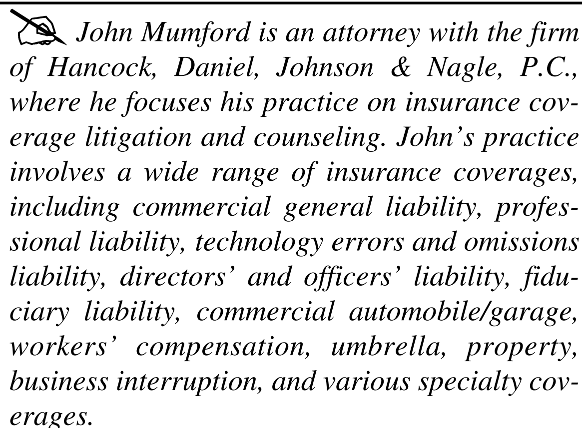
When Settlement Is Not Enough: Could An Insurer Be In Bad Faith Because It Settled?

by John Mumford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Bad faith failure to refuse to settle? This is not a typo. There was a time when insurers could rest easy that once they settled a claim for the policyholder within the policy limits, any extra-contractual exposure was eliminated. But some insurers have recently discovered that this is not always the case. Policyholders under professional liability insurance policies have begun to assert extra-contractual damages claims against their insurers based solely on the insurers' actions in settling a covered claim—even though the settlement freed the policyholder from any exposure related to that claim.

What, or who, is driving this phenomenon? For now, it is physicians who have become disillusioned by the aftermath of the settlement of malpractice claims—often policy nonrenewal, cancellation, or increased rates. But at least two appeals courts, one state and one federal, have sanctioned this theory of liability. Given this acceptance, it is possibly only a matter of time until similar claims spill over into other insurance lines, preventing carriers from resting easy even after claims have been settled.

The cause of action goes something like this—the policyholder physician is sued, and the physician's insurance carrier provides a defense. The insurance carrier assesses the case and determines that it is one that should be settled. In discussing this potential settlement with the physician, the claims adjuster learns that the physician is nervous about settling the claim. Will it affect my premiums? Will I be able to obtain coverage in the future? After learning of these fears, the claims adjuster allegedly represents to the physician that the settlement will not adversely affect the physician's current insurance coverage or ability to obtain coverage in the future. Then, with the physician's consent, the insurance carrier settles the claim.

"As a result, the physician sues the carrier under a variety of theories, including common law fraud, bad faith/breach of fiduciary duty, violations of state unfair trade practices statutes, and breach of contract, seeking damages from the carrier. Of the two appeals courts to consider this type of claim so far, both have upheld it."

After the claim is settled, the physician's worst fears become reality—a significant premium increase, or possibly policy cancellation or nonrenewal. In some cases, the physician will be unable to obtain malpractice insurance coverage at all. As a result, the physician sues the carrier under a variety of theories, including common law fraud, bad faith/breach of fiduciary duty, violations of state unfair trade practices statutes, and breach of contract, seeking damages from the carrier. Of the two appeals courts to consider this type of claim so far, both have upheld it.

A. *Herrin v. Medical Protective Company*[1]

Dr. Bob Herrin, a general surgeon, was insured for nearly forty-one years under a professional liability insurance policy issued by Medical Protective

Company ("MPC").[2] Near the end of this period, a medical malpractice claim was filed against Dr. Herrin.[3] MPC settled this claim with Dr. Herrin's consent in 1996.[4] According to Dr. Herrin, MPC never advised him that the settlement would have any negative consequences on his insurance coverage—in fact, an employee of MPC allegedly told Dr. Herrin the settlement was not unusual and would have no effect on Dr. Herrin's relationship with MPC.[5]

Dr. Herrin further asserted that MPC's employee "implied the settlement would not result in [Dr.] Herrin's policy being cancelled or not renewed in the future because [Dr.] Herrin had a long-standing relationship with [MPC], coupled with only a few claims over the span of his career."[6] Regardless, the year after the claim was settled, MPC notified Dr. Herrin that his policy would not be renewed for the 1997–1998 policy year due to the frequency and severity of claims filed against him. As a result of this non-renewal, Dr. Herrin was unable to obtain other sufficient professional liability insurance coverage.[7] This ultimately led to his early retirement from the practice of medicine.[8]

Dr. Herrin brought a lawsuit against MPC, alleging common law fraud, breach of fiduciary duty, violations of the Texas Deceptive Trade Practices Act ("DTPA") and the Texas Insurance Code, and breach of contract.[9] The trial court granted MPC's motion for summary judgment as to all counts and dismissed the entire case. Dr. Herrin appealed.[10]

On appeal, the trial court's grant of summary judgment regarding Dr. Herrin's common-law fraud claim was reversed. In reversing, the Texarkana Court of Appeals found that Dr. Herrin had raised a genuine issue of material fact as to each of the elements of common-law fraud, making a grant of summary judgment improper.[11] The Court of Appeals paid particular attention to the issue of whether the MPC employee must have known that the statements he made to Dr. Herrin were false at the time he made them—specifically, whether he was aware that MPC would nonrenew Dr. Herrin's policy if the claim was settled for $300,000.[12] The Court of Appeals found that it was enough that Dr. Herrin raised an issue of material fact as to whether the employee should have known that the settlement would cause the nonrenewal of the policy.[13]

In the employee's deposition, he indicated that it is MPC's policy to review an insured's claims history and consider nonrenewal of that insured's policy when a claim over $100,000 is paid.[14] The court found this testimony was sufficient to raise an issue of material fact as to whether the employee should have known that Dr. Herrin's policy would not be renewed when he made statements to Dr. Herrin regarding the settlement.[15]

The court next addressed Dr. Herrin's claims for breach of fiduciary duty and breach of good faith and fair dealing. In his complaint, Dr. Herrin claimed that a fiduciary relationship existed between himself and MPC.[16] The court found that proof existed to establish the existence of such a relationship, primarily through Dr. Herrin's relationship with the MPC employee who had discussed the settlement with him.[17] In his deposition, the MPC employee testified that he had worked with Dr. Herrin for fifteen years.[18]

In addition, Dr. Herrin had stated that he considered his relationship with the employee to be a confidential one, and that he trusted the advice he received from the employee because of the nature of their long-standing relationship.[19] The Court of Appeals also found significance in the length of Dr. Herrin's relationship with MPC and the fact that Dr. Herrin repeatedly referred to the "special relationship" he had with MPC and the trust, honesty, and disclosure existing in that relationship.[20] Based upon much of the same evidence, the court also found that Dr. Herrin had raised a genuine issue of material fact as to the good faith and fair dealing claim.[21] In addition, the Court of Appeals found that Dr. Herrin had produced sufficient evidence to raise a genuine issue of material fact with regard to his unfair insurance practices claim, brought under former Article 21.21 of the Texas Insurance Code.[22] This finding was based largely on the same evidence used to support Dr. Herrin's common-law fraud claim, including the fact that Dr. Herrin was not aware that his coverage would be terminated if he consented to the settlement, that he was induced to consent, and that his coverage was later terminated.[23]

Likewise, it was held that Dr. Herrin produced enough evidence to support his DTPA claims.[24] In part, the DTPA prohibits the failure to disclose information regarding services which was known at the time of the transaction when withholding such information was intended to induce the consumer to do something he would not have done absent that withholding.[25] No intent of misrepresentation is required for there to be a violation of this provision.[26] The court found that in failing to disclose the consequences of consenting to a $300,000 settlement, MPC engaged in false, misleading, or deceptive acts.[27]

The Court of Appeals remanded this case to the trial court.[28] The Supreme Court of Texas denied the petition for review filed by MPC in 2003.[29] The case is still pending before the trial court.

B. *Merenstein v. St. Paul Fire & Marine Insurance Company*[30]

Dr. Daniel J. Merenstein was insured under a professional liability insurance policy issued by St. Paul Fire and Marine Insurance Company ("St. Paul") to his employer, INOVA Health System Foundation ("INOVA").[31] While insured under this policy, Dr. Merenstein was sued for medical malpractice.[32] A St. Paul employee requested that Dr. Merenstein consent to the settlement of this claim for an amount within the policy limits—although the specific policy language did not require his consent.[33] Dr. Merenstein asked whether settling this claim " 'would be likely to have any possible adverse implications' " on his ability to obtain professional liability insurance coverage in the future, or on his ability to continue to practice medicine.[34] Dr. Merenstein was allegedly told the settlement would have no negative impact on his ability to obtain adequate insurance coverage in the future, and he approved the settlement.[35]

> ***"The Fourth Circuit found that the complaint was sufficient to state a claim of actual fraud. In reaching this conclusion, the court held that although Virginia law requires a claim of actual fraud not be based on 'unfulfilled promises or statements as to future events,' an exception allows claims for actual fraud to be based upon promises that are made without the present intention to perform."***

Following this settlement and St. Paul's withdrawal from the physician's malpractice insurance market, Dr. Merenstein attempted to obtain professional liability insurance from numerous companies, but was repeatedly denied coverage because of the settlement.[36] As a result of this inability to obtain adequate insurance coverage, Dr. Merenstein was unable to continue his medical practice.[37]

Dr. Merenstein filed a lawsuit against St. Paul alleging actual fraud under Virginia law.[38] Specifically, Dr. Merenstein claimed that the assurance he received from the St. Paul employee with regard to the impact that the settlement would have on his future insurance coverage and ability to practice medicine constituted an intentional misrepresentation of material fact.[39] He sought compensation for his loss of earning capacity, as well as for his mental anguish.[40]

St. Paul's motion to dismiss Dr. Merenstein's complaint for failure to state a claim was granted by the trial court, based solely upon St. Paul's contention that the alleged representation made by its employee to Dr. Merenstein was not actionable under Virginia law because it was an opinion, not a statement of present existing fact.[41] Dr. Merenstein appealed this dismissal to the United States Court of Appeals for the Fourth Circuit, where the district court's decision was reversed.[42] The Fourth Circuit found that the complaint was sufficient to state a claim of actual fraud.[43] In reaching this conclusion, the court held that although Virginia law requires a claim of actual fraud not be based on "unfulfilled promises or statements as to future events," an exception allows claims for actual fraud to be based upon promises that are made without the present intention to perform.[44] As such, the Fourth Circuit disagreed with the district court's characterization of the alleged representation as an opinion, and found that it could be appropriately characterized as a "litigable affirmation of present fact."[45] According to the court, the representation was "an affirmation of a present fact: insured physicians who agree to settle medical malpractice claims do not encounter difficulty in thereafter obtaining liability coverage."[46] Finding that all elements of a claim for actual fraud had been satisfied, the Fourth Circuit reversed the decision of the district court.[47]

Even so, following this reversal, the Eastern District of Virginia again granted summary judgment in St. Paul's favor in 2006, finding that Dr. Merenstein failed to produce evidence sufficient to support his claims of fraud and breach of the duty of good faith.[48] Dr. Merenstein chose not to appeal further.

> ***"When a policyholder asks during the settlement process how the settlement will affect their current insurance coverage—including renewal premiums—or ability to obtain coverage in the future, insurers must be very careful how they respond."***

C. Lessons Learned

There are clear lessons that insurance carriers can take away from these cases. When a policyholder asks during the settlement process how the settlement will affect their current insurance coverage—including renewal premiums—or ability to obtain coverage in the future, insurers must be very careful how they respond. Ideally, the insurer will have in place a company policy that specifically tells claims staff how to respond to such inquiries. At a minimum, this policy should prohibit all speculative representations on how the settlement will affect the policyholder's current coverage or ability to obtain future coverage. In other words, the rule of thumb for claims staff should be "unless you know it to be true, don't say it." Because an insurer's silence is

truly golden in avoiding claims like those presented in *Herrin* and *Merenstein.*

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[1] Herrin v. Medical Protective Company, 89 S.W.3d 301 (Tex. App. 2002).

[2] *Herrin*, 89 S.W.3d at 304.

[3] *Herrin*, 89 S.W.3d at 304.

[4] *Herrin*, 89 S.W.3d at 304.

[5] *Herrin*, 89 S.W.3d at 304.

[6] *Herrin*, 89 S.W.3d at 304.

[7] *Herrin*, 89 S.W.3d at 304.

[8] *Herrin*, 89 S.W.3d at 304.

[9] *Herrin*, 89 S.W.3d at 303–304.

[10] *Herrin*, 89 S.W.3d at 303.

[11] *Herrin*, 89 S.W.3d at 307. The elements of common-law fraud, as laid out by the court, are "(1) a material representation was made; (2) the representation was false; (3) when the representation was made, the speaker knew it was false or made it recklessly without any knowledge of its truth and as a positive assertion; (4) the representation was made with the intention that it be acted upon by the other party; (5) the party acted in reliance on the representation; and (6) the party suffered injury." *Herrin*, 89 S.W.3d at 305 (citations omitted).

[12] *Herrin*, 89 S.W.3d at 306.

[13] *Herrin*, 89 S.W.3d at 306.

[14] *Herrin*, 89 S.W.3d at 306.

[15] *Herrin*, 89 S.W.3d at 306.

[16] *Herrin*, 89 S.W.3d at 307.

[17] *Herrin*, 89 S.W.3d at 308.

[18] *Herrin*, 89 S.W.3d at 308.

[19] *Herrin*, 89 S.W.3d at 308.

[20] *Herrin*, 89 S.W.3d at 308.

[21] *Herrin*, 89 S.W.3d at 308–309. Significantly, however, the court also noted that the fact that Dr. Herrin's insurance policy included a consent to settle clause provided further evidence that MPC owed a duty of good faith and fair dealing to Dr. Herrin. *Herrin*, 89 S.W.3d at 309.

[22] *Herrin*, 89 S.W.3d at 310. Specifically, Dr. Herrin alleged that MPC violated § 4(11)(b), (c), and (e) of former Article 21.21, which reads:

> 'Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: (11) Misrepresentation of Insurance Policy. Misrepresenting an insurance policy by: . . . (b) failing to state a material fact that is necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (c) making a statement in such manner as to mislead a reasonably prudent person to a false conclusion of a material fact; . . . (e) failing to disclose any matter required by law to be disclosed, including a failure to make disclosure in accordance with another provision of this code.'

Herrin, 89 S.W.3d at 309 (quoting Tex. Ins. Code Ann. former art. 21.21 § 4(11) (Vernon Supp. 2002)).

[23] *Herrin*, 89 S.W.3d at 310.

[24] *Herrin*, 89 S.W.3d at 311. The elements of such a claim, as set out by the court, are " '(1) plaintiff is a consumer; (2) defendant engaged in false, misleading, or deceptive acts; and (3) the acts were a producing cause of the plaintiff's injuries.' " *Id.* at 310 (quoting Tex. Bus. & Com. Code Ann. § 17.46 (Vernon 2002)).

[25] *Herrin*, 89 S.W.3d at 311 (quoting Tex. Bus. & Com. Code Ann. § 17.46(b)(23) (Vernon 2002)).

[26] *Herrin*, 89 S.W.3d at 311.

[27] *Herrin*, 89 S.W.3d at 311. Although successful on all other counts, Dr. Herrin did not fare well with regard to his breach of contract claim. The court found that the insurance policy issued to Dr. Herrin required that MPC give him at least ninety days notice of nonrenewal, and this was complied with by MPC. The court also found no ambiguity in the notice requirement. Interestingly, however, the court did note that "[t]here may have been summary judgment proof of a subsequent oral contract between [Dr.] Herrin and [MPC]; however, [Dr.] Herrin failed to raise this issue." The court affirmed summary judgment for the breach of contract claim, but reversed summary judgment for all other claims, remanding them for trial. *Herrin*, 89 S.W.3d at 311–312.

[28] *Herrin*, 89 S.W.3d at 312.

[29] Medical Protective Co. v. Herrin, 2003 Tex. LEXIS 672 (Oct. 3, 2003).

[30] Merenstein v. St. Paul Fire & Marine Insurance Company, 142 Fed. Appx. 136 (4th Cir. 2005).

[31] *Merenstein*, 142 Fed. Appx at 137.

[32] *Merenstein*, 142 Fed. Appx at 137.

[33] *Merenstein*, 142 Fed. Appx at 137.

34 *Merenstein*, 142 Fed. Appx at 137 (quoting Dr. Merenstein's Complaint).

35 *Merenstein*, 142 Fed. Appx at 137.

36 *Merenstein*, 142 Fed. Appx at 137.

37 *Merenstein*, 142 Fed. Appx at 137.

38 *Merenstein*, 142 Fed. Appx at 137.

39 *Merenstein*, 142 Fed. Appx at 137–138.

40 *Merenstein*, 142 Fed. Appx at 138.

41 *Merenstein*, 142 Fed. Appx at 138.

42 *Merenstein*, 142 Fed. Appx at 138, 141.

43 *Merenstein*, 142 Fed. Appx at 141. The court explained that under Virginia law, a plaintiff must establish six elements to state a claim for actual fraud: (1) a false representation, (2) of a material fact, (3) made intentionally and knowingly, (4) with intent to mislead, (5) reliance by the party misled, and (6) resulting damage to the party misled. *Merenstein*, 142 Fed. Appx at 138.

44 *Merenstein*, 142 Fed. Appx at 139. This was said to be because the promisor's state of mind at the time he makes a promise is a fact, and as such, if that state of mind is misrepresented, a then existing fact is being misrepresented. *Merenstein*, 142 Fed. Appx at 139.

45 *Merenstein*, 142 Fed. Appx at 139.

46 *Merenstein*, 142 Fed. Appx at 140.

47 *Merenstein*, 142 Fed. Appx at 141. The court had found that

> the Complaint alleges that [the St. Paul employee] gave an unequivocal assurance respecting Merenstein's future insurability to induce him to agree to the malpractice settlement—something he otherwise would not have done . . . . [The St. Paul employee's] assurance related to the prospective conduct of third parties (i.e., other insurers). And, according to the Complaint, [the St. Paul employee] knew that his representation was false at the time of its making. Therefore, . . . [the St. Paul employee's] assurance—construed as a promise made with present fraudulent intent—constitutes a sufficient predicate for Merenstein's actual fraud claim.

Merenstein, 142 Fed. Appx at 140.

48 Merenstein v. St. Paul Fire and Marine Ins. Co., 2006 U.S. Dist. LEXIS 22440 (E.D. Va. Mar. 28, 2006). The court's decision regarding Dr. Merenstein's fraud claim was based largely on the fact that his insurance policy contained a provision which granted the insurer permission to settle claims without the consent of the insured. *Merenstein*, 2006 U.S. Dist. LEXIS 22440 at *2. The court explained that an element of fraud is damages to the party who was misled, and that no damage is alleged in cases where the complaining party is not left in a position that is worse than he would have been in if the alleged fraud had not occurred. *Merenstein*, 2006 U.S. Dist. LEXIS 22440 at *3–*4. The provision giving the insurer the right to settle claims without consent meant that anything that may have been said to Dr. Merenstein in order to induce him to settle had no bearing on the settlement—the insurer could have settled even if he had not consented to the settlement. *Merenstein*, 2006 U.S. Dist. LEXIS 22440 at *4. The court also indicated that the other elements of a fraud claim were not satisfied by the evidence presented by Dr. Merenstein in this matter. *Merenstein*, 2006 U.S. Dist. LEXIS 22440 at *4–*5.