because the policyholder's expected liability would be \$3.5M ($0.5 \times \$7M = \$3.5M$) and the excess insurer would be unwilling to pay more than \$1.5M ($0.5 \times \$3M$) in addition to the primary insurer's \$2M in limits to settle. Consequently, the reasonable settlement value of the case from the policyholder's and excess insurer's perspectives becomes the same.

Of course, in shareholder lawsuits, the alleged damages typically far exceed the limits of coverage, even though data comparing the policyholder's total amount of insurance versus the alleged damages is not available. Also, the plaintiffs' chances of success at trial are often relatively low, so the temptation for excess insurers to pay more than they are contractually obligated to do is not a common occurrence.³⁶ In addition, in the odd case in which such a scenario could arise, only the highest layer of coverage implicated by the settlement demand would be presented with this temptation due to the way corporate insurance programs are structured. This is because the policyholder's expected trial liability must exceed each of the lower layers

³⁵ See Squire, *supra* note 1, at 29.

³⁶ See BAKER & GRIFFITH, *supra* note 23, at 142.

of coverage before the higher layer of coverage would be obligated to contribute anything to the settlement. Thus, it is a phenomenon that would only impact the highest layer of coverage in the insurance program.³⁷

In sum, “cramdown” settlements should not occur under the existing policy language and law because only reasonable settlements must be accepted, and the reasonableness of the settlement is based on the policyholder’s expected liability. Although the risk of overcompensation by the highest layer excess insurer theoretically could arise in some very limited circumstances, the risk is not created by the contractual or legal obligations of the insurers. In practice, excess insurers do not overpay plaintiffs in order to settle because of the exhaustion requirement in their policies, their coverage defenses, and their differing views regarding the plaintiffs’ chances of success at trial. Instead, they resist settling and insist on discounts off their policies’ limits in order to settle because they do not face significant downside risks if they refuse to settle.

II. ANALYSIS OF CERTAIN ISSUES ASSOCIATED WITH THE IMPLEMENTATION OF A SEGMENTED SETTLEMENT SCHEME

In this Part, the theoretical solution that Professor Squire sets forth to address the alleged problem of “cramdown” settlements and the overcompensation of plaintiffs is discussed in two sections. The first section discusses the practical and legal problems that the implementation of a segmented settlement scheme would present. The second section discusses whether the claimed benefits of a segmented settlement scheme – less compensation to plaintiffs and lower premiums – warrant changing to such a scheme.

A. The Problems and Complexities Presented by the Implementation of a Segmented Settlement Scheme

1. *Practical Problems Associated with a Segmented Settlement Scheme*

A segmented approach to settlements would present a number of serious practical problems, some of which are acknowledged by Professor Squire in his article.³⁸ Under a segmented approach, the policyholder and each insurer would be allowed to settle separately with the underlying plaintiffs, and the underlying

³⁷ See *infra* Figure 1; BAKER & GRIFFITH, *supra* note 23, at 52–54.

³⁸ See Squire, *supra* note 1, at Part IV.

plaintiffs would then proceed to trial against the insurers that refused to settle. Under such a scenario, the underlying case would be tried against an empty chair – the policyholder that settled with a full release.³⁹ Of course, in shareholder cases, much of the relevant trial evidence would be documents and testimony from the directors and officers of the policyholder, particularly because shareholders need to prove that the corporation made intentional, or at least reckless, misrepresentations.⁴⁰ Also remember that one of the reasons policyholders desire to settle shareholder suits is to avoid the negative publicity associated with a public trial, including the alleged misconduct of its corporate management that allegedly resulted in the bilking of the company's shareholders.⁴¹

With those facts in mind, what incentive would the policyholder have to appear at trial after it has settled with a full release? Since the policyholder has paid to get out of the case when its insurers refused to settle, what incentive would it have to cooperate with its insurers during discovery or at trial?⁴² Why would the policyholder spend time and resources preparing for a trial in which its directors and officers would be exposed to cross examination designed to prove that they defrauded their own shareholders? The directors and officers would be confronted with every bad document that the shareholders' counsel could uncover, which would then be published in newspapers and televised over and over again. With a lot of downside and nothing to gain at trial, the policyholder would want nothing to do with it. Consequently, the shareholder plaintiffs and non-settling insurers would need to subpoena the policyholder's witnesses and documents, which the policyholder would resist with all legal means available.

³⁹ Cases in which a plaintiff pursues a policyholder's insurers without the policyholder as a defendant in the case are not empty chair cases because such actions typically occur *after* a judgment has been entered against the policyholder or the policyholder has stipulated to liability and assigned its insurance rights to the plaintiff. *See, e.g.*, *Pruyn v. Agric. Ins. Co.*, 36 Cal. App. 4th 500, 515, 522–23 (1995) (noting that so long as the judgment amount is reasonable and not the result of fraud or collusion, the policyholder can settle by agreeing to the entry of a consent judgment with a covenant not to execute against the policyholder where the insurer breached the duty to defend); *Ayers v. C & D Gen. Contractors*, 269 F. Supp. 2d 911, 917 (W.D. Ky. 2003) (same).

⁴⁰ *See* BAKER & GRIFFITH, *supra* note 23, at 32.

⁴¹ *See id.* at 160.

⁴² Under existing law and the current policy language, the policyholder is obligated to cooperate with its insurers. *See, e.g.*, *JERRY & RICHMOND*, *supra* note 21, at 603–10. If a policyholder's failure to cooperate with the insurer materially prejudices the insurer's defense of the case, then coverage is forfeited. *See* *JERRY & RICHMOND*, *supra* note 21, at 607–08. Although Professor Squire does not address this issue, presumably that obligation also would either be removed or ignored under a segmented settlement scheme because the policyholder would be able to act solely in its own self-interest and settle while its insurers remained in the case.

Further, unless the policy language and case law were changed, the shareholder claimants should expect that as soon as some of the underlying insurers and policyholder settle, the remaining insurers would move for summary judgment based on current case law that holds an excess insurer's liability is extinguished once the policyholder settles with a full release.⁴³ In addition, the excess insurers would likely move for summary judgment based on case law that holds a settlement of the underlying insurance for less than the full policy limits does not satisfy the exhaustion requirement of the policies.⁴⁴ The non-settling insurers also would move for summary judgment on the basis that the policyholder's failure to cooperate in the defense of the case should result in the forfeiture of coverage.⁴⁵ Finally, with Louisiana being the most notable exception, very few states allow

⁴³ See, e.g., *United States Fire Ins. Co. v. Lay*, 577 F.2d 421 (7th Cir. 1978) (finding an excess insurer had no liability where the primary insurer settled for less than its full policy limits and the policyholder agreed to the entry of a consent judgment, under which the claimant could only execute against the excess insurer because the policyholder effectively had been released under the consent judgment and had no liability to the underlying claimant for which the excess insurer could be liable).

⁴⁴ See, e.g., *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1028 (E.D. Mich. 2007) (finding an excess insurer had no liability where underlying insurance was settled for less than the full policy limits); *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184, 194 (2008) (same). A policyholder, unlike an insurer, often is able to successfully argue it has satisfied the exhaustion requirement for primary or lower layers of insurance in situations if the loss exceeds the amount of the underlying insurance or the policyholder has paid a settlement to the underlying claimant that exceeds the limits of the underlying insurance. This is true even if the policyholder settles with some of the lower layer insurers for less than the full policy limits before pursuing the excess insurers for reimbursement. In such circumstances, the limits of the underlying insurance are deemed to have been exhausted because the policyholder has actually suffered a loss in an amount greater than the underlying insurance's limits and/or paid the full amount of the limits to the underlying claimant. See, e.g., *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665, 665 (S.D.N.Y. 1928) (finding that the policyholder satisfied the exhaustion requirement in an excess insurer's policy even though the policyholder settled with the primary insurer for less than the full limits because the loss exceeded the full limits of the primary policy); *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1454 (3d Cir. 1996) (same); *Archer Daniels Midland Co. v. Aon Risk Servs., Inc.*, 356 F.3d 850, 859 (8th Cir. 2004) (same).

⁴⁵ See *JERRY & RICHMOND*, *supra* note 42, at 607–08. Of course, if a policyholder settles with the plaintiffs and obtains a full release, then the policyholder would not care whether its failure to cooperate results in the forfeiture of coverage under the remaining policies. The plaintiffs would, however, care because they would lose that potential coverage if the policyholder breaches the duty to cooperate. Nonetheless, due to the inherent conflicts, it is hard to imagine a scenario in which the policyholder would be required to cooperate with the remaining insurers in their efforts to defeat the plaintiffs' claims when doing so would preserve coverage for the benefit of the very plaintiffs whose claim the policyholder is also being asked to help defeat.

direct actions by claimants against insurers.⁴⁶ Consequently, unless numerous laws were changed, once the policyholder settles, the remaining insurers likely would move for the dismissal of the case as well.

In short, as Professor Squire correctly notes, one should not expect shareholders, shareholders' counsel or policyholders to support a segmented settlement scheme, particularly where the goal of the system is to drive down the amount shareholders and their counsel recover and to shift more of the settlement's costs onto policyholders.⁴⁷ Nor, as is discussed in the next section, would such an approach likely be attractive to judges because, instead of promoting settlements, it likely would lead to additional litigation and motions practice in situations where the actual defendant in the litigation – the policyholder – is no longer even a party.

2. Public Policy Considerations Regarding Segmented Settlements

It also is worth observing that a segmented approach to settlement is inconsistent with well-established public policy that favors settlements in order to avoid the expense and delay caused by litigation.⁴⁸ As many courts and commentators have noted, “settlements produce a substantial savings in judicial resources and thus aid in controlling backlog in the courts.”⁴⁹ Another advantage of settlements is that they provide “greater control over the outcome [of a dispute] and its timing.”⁵⁰ Consequently, settlements enjoy

⁴⁶ See, e.g., Mark Mese, *Direct Action Statutes*, 15 COMPREHENSIVE GEN. LIAB. REP. S520, at 3–10 (Int'l Risk Mgmt. Inst. ed. 2003).

⁴⁷ See Squire, *supra* note 1, at Part IV. Professor Squire opines that a segmented settlement scheme would be beneficial to shareholders because the overall cost to the company would be lower under such a system. The plaintiff shareholders nonetheless might not endorse such a scheme because one of the scheme's goals would be to lower the compensation they would receive. See Squire, *supra* note 1, at 41–45.

⁴⁸ See, e.g., Margaret M. Cordray, *Settlement Agreements and the Supreme Court*, 48 HASTINGS L.J. 9, 74 (1996); Ehrheart v. Verizon Wireless, 609 F.3d 590, 595 (3d Cir. 2010) (“Settlement agreements are to be encouraged because they promote the amicable resolution of disputes and lighten the increasing load of litigation faced by the federal courts. In addition to the conservation of judicial resources, the parties may also gain significantly from avoiding the costs and risks of a lengthy and complex trial.”) (citations omitted); Murchison v. Grand Cypress Hotel Corp., 13 F.3d 1483, 1486 (11th Cir. 1994) (“We favor and encourage settlements in order to conserve judicial resources.”); Miller v. State Farm Mut. Auto. Ins. Co., 155 P.3d 1278, 1281 (Mont. 2007) (“The declared public policy of this State is to encourage settlement and avoid unnecessary litigation. . . . Settlement eliminates cost, stress, and waste of judicial resources.”).

⁴⁹ Am. Sec. Vanlines, Inc. v. Gallagher, 782 F.2d 1056, 1060 n.5 (D.C. Cir. 1986).

⁵⁰ Thomas E. Carbonneau, *Arguments in Favor of the Triumph of Arbitration*, 10 CARDOZO J. CONFLICT RESOL. 395, 405 (2009).

the enthusiastic support of courts because they help alleviate the congestion of court dockets.⁵¹

Although Professor Squire disagrees,⁵² if adopted, a segmented settlement scheme would discourage settlements and encourage trials because insurers would have little reason to settle in many, if not most, cases since their potential liability at trial would never exceed their policy limits. Their expected liability would also always be lower than the full policy limits unless the policyholder's liability went undisputed. Consequently, if the reasonableness of settlements were analyzed on an individual insurer-by-insurer basis without regard for the overall expected liability of the policyholder, and if insurers had no liability for refusing to settle, then insurers would have little incentive to settle unless they were offered incredible discounts off their policy limits. This is because they would lose the investment income they could earn on the amounts paid to settle by waiting until a final judgment is entered after a trial. Further, their coverage defenses based on the unjust enrichment and deliberate misconduct exclusions may completely eliminate their coverage obligation if they wait for a judgment in the case, so their incentive to wait for trial would continue, as it currently does. In addition, with each insurer independently evaluating the plaintiffs' chances of success at trial, at least some insurers would assess those chances differently than the plaintiffs, further increasing the likelihood that some insurers would refuse to settle. Thus, a segmented settlement scheme would be contrary to the public policy that encourages settlements.

A segmented settlement scheme also runs afoul of the long-standing public policy to enforce contracts and require insurers to honor the terms of the policies that they draft and for which they accept handsome premiums.⁵³ Insurers draft the language in liability policies, which generally are then sold on a take-it-or-leave-it basis.⁵⁴ As numerous courts have noted, an important

⁵¹ See Cordray, *supra* note 48, at 36; see also Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1191–92 (1990) (noting reasons for judicial encouragement of settlement agreements).

⁵² See Squire, *supra* note 1, at 61–62.

⁵³ See, e.g., Sch. Dist. of Royal Oak v. Cont'l Cas. Co., 912 F.2d 844, 848–49 (6th Cir. 1990) (explaining that public policy favors enforcing the terms of insurance); Nw. Nat'l. Cas. Co. v. McNulty, 307 F.2d 432, 444 (5th Cir. 1962) (Gwin, J., concurring) (noting the public policy favoring the enforcement of contracts); Union Camp Corp. v. Cont'l Cas. Co., 452 F. Supp. 565, 568 (S.D. Ga. 1978) (“Exercise of the freedom of contract is not lightly to be interfered with. It is only in clear cases that contracts will be held void as against public policy.”).

⁵⁴ See, e.g., Michelle Boardman, *Insuring Understanding: The Tested Language Defense*, 95 IOWA L. REV. 1072, 1091 (2010) (describing the “hyperstandardization” of insurance policies); Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 125 (2007) (“[I]n

public policy that applies to insurance “is that an insurance company which accepts a premium for covering all liability for damages should honor its obligation.”⁵⁵ As is discussed above, there are several existing policy provisions that are inconsistent with a segmented settlement scheme. Thus, in order to avoid running afoul of the public policy that favors enforcing contracts as written, liability policies would need to be redrafted before a segmented settlement scheme could be implemented, particularly in light of the fact that the policyholder has already performed by paying the policy’s premium when the issue of settlement arises. Consequently, the entire risk management equation between policyholders, primary insurers and excess insurers would also need to be changed.

3. *The Unfavorable Consequences for Policyholders That Would Occur Under a Segmented Settlement Scheme*

Policyholders, who are seeking to transfer the risk of loss to insurers when they buy insurance, would also be unpleasantly surprised by the results of a segmented settlement scheme. Under a segmented settlement scheme, the contractual relationship between insurers and policyholders would be quite different because the reasonableness of settlements would be measured by each individual insurer’s expected trial liability, as opposed to the total expected liability of the policyholder.⁵⁶ Consequently, unless the policyholder’s liability has been stipulated to by the parties, it would never be reasonable for the insurer to pay its full policy limits, regardless of which layer in an insurance program an insurer sits. This is because it will always have some percentage chance at trial for a defense victory or a damage award for less than its full policy limits. Thus, under a segmented settlement scheme, insurers would be free to reject settlements that are reasonable when the case is valued as a whole because there would be no penalty for deciding not to

some lines of insurance, all insurance companies provide identical coverage on the same take-it-or-leave-it basis.”); JEFFREY W. STEMPEL, 1 LAW OF INSURANCE CONTRACT DISPUTES § 4.06[b] 4–37 (2d ed. 1999) (“In a sense, the typical insurance contract is one of ‘super-adhesion’ in that the contract is completely standardized and not even reviewed prior to contract formation.”); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995, 996 (1992) (“The only part of the standard policy that is generally customized to the consumer-insured is the Declaration Sheet. . . . [T]here is little, if any, freedom to negotiate the standardized language of the insurance contract that determines the scope of coverage.”).

⁵⁵ *Creech v. Aetna Cas. & Sur. Co.*, 516 So. 2d 1168, 1174 (La. Ct. App. 1987); *see also Sch. Dist. of Royal Oak*, 912 F.2d at 849; *McNulty*, 307 F.2d at 444; *Union Camp*, 452 F. Supp. at 568.

⁵⁶ *See Squire*, *supra* note 1, at 39–40.

settle and insurers would never be held liable for more than their policy limits. As discussed above, such a scenario would create little, if any, incentive for insurers to settle. Consequently, much more of the burden to fund settlements would fall to policyholders.

To really understand the shift in settlement burden that would occur under a segmented settlement scheme, consider another scenario that is more complex and realistic in shareholder litigation against large corporate policyholders. Based on the way damages are calculated in shareholder litigation (the number of outstanding shares are multiplied by the movement in the stock price caused by the alleged misconduct),⁵⁷ assume that the policyholder faces a potential liability of \$1 billion if the shareholders are successful at trial. Also assume that the policyholder's primary insurance has a policy limit of \$10 million and the policyholder has additional layers of excess insurance for a total of \$300 million in insurance coverage.⁵⁸ Also assume that the shareholders have a 10% chance of prevailing at trial, which means the policyholder's expected liability is \$100 million ($0.10 \times \$1B = \$100M$). Finally, assume that shareholders are willing to settle for \$100 million, the expected trial value of the case. From the policyholder's perspective, not only would it be reasonable to settle for \$100 million to avoid a potential liability of \$1 billion, it would be indefensible to put \$700 million of the policyholder's and \$200 million of the insurers' assets at risk by proceeding to trial when the case could be settled for \$100 million. Under the existing policy language and case law, the primary insurer and the excess insurers up to the \$100 million layer of coverage would be required to consent to the settlement because it would be unreasonable not to do so. Also, none of the excess insurers above the \$100 million layer would be asked to contribute anything to settle the case because the entire settlement amount is below their layers of coverage.

Under a segmented settlement scheme where each insurer makes its settlement decision without regard to any other party's interests or the current policy language and law, the reasonable settlement value for all of the insurers in total would be \$30 million ($0.10 \times \$300M = \$30M$). The policyholder, on the other hand, would be required to contribute the other \$70 million in order to settle the case for the expected trial value of \$100 million ($0.10 \times \$1B = \$100M$) even though it has paid premiums for \$300 million in coverage.

⁵⁷ BAKER & GRIFFITH, *supra* note 23, at 34.

⁵⁸ According to Tom Baker's and Sean Griffith's study, \$300 million is the maximum amount of D&O insurance that large corporations currently purchase. BAKER & GRIFFITH, *supra* note 23, at 53.

In short, this example illustrates why a segmented settlement scheme would be extremely unfavorable to policyholders and would be inconsistent with the very purpose of insurance – to transfer the risk of loss from policyholders to insurers.

B. Questions Regarding the Realization of the Benefits of a Segmented Settlement Scheme

It is questionable whether the principal benefits that a segmented settlement scheme are intended to produce – avoiding overcompensation of plaintiffs and lower premiums – would actually occur under such a scheme. As an initial matter, it is questionable whether plaintiffs are actually overcompensated due to the existing policy language and laws, as discussed above in Part I. It is also questionable whether premiums would be lower.

Currently, the premiums charged for primary insurance are much higher than the premiums charged for excess insurance.⁵⁹ Indeed, the higher the attachment point of an excess insurer, the lower the premium charged for the same amount of limits. This is because the risk being borne by the higher layer excess insurers is lower due to the lower chances of a claim reaching the higher layers of coverage.⁶⁰ Because the primary insurer could settle cases for far less than its policy limits and would have no risk of being held liable for judgments that exceed its policy limits under a segmented settlement scheme, the premiums for primary insurance should go down. Conversely, however, the premiums excess insurers charge would go up because they would be assuming a greater risk now that they would no longer have the benefit of the requirements that: (1) lower layers of insurance must be exhausted by the payment of their full policy limits, and (2) lower layer insurers must accept settlements that are reasonable from the perspective of the policyholder. Consequently, the result would simply be a shifting of premium payments from primary and lower layer excess insurers to higher layer excess insurers.

Would there nonetheless be a net savings in premiums for policyholders as Professor Squire theorizes? It is unlikely. As an initial matter, shareholders are already only receiving on average less than 3% of their alleged damages in the average settlement.⁶¹ Thus, there is no reason to believe that shareholders would be willing to accept even less to settle cases simply because less insurance would be available to settle if the policyholder decided not to

⁵⁹ See JERRY & RICHMOND, *supra* note 21; Marick, *supra* note 21.

⁶⁰ See sources cited *supra* note 59.

⁶¹ BAKER & GRIFFITH, *supra* note 23, at 8.

purchase additional insurance to make up for the lower amount of insurance that would be available to settle cases. Consequently, if the policyholder purchased additional excess insurance to make up for the lost amount of insurance available to settle cases under a segmented settlement scheme, then there would not be a net savings in premiums for policyholders. This is because the policyholder would be using the premium savings, resulting from lower premiums charged by the primary and low level excess insurers, to purchase higher layers of insurance in an attempt to replace the “true” insurance that would be available to fund the payment of claims. Thus, the only way real savings in premiums would occur is if policyholders chose not to use the premium savings created by the segmented settlement scheme to purchase additional insurance, but instead simply funded more of the settlements with money from their own coffers. Of course, such a result would be exactly contrary to the very reason that policyholders buy insurance in the first place. There is consequently little reason to think that policyholders would choose to become more self-insured simply because the rules were changed to decrease the amount of insurance actually available in each layer of coverage to settle cases.

Although Professor Squire favors a scenario in which policyholders would purchase higher, thinner layers of coverage,⁶² such insurance may not actually be available to purchase due to the capital requirements for insurers. Professors Baker and Griffith uncovered that the highest total amount of D&O insurance currently purchased is \$300 million.⁶³ Large corporations, however, routinely face shareholder lawsuits with alleged damages that far exceed \$300 million, so the end result of a segmented settlement scheme could be that some policyholders would be forced to become even more self-insured than they currently are.⁶⁴ Further, common sense dictates that if the amount of insurance available to fund judgments were increased, plaintiffs’ counsel would demand greater amounts to settle.⁶⁵

The discussion above also reveals that one of the primary justifications for the implementation of a segmented settlement scheme is predicated upon the questionable assumption that corporations are risk neutral or should be forced to become more risk neutral. Corporations that purchase insurance, by definition, are not risk neutral. One of the principal reasons corporations purchase insurance is to avoid the payment of uncertain future losses.⁶⁶

⁶² See Squire, *supra* note 1, at 43.

⁶³ BAKER & GRIFFITH, *supra* note 23, at 53.

⁶⁴ *Id.* at 142.

⁶⁵ *Id.* at 144–45 (stating the amount of insurance available impacts settlement amounts).

⁶⁶ See, e.g., JERRY & RICHMOND, *supra* note 21, at 10.

When a company purchases insurance, it is exchanging a relatively small certain loss (i.e., the premium) in order to transfer the risk of larger, uncertain future losses to an insurer.⁶⁷ If corporations were risk neutral, then they would simply self-insure. Indeed, even though Professor Squire acknowledges that it would be cheaper to self-insure for many companies because they could save the cost of insurers' profits imbedded in the premiums, most companies do not. That, of course, is true for many types of insurance and is not unique to D&O insurance.⁶⁸

Ultimately, if the goal of a segmented settlement scheme is to make the costs associated with shareholder litigation transparent to shareholders by forcing corporations to become more self-insured for shareholder litigation, then there is a better and more open way of achieving it. Corporations could simply be prohibited from purchasing D&O insurance.⁶⁹ As Professor Squire

⁶⁷ *Id.*

⁶⁸ The reasons many corporations are not risk neutral and choose to purchase insurance instead of "going bare," as self-insurance is referred to in the world of insurance, are generally beyond the scope of this Response, but a few observations on that front are in order. There are tax advantages for corporations that purchase insurance. Corporations can deduct premiums as business expenses. BAKER & GRIFFITH, *supra* note 23, at 63. On the other hand, a corporation that simply puts aside the funds that would be used to pay premiums into a reserve fund to pay claims would not be able to receive a deduction for those amounts and the company also would have to pay taxes on the income the reserves earned. *Id.* Insurance also protects against the risk of bankruptcy. *Id.* at 63–64. In addition, many lenders require corporate borrowers to have insurance so corporations that do not have insurance incur higher borrowing costs. *Id.* at 64. Similarly, when a company is confronting a crisis that creates an uncertain future due to, for example, allegations of corporate misconduct or a catastrophe such as a flood, the company's ability to raise capital is limited and insurance provides a ready source of funds to address such situations. *Id.* at 65. Although less applicable to D&O insurance, many companies also purchase insurance for the loss-prevention expertise of insurers that the companies themselves lack. *Id.* at 66. Finally, insurance protects the shareholders' investments in the company by lowering the volatility of a company's share price by smoothing the company's profits and losses that otherwise would be impacted by the payments of settlements and judgments. *Id.* at 67.

⁶⁹ Even though D&O policies contain exclusions that are intended to deny coverage for intentional misconduct such as fraud, shareholder lawsuits are carefully crafted to plead around such exclusions. BAKER & GRIFFITH, *supra* note 23, at 30, 49. Nonetheless, because shareholder lawsuits must be predicated on allegations of deliberate or reckless corporate misconduct, a public policy argument against allowing insurance for shareholder lawsuits certainly can be made. *See id.* Although this Response does not allow for a fulsome exploration of the argument, for a discussion of the public policies in favor of and against allowing insurance for intentional injuries or damages, see generally, Christopher C. French, *Debunking the Myth that Insurance Coverage is Not Available or Allowed for Intentional Torts or Damages*, 8 HASTINGS BUS. L.J. 65 (2012).

acknowledges,⁷⁰ such a proposal is not novel and it already has been considered and rejected by state legislatures.⁷¹

III. ANALYSIS OF SEGMENTED SETTLEMENTS UNDER OTHER LINES OF CORPORATE INSURANCE

Although Professor Squire's article focuses on D&O insurance, he asserts that due to the existing rules regarding insurers' obligations to settle, the risk of unreasonable "cramdown" settlements and overcompensation of plaintiffs in lawsuits against corporations may also exist under other lines of insurance.⁷² Consequently, he suggests that segmented settlements be considered for such lines of insurance as well.⁷³ The case law and my experience indicate that there is little risk of unreasonable "cramdown" settlements or overcompensation of plaintiffs under other lines of corporate insurance.⁷⁴

As an example, let us consider the typical experience of a major corporation with CGL insurance, a line of insurance that most large corporations have. As an initial matter, the policies typically are occurrence-based, as opposed to claims-made policies like D&O insurance.⁷⁵ The distinction is important because occurrence-based policies are triggered when an injury or damage takes place during the policy period, while claims-made policies cover claims first presented during the policy period.⁷⁶ Thus, claims often trigger multiple policy periods under occurrence-based policies, while claims typically only trigger a single policy period under claims-made policies. As such, a lot more insurance is often potentially available to cover CGL claims.⁷⁷

In addition, because most large corporations in America are willing to bear some risk in order to save on the higher costs of premiums for primary and low level excess insurance, their insurance programs often have a significant self-insured retention ("SIR") with only excess insurance above

⁷⁰ See Squire, *supra* note 1, at 64.

⁷¹ BAKER & GRIFFITH, *supra* note 23, at 43–44.

⁷² See Squire, *supra* note 1, at 70, 72–73.

⁷³ *Id.*

⁷⁴ See *supra* notes 25–27.

⁷⁵ See, e.g., JERRY & RICHMOND, *supra* note 21, at 482–85.

⁷⁶ *Id.*

⁷⁷ *Id.* See also Christopher C. French, *The "Non-Cumulation Clause": An "Other Insurance Clause" by Another Name*, 60 KAN. L. REV. 375, 378–85 (2011) (analyzing the complexities in determining the amount each insurer should be obligated to pay when a claim triggers coverage in multiple years and multiple layers of coverage).

it.⁷⁸ Consequently, similar to D&O insurance, the policyholder controls the defense and settlement of cases asserted against it. Also, insurers' obligations to pay the defense costs, settlements and judgments arise as indemnity obligations, because such amounts are included as covered costs under the definition of "ultimate net loss" that insurers agree to pay.⁷⁹ And, similar to the D&O insurance policy language discussed above, the policyholder must obtain the consent of the insurer in order to settle, and that consent shall be reasonably given.⁸⁰

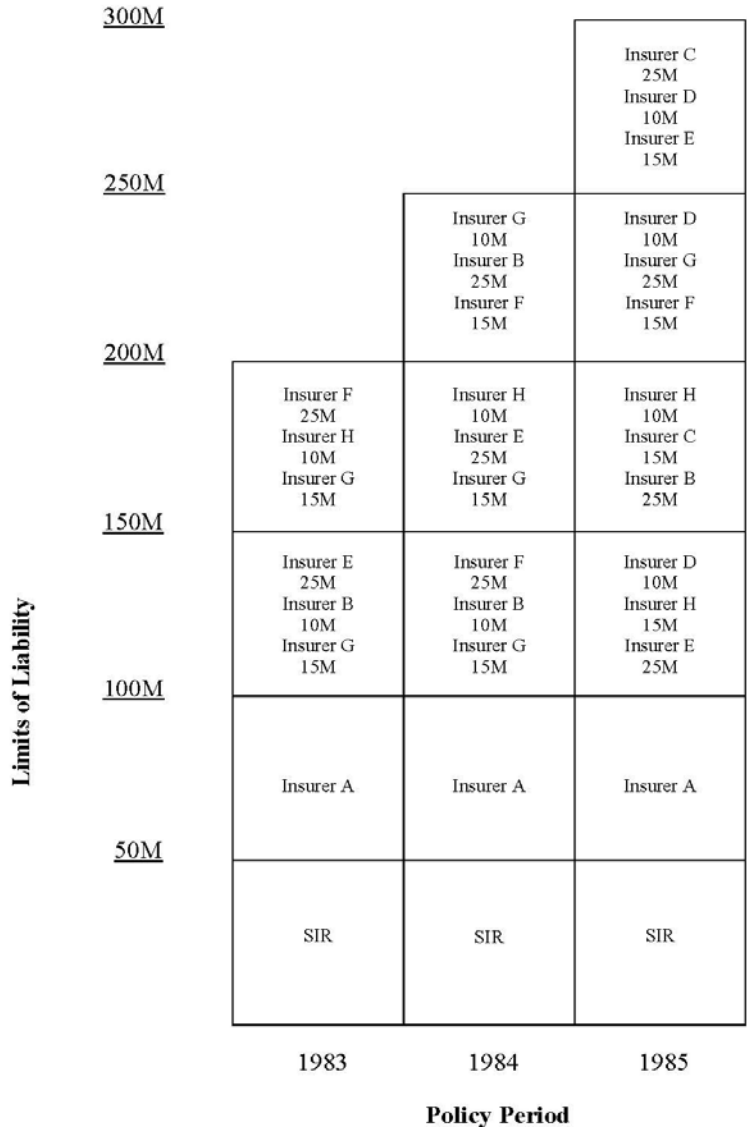
A graphic depiction of three years in a typical corporate insurance program for CGL insurance that has a total of \$300 million in limits in the highest year with a \$50 million SIR is set forth below.

⁷⁸ See, e.g., *Stonewall Ins. Co. v. E.I. du Pont de Nemours & Co.*, 996 A.2d 1254, 1255 (Del. 2010) (analyzing coverage issues for a policyholder that was self-insured for losses up to \$50 million with excess insurance above that amount); Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 DENV. U. L. REV. 29, 29 (2000) ("Larger businesses often self-insure up to some amount, with their self-insured retentions (SIRs) substituting for primary insurance.").

⁷⁹ See, e.g., *Planet Ins. Co v. Mead Reinsurance Corp.*, 789 F.2d 668, 671 (1986) (finding the term "Ultimate Net Loss" is defined as "(1) The sum actually paid or payable in cash in the settlement or satisfaction of losses for which the insured is liable either by adjudication or compromise with the written consent of the 'Company', after making proper deduction for all recoveries and salvages collectible, (2) and includes attorney's fees, court costs and interest on any judgment or award, (3) but excludes all loss adjustment expenses and all salaries of employees and office expenses of the insured, the 'Company' or any underlying insurer so incurred.").

⁸⁰ See, e.g., *Fuller-Austin Installation Co. v. Highlands Ins. Co.*, 135 Cal. App. 4th 958, 982 (2006); *Taylor v. Gov't Emps. Ins. Co.*, 978 P.2d 740, 747 (Haw. 1999); *Hilco Capital, LP v. Fed. Ins. Co.*, 978 A.2d 174, 179 (Del. 2009); *Vigilant Ins. Co. v. Bear Stearns Cos.*, 10 N.Y.3d 170, 177 (N.Y. 2008); RUSS & SEGALLA, *supra* note 10, at § 203:37.

Figure 1: Typical Insurance Program of a Commercial Policyholder



Notably, unlike many D&O insurance programs,⁸¹ multiple insurers often share a single layer of coverage.⁸²

In order to illustrate how claims are defended and settled under a typical CGL program for a corporate policyholder, we will consider two actual experiences of DuPont, a Fortune 100 company, which are matters of public record. The first experience involved a products liability case related to an acetal resin product known as Delrin.⁸³ It is a case that I ultimately tried on behalf of DuPont against the final insurer holdout, Stonewall Insurance Company, after a decade of litigation.

In the Delrin case, DuPont manufactured plastic resin pellets in the 1980s that were used by a plumbing manufacturer to create fittings used in plumbing systems.⁸⁴ Years after the plumbing systems were installed, it was discovered that the fittings slowly degraded allegedly due to chemical attack by elements commonly found in household water such as chlorine.⁸⁵ Consequently, some of the plumbing systems in which the fittings were used eventually leaked and caused damage to the homes.⁸⁶

Numerous lawsuits were filed on behalf of hundreds of thousands of homeowners against various defendants, including the designer and manufacturers of the plumbing systems as well as several manufacturers of the raw materials used in the systems such as DuPont.⁸⁷ DuPont had an insurance program in the 1980s with a \$50 million SIR and excess coverage above the SIR in each year, which is very similar to the insurance program depicted in Figure 1.⁸⁸ Because the claims implicated multiple years of insurance, DuPont provided notice of the lawsuits to dozens of its CGL insurers in multiple policy years and then kept its insurers apprised of the defense strategy as well as potential settlement opportunities during the

⁸¹ BAKER & GRIFFITH, *supra* note 23, at 148.

⁸² See, e.g., *Stonewall Ins. Co.*, 996 A.2d at 1255; *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929, 933 (Del. Super. Ct. 2004); *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, No. 99C-12-253 JTV, 2006 WL2338045 *1, *4 (Del. Super. Ct. July 31, 2006), *aff'd*, *Travelers Cas. & Sur. Co. v. E.I. du Pont de Nemours & Co.*, 933 A.2d 1250 (Del. 2007); Richmond, *supra* note 77, at 29.

⁸³ See *Stonewall Ins. Co.*, 996 A.2d. 1254 (Del. 2010).

⁸⁴ See *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929, 933 (Del. Super. Ct. 2004).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.* at 933–34.

⁸⁸ *Id.* at 935.

course of the litigation.⁸⁹ Although invited to do so during the course of the litigation, no insurer provided any input to DuPont regarding how the cases should be defended or whether, and for how much, the cases should be settled. Although none of the insurers had any basis to contend that the proposed settlements were unreasonable, the insurers neither consented nor objected to the settlements that were proposed. DuPont ultimately settled by agreeing to pay a 10% share of all the amounts paid by the group of defendants to the underlying claimants.⁹⁰ DuPont's total costs associated with the defense and settlement of the cases exceeded \$239 million.⁹¹

While DuPont was spending tens of millions of dollars defending itself, the insurers reserved their rights and asserted dozens of defenses to coverage that were largely based on arguments that insurers in other years should pay instead of them, as opposed to defenses that were based upon arguments that the claims at issue were not actually covered under the terms of their policies.⁹² Thus, DuPont was left to fund the hundreds of millions of dollars of settlements on its own and subsequently sued its insurers to recover the amount it spent to defend and settle the cases.

The second experience relates to DuPont's efforts to collect from its insurers for its asbestos liabilities. It is another case in which I represented DuPont. As was the case with many companies in America, although DuPont did not make asbestos-containing products, asbestos was present at some of its manufacturing plants. Consequently, DuPont was sued by thousands of contractors who allegedly were exposed to asbestos while working at DuPont's plants.⁹³ Similar to the Delrin case, DuPont notified its insurers of the underlying lawsuits and kept them informed regarding the defense strategy and potential settlement opportunities. Nonetheless, none of the insurers agreed to pay any of the defense costs or settlements, with each insurer claiming that other insurers should pay instead.⁹⁴ As a result, DuPont paid millions of dollars to defend and settle the cases over the course of many years and then sued its insurers to recover the amounts it had paid, focusing

⁸⁹ See *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, No. 99C-12-253 JTV, 2006 WL2338045 *1, *4 (Del. Super. Ct. July 31, 2006), *aff'd*, *Travelers Cas. & Sur. Co. v. E.I. du Pont de Nemours & Co.*, 933 A.2d 1250 (Del. 2007).

⁹⁰ *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929, 934 (Del. Super. Ct. 2004).

⁹¹ *Stonewall Ins. Co. v. E.I. du Pont de Nemours & Co.*, 996 A.2d 1254, 1256 (Del. 2010).

⁹² *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929, 936–37 (Del. Super. Ct. 2004).

⁹³ See Complaint at ¶ 24, *E.I. duPont de Nemours and Co. v. Travelers Cas. and Sur. Co., et al.*, (No. B-0176143) (Dist. Ct. Jefferson County, Texas, Nov. 23, 2005).

⁹⁴ *Id.* at ¶ 36.

its coverage claim on the insurers that had sold DuPont policies from 1967 to 1972.⁹⁵ After DuPont defeated the insurers' motion for summary judgment, the insurers finally settled.⁹⁶

What are the lessons from these two examples of DuPont's experience with respect to the issues of whether multi-layered towers of insurance lead to unreasonable "cramdown" settlements and the overcompensation of the underlying plaintiffs? There are several.

First, despite the insurers' obligation to consent to reasonable settlements, none of the insurers actually consented to any of the settlements even though they ultimately could not successfully contest the reasonableness of them. Obviously, that means the higher layer excess insurers were not overly eager to settle, and they did not "cramdown" unreasonable settlements on the lower layer insurers. Nor did any of the insurers feel compelled to tender their policy limits in order to avoid being held liable for more than the policy's limits. To the contrary, none of the insurers wanted to settle, not because they contended the underlying cases lacked merit or the settlements were unreasonable, but rather, principally because DuPont had multiple policy years that covered the claims and each of the insurers were hoping other insurers would be required to pay in its stead. They also preferred to continue holding and investing the premiums paid by DuPont while DuPont spent its own money on the litigation.⁹⁷ Consequently, DuPont had to sue them to collect anything and then had to overcome numerous coverage defenses that were intended to eliminate, or reduce, the insurers' coverage obligations.

Second, the existence of a multi-layered insurance program, and the purported coercive effect of the legal and contractual obligation of insurers to accept reasonable settlements, did not result in the overcompensation of the claimants. To the contrary, DuPont and the underlying claimants negotiated the settlements without regard to whether DuPont's insurance would cover the settlements because the availability of insurance was uncertain when the settlements were negotiated.

⁹⁵ *Id.* at ¶ 28.

⁹⁶ See Hearing Transcript at 18, *E.I. duPont de Nemours and Co. v. Travelers Cas. and Sur. Co., et. al.*, (No. B-0176143) (Dist. Ct. Jefferson County, Texas, Oct. 6, 2006).

⁹⁷ See, e.g., Eliot M. Blake, *Rumors of Crisis: Considering the Insurance Crisis and Tort Reform in an Information Vacuum*, 37 EMORY L.J. 401, 422–23 (1988) ("Insurers do not simply hang onto premiums, of course; they invest them for the time period between payment of premiums and payment of losses. . . . The role of investment income in the [insurance] industry is particularly important. Studies have concluded that investment income allows the industry to remain profitable as a whole even with significant negative underwriting losses.").

Third, DuPont's experiences are not unusual. In complex, multimillion dollar lawsuits against corporate policyholders, it is quite common to find that multiple layers and years of insurance potentially cover the claims and that the insurers rarely are eager to settle regardless of which layer of coverage they occupy.⁹⁸ Indeed, a policyholder must often make settlement decisions without any input from insurers and the policyholder must fund the settlements itself and later pursue its insurers; thus, collective settlements are not pervasive.⁹⁹ Indeed, collective or segmented settlements would actually be an impediment to the settlement process. Under such a system, instead of negotiating with just the policyholder, the underlying plaintiffs would need to negotiate separately with dozens of insurers, each of which evaluates the underlying plaintiffs' chances of success at trial differently and expects a discount off its policy limits for its coverage defenses.

In short, under other lines of insurance such as CGL insurance purchased by large corporations, there is little risk of either overcompensation to the underlying claimants in complex, high stakes litigation, or coercive "cramdown" settlements on lower layer insurers due to the insurers' obligation to consent to reasonable settlements. Thus, overcompensation and "cramdown" settlements are not pervasive problems that need to be addressed by changing the policy language or laws related to settlements. To the contrary, although outside the scope of this Response, more incentives to induce insurers to accept reasonable settlements need to be created because insurers currently often refuse to do so without negative financial consequences.

CONCLUSION

Professor Squire's article represents a significant advancement in the scholarly literature on insurance law. He has coined the previously unnamed "duty to contribute" to describe insurers' obligations to pay the amounts of reasonable settlements that implicate their layers of coverage. He also has identified a theoretical situation in which excess insurers may have an economic incentive, but not a contractual obligation, to overpay the plaintiffs

⁹⁸ See French, *supra* note 77. See also E.I. du Pont de Nemours & Co. v. Allstate Ins. Co., No. 99C-12-253 JTV, 2006 WL2338045 *1, *4 (Del. Super. Ct. July 31, 2006), *aff'd*, Travelers Cas. & Sur. Co. v. E.I. du Pont de Nemours & Co., 933 A.2d 1250 (Del. 2007); Comerica Inc. v. Zurich American Ins. Co., 498 F. Supp. 2d 1019, 1034 (E.D. Mich. 2007); Aylward, *supra* note 25.

⁹⁹ See sources cited *supra* note 97.

in order to settle. He then identifies and discusses a novel solution to address this problem, which he calls “segmented settlements.”

Although there are some very limited circumstances in which an excess insurer theoretically might be tempted to overpay despite its contractual obligation to only pay reasonable amounts to settle based upon the policyholder’s expected trial liability, in practice insurers do not intentionally overpay in order to settle. In addition, changing to a segmented settlement scheme would create a number of complex, practical problems that are inconsistent with some important public policies. Such a scheme would require significant changes to the existing policy language and would lead to more trials with “empty chair” defendants. Thus, considering the limited theoretical circumstances in which the temptation to overpay could arise, and weighing the problems that would accompany a change to a segmented settlement scheme against the benefits such a change is intended to confer, the scales tip against implementing a segmented settlement scheme.