2016 ACCEC Insurance Law Symposium

January 22 | Boston College Law School, Newton, Massachusetts

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American College of Coverage and Extracontractual Counsel

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Program Schedule

Click on the panel name to view all papers associated with that panel.

Friday, January 22, 2016

8:30–9:00	**Registration and Coffee**
9:00–9:15	**Welcoming Remarks** **Hon. Daniel Judson** Commissioner, Massachusetts Division of Insurance
9:15–10:05 *Speakers:*	**The Changing World of Intellectual Property Disputes—Can Insurers Keep Up?** **Andrew Downs** (Bullivant — San Francisco, CA) **Professor David Olson** (Boston College Law School) **Sheri Pastor** (McCarter & English — Newark, NJ)
10:05–10:55 *Speakers:*	**Boardroom or Cell Block—The Emerging Criminalization Of D&O Liability Claims** **Dan Bailey** (Bailey & Cavalieri — Columbus, OH) **Carl Metzger** (Goodwin Procter — Boston, MA) **Mary Craig Calkins** (Kilpatrick Townsend — Beverly Hills, CA) **Professor Patricia McCoy** (Boston College Law)
10:55–11:10	**Morning Break**
11:10–12:00 *Speakers:*	**Cyber-Coverage and Data Breach Claims** **Lon Berk** (Hunton & Williams — Washington, DC) **Richard Traub** (Traub, Lieberman — New York, NY) **Kate Browne** (Swiss Re — New York, NY)
12:00–12:45	**Buffet lunch on site**
12:45–1:45 *Speaker:*	**The Restatement of the Law of Liability Insurance** **Professor Kyle Logue** (Restatement Reporter — University of Michigan Law School)
1:45–2:15 *Speaker:*	**A Chief Justice's Perspective on Restatements and the Law** **Hon. Herbert Wilkins** (ALI Council member and former Chief Justice, Supreme Judicial Court of Massachusetts)
2:15–2:45 *Speakers:*	**A Principled Approach to Coverage?—How Will Policyholders Respond to the Restatement?** **John Buchanan** (Covington & Burling — Washington, DC) **Lorie Masters** (Perkins Coie — Washington, DC)
2:45–3:15 *Speakers:*	**The Empire Strikes Back! What is the Insurance Industry's Perspective on the Restatement?** **Michael Aylward** (Morrison Mahoney — Boston, MA) **Laura Foggan** (Wiley Rein — Washington, DC)
3:15–3:30	**Afternoon Break**
3:30–4:30 *Speakers:*	**Selected Privilege and Ethical Issues Arising in the Insurance Context** **Martin Pentz** (Foley Hoag — Boston, MA) **Tony Zelle** (Zelle McDonough — Boston, MA) **Ned Currie** (Currie Johnson — Jackson, MS)
4:30–6:00	**Networking Reception: Wine and Cheese**

2016 Insurance Law Symposium: The New Face of Insurance Litigation
Speakers

Michael Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firm's complex insurance claims resolution group. For nearly thirty years, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He also consults frequently on bad faith and ethics disputes and has served as an arbitrator and testified as an expert in various matters involving coverage and reinsurance issues arising out of such claims. He has served in leadership roles in the major legal defense organizations, including ADTA, DRI, FDCC and IADC and was among the founding members of the American College of Coverage and Extracontractual Counsel, whose Board he has sat on since 2010. In 2014, he was elected to membership in the American Law Institute and presently serves as an appointed advisor on the ALI's *Restatement of the Law of Liability Insurance.* Michael graduated from the Boston College Law School in 1981.

Dan Bailey is a nationally recognized expert regarding directors' and officers' responsibilities, liabilities, indemnification and insurance. As Chair of Bailey Cavalieri LLC's "D&O" practice group, he represents directors and officers, corporations and insurance companies relating to corporate governance matters, and has been involved in most of the largest D&O lawsuits in the country for more than 25 years. In addition to publishing dozens of articles on the subject, he is co-author with William E. Knepper of *Liability of Corporate Officers and Directors* (8th Edition), which is cited as the standard treatise on the topic.

Lon Berk is a partner in the McLean, Virginia office of Hunton & Williams, where he assists clients to resolve insurance disputes relating to mass torts, catastrophic events and cyber security issues. Lon advises clients on liabilities arising out of emerging technologies, including issues concerning internet security, and provides advice regarding insurance covering such exposures. Lon's experience also includes the trial of cases involving commercial and insurance disputes. He has represented clients in insurance disputes in state and federal, trial and appellate courts nationwide and in international arbitrations. Lon is a prolific author and speaker on insurance law, including *Cyber Insurance Products: New Issues For Lawyers And Clients*, Understanding Developments in Cyberspace Law. Chambers USA has recognized him as a leader in the field of insurance law. Lon is co-chair of ACCEC's Cyber Insurance and Computer Crime Committee. Lon is no stranger to Boston, having graduated from the Harvard Law School and received his Ph.D from MIT.

Kate Browne is a Senior Vice-President in the Corporate Solutions Claims group of Swiss Re. Kate began her career in insurance in 1989 at Mendes & Mount where she represented the London Market insurers in complex litigation including asbestos, pollution, and toxic torts. In 2002 she joined AIG as a Complex Director in the Coverage Unit before moving to Swiss Re. Kate's present duties at Swiss Re include monitoring the legal and insurance applications of emerging claim areas such as Self Driving Cars, Uber and the sharing economy and drones. She is an active member of the Federation of Defense and Corporate Counsel as well as DRI and TIDA.

John Buchanan is a partner at Covington & Burling LLP in Washington, DC where he has been engaged in insurance coverage advocacy, dispute resolution and counseling for policyholders since the early 1980s. John's coverage career started with complex litigations over DES and asbestos claims. He has subsequently litigated, arbitrated, mediated and negotiated insurance recoveries for a wide variety of other losses, ranging from environmental and mass-tort disease liabilities, to satellite in-orbit losses, to cyber liabilities from data breaches reported to have been among the largest in history. He has also served as a coverage-dispute arbitrator and advises clients on the insurance aspects of large transactions and on the terms of cyber-risk and other specialty insurance programs. John serves as an Adviser to the American Law Institute's Restatement of the Law of Liability Insurance project. He also teaches a graduate-level course on Current Trends in Insurance Litigation at the Insurance Law Center of the University of Connecticut Law School. A frequent speaker on insurance and dispute resolution topics, he is also active in the Insurance Coverage Litigation Committee of the American Bar Association's Litigation Section. John is a graduate of Harvard Law School, Oxford and Princeton. He clerked on the U.S. Court of Appeals for the Third Circuit before joining Covington, where he has spent his entire professional career.

Mary Craig Calkins handles all aspects of insurance recovery for policyholders in complex, high value matters. She has collected millions of dollars of insurance coverage for directors and officers liability, professional errors and omissions, entertainment and intellectual property claims, cyber liabilities, e-commerce and technology claims, labor and employment claims, construction defects, first party property and business interruption losses, and broker liability claims. Ms. Calkins also advises in-house counsel, senior executives and company management on how to maximize insurance protection and recovery. Mary-Craig has been listed by *Chambers USA* in the area of Insurance: Policyholder (2006-2015) and as one of California's "Top 100 Women Lawyer" by the *Los Angeles/San Francisco Daily Journal*. She is the President Elect of the American College of Coverage and Extracontractual Counsel and the past Co-Chair of the American Bar Association Section of Litigation's Insurance Coverage Litigation Committee (2009-2012) and Division Director for substantive areas of litigation (2012-2014).

Ned Currie is a founding shareholder of Currie Johnson Griffin & Myers, P.A., with offices in Jackson and Biloxi, Mississippi. A graduate of the University of Mississippi School of Law, Ned's 38-year practice has covered a broad range of insurance defense representing the interests of insurers, with primary emphasis on coverage and bad faith. In addition to having tried well over 175 cases to verdict, Ned is a frequent speaker on insurance and bad faith topics. He is a Founding Regent and currently serves as President of the American College of Coverage and Extracontractual Counsel. He also serves on the Board of Directors of the Federation of Defense and Corporate Counsel, the Mississippi Supreme Court Advisory Committee for the Rules of Civil Procedure, and is past President of the Mississippi Defense Lawyers Association. Ned was selected as 2016 Mississippi Lawyer of the Year for Personal Injury – Defense by Best Lawyers, 2013 Mississippi Product Liability Lawyer of the Year by International Global Law Experts, and 2012 Mississippi Lawyer of the Year for Insurance Law by Best Lawyers. He has been included in the Mississippi Business Journal's Top 10 Leaders in Law in Mississippi, ranked in the Top 50 Mississippi Super Lawyers for 2014 and 2015, and has been listed by Am Law & Martindale Hubbell as a Top Rated Lawyer in Insurance Law.

Andrew Downs is a Shareholder of the firm of Bullivant Houser Bailey PC resident in its San Francisco, California office and is a member of Bullivant's Board of Directors. Licensed in both California and Nevada, Andy's practice focuses on the defense of complex coverage and bad faith litigation. Along with being a fellow of the American College of Coverage and Extracontractual Counsel, Andy is a former Director of the Federation of Defense & Corporate Counsel, a former Co-Chair of the Federation's Insurance Industry Committee and was the recipient of the Federation's Joseph Olshan Award in 2014 for his work chairing the Federation's Social Media and Website Committee. Recognized for insurance litigation in Chambers USA: America's Leading Lawyers for Business (2010 through 2015), and consistently selected as a Northern California SuperLawyer, Andy is also a regular speaker and author. He is one of the Editors of the Property Insurance Litigator's Handbook published by the ABA, as well as a chapter author in the Defense Research Institute's Professional Liability Insurance: A Compendium of State Law, a chapter author in California Property Insurance Law & Litigation published by California Continuing Education of the Bar and a chapter author in Law and Practice of Insurance Coverage Litigation published by West. In addition, he served a three year term as a member of the PLRB's Claims Conference Committee.

Laura Foggan leads the Insurance Appellate Group at Wiley Rein LLP. Laura has served as lead counsel in trial and appellate matters involving complex insurance claims. She has participated in more than 200 insurance coverage appeals nationwide and has made significant contributions to the development of key insurance law precedents across the country. A former co-chair of the Insurance Coverage Litigation Committee of the American Bar Association (ABA) Litigation Section, Laura is praised by *Chambers USA* as an "acknowledged expert in her field" (2013) with an "encyclopedic knowledge of insurance law" (2014) and by *LawDragon 500 Magazine* as "the best in the business at protecting insurers facing all types of major claims with an unmatched track record in significant trials and appellate cases, "In addition to her litigation work, Laura counsels insurers on emerging exposures, currently addressing issues such as cyber risk, privacy and data breach claims, and risks and opportunities relating to the commercial use of unmanned aircraft systems ("UAS" or, more commonly, drones). She also represents insurers in arbitration and mediation settings. In 2014, she was appointed by the American Insurance Association to serve as its liaison to the ALI's *Restatement of the Law of Liability Insurance.*

Daniel Judson is Commissioner of Insurance for the Commonwealth of Massachusetts. Judson is a lawyer with over 25 years of experience in insurance in both the public and private sectors. Judson spent 15 years as an insurance regulator at the Massachusetts Division of Insurance, and spent the last 12 years as a private attorney with a broad insurance practice, as compliance manager of a Massachusetts insurance company. Prior to his appointment to be Insurance Commissioner, Judson was the president of Commonwealth Auto Reinsurance (CAR) the high risk pool for auto insurance in Massachusetts.

Kyle Logue is the Wade H. and Dores M. McCree Collegiate Professor of Law at the University of Michigan Law School, where he has taught since 1993 and where he previously served as the school's associate dean for academic affairs. Kyle is one of the nation's leading scholars in the fields of insurance, tax, and torts, blending insights from economics, cognitive psychology, and other disciplines to illuminate how the law can and should affect the allocation of resources and risk in society. He is the co-author of a leading casebook on insurance law and policy and is the

Associate Reporter for the American Law Institute's Restatement of the Law of Liability Insurance. Kyle earned his bachelor's degree summa cum laude from Auburn University, where he was a National Harry S. Truman Scholar. He received his law degree from Yale Law School, where he was an Olin Scholar in Law and Economics and an articles editor of the Yale Law Journal. Before beginning his teaching career at Michigan, he served as a law clerk to the Hon. Patrick E. Higginbotham of the U.S. Court of Appeals for the Fifth Circuit and worked as attorney for the law firm of Sutherland, Asbill & Brennan in Atlanta.

Lorelie Masters is a partner in Perkins Coie's Insurance Recovery litigation group. She has more than 30 years of experience representing policyholders in litigation, arbitration, and settlement negotiations, recovering more than a billion dollars in insurance recoveries for her clients. She is co-author of two treatises: (i) *Insurance Coverage Litigation* and (ii) *Liability Insurance in International Arbitration*, which won the 2012 Book Prize awarded by the British Insurance Law Association for "significant contributions to the literature in insurance law." Lorie has been a leader in the American Bar Association's Section of Litigation, serving as an officer, on the Council, and as the Policyholder Chair of the Insurance Coverage Litigation Committee from 2000 to 2003. From August 2009 to August 2012, she served on the ABA Commission on Women in the Profession. As co-chair of the Commission on Women's Research Initiative, she co-authored *Visible Invisibility: Women of Color in Fortune 500 Legal Departments*. She is one of the founding members of the American College of Coverage and Extracontractual Counsel, and, from 2014 to 2015, served as its second President. Since 2010, she has served as an Advisor to the American Law Institute's *Restatement of the Law, Liability Insurance.*

Patricia McCoy is the Liberty Mutual Insurance Professor at Boston College Law School. In 2014, she moved to Boston College from the University of Connecticut School of Law, where she was the Connecticut Mutual Professor of Law and Director of the Insurance Law Center. Professor McCoy's research interests focus on the nexus between financial products, consumer welfare, and systemic risk, analyzed through the lens of law, economics, and empirical methods. In 2010-2011, she was a senior official at the newly formed federal Consumer Financial Protection Bureau in Washington, D.C., where she established the Mortgage Markets section and oversaw all of the Bureau's mortgage policy initiatives. Professor McCoy received her J.D. from the University of California at Berkeley. At law school, she was Editor-in-Chief of the *Industrial Relations Law Journal*. Following graduation, she clerked for the late Hon. Robert S. Vance on the U.S. Court of Appeals for the Eleventh Circuit. Before entering academe, Professor McCoy was a partner at the law firm of Mayer, Brown in Washington, D.C. Previously a member of the Consumer Advisory Council of the Federal Reserve Board of Governors and the board of directors of the Insurance Marketplace Standards Association, she now sits on the Advisory Committee on Economic Inclusion of the Federal Deposit Insurance Corporation. She spent the 2002-2003 school year as a Visiting Scholar at the MIT Economics Department. Professor McCoy's latest book, *The Subprime Virus*, was published by Oxford University Press in 2011.

Carl Metzger is a partner in the Boston office of Goodwin Procter, where he leads the firm's Risk Management & Insurance practice. His clients include both public and private companies, private equity and venture capital firms, and non-profit and educational institutions. He is recognized as an expert in advising boards of directors and senior officers on liability and risk

management issues, as well as D&O insurance, indemnification and fiduciary duty issues. His experience includes securities litigation defense, financial fraud litigation, governmental and self-regulatory organization investigations, and complex business disputes.

David Olson is an associate professor at Boston College Law School. He teaches patents, intellectual property, and antitrust law. Professor Olson researches and writes primarily in the areas of patent law and copyright. Professor Olson came to Boston College from Stanford Law School's Center for Internet and Society, where he researched patent law and litigated copyright fair use impact cases. Before entering academia, Professor Olson practiced as a patent litigator at the law firm of Kirkland & Ellis LLP. Professor Olson clerked for Judge Jerry Smith of the U.S. Court of Appeals for the Fifth Circuit.

Sherilyn Pastor is Practice Group Leader of McCarter and English's Insurance Coverage Group in Newark, New Jersey. Over the years, she has secured hundreds of millions of dollars in insurance assets for a broad range of policyholder clients. She litigates complex coverage matters throughout the country and provides advice to clients assessing their potential risks, analyzing new insurance products and considering the adequacy of their programs. Ms. Pastor holds the AV Preeminent Rating from Martindale-Hubbell, its highest rating for ethics and legal ability, and she has been honored as a *New Jersey Super Lawyer* since 2006. Sheri Pastor has been recognized as a leader in her field by Chambers USA and as one of New Jersey's "Best 50 Women in Business" by NJBIZ. She is the immediate past Policyholder Chair of the ABA Section of Litigation, Insurance Coverage Litigation Committee. She has been in the ICLCs leadership since 2002. Ms. Pastor serves on the Editorial Board of the Insurance Coverage Law Bulletin, and is a member of the International Center for Conflict Prevention & Resolution's Director & Officer Liability Insurance Committee and its Insurance Neutrals Review Committee. Ms. Pastor also is on the Board of the American College of Coverage and Extra-Contractual Counsel.

Martin Pentz is a Partner in Foley Hoag LLP's Boston office and Chair of its Insurance Recovery Practice Group. He is highly experienced in representing policyholders in insurance coverage litigation. He has been recognized by Chambers USA, The Best Lawyers in America and Massachusetts SuperLawyers for his effectiveness in these matters, as well as for his skills in commercial litigation in all courts. Marty represents insured businesses nationwide in lawsuits and ADR proceedings seeking recovery under various lines of property and casualty insurance, including general and umbrella liability insurance, directors and officers liability insurance, business property and business interruption insurance, professional liability (E&O) insurance and crime insurance. Marty has tried and won major insurance coverage suits and successfully handled appeals in key precedent-setting cases. Marty is a Fellow of the American College of Coverage and Extracontractual Counsel and Co-Chair of the Insurance and Reinsurance Committee of the Insurance and Tort Litigation Section of the Boston Bar Association. He is a 1982 graduate of the Boston College Law School.

Richard Traub is a founding partner of Traub Lieberman Straus & Shrewsberry LLP in New York City where he represents insurers and reinsurers in connection with coverage litigation. Rich has been extensively involved with technology, privacy issues and disaster management. Mr. Traub has published a number of articles, books and papers dealing with environmental forensics, technology and e-commerce liabilities; construction defect litigation. Most recently

Rich was a contributing author to the *Reinsurance Professional's Deskbook – A Practical Guide* (Thomson-Reuters). Rich is a former member of the Board of Directors of the Federation of Defense and Corporate Counsel (FDCC); Chair, International Initiatives Committee (FDCC), Past Chair, Technology Committee (FDCC); Past Dean of the Litigation Management College.

Herbert Wilkins was appointed to the Supreme Judicial Court of Massachusetts in 1972 and served for 27 years on the court and was its Chief Justice from 1996 until his retirement in 1999. Before his appointment to the court, he was a partner in the law firm of Palmer & Dodge. Following his retirement from the court, Chief Justice Wilkins was appointed to be the first Liberty Mutual Professor of insurance studies at BCLS. He is an emeritus member of the Council of the American Law Institute and an active member of the Advisors who are working with the ALI reporters on the *Restatement of the Law of Liability Insurance.* He has received the Boston Bar Association's Citation of Judicial Excellence Award, and the Haskell Cohn Distinguished Judicial Service Award. Chief Justice Wilkins received his undergraduate and law degrees at Harvard and is a former president of the Board of Oversees of Harvard College.

Anthony Zelle is a founding partner of Zelle, McDonough & Cohen in Boston. Over the past several decades, he has developed a national reputation representing insurance companies in coverage and bad faith claims, including several of the leading cases in Massachusetts and Rhode Island. Tony presently serves on DRI's Board of Directors and was previously the chair of DRI's Insurance Committee. As chair of the Bad Faith and Extra-Contractual Claims Subcommittee, he compiled and edited the first edition of the Compendium of Bad Faith Law in 2002. He is a 1986 graduate of the Boston College Law School.

The Changing World of Intellectual Property Disputes—Can Insurers Keep Up?

Speakers:

Andrew Downs (Bullivant – San Francisco, CA)

Professor David Olson (Boston College Law School)

Sheri Pastor (McCarter & English – Newark, NJ)

EMERGING TRENDS IN INTELLECTUAL PROPERTY LITIGATION

Will The Insurance Industry Keep Up?

Andrews Downs, Esq.
Bullivant Houser (San Francisco, CA)

Professor David Olson
Boston College Law School

Sherilyn Pastor, Esq.
McCarter English (Newark, NJ)

I. COVERAGE FOR INTELLECTUAL PROPERTY RELATED ACTIONS[1]

A. Introduction

One of the most fertile areas of litigation in recent years has involved the alleged theft or misappropriation of trade secrets, usually by former employees of the policyholder plaintiff. Rapidly gaining, however, are claims for infringement of copyrights, trademarks, patents and trade dress. One thing is clear, intellectual property litigation and regulation relating to such litigation will continue to be a focus for companies in 2016.

Technology companies have traditionally pressed lawmakers for measures limiting patent rights, while pharmaceutical companies, which spend significant sums and years on research and development, have generally pressed to strengthen patent protections. In response, lawmakers have recently introduced a number of patent and intellectual property-related bills. The Innovation Act introduced in 2015, for example, seeks to curb abusive litigation by "patent trolls." It seeks revision to patent litigation, including raising the pleading standards for patent complaints, limiting discovery, limiting the venues in which patent suits can be brought and requiring fee-shifting. The Support Technology and Research for Our Nation's Growth, or STRONG, Patents Act, also was introduced in 2014. It is geared toward concerns that America Invents Act reviews have made it too easy to invalidate patents. It seeks modifications to review and reexamination proceedings, and offers measures making it easier to show willful infringement. What legislation will develop, and what impact it will have on litigation, remains to be seen.

Parties accused of misappropriation of trade secrets, false advertising, patent or copyright infringement, contributory and vicarious copyright infringement, disparagement, and trade dress or trademark infringement often turn to their insurers seeking at least a defense, if not indemnity for any liability or loss. This paper discusses intellectual property law claims, and coverage under standard form general liability policies and some of the more specialized policies that policyholders with significant intellectual property exposures may opt to purchase.

B. Overview of Intellectual Property Law Claims

1. Trade Secrets

Broadly speaking, a trade secret is secret information that confers a competitive business advantage on its owner by virtue of not being known to competitors. Trade secret laws protect against competitors improperly obtaining a trade secret (such as by breach of a

[1] This paper has been jointly submitted by Andrew B. Downs, Sherilyn Pastor, and David Olson in connection with their ACCEC presentation. It is for general educational purposes and therefore the views expressed are not necessarily those of its authors, their firms or organizations, or their current or future clients.

confidentiality agreement or theft), and/or improperly publishing them. To make out a trade secret claim, one must demonstrate:

- The subject matter qualifies as a trade secret, either because the information is not generally known, or not readily ascertainable (if the information is readily ascertainable, this may provide an affirmative defense in jurisdictions such as California);

- Reasonable efforts were made under the circumstances to maintain the secret, and the secret has commercial value; and

- The secret was misappropriated by improper means, or a breach of confidence.

The breach of confidence can be express, where the person made an express promise of confidentiality prior to the disclosure of the trade secret, or implied. Where implied, the trade secret need be disclosed to another under circumstances in which the relationship between the parties to the disclosure or the other facts surrounding the disclosure justify the conclusions that, at the time of disclosure, the other person knew or had reason to know that the disclosure was intended to be in confidence, and the party making the disclosure reasonably inferred that the person consented to an obligation of confidentiality.

2. Patent Infringement

A patent is an exclusive right given by law to inventors to make use of their inventions for a limited period of time. The U.S. Patent Act, 35 U.S.C. §271 (a), provides that except as otherwise provided in this title, whoever without authority makes, uses, offers to sell, or sells any patented invention, within the United States or imports into the United States any patented invention during the term of the patent therefor, infringes the patent.

3. Copyright Infringement

A copyright is a form of protection, provided by title 17 U.S.C. §106, to the authors of "original works of authorship," including literary, dramatic, musical, artistic, and certain other intellectual works. Subject to sections 107 through 122, the owner of copyright under this title has the exclusive rights to do and/or authorize any of the following:

- to reproduce the copyrighted work in copies or phonorecords;
- to prepare derivative works based upon the copyrighted work;
- to distribute copies or phonorecords of the copyrighted work to the public by sale or other transfer of ownership, or by rental, lease, or lending;
- in the case of literary, musical, dramatic, and choreographic works, pantomimes, and motion pictures and other audiovisual works, to perform the copyrighted work publicly;

- in the case of literary, musical, dramatic, and choreographic works, pantomimes, and pictorial, graphic, or sculptural works, including the individual images of a motion picture or other audiovisual work, to display the copyrighted work publicly; and
- in the case of sound recordings, to perform the copyrighted work publicly by means of a digital audio transmission.

Copyright infringement, broadly speaking, is the use of works protected by copyright law without permission, infringing those exclusive rights granted to a copyright holder.

4. Trademark Infringement

A trademark is a recognizable design, sign, or expression that identifies products or services of a particular source from those of others. Trademarks used to identify services are often referred to as service marks. Trademark infringement involves the unauthorized use of a trademark or service mark on or in connection with goods or services in a manner that is likely to cause confusion, deception, or mistake about the source of the goods and/or services. Section 32(1) of the Lanham Act provides that any person who shall, without the consent of the registrant:

- use in commerce any reproduction, counterfeit, copy, or colorable imitation of a registered mark in connection with the sale, offering for sale, distribution, or advertising of any goods or services in connection with which such use is likely to cause confusion, or to cause mistake, or to deceive; or
- reproduce, counterfeit, copy, or colorably imitate a registered mark and apply such reproduction . . . to labels, signs, prints, packages, . . . or advertisements intended to be used in commerce upon or in connection with the sale, offering for sale, distribution, or advertising of goods or services on or in connection with which such use is likely to cause confusion, or to cause mistake, or to deceive,

shall be liable in a civil action by the registrant.

C. Commercial General Liability Policies

Advertising injury coverage first appeared in early umbrella insurance policies developed by Lloyd's of London. The London umbrella insurance policy, which was marketed as the broadest coverage available in the marketplace, provided complete coverage for a policyholder's business tort liabilities. The Insurance Services Office, Inc. ("ISO") added advertising injury coverage to its standard CGL policies in the 1970s. *See, e.g., Hartford Ins. Co. v. California*, 509 U.S. 764, 771 (1993); *Great Central Ins. Co. v. Insurance Serv. Office, Inc.*, 74 F.3d 778, 780 (7th Cir. 1996). The scope of such coverage has changed over time.

The ISO general liability policies have, since the mid-1980s, included both advertising injury and personal injury coverage alongside the coverage grants for bodily injury and property damage. Advertising injury coverage is offered in sub-part B of the CGL

policy, in the section entitled "Personal and Advertising Injury Liability." Coverage is afforded for injury caused by various enumerated "offenses." Coverage is therefore dependent upon their being a triggering "offense."

1. Applicable Policy Provisions

Under the 2001 edition of the CG 00 01 form (there are several more recent editions, but their use varies), an offense includes:

> f. The use of another's advertising idea in your "advertisement"; or
>
> g. Infringing upon another's copyright, trade dress or slogan in your "advertisement".

"Advertisement" is defined as:

> [A] notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters. For the purposes of this definition:
>
> a. Notices that are published include material placed on the Internet or on similar electronic means of communication; and
>
> b. Regarding web-sites, only that part of a web-site that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement.

Id.

The ISO form also contains the following exclusions:[2]

> **a. Knowing Violation Of Rights Of Another**
>
> "Personal and advertising injury" caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict "personal and advertising injury".
>
> **b. Material Published With Knowledge Of Falsity**

[2] Except as noted, all quotes are from the 2001 edition.

"Personal and advertising injury" arising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity.

c. Material Published Prior To Policy Period

"Personal and advertising injury" arising out of oral or written publication of material whose first publication took place before the beginning of the policy period.

. . .

i. Infringement Of Copyright, Patent, Trademark Or Trade Secret

"Personal and advertising injury" arising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights.

However, this exclusion does not apply to infringement, in your "advertisement," of copyright, trade dress or slogan. [2001 Ed.]

i. Infringement Of Copyright, Patent, Trademark Or Trade Secret

"Personal and advertising injury" arising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights. Under this exclusion, such other intellectual property rights do not include the use of another's advertising idea in your "advertisement."

However, this exclusion does not apply to infringement, in your "advertisement," of copyright, trade dress or slogan. [2013 Ed.]

. . .

l. Unauthorized Use Of Another's Name Or Product

"Personal and advertising injury" arising out of the unauthorized use of another's name or product in your e-mail address, domain name or metatag, or any other similar tactics to mislead another's potential customers.

ISO's CGL policies also traditionally excluded advertising injury coverage for policyholders in advertising, publishing, telecasting and broadcasting businesses. The 2001 ISO policy, for example, excludes advertising injury coverage to policyholders: (1) in the business of designing or determining the content of others' web sites; (2) in the business of acting as an Internet search, access, content or service provider; and (3) who own, host or exercise control over an electronic chatroom or bulletin board.

2. Coverage Issues and Decisions

The Personal Injury and Advertising injury coverage grants in the ISO general liability policy expressly include infringements of copyrights, trade dress and slogans, but the policy form then excludes all claims of infringements except for those occurring in the policyholder's advertising.

To obtain advertising injury coverage, a policyholder generally is required to demonstrate that:

- it engaged in advertising activity;

- the underlying claim falls or arguably falls within one of the policy's enumerated offenses; and

- a nexus exists between the underlying claim and its advertising activity.

See, e.g., Knoll Pharm. Co. v. Automobile Ins. Co. of Hartford, 152 F. Supp.2d 1026, 1036 (N.D. Ill. 2001); *Zurich Ins. Co. v. Sunclipse, Inc.*, 85 F. Supp.2d 842, 852 (N.D. Ill. 2000), *aff'd, Zurich Ins. Co. v. Amcor Sunclipse N. Am.*, 241 F.3d 605 (7th Cir. 2001); *Hameid v. Nat'l Fire Ins. of Hartford*, 31 Cal.4th 16, 21-22, 71 P.3d 761, 764, 1 Cal. Rptr.3d 401, 405 (2003), *reh'g den.*, (2003).

Courts analyzing advertising injury coverage provisions generally have approached them in a relatively direct fashion, with there being a strong correlation between how well the facts of the case fit within the policy language and the result. Cases finding no coverage include:

- *Citizens Ins. Co. of America v. Uncommon, LLC*, 812 F.Supp.2d 905 (N.D. Ill. 2011) [no coverage for Lanham Act claims because of "IP Exclusion" (the equivalent of Exclusion i. quoted above)].

- *Liberty Corporate Capital, Ltd. v. Security Safe Outlet, Inc*., 937 F.Supp.2d 891 (E.D. Ky. 2013) [misappropriation of trade secrets is not personal injury or advertising injury].

- *Feldman Law Group, P.C. v. Liberty Mutual Ins. Co.*, 819 F.Supp.2d 247 (S.D.N.Y. 2011) [underlying Lanham Act and copyright infringement claims not within scope of advertising injury coverage]

- *Alterra Excess & Surplus Ins. Co. v. Snyder*, 234 Cal.App.4th 1390, 184 Cal.Rptr.3d 831 (2015) [Exclusion i. eliminated coverage].[3]

- *America's Recommended Mailers v. Maryland Cas. Co.*, 579 F.Supp.2d 791 (E.D. Tex. 2008) [particular Lanham Act claims found to be outside advertising injury coverage grant].

Cases finding some coverage include:

- *Burlington Ins. Co. v. Eden Cryogenics LLC*, --- F.Supp.3d ---, 2015 WL 5145554 (S.D. Ohio 2015) [court finds "IP exclusion" added by endorsement is ambiguous, but finds knowing violation exclusion applies to some policyholders].

- *Hudson Ins. Co. v. Colony Ins. Co.*, 624 F.3d 1264 (9th Cir. 2010) [possibility of claim for slogan infringement in underlying action created duty to defend].

- *Super Duper, Inc. v. Pennsylvania NationalMut. Cas. Ins. Co.*, 385 S.C. 201, 663 S.E.2d 792 (2009) [Court answers certified questions finding trademark infringement arises out of offense of misappropriation of advertising ideas or style of doing business as well as infringement of copyright, etc.].

- *Foliar Nutrients, Inc. v. Nationwide Agribusiness Ins. Co.*, --- F.Supp.3d ---, 2015 WL5595523 (M.D. Ga. 2015) [court concludes claims are advertising injury or personal injury claims but not IP claims within scope of exclusion, for duty to defend purposes].

- *Atlapac Trading Co., Inc. v. Am. Motorists Ins. Co.*, 1997 WL 1941512, at *1, 6-7 (C.D.Cal. Sept. 19, 1997) [court finds "misappropriation of advertising ideas" is an ambiguous term, and interpreted it to require defense of false advertising claims by rival distributor claiming injuries resulting from improper use of slogan "pure olive oil"].

- *Interface Inc. v. Standard Fire Ins. Co.*, 2000 WL 33194955, *2 (N.D. Ga. Aug. 15, 2000) [court finds duty to defend underlying suit alleging infringement of a competitor's copyrighted carpet patterns].

- *Western Am. Ins. Co. v. Moonlight Design, Inc.*, 95 F. Supp.2d 838, 844-45 (N.D. Ill. 2000) [court holds duty to defend policyholder sued for, among other things, advertising "knock-off" bridal dresses that infringed a competitor's copyrighted design].

[3] A case involving the product "Buckyballs," withdrawn from the market at the insistence of the Consumer Product Safety Commission.

- *Ryland Group, Inc. v. Travelers Indem. Co. of Ill.*, 2000 WL 33544086, *5 (W.D. Tex. Oct. 25, 2000) [court upholds duty to defend policyholder that allegedly constructed and sold houses based on another's copyrighted architectural plans, where underlying complaint avers that the policyholder's promotional materials, containing depictions of the plans, infringed its copyrights].

D. Specialty Policies

Certain industries in the technology and media sectors of the economy face significant risks of intellectual property litigation and buy policies specifically designed to cover selected IP risks. These policies are not drafted by the Insurance Services Office. While the insurance marketplace imposes a degree of uniformity upon the insurers who write in this sector (often in multiple layer "tower" programs), there is no standard policy.

Many of these policies are structured similarly to professional liability and Directors & Officers policies in that they are written on a claims made and reported basis and seek to define the scope of policyholder activities for which coverage will be provided. There are relatively few published decisions involving these policies.

E. Conclusion

Insurance coverage for intellectual property claims will continue to be significant as intellectual property law develops and expands potential liabilities. Recent developments include the U.S. Court of Appeals for the Federal Circuit's 2015 ruling that divided infringement can constitute direct infringement of a patent. *Akamai Technologies, Inc. v. Limelight Networks, Inc.*, No. 2009-1372, at *5 (Fed. Cir. Aug. 13, 2015) (en banc) (finding that a defendant can be liable for direct infringement when it "conditions participation in an activity or receipt of a benefit upon performance of a step or steps of a patented method and establishes the manner or timing of that performance"). Also, laws relating to vicarious liability for copyright infringement continued to evolve. In March 2015, the United States District Court for the Southern District of New York in *Capitol Records LLC v. Escape Media Group, Inc.*, No. 12-CV-6646(AJN), 2015 WL 1402049 (S.D.N.Y. Mar. 25, 2015), held that a streaming music service did not qualify under the safe harbor immunity of the Digital Millennium Copyright Act because it had an insufficient "repeat infringer policy," which failed to terminate users accused repeatedly of uploading infringing works. The Patent and Trademark Office also continued to strike down patent claims under *Alice Corp. v. CLS Bank International*, 573 U.S. __, 134 S. Ct. 2347 (2014), for being too abstract.

Boardroom or Cell Block—The Emerging Criminalization Of D&O Liability Claims

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INCREASING D&O CRIMINAL EXPOSURES: INSURANCE AND INDEMNIFICATION ISSUES

In response to recent criticisms, federal law enforcement authorities are now investigating with greater frequency and vigor potential criminal charges against directors and officers in a variety of contexts. Most notably, on September 9, 2015, deputy attorney general Sally Quillian Yates issued a memorandum to all Assistant U.S. Attorneys and other key agencies which sets forth the federal government's focus on individual criminal accountability for corporate wrongdoing. In the so-called Yates Memorandum, the Department of Justice recognized that "[o]ne of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing" and that it is "important that the Department fully leverage its resources to identify culpable individuals at all levels in corporate cases."

The cornerstone of the policies and procedures set forth in the Yates Memorandum (which have now been incorporated into the U.S. Attorneys' Manual) is that in order for a company which is targeted in a federal investigation to gain any credit for cooperation with the government, the company must provide to the DOJ "all relevant facts relating to the individuals responsible for the misconduct." In other words, a company is now highly motivated to disclose to federal investigators the identify and "all relevant facts" relating to directors, officers and other individuals arguably responsible for the company's alleged wrongdoing, thereby creating a huge conflict between the company and those potentially responsible individuals.

The practical impact of this new and aggressive DOJ initiative is still largely unknown. However, when combined with several highly publicized recent D&O criminal trials (including trials against the CEO of Massey Energy arising out of a deadly mining incident and against senior officers of the Dewey LeBoeuf law firm arising out of that firm's financial collapse), it is clear that directors and officers—and their advisors—should reconsider the adequacy of the insurance and indemnification protection for the directors and officers. This article summarizes many of the more important features of a D&O insurance policy and corporate indemnification provisions which should be examined when evaluating the quality of financial protection for a criminal investigation of or charges against directors and officers.

A. INSURANCE ISSUES

Coverage under a D&O policy for criminal proceedings is subject to many of the same provisions which are equally applicable to coverage for civil proceedings. However, there are several unique considerations which apply to criminal investigations and proceedings against Insured Persons, many of which are summarized below.

1. Definition of Claim

Under most D&O policies today, coverage is likely triggered for an Insured Person who is involved in any stage of a criminal investigation or proceeding, although different provisions within the policy's definition of "Claim" will apply to different stages of that criminal matter. Virtually all Side A policies and most ABC D&O policies today include coverage for the costs incurred by an Insured Person in responding to a request from an enforcement authority to provide testimony or produce documents in connection with a criminal or civil investigation by the enforcement authority, whether or not the Insured Person is a target of the investigation or is alleged to have committed any wrongdoing. This so-called Pre-Claim Inquiry coverage applies, though, only if the Insureds elect to provide notice of the inquiry to the insurer.

If that inquiry progresses to a formal investigation of the Insured Person, pursuant to which the Insured Person receives a target letter or similar communication from the enforcement authority identifying the Insured Person as someone against whom a criminal proceeding may be commenced, another provision within the definition of "Claim" is triggered and the Insureds are then obligated to give notice of that investigation to the insurer as soon as practicable.

Finally, if the investigation culminates in the indictment of the Insured Person, yet another provision within the definition of "Claim" is triggered, and the Insureds should give notice of that indictment to the insurer as soon as practicable.

The net effect of these various provisions within the definition of "Claim" in the D&O policy is that Insured Persons likely have "cradle to grave" coverage for defense costs incurred in connection with criminal investigations and proceedings involving the Insured Person (subject to the other terms, conditions and coverage limitations in the policy), whether or not the company indemnifies the Insured Person for those defense costs.

2. Definition of Loss

Historically, D&O policies routinely excluded from the definition of "Loss" any fines or penalties. Because this exclusion is in the definition of "Loss" rather than in the Exclusions section of the policy, this exclusion eliminates coverage only for the fine or penalty itself, and does not apply to defense costs incurred in connection with a criminal proceeding which seeks to impose the fine or penalty.

In recent years, this fine/penalty exclusion has been narrowed in many D&O policies. Initially, a carve-out to the exclusion was added for certain fines and penalties imposed under the Foreign Corrupt Practices Act for unintentional violations of that Act. More recently, some D&O policies include a carve-out for fines or penalties assessed for any unintentional or non-willful violation of law. A few Side A policies now delete the fine/penalty exclusion in its entirety. Another important variable among policies with respect to this exclusion relates to whether the exclusion, or the carve-outs to the exclusion, apply to both civil and criminal fines/penalties or apply only to civil or only to criminal fines/penalties.

In addition to the express terms of the fine/penalty exclusion, it is also important to consider whether any fine or penalty is insurable under applicable law even if coverage is otherwise afforded for the fine or penalty. To maximize the likelihood that an otherwise covered fine or penalty is insurable, the policy could extend the "most favorable jurisdiction" provision

which typically applies to the insurability of punitive damages, to also apply to the insurability of fines or penalties.

3. Conduct Exclusion

All D&O policies have some type of conduct exclusion, which eliminates coverage for certain types of egregious wrongdoing by an Insured Person. However, this exclusion varies significantly among policies in several respects, as summarized below.

First, the conduct falling within the exclusion varies among policies. Historically, the exclusion typically applied only to "dishonest" or "fraudulent" conduct, which would likely not apply to many criminal claims. Subsequently, additional types of egregious conduct were added to the exclusion in many policies. Today, the exclusion frequently applies not only to deliberately fraudulent or dishonest conduct, but also to "intentional violations of law" and, under many policies, "criminal" conduct.

Second, different policies apply different triggers to the applicability of this exclusion. Some policies require a "judgment or other final adjudication" which establishes that the referenced conduct actually occurred. More recent policies frequently require a "final and non-appealable adjudication in the underlying proceeding." Under this very narrow trigger, the exclusion does not apply unless and until the underlying proceeding is completely resolved (including all appeals) and the requisite adjudication exists in the underlying proceeding (not in a related coverage proceeding). Whether this type of exclusion trigger would apply the exclusion to a related civil claim if the adjudication occurs in a criminal proceeding has been debated by insurers and insureds, but there is little authority addressing that question.

Third, the exclusion typically applies only to the Insured Persons who committed the egregious conduct and does not apply to other Insured Persons (i.e., the exclusion states that the conduct of one Insured Person is not imputed to another Insured Person).

Fourth, many versions of the exclusion contain exceptions or carve-outs to which the exclusion does not apply. For example, the exclusion as contained in many Side A policies (and some ABC policies) expressly does not apply to outside directors and/or defense costs.

Importantly, prior to the exclusion being triggered, D&O policies typically require the insurer to advance defense costs in a claim which alleges conduct described in the exclusion (including criminal conduct), subject to the Insureds being required to repay the advanced defense costs to the insurer if and when the exclusion is ultimately triggered.

4. Fifth Amendment Privilege Impacting Coverage

Several courts have held that an insured breaches his duty to cooperate with the insurer under an insurance policy when the insured asserts the Fifth Amendment privilege against self-incrimination in response to questions by an insurer in connection with a claim for coverage under the policy. See, *U.S. Specialty Ins. Co. v. Skymaster of Va., Inc.*, 2001 U.S. App. LEXIS 26786, * 8 (4th Cir. 2001) ("Any argument of the insured that giving the [examination under oath] provision such a broad scope would effectively abrogate their right against self-incrimination is unavailing; they may avoid incriminating themselves by refusing to submit to relevant requests made by the insurer under the policy provision, although to do so may

ultimately cost the insurance coverage under the terms of the contract for which they and the insurer bargained."); *Miller v. Augusta Mut. Ins. Co.*, 335 F. Supp. 2d 727, 731 (W.D. Va. 2004), *aff'd*, 2005 U.S. App. LEXIS 26862 (4th Cir. Dec. 8, 2005) ("[The insured's] assertion of the Fifth Amendment in response to [the insurer's] questioning therefore constituted a failure to cooperate as a matter of law."); *U.S. Fidelity & Guaranty Co. v. Wigginton*, 964 F.2d 487, 491 (5th Cir. 1992) ("[The insured] cannot, however, rely upon his Fifth Amendment right against self-incrimination as a valid excuse to avoid examination in this civil case."); *State Farm Fire & Cas. Co. v. Richardson*, 2008 U.S. Dist. LEXIS 80150, *29 (S.D. Ala. Oct. 9, 2008) ("[W]hen an insured seeks to recover proceeds from an insurance contract to which he is a party, he must be held to the express terms of the agreement. He is not compelled to incriminate himself. He is, however, bound by the provisions to which he stipulated when he signed the insurance agreement and cannot expect [the insurer] to perform its obligations under the contract, by being subject to suit for payment of proceeds, without compliance on his part."); *Aetna Cas. & Surety Co. v. State Farm Mut. Auto. Ins. Co.*, 771 F. Supp. 704, 707 (W.D. Pa. 1991) (rejecting an argument that "the Fifth Amendment privilege trumps the insurance policy's duty to cooperate requirement"); *FT Mortgage Co. v. Williams*, 2001 Ohio App. LEXIS 4728 (12th Dist. Oct. 22, 2001) (insured breached the cooperation clause in the insurance policy by invoking her Fifth Amendment right and therefore lost coverage under the insurance policy); *Ohio Bar Liability Ins. Co. v. Silverman*, 2006 Ohio App. LEXIS 2881 (10th Dist. June 15, 2006) (an insured "cannot wield [his] Fifth Amendment privilege as a shield and a sword by demanding coverage and a defense under the insurance contract, while at the same time refusing to answer questions material to determining [the insurer's] duties under the contract.").

At least one court applied this same reasoning to preclude coverage where the insured invoked the Fifth Amendment privilege in the underlying proceeding. The 8th Circuit reconciled the cooperation duty of an Insured Person under an insurance policy with the Insured Person's Fifth Amendment rights as follows:

> "[T]he insurance policy did not require an actual waiver of [the insured's] constitutional rights. He retained the choice whether to invoke his Fifth Amendment rights at the price of losing his insurance coverage or to cooperate with the defense attorneys provided him and retain his coverage. Both options remained available to him throughout the pendency of the [underlying] case. We conclude that the district court did not err in concluding that [the insured] materially breached the cooperation clause in his insurance policy.

Medical Protective Co. v. Bubenik, 594 F.3d 1047, 1052 (8th Cir. 2010).

To address this potential coverage limitation, the D&O policy could include a provision which prohibits the insurer from raising a lack of cooperation coverage defense based on an insured's assertion of the Fifth Amendment privilege. Because D&O policy forms do not typically contain this provision, the insureds and their broker will need to specifically request such a provision.

5. Insurance Claims Handling

Criminal investigations and proceedings raise unique issues regarding communications between the insured and the D&O insurer. Like any other type of claim submitted for coverage,

insurers expect to receive from the insured full information regarding any criminal investigation or proceeding, including frank discussions concerning defense strategies and exposures. However, unlike civil claims, various statutes and rules applicable to criminal investigations and proceedings potentially limit the extent to which the insured can fully comply with the insurers' requests.

For example, Rule 6(e) of the Federal Rules of Criminal Procedure impose upon certain participants in the grand jury process a strict duty to keep any "matter occurring before the grand jury" a secret. Although that secrecy obligation does not apply to grand jury witnesses, prosecutors frequently request witnesses (including the target defendant) to maintain the confidentiality of the grand jury proceeding.

In addition, defense counsel and D&O insurers should avoid creating the appearance of influencing witness testimony or otherwise obstructing the criminal justice process by exchanging information or ideas about defense strategies. Federal statutes prohibit witness tampering (18 U.S.C. §1512(b)) and any attempt to "influence, obstruct or impede the due administration of justice" (18 U.S.C. §1503(a)).

Both defense counsel and D&O insurers should be sensitive to but not over react to these potential impediments to the insurer's involvement in the criminal defense process. Typical insurer involvement in a claim should not technically violate any of these statutes or rules. The potential concern relates to creating the appearance of impropriety rather than actual illegal behavior.

B. INDEMNIFICATION ISSUES

A criminal investigation or proceeding against directors and officers also raises several important issues with respect to the company's legal ability and obligation to indemnify the director or officer for defense costs, fines, penalties or other loss incurred as a result of the criminal investigation or proceeding. The following summarizes many of those issues. The indemnification law of the state in which the company is incorporated typically applies. Although generally consistent, those state indemnification laws vary in several important respects. Therefore, the applicable state law should be reviewed when evaluating indemnification protection by a particular company. The discussion below is generally based upon Section 145 of the Delaware General Corporation Law, which describes indemnification of directors and officers for a company incorporate in Delaware.

1. Permissive/Mandatory

State indemnification statutes generally permit but do not require a company to indemnify its directors and officers. The one exception is where the defendant director and officer is successful in defending the claim, in which case indemnification statutes usually require the company to indemnify the person's costs incurred in that successful defense.

A company can, and almost always does, create an obligation to indemnify its directors and officers by adopting an indemnification provision in the company's bylaws or certificate of incorporation. Therefore, to evaluate a company's right and obligation to indemnify its directors and officers in connection with criminal matters, one should examine both the company's internal indemnification provision as well as the applicable state indemnification statute. In

addition, some companies enter into formal indemnification agreements with certain key officers and directors in order to create extraordinary indemnification protection, although virtually all of the benefits of an indemnification agreement can be created through a broadly drafted bylaw indemnification provision if a company wants to afford those extraordinary protections to all directors and officers rather than a few select directors and officers.

2. Standard of Conduct

Indemnification statutes generally apply to both civil and criminal proceedings which are commenced or threatened against current or former directors and officers (as well as employees and agents, although a company's bylaw indemnification provision frequently does not mandate indemnification for employees or agents). This indemnification is subject to the person satisfying a standard of conduct set forth in the statute. For example, to qualify for indemnification under the Delaware statute, a director or officer must have acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the company. With respect to any criminal proceeding, the person must also have had no reasonable cause to believe his conduct was unlawful. The Delaware statute further states that the termination of any civil or criminal proceeding by judgment, order, settlement, conviction or upon a plea of *nolo contendere* does not alone create a presumption that the person's conduct failed to satisfy the statutory standard of conduct.

State indemnification statutes require a majority of disinterested directors or independent legal counsel to make a determination, based upon the facts of each claim, whether the conduct of the director or officer satisfies this statutory standard of conduct and thus whether indemnification for the director or officer is authorized. Like D&O policies, indemnification statutes permit, and bylaw indemnification provisions should require, the company to advance defense costs throughout the pendency of a claim until such a determination can be made at the end of the claim. However, if it is ultimately determined that indemnification is not permitted, then the director and officer must repay to the company the amount of defense costs advanced by the company.

3. Fine/Penalty Indemnification

State indemnification statutes describe the type of loss incurred by a director and officer which may be indemnified by the company. The Delaware statute, like most state indemnification statutes, expressly authorizes indemnification of a wide variety of losses, including among other things, not only defense costs in a criminal proceeding but also fines incurred by the director or officer, provided the fine is assessed with respect to conduct which is indemnifiable.

4. Conflict with the Company

Based on the foregoing, directors and officers who are targets of or defendants in a criminal proceeding will in most instances be entitled to advancement of defense costs and potentially to indemnification if the conduct giving rise to the criminal investigation or proceeding is found to satisfy the statutory standard of conduct. However, that standard of conduct will likely be difficult to satisfy in many criminal matters where the director or officer is convicted or pleads guilty. Therefore, indemnification is far from certain in this context. In addition, the new strategy by the DOJ, as evidenced in the Yates Memorandum, to require

companies to disclose to the DOJ full details of potential director and officer criminal wrongdoing as part of the company's cooperation with the DOJ could further reduce the likelihood of indemnification in criminal matters. Companies may now be reluctant to grant indemnification for targeted directors and officers out of concern that the DOJ may view that indemnification as evidence of both the company's lack of cooperation and the company's failure to support the DOJ's efforts to deter future illegal activity.

5. Indemnification Planning

Because mandatory indemnification of directors and officers generally exists only pursuant to a bylaw indemnification provision, it is important that the bylaw provision affords the broadest indemnification protection for directors and officers which is desired by the company. Most such provisions mandate indemnification and defense costs advancement "to the fullest extent permitted by law." A number of other protective provisions could be (but frequently are not) included in order to maximize the protections afforded to directors and officers. Some of those additional provisions are summarized below.

Discourage Wrongful Refusal. Even under a mandatory indemnification provision, there is some subjectivity to the indemnification process since the incumbent board of directors must determine that the defendant director or officer qualifies for indemnification. If the defendant and the incumbent directors are antagonistic, the indemnification protection may be wrongly withheld. The bylaw indemnification provision can contain several features which disincentivize the company from wrongfully refusing to indemnify a director or officer. For example, the provision can state that a director or officer who is denied indemnification and who is successful in whole or in part in a lawsuit against the company to enforce his or her indemnification rights, is entitled to reimbursement from the company of costs incurred in enforcing his or her indemnification rights. In addition, the provision can state that in any such suit to enforce one's indemnification rights, the company bears the burden of proof to establish that the claimant is not entitled to indemnification. Also, the provision can state that any determination by the board of directors with respect to the claimant's right to indemnification is not a defense for the company in such a suit, and does not create a presumption against the claimant. All of these provisions minimize the chance the company will wrongly withhold indemnification, and maximize the chance the director or officer will prevail in any suit to enforce his or her indemnification rights.

Contractual Rights. The provision can expressly create a contractual right in favor of the directors and officers to the broad indemnification protection described in the provision. Because of such a provision, the company should not be permitted to unilaterally and retroactively amend or eliminate those indemnification rights. This provision affords protection equivalent to that available under a separate indemnification contract between the company and its directors and officers.

Subsidiaries. By statute, a company is authorized to indemnify its directors, officers, employees and agents, as well as any person serving at the request of the company as a director or officer of another organization. As a result, a parent company is probably not permitted or required to indemnify the directors and officers of its direct and indirect subsidiaries unless those subsidiary directors and officers are serving in that capacity at the request of the parent company. The parent company's bylaw indemnification provision can state that a director or officer of a direct or indirect subsidiary of the company or any employee benefit plan of the company or such subsidiary, is deemed to be serving in that capacity at the request of the company. This

provision requires a parent company to indemnify all of the directors and officers of all of its subsidiaries as well as fiduciaries of their employee benefit plans. Although ultra-protective for the directors and officers of the subsidiaries, this provision obviously creates new liability exposures for the parent company that should be considered before adopting such a provision. An alternative approach would be to afford this indemnification protection only to directors and officers of the parent company who serve a subsidiary in any capacity.

GOODWIN PROCTER

WHEN THE GOVERNMENT COMES KNOCKING: MAXIMIZING INSURANCE COVERAGE FOR GOVERNMENT INVESTIGATIONS

by Carl E. Metzger and Brian H. Mukherjee

In 2015, the specter of a government investigation, whether it be by the U.S. Department of Justice, the U.S. Securities and Exchange Commission, or some other federal or state regulator, still looms large for many companies. Recent pronouncements by the DOJ – perhaps stung by criticism for a perceived lack of prosecutions relating to the financial crisis – make clear that the government intends to more aggressively root out alleged corporate misconduct through civil and criminal enforcement proceedings. Indeed, the DOJ's recent "Yates Memo" states that this increased governmental scrutiny will now include a greater focus on targeting a company's directors, officers and any other personnel alleged to have been involved in wrongdoing.

As many readers will know, a government investigation can begin with something as seemingly innocuous as an email from a governmental agency to a company's general counsel asking for information, or as attention-grabbing as a search warrant (or even arrests) executed at corporate headquarters. Regardless of how an investigation begins, it rapidly becomes a serious matter that any company must quickly mobilize in response to. Many questions will arise, concerning both the substance of the matter being investigated and how to deal with the government's demands. Inevitably, though, a senior officer or director of the company will ask a question that may cause even the most seasoned in-house counsel to worry: *does our company's directors and officers (D&O) insurance cover this*?

The answer to that question, of course, will depend on the specific coverage terms of your company's D&O insurance program, as well as the facts and circumstances of the investigation.[1] In this article, we take a close look at some of the key issues associated with D&O insurance coverage for government investigations and discuss how to maximize that coverage if an investigation arises.

Start By Having A Strong D&O Insurance Program Already In Place

The inescapable (and sometimes unfortunate) fact is that once an investigation or other type of claim arises, the insurance coverage is already "baked," and the matter will be handled pursuant to the coverage terms then in existence. Accordingly, you should confirm that your company's insurance program is ready and top-notch *before* an investigation or claim hits. The process is straightforward – start by making sure that your company has been working with an experienced insurance brokerage that has identified the right types of coverages and limits of insurance for your company. Your broker also should have carefully negotiated the terms and conditions of the coverage to ensure your company is getting the best terms the market currently has to offer. Such a review should be done in conjunction with outside counsel to confirm those terms offer the broadest possible coverage. Your D&O insurance program should be scrutinized on an annual basis to confirm it

[1] Depending on the nature of the investigation, other insurance policies also could be triggered, such as professional liability, crime, employment practices or cyber-liability coverages.

incorporates all coverage improvements that may have become available in the preceding year, as well as to confirm that the insurance limits remain appropriate for the company's size and risk profile.

Know What Constitutes A "Claim" Under The Company's D&O Coverage, Particularly As To Government Investigations

A threshold question to ask at the outset of a government investigation is whether any communication received from the government constitutes a "claim" as that term is defined under the D&O insurance policy. To answer that question, first refer to the policy's definition of claim (taking care also to review any policy endorsements that may modify the definition.) Many policies, especially for public companies, will distinguish between claims asserted against "insured persons" (typically directors and officers, and in some cases, employees) and claims against the company itself. The former category of claims may include an investigation of an insured person commenced by the service of subpoena on the person. Alternatively, it may involve the person being identified in writing (for example, through a Wells or target letter) as a subject of an investigation that may lead to a future proceeding. An arrest or extradition attempt may also constitute a claim against an insured person under many policies. Also bear in mind that, in addition to the presence of a claim, policies will often require an allegation of a "wrongful act" against an insured in order to trigger coverage.[2]

More D&O insurance policies these days also contain an additional type of coverage, known as "pre-claim" or "inquiry" coverage, designed to provide enhanced protection to individuals facing a government inquiry. The intent of this coverage, among other things, is to provide coverage for individuals facing requests by a governmental body to appear at a meeting or an interview or to produce documents concerning the company's business. Unlike a traditional claim, pre-claim coverage may not require that a wrongful act be alleged against an insured in order to trigger coverage.

For coverage for the company itself, most D&O policies will define a claim more narrowly. Coverage for the company is primarily limited to certain types of "proceedings" against the company. For public companies, the proceeding generally must arise in connection with trading in the company's securities. Under some D&O policies, there may also need to be a claim simultaneously maintained against an insured person in order for the company to have coverage. Given such variation in coverage among various types of D&O insurance policies, there is no "one size fits all" rule defining the scope of corporate entity coverage. It thus is important to know ahead of time what entity coverage your company has and that it is appropriate in scope for your organization.

Beyond traditional D&O insurance coverage, a limited number of insurers have introduced separate, dedicated policies for coverage for government investigations against public companies. These policies provide coverage to a company for costs incurred when responding to specific types of regulatory investigations, as well as certain amounts paid in connection with regulatory settlements. Such coverage can be a godsend for a company faced with defense costs that easily can rise to millions of dollars before the government has even levied a single charge against the company or its personnel. Companies therefore should evaluate whether the cost to purchase this type of specialized coverage makes sense in light of their particular risk profile.

Make Sure That The Company Understands And Fulfills Its Notice Obligations

Most policies require prompt notice of a claim as a prerequisite to coverage. The importance of this point can not be overstated. Failure to fulfill that obligation may be fatal to your coverage, even if the insurer has not been materially prejudiced. Further, failure to provide notice or providing late notice can potentially bar

[2] Of course, even without the presence of an identifiable "wrongful act" allegation, notice to an insurer of a particular matter may still be advisable under the policy terms.

coverage for later-filed proceedings or other claims relating to the subject matter of the original claim. Even where the impact of late notice is not so drastic, the insurer's obligation to pay defense costs for a covered claim typically does not start until the date it receives the claim notice, so prompt notice can also mean the difference between significant legal fees being covered by insurance, or disallowed because they were incurred prior to the notice date. When providing an insurance claim notice, you also must not forget about providing notice under any "excess" policies that may sit above the "primary" policy.

In some situations, it may not be clear at the outset of a government investigation whether a "claim" actually has been made against an insured, perhaps because the government's communications do not identify a particular target of the investigation or do not allege that an insured violated the law or committed some other wrongful act. In those situations, it often is wise to err on the side of providing notice of the matter. You may even consider providing a so-called "notice of circumstances" to the insurer. That notice, in essence, acts as a placeholder for a future claim by identifying facts and circumstances that the insured believes could give rise to a claim in the future. In the event that a claim ultimately does arise relating to the subject matter of the notice of circumstances, the claim will be treated as having been made at the time the original notice was provided to the insurer. This type of notice has several benefits. First, it removes uncertainty concerning whether the insured was required to provide notice to the insurer and thereby preserves coverage rights that may be applicable in the future. Second, the notice "locks in" coverage for any related future claim to the policy period in which the notice was provided. Limits in the next policy period can remain available for later claims unrelated to the subject matter of the notice. There are potential drawbacks, however, to utilizing a notice of circumstances which should also be carefully considered and discussed with counsel. The bottom line is that the D&O insurance notice considerations can be complex, and your company's obligations need to be well understood in advance of any claim and then well-executed upon after a matter has surfaced.

Take The Time To Work Through And Respond To Any Issues Raised By The Insurer's "Reservation Of Rights" Letter

If you have provided notice of a claim to your company's D&O insurers, you will likely receive a "reservation of rights" letter from the insurer detailing the insurer's view on coverage for the investigation. To preserve its rights (*i.e.*, the right to limit or deny coverage), the insurer is required to identify every ground on which it believes the policy potentially may not cover the claim. Accordingly, a reservation of rights letter, even for a claim that likely will be covered in full, may at times seem voluminous and difficult to decipher. It is important to carefully read and understand the letter and, if necessary, respond in detail to the issues raised. Does the letter, for example, correctly identify the facts and legal allegations at play in the claim? Does it correctly identify and apply the relevant policy terms and coverages? Despite its reserved rights, does the insurer still agree to advance defense costs? While you would think that such issues would be correct as a matter of course, we often find that there are a number of areas in the typical reservation of rights letter which merit a written response in order to set the record straight and fully preserve the insured's coverage rights.

Finally, the reservation of rights letter may also contain certain requests for information concerning the claim. As discussed in the next section, the insured is required under the policy to cooperate with the insurer as the insurer manages the claim. It is therefore crucial that any questions or requests for information from the insurer (whether communicated in a coverage letter or by other means) be promptly responded to.

Cooperate With The Insurer, And Follow Through On The Company's Claims Handling Obligations

Most policies require that the insured secure the insurer's advance consent to the engagement of defense counsel. Likewise, the insurer's consent typically is required before any defense costs or other loss covered under the policy can be incurred, and insurer consent also is needed before any settlement offers can be made.

Failing to secure the insurer's consent in advance on these kinds of issues could potentially lead to the insurer denying or limiting coverage. At best, it means a potentially difficult and time-consuming *post hoc* discussion with the insurer concerning why its advance approval was not sought, and why it should nevertheless agree to cover the costs incurred.

It is also important to keep the insurer apprised of all material developments in a claim. In our experience, an insurer is more willing to participate (including financial participation) in mediations and other types of settlement dialog when it has been provided with both appropriate updates and any information it has requested during the pendency of a claim. Conversely, an insurer may react negatively to a request to participate in a mediation or settlement discussions when it feels that it has not been kept fully informed concerning the progress of the claim and that updates to the insurer have not been timely.

A Final Note: Be Prepared, Be Proactive

While our recommendations may seem straightforward, it can be surprisingly difficult for companies to follow through on them when caught up in the midst of responding to a government investigation. Adding to the complexity, civil litigation (such as a securities class action suit) can often follow on the heels of an investigation which only adds to the insurance-related workload. Indeed, understanding and managing the various action items relating to the D&O insurance coverage can seem at times like a Herculean task to company personnel already stretched thin by addressing the government's demands. Nevertheless, at the end of that government investigation, a key factor in assessing how well the company fared will be what the investigation cost. Maximizing the D&O insurance recovery may play a critical role in allowing a company to get back on its feet and recover effectively. This requires having a strong D&O insurance coverage program in place from the outset, knowing what the Company's obligations are in the event of a claim, and having the right team in place to proactively manage the ongoing responsibilities associated with a complex D&O insurance claim.

The information in this article should not be construed as legal advice.

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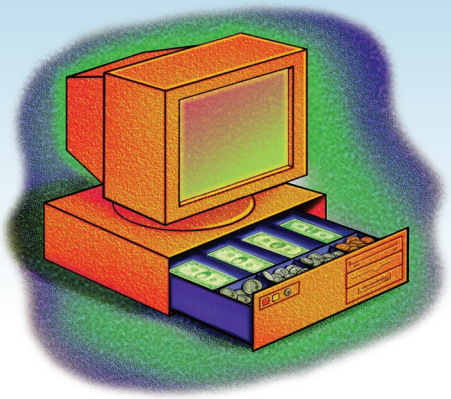

Buyer Beware

Lon A. Berk

Counting on cyber-insurance to cover fraud loss could be a big mistake if the policy excludes man-in-the-middle attacks or other common scenarios.

You are in charge of finances for a small business and are on vacation at the beach. Suddenly, you remember you have forgotten to pay a company bill. All is not lost, you think. You run to your room, grab a laptop, and bring it down to the Tiki Bar.

There, you order a drink and connect to the hotel's wireless system. Then you call up your company's bank's Web page, click the "log-in" button, enter your password, and order a check issued to the creditor.

You sign off; finish your drink and breathe a sigh of relief, appreciating the wonders of modern technology.

A week later, you are back in the office and all is chaos. Somehow, while you were gone, a series of transfers totaling nearly $2 million occurred from the company's account to banks in China, Indonesia, and Russia. Needless to say, the transfers have seriously hampered cash flow, and there is talk of filing for bankruptcy.

Worst of all, everyone is in your office asking you what happened. You do not know. But, you say, the company is safe because it purchased a cyber-insurance policy with $10-million limits.

Just as you say this, the phone rings. It is the insurance company saying that, after discussing matters with the bank and some lawyers, they are denying coverage. You hang up. The phone rings again. It is the bank claiming their logs show that you were the only one to use the online system recently.

A Costly Shower

So what happened? You were the victim of a man-in-the-middle attack. While you were sitting in that Tiki Bar, a gentleman sat at the table across from you, using a laptop. You probably took him to be another person scrambling to meet a work deadline while on vacation.

He was no such thing. Instead, on his laptop was a suite of network-security software that can be easily collected for download on the Internet. That software allowed him to collect and decode your exchange of information with the bank.

Network traffic travels over the Internet in sequential batches of code, called "packets." For a laptop to send these packets over the Internet, it needs to find an access point. Wireless routers generally send beacons alerting wireless hosts, such as your laptop, of their existence. The host then chooses one of the available routers, with which it forms a wireless connection.

Some of the software on that gentleman's computer allowed him to fool *your* laptop into thinking that *his* laptop was the router. He effectively copied the beacons from the router and transmitted them from his laptop to yours.

Consequently, unbeknownst to you, your laptop connected to his laptop. He then copied all the packets your laptop sent before sending them on to the hotel's router. From there, they were sent over the Internet to your bank. He thus had all the information he needed to sign on to your company's bank account, including cookies, bank-account numbers, user names, and passwords.

If there had been a lot of people using laptops in that hotel bar, traffic to the router might have been significantly slowed, since it would have had to first go through his laptop and then on to the router. His laptop might have created a bottleneck, possibly alerting you something was amiss. But, as it was just he and you in the bar, you probably attributed any slowdown to the nature of island living.

Similarly, you might have received a notice from your browser that there was an issue with the certificate of the site to which you were connecting. You likely clicked "ignore," figuring this too was a necessary consequence of signing on to the Internet from the tropics.

Had you looked, perhaps you might have noticed that the "lock" symbol in

your browser was not present, as it usually is when you sign on to the bank's Web site. No surprise. Most people do not even notice that.

With your account number, user name, and password, the man in the bar probably signed on to a legitimate VPN service and then logged on to the bank's Web site, using your credentials. He might even have done this while you were still logged on. In any event, by the time you were showering for dinner, he had siphoned $2 million from your company's bank account.

Subtle Differences

Now, what about that insurance policy? Why was there no coverage?

The risk of being victimized by this sort of attack is, naturally, one of the reasons your company acquired cyber-insurance. It is this sort of risk that many insureds rightly think they are protected against when they purchase such insurance. Unfortunately, even though many cyber policies are marketed as if they provide such protection, some of the policies sold do not.

A recent decision by a New York court illustrates this point. In *Universal American v. National Union Fire Insurance Company,* Index No. 6501613/2010 (Jan. 7, 2013), Universal American bought insurance to

cover cyber risk. The policy provided coverage for:

Loss resulting directly from a fraudulent
(1) entry of Electronic Data or Computer Program into, or
(2) change of Electronic Data or Computer Program within the Insured's proprietary Computer System ... provided that the entry or change causes
(a) Property to be transferred, paid or delivered,
(b) an account of the Insured, or of its customer, to be added, deleted, debited or credited, or
(c) an unauthorized account or a fictitious account to be debited or credited.

In 2008, Universal lost more than $18 million as a result of entries with access based upon legitimate user authorizations. Upon discovery of its loss, Universal submitted a claim to National Union. The claim was denied. National Union argued that the intent of the policy was "to provide coverage against computer hackers, i.e., situations in which an unauthorized user accessed the system and caused money to be paid out."

A trial court agreed with National Union, and the appellate division recently affirmed that decision as well.

The same reasoning explains why there was no coverage for the man-in-the-middle attack in that hotel bar. There was no "situation in which an unauthorized user accessed the [insured's] system ..." Arguably, your computer was not accessed; nor was the hotel's. In fact, in a sense, your computer accessed the *hacker's* machine. And the bank's system was used, just as in the *Universal American* decision, with legitimate user credentials, albeit by an illegitimate user.

There is little doubt that the right cyber insurance is a sound investment and an important way to transfer the financial burden of cyber risk. But in many cases, the insurance may not protect against all cyber risks. Perhaps more than with any other insurance product, it is important to know what is being bought.

There is little doubt that the right cyber insurance is a sound investment and an important way to transfer the financial burden of cyber risk.

(Photo: Hunton & Williams)

Lon Berk

But in many cases, the insurance may not protect against all cyber risks. It is important to know what is being bought.

This may require consultation with legal and information technology professionals who can review the company's network practices and evaluate whether the coverage offered responds appropriately to the risks faced. Companies with many users accessing networks from the road should, for example, be sure to buy insurance that would cover man-in-the-middle attacks.

With no standard form for cyber insurance, coverages may differ in subtle ways. Many policies, for instance, only cover loss of banking credentials where the credentials are lost as a result of unauthorized access to the insured's computer system.

Companies need to ensure that the form they buy defines "unauthorized access of computer systems" so that it is broad enough to include man-in-the-middle attacks. If there is any doubt about the extent of coverage, seek clarification from the insurer and/or the insurance professional.

There are benefits in addition to financial coverage that some insurers offer policyholders buying cyber insurance. From such insurers, policyholders may obtain information on cyber risks and loss control, as well as educational programs. These programs may assist companies in developing cyber-security practices, including, for example, educating employees on the tools needed when they engage in company business over the Internet.

One leading security professional, for instance, recommends that banking business only be conducted on a computer dedicated to that task, which is booted from a live CD.

In the end, to protect themselves against cyber risks, companies need to be as careful with the cyber insurance they buy as they are with the networks they access. DT

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Coverage Risks in the Age of the 'Internet of Things'

by Lon Berk and Paul Moura


The "Internet of things" is here. According to Cisco, sometime during 2008, the number of things connected to the Internet exceeded the number of people. Cows, corn, cars, fish, medical devices, appliances, power meters — practically any item imaginable has been or can be connected. Eventually, we will be able to "sync" an entire home so that its heating system is programmed to adjust to weather patterns and inhabitants' activities, its dishwasher automatically orders soap refills, its refrigerator is always stocked with milk (or beer), and maybe even its lights blink on and off when important emails are received.

These are just a few examples of what can be done with "the Internet of Things" ("IOT") — ordinary objects and devices able to process and transmit information based upon their environments that they then communicate to servers running algorithms designed to anticipate and address user needs. Businesses ranging from small startups to long-standing conglomerates are now embedding adaptive "smart" technologies into even mundane products, including window shades, light bulbs and door locks.

While IOT devices create obvious value, they also expand risk. In effect, we are creating an "infrastructure for surveillance," that constantly generates critical, sometimes exceptionally private, data transmitted for use on servers perhaps thousands of miles away. Although the benefits of this infrastructure are evident, the risks can be hidden within a technological "black box." The degree to which our well-being depends upon the integrity and security of networks, software and data will increase exponentially.

If an IOT device malfunctions, or if data or software is compromised or lost, individuals and businesses may suffer devastating losses. Dosages of critical medication might be missed, for instance, or needed medical treatments omitted. In fact, the risks posed by IOT have already attracted the attention of regulatory authorities. This past June, the U.S. Food and Drug Administration surveyed the industry and decided to update its guidance on cybersecurity for IOT medical devices and the Federal Trade Commission held a symposium addressing IOT issues on Nov. 19.

As use of these products continues to expand, such risks will be realized and manufacturers will look to their insurers for defense and indemnity protection. Coverage for products liability is typically provided under liability policies, which can be written on an occurrence or claims-made basis. Liability of the manufacturer of a malfunctioning fire alarm that fails to alert homeowners of a fire should be covered under such policies, as should bodily injuries or property damage caused by other defective products, including products that are part of the IOT. Injuries from such products may result not only from a device's failure to work but also from a network's failure to provide communications as needed. These failures, as well as the more traditional product failures, should continue to be covered if insurance is to continue to serve its function and transfer financial risk.

Coverage Risks in the Age of the 'Internet of Things'
by Lon Berk and Paul Moura | Law360, January 3, 2014

Liability policies generally define the products risk to include

All bodily injury and property damage occurring away from premises you own or rent and arising out of your product or your work except:

1. products that are still in your physical possession; or
2. work that has not yet been completed or abandoned.

The policies define "your products" to be any property (other than real property) manufactured, sold, handled, distributed or disposed of by the insured and to include warranties or representations made at any time with respect to the fitness, quality durability, performance or use of your product; and the providing of or failure to provide warnings or instructions.

Liabilities for malfunctions of IOT products appear to fit squarely within this definition. There are, however, some complications that insurers might put forward were they interested in denying coverage, and policyholders will need to examine their insurance proactively to avoid the uncertainty and cost of coverage litigation.

Coverage for IOT risk is complicated by the fact that the devices add value and efficiency by communicating with each other and distant servers on which data is stored and algorithms run. Indeed, this interoperability is the critical and promoted feature of IOT products. To see how this can complicate the coverage question, let us take a concrete example.

Let us imagine a refrigerator — the eFridge — that communicates data concerning the products it holds. When combined with complementary devices — called eShelves — it is able to keep track of all food in the kitchen. The refrigerator also keeps track of its states, including its internal temperature, and transmits its state data and food stocked to a server maintained by smartKitchens Inc., at a distant location. On this server the data is stored and analyzed by an algorithm designed by smartKitchens' software engineers. The algorithm, based upon eFridge state data and data on stocked food, generates recommended recipes for the week so that all food is used before it is spoilt. The recommendations sent from the server to the eFridge appear on a screen on the refrigerator's front door.

There are two Internet transport protocols, TCP and UDP. The latter is often used when broadcasting within a network is needed (as it is so that the eShelves can be configured) and can be cheaper to implement, but it is also less reliable because communicating devices receive no notice when UDP datagrams — the electronic containers of transmitted data — are lost or dropped. The eFridge is designed to use UDP, and the software engineers have developed their algorithm to deal with the problem of dropped datagrams as follows. Rather than generating a warning that there is incomplete information, the algorithm assumes that the refrigerator's state is consistent with the average state maintained over the prior two weeks. This is done to avoid multiple appearances of "error" messages on the eFridge door/screen and to increase customer satisfaction.

Now imagine that one week the server fails to receive datagrams regarding the state of the refrigerator on Monday, during which for some unknown reason the temperature inside the refrigerator exceeded room temperature. Unfortunately, as of Monday, the refrigerator contained a pound of mussels, which as a result of the temperature change are spoilt. Data concerning this

temperature increase were not received by the server, and therefore the algorithm, having been designed to assume that the temperature was maintained at its average, recommends a recipe for Wednesday of Mussels Provençale. As a result, the consumer sustains a very serious case of food poisoning and naturally seeks compensation from smartKitchens, which demands coverage from its insurer. Is smartKitchens covered?

The event appears to be squarely within the sort of products liability coverage that product manufacturers and distributors expect. There is a product away from the insured's premises that made a "defective" recommendation and caused bodily injury. As such, there should be coverage.

But an aggressive insurer could construct an argument to the contrary. They might contend that in fact the injury was caused by the algorithm, not the refrigerator, and that had the algorithm been designed to indicate through an error signal that data had not been received, there would have been no recommendation of Mussels Provençale on Wednesday. Insurers might contend that the algorithm constitutes "work that has not been completed or abandoned," pointing to the fact that the engineers have the ability to change the algorithm to address the possibility of spoilt mussels and that therefore the risk is not within the product's coverage.

Such an argument should ultimately fail. The fact that smartKitchens' software engineers can update the algorithm does not mean that they have not "completed or abandoned" it for purposes of the insurance policy. Moreover, liability policies generally provide that "work which requires further … correction … because of defect or deficiency, but which is otherwise complete, shall be deemed completed." In fact, here, smartKitchens let the algorithm run as it was designed to and it did so. Nonetheless, although the insured should eventually obtain the benefit of coverage, that could very well be only after protracted and expensive litigation, reducing the value of the insurance purchased.

There is another argument as well the insurer might make. Since about 2003, liability policies have generally included an exclusion — exclusion p, on the Insurance Services Office Inc. form — barring coverage for damages arising out of the loss of, loss of use of, damage to, corruption of, inability to access, or inability to manipulate electronic data.

As used in this exclusion, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or from computer software, including systems and applications software, hard or floppy disks, CD-ROM[s], tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.

An insurer might contend that the problem was created, not by the eFridge, but by the loss of electronic data, when the packets were dropped. They might use this argument to contend that coverage is barred. Again, however, the insured should prevail were the insurer to make such an argument. The algorithm functioned as it was designed. It did not fail to process data, but processed data exactly as intended. It was merely responding as designed to an unfortunate consequence of the decision to implement the UDP protocol. But here too, the insured is likely to find itself in an expensive coverage dispute, depriving the insured of the value of the insurance purchased.

As always, new technologies create new risks, and new risks create the possibility of coverage disputes. These disputes should be resolved in the insured's favor, as it is the responsibility of an insurer to draft policy language to clearly and unequivocally exclude risks. This rule has especial force where, as in our example, there is an expectation that liability for products would be covered. It should, in other words, be the responsibility of underwriters to understand the products they insure and clearly state if they do not desire to cover an attendant risk. Nonetheless, as the use of IOT devices continues and expands, the past has taught that we can expect to see risks expand and insurers attempt to restrict coverage.

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Law360

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Cyberinsurance: It's Not Just for Protecting Data

by Lon Berk

A year ago, President Obama issued Executive Order 13636, or "Improving Critical Infrastructure Cybersecurity." The order concerned "critical infrastructure," which it defined as "systems and assets, whether physical or virtual, so vital to the United States that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety or any combination of those matters."[1]

The executive order also directed that a set of incentives be established for voluntary compliance with cybersecurity guidelines, including "insurance liability considerations."[2] The idea, presumably, was that insurers would provide coverage for cybersecurity risks, lower premiums for companies that satisfied cybersecurity standards and would also be a repository for information about the latest cyber risks. If it worked, companies would have additional protection from cyber risk, both financial and technological. For it to work, though, there needs to be a market for cyberinsurance coverage protecting critical infrastructure against cyber risks.

Over the year since the executive order, there has, indeed, been a great deal of activity in the cyberinsurance market. Brokers and underwriters are aggressively marketing cyberinsurance products. There are reports of increased interest among policyholders in acquiring cyberinsurance, no doubt fueled by the recent publicity of large-scale cyberattacks on retailer point-of-sales systems, as well as the increased attention on cybersecurity generated by the executive order.

Unfortunately, the sort of cyberinsurance being sold does not protect against the main risks faced by critical infrastructure. Moreover, there appears to have been, simultaneously, an attempt by insurers to restrict coverage of that risk under more traditional products. The result has been that since the executive order there has been a contraction of insurance-protecting infrastructure against cyber risk, rather than an expansion, and it is less likely that insurance can serve as an incentive to protect critical infrastructure risk.

Cyber risk is not limited to data loss and, as "The Internet of Things" expands, it is possible that the risk of data loss will be eclipsed by other events. On the other hand, cyber policies being marketed are primarily designed to address data loss and, in particular, exposure of personally identifiable information. But, notwithstanding the magnitude of recent retail breaches, that is not the only — and perhaps not even the main — cyber risk to infrastructure.

Much infrastructure, if not all, is controlled by supervisory control and data acquisition ("SCADA") systems, an often private, geographically-expansive network that controls and obtains data regarding system operations. Interference with SCADA has the potential of causing large-scale bodily injury and property-damage losses.

SCADA has not been immune from cyber risk. For instance, malware has been found in an electric utility's turbine control[3] system that impacted computers on the control system network. SCADA exploits have been released by Metasploit, the well-known penetration testing software suite. The Federal Bureau of Investigation's Cyber Division reported that SCADA systems in three cities had been compromised.[4] There is, however, a gap in cyber coverage for much SCADA loss.

What is SCADA?

SCADA is a combination of telemetry, data acquisition and control systems used to automate industrial systems. In its most simplified version, it consists of a central operating unit through which user interface generally occurs, called the main terminal unit ("MTU"). The MTU is networked to a series of scattered computers called regional terminal units ("RTUs"), which monitor input from operations and control operations through data outputs.

Taking a very simple example, consider a traffic light system in a town. Here we might have at each light an RTU that monitors traffic and, when, say, the difference between traffic in the north-south direction and traffic in the east-west direction exceeds a certain value the RTU changes the timing of traffic lights so that the traffic going north or south receives shorter red lights than those going east or west. The MTU, back in police headquarters, shows data regarding the various traffic patterns and can be used to upload new software to RTU's as well as to override existing programs on special occasions, for instance, to address anticipated motorcades.

More complicated versions of such systems are used in manufacturing and utility facilities, to control oil and gas pipelines and elsewhere. They are the computer work horses of industry.

What is the Cyber Risk?

Although a cyberattack on such a traffic system could obtain data, for instance, it might download data regarding traffic flows, data loss is not the primary risk. What would be of most concern is the risk of traffic jams, or of bodily injury and property damage caused by malfunctioning traffic signals. It is sometimes thought that SCADA systems are air gapped (i.e., not interconnected with other networks) and, therefore, not as seriously impacted by cyber risks as other networks.

This impression, however, is not accurate. In fact, SCADA components are often connected to the Internet and, as such, can be subjected to malicious code. In fact, there is a search engine that permits one to find SCADA components that are connected to the Internet. Researchers using this tool have found that there are numerous SCADA components on the Internet.

Moreover, even if a SCADA component is not directly connected to the Internet, many SCADA systems share components with other systems that are open to the web. For example, a company may share a router with its email server and its MTU and, while the MTU may be unable to receive and send emails through that router, a compromise of the router through the email server can be a compromise of SCADA. Additionally malicious code can be and has been uploaded directly onto SCADA components through USB devices and computers used to program and/or update SCADA software. Indeed, many SCADA systems communicate wirelessly and can be subjected to man-in-the-middle attacks, like any device communicating over a wireless network.

In short, SCADA systems are subject to the range of cyber risks, malware, denial of service attacks and others — as are all systems directly connected to the Internet. In fact, in a way, the risk to SCADA may be even greater. The assumption that it is air gapped may lead to a certain complacency not present with components designed to interact directly over interconnected networks.

The risk of loss from a SCADA system is not limited to data. Rather, the risk includes a risk of bodily injury as well as property damage. The Stuxnet malware is the most well-known example of such a compromise. It infected files on SCADA-controlled software and eventually resulted in the destruction of 1,000 fuel centrifuges inside Iran's uranium fuel enrichment program.

It is not hard to conjure up vast property and personal-injury losses resulting from a cyberattack on SCADA. Electric grids might be shut down through denial-of-service attacks and fuel might be diverted from delivery to refineries. Yet, as discussed below, these losses, to the extent they do not involve data loss, may be beyond the scope of many cyberinsurance policies.

Insurance

Many, if not all, cyberinsurance policies include exclusions for bodily injury and property damage. Others define coverage so narrowly that sound arguments can be made that bodily injury or property damage caused by cyberattacks on SCADA are outside the scope of coverage.

For example, some policies limit their coverage to expenses and costs, including legal fees, related to determining the identity of persons who must be notified of the breach and of providing notice. That, as noted, is not a concern of compromised SCADA systems. They may contain no personally identifiable information requiring notification. Companies seeking a policy to cover a SCADA system may be hard-pressed to find one in those commonly found in the market.

At the same time insurers are issuing cyber policies, they are also attempting to limit the coverage provided for cyber risks under traditional property and liability policies. For example, The Insurance Services Office Inc. has proposed that certain exclusions be incorporated into those policies.

These exclusions, although apparently intended to bar coverage for claims relating to loss of personally identifiable information, such as those recently suffered by retailers, could be read more broadly by insurer advocates seeking to limit coverage. In a high-stakes dispute involving coverage for property damage or bodily injury caused by the breach of a SCADA system, a carrier might contend these exclusions apply. One exclusion, for instance, bars coverage for injuries resulting from, "The loss of, loss of use of, damage to, corruption of, inability to access or inability to manipulate electronic data."

A carrier might stretch this language to bar coverage for a denial of service attack on a RTU, or the injury caused to system hardware by a Stuxnet-like code as well as damage resulting from the loss of data. It might contend that the Stuxnet code corrupted electronic data or that the denial of service attack constituted an inability to manipulate data, and that it was this that led to the bodily injury or property damage for which coverage was sought.

The Conundrum

As noted at the outset, Executive Order 13636 was issued to protect critical infrastructure against cyberattack. One method the Obama administration hoped to use to incentivize companies to increase cybersecurity was insurance.

It was thought that insurance might create an incentive to adjust cyber practices so that lower premiums might be obtained. It is true that insurers are intensely marketing cyberinsurance policies. Unfortunately, the products being marketed are not generally of the sort needed to protect critical infrastructure and appear to leave unprotected critical risks of loss that would be faced in the event of a cyberattack on SCADA.

Cybersecurity is not merely the protection of data, although that is a function. Especially where SCADA systems are at issue, cybersecurity involves the protection of lives and property as well. Companies buying cyberinsurance need to be sure they have protection against the full risk of a cyberattack and not limit their protection to lost or publicized data.

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[1] http://www.whitehouse.gov/the-press-office/2013/02/12/executive-order-improving-critical-infrastructure-cybersecurity, Section, 2.

[2] DHS Analysis Report Cyber Security Incentives

[3] See ICS-CERT Monitor October/November December 2012 at 1.

[4] http://nakedsecurity.sophos.com/2011/12/13/fbi-acknowledges-more-scada-attacks-increases-cyber-budget/

Understanding Cyber Liability Insurance Coverage

By Rick Bortnick; Stu Panensky and Rich Traub – Traub Lieberman Straus & Shrewsberry LLP

The last two years of headline news about cyber-breaches and computer system malfunctions have led a rapidly-growing number of companies to purchase insurance coverage to protect themselves from technology and cyber privacy risks. As our technology-driven economy continues to evolve and businesses become more reliant on electronic communication and data storage, they are developing a heightened awareness that an unauthorized intrusion could endanger their tangible and intangible assets (including their intellectual property) and, in many cases, their reputations and abilities to conduct business. As such, prospective policyholders are becoming more cognizant of the necessity for insurance covering cyber exposures.

Still, there is significant uncertainty about the nature and scope of insurance products which might cover a company's technology and cyber privacy risks, whether the entity is in the technology space or in a vertical that uses technology to run its business operations. While businesses and their insurance brokers typically are knowledgeable about insurance policies covering traditional general and professional liability exposures, today's online-society introduces new dynamics, many of which are not covered under traditional general and professional liability policy forms.

The growing number of technology and cyber products offered throughout the global insurance markets highlights the importance of the insurance brokerage community and the value of a sophisticated broker who can perform a thorough analysis of a policyholder's insurance needs, and who can work with underwriters to obtain and tailor insurance policies to meet those needs.

Many policyholders are surprised to learn that a standard CGL policy likely would not apply to a technology or cyber privacy claim, notwithstanding that the form typically includes coverage for "property damage" and "personal and advertising injury." More surprisingly, some insurance brokers are not aware of a CGL policy's limitations or their clients' needs for a comprehensive multi-line insurance program. But, such is the nature of our changing society and a client's evolving insurance needs.

Cyber Risks as "Property Damage"

A typical CGL policy defines "property damage" as "physical injury to tangible property, including all resulting loss of use of that property." While it is well- and widely- known that this definition would apply to traditional property damage losses (such as those arising from fires, impaired property and the like) many policyholders and brokers, without due consideration, mistakenly take it for granted that this definition also includes technology and cyber privacy losses involving intangible property such as electronic data. But, that is clearly not the case or the policy's intent. To emphasize this point, and to add a belt to the suspenders, some CGL policy forms specifically exclude electronic data from their definition of "property damage." In such policies, "electronic data" is generally defined as the "information, facts or programs stored as or on, created or used on, or transmitted to or from computer software." Despite this self-evident precept, some policyholders have elected to test this principle, arguing that "property damage" includes damage to computer software, information and data. And in most cases, they have lost.

In the most well-reasoned cases, the results were not surprising. For example, in *America Online, Inc. v. St. Paul Mercury Insurance Co*., 347 F.3d 89, 96 (4th Cir. 2003), the Fourth Circuit properly recognized that data, web pages and computer systems do not constitute tangible property because they are not

capable of being touched, held or sensed by the human mind. As such, they were not "property damage," as that term is used in a CGL policy. The Eighth Circuit concurred with this self-evident proposition, holding in *Eyeblaster, Inc. v. Federal Insurance Co*., 613 F.3d 797, 802 (8th Cir. 2010), that a "complaint would have had to make a claim for physical injury to the hardware in order for [the policyholder] to have coverage for 'physical injury to tangible property'" under a general liability policy's "property damage" coverage.

Despite the inherent logic of these appellate decisions, one trial court, in dicta, endorsed a distorted view of "property damage," expanding its definition beyond the plain and ordinary language. In *Am. Guar. & Liab. Ins. Co. v. Ingram Micro, Inc*., No. 99-185, 2000 WL 726789 (D. Ariz. Apr. 18, 2000), the court considered whether a first-party property policy covered losses incurred after a power outage rendered the computer systems inoperable. The court purported to focus on the physical attributes of "bytes," as well as the particles and atoms that comprise a hard drive, in order to justify its result-oriented conclusion that the corruption of data constitutes "physical damage," as required by the policy.

The Ingram Micro court rationalized its construct by hypothesizing that "[a]t a time when computer technology dominates our professional as well as our personal lives . . . 'physical damage' is not restricted to the physical destruction or harm of computer circuitry but includes loss of access, loss of use, and loss of functionality." Though the policy insured against "direct physical loss or damage," the court incorrectly conflated the phrases "physical damage" and "property damage" and held that the loss of programming information and network configurations "does allege property damage." The Ingram Micro decision is frequently cited by policyholder counsel seeking to argue away the realities of a CGL policy's limitation, despite the fact that the issues are presented in the context of a property damage policy. Not surprisingly, however, and for good reason, such counsel inevitably do not choose to litigate this issue.

Cyber Risks under Endorsements

Notwithstanding the "property damage" jurisprudence and plain old logic, certain CGL policy forms may expand the scope of their traditional coverages to include certain data losses. Because traditional CGL policies typically do not provide property coverage for technology and cyber privacy risks, insurance companies are marketing specific policies and endorsements with specialized forms of coverage. For example, there is an ISO form endorsement for use with CGL policies that provides coverage for loss and loss of use of electronic data resulting from physical injury to tangible property. Insurers also offer technology stretch, computers and media, and technology services coverage endorsements in combination with CGL policies.

Cyber Risks as "Personal and Advertising Injury"

Of course, this is not to say that a standard CGL policy may never apply to a cyber privacy claim. Indeed, many general liability policies include "personal and advertising injury" coverage which, in some cases, may subsume to certain portions of a cyber privacy event. The term "personal injury and advertising injury" typically is defined to include a list of enumerated offenses such as injury arising out of the infringement of another's copyright and the oral or written publication of material that slanders a person or organization, or violates a person's right to privacy.

In *Netscape Communications Corp. v. Federal Insurance Co*., 343 Fed. Appx. 271, 272 (9th Cir. 2009), the Ninth Circuit held that a CGL insurer providing "personal and advertising injury" coverage had a duty to defend where AOL was alleged to have intercepted and disseminated private online communications. The Netscape court found such claims implicated a person's right to privacy and thereby potentially triggered the policy's "personal and advertising injury" coverage section.

In addition, in *Zurich American Insurance Company v. Fieldstone Mortgage Co*, No. CCB-06-2055, 2007 U.S. Dist. LEXIS 81570 (D. Md. Oct. 26, 2007), the court found that Zurich had a duty to defend against claims brought by individuals who received prescreened offers based on information contained in their consumer credit reports, allegedly in violation of the Fair Credit Reporting Act. The court held that even though the solicitations were not divulged to a third party and did not contain protected information, the solicitations constituted "publication" of material violating a person's right to privacy, in the context of an "advertising injury" policy provision.

Overlapping Coverage

Of course, the question of whether a CGL insurer has a duty to defend, or even a duty to indemnify, a technology and/or cyber privacy claim is not the only one which a policyholder — or a CGL insurer — may face. In many cases where a policyholder has obtained multiple policies covering multiple types of exposures and risks — as a proactive policyholder with a sophisticated insurance broker should — a CGL policy's coverage could overlap and converge with those provided by other insurance products. These include pure cyber and technology forms, third-party professional liability and directors and officers liability policies, and first-party and business interruption certificates.

This situation will then present issues such as what damages are covered under what form (i.e., in the third-party context, damage to hardware may be covered under a CGL form policy while corresponding corruption of software may be covered under a technology policy), allocation of defense costs, the implications of "other insurance" clauses, and the scope of an insurer's duty to defend and/or pay defense costs under a pure indemnity policy.

Conclusion

Product-related and service-oriented businesses reliant on technology can — and should — take all reasonable steps to ensure that they have virtually seamless insurance coverage by working with sophisticated insurance brokers well-versed in the myriad policies and forms available to cover technology and cyber privacy risks. Just as our economy is quickly evolving, so too are the types of insurance products and coverage available to meet a policyholder's changing needs. Understanding the components of these new-age policies is critical, and prudent business executives should devote the necessary time and resources to identify a sophisticated insurance broker who can assess a company's vulnerabilities and ensure that the necessary insurance products are purchased.

- See more at: http://www.traublieberman.com/cyber-law/2015/0729/6718/#sthash.NbhyWyar.dpuf

The Restatement of the Law of Liability Insurance

Speaker:

Professor Kyle Logue (Restatement Reporter — University of Michigan Law School)

Restatement of the Law Liability Insurance

Council Draft No. 2

(December 28, 2015)

SUBJECTS COVERED

CHAPTER 2 Management of Potentially Insured Liability Claims (§§ 13, 18, 19) (revised)
CHAPTER 3 General Principles Regarding the Risks Insured
APPENDIX Black Letter of Council Draft No. 2

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Restatement of the Law
Liability Insurance
Council Draft No. 2

Comments and Suggestions Invited

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The typical ALI Section is divided into three parts: black letter, Comment, and Reporter's Notes. In some instances there may also be a separate Statutory Note. Although each of these components is subject to review by the project's Advisers and Members Consultative Group and by the Council and Annual Meeting of the Institute, only the black letter and Comment are regarded as the work of the Institute. The Reporter's and Statutory Notes remain the work of the Reporter.

The Council approved the initiation of this project as a Principles project in May 2010, and two Tentative Drafts covering Chapters 1 and 2 were approved by the membership in 2013 and 2014.

The Council approved this project as a Restatement in 2014. This Restatement Draft contains revisions to §§ 13, 18, and 19 of Chapter 2 and revisions to Chapter 3. Earlier versions of §§ 13 and 18 can be found in Council Draft No. 1 (2015). Earlier versions of § 19 and Chapter 3 can be found in Preliminary Draft No. 2 (2015).

Restatements (excerpt of the Revised Style Manual approved by the ALI Council in January 2015)

Restatements are primarily addressed to courts. They aim at clear formulations of common law and its statutory elements or variations and reflect the law as it presently stands or might appropriately be stated by a court.

a. Nature of a Restatement. Webster's Third New International Dictionary defines the verb "restate" as "to state again *or* in a new form" [emphasis added]. This definition neatly captures the central tension between the two impulses at the heart of the Restatement process from the beginning, the impulse to recapitulate the law as it presently exists and the impulse to reformulate it, thereby rendering it clearer and more coherent while subtly transforming it in the process.

The law of the Restatements is generally common law, the law developed and articulated by judges in the course of deciding specific cases. For the most part Restatements thus assume a body of shared doctrine enabling courts to render their judgments in a consistent and reasonably predictable manner. In the view of the Institute's founders, however, the underlying principles of the common law had become obscured by the ever-growing mass of decisions in the many different jurisdictions, state and federal, within the United States. The 1923 report suggested that, in contrast, the Restatements were to be at once "analytical, critical and constructive." In seeing each subject clearly and as a whole, they would discern the underlying principles that gave it coherence and thus restore the unity of the common law as properly apprehended.

Unlike the episodic occasions for judicial formulations presented by particular cases, however, Restatements scan an entire legal field and render it intelligible by a precise use of legal terms to which a body reasonably representative of the legal profession, The American Law Institute, has ultimately agreed. Restatements—"analytical, critical and constructive"—accordingly resemble codifications more than mere compilations of the pronouncements of judges. The Institute's founders envisioned a Restatement's black-letter statement of legal rules as being "made with the care and precision of a well-drawn statute." They cautioned, however, that "a statutory form might be understood to imply a lack of flexibility in the application of the principle, a result which is not intended." Although Restatements are expected to aspire toward the precision of statutory language, they are also intended to reflect the flexibility and capacity for development and growth of the common law. They are therefore phrased not in the mandatory terms of a statute but in the descriptive terms of a judge announcing the law to be applied in a given case.

A Restatement thus assumes the perspective of a common-law court, attentive to and respectful of precedent, but not bound by precedent that is inappropriate or inconsistent with the law as a whole. Faced with such precedent, an Institute Reporter is not compelled to adhere to what Herbert Wechsler called "a preponderating balance of authority" but is instead expected to propose the better rule and provide the rationale for choosing it. A significant contribution of the Restatements has also been anticipation of the direction in which the law is tending and expression of that development in a manner consistent with previously established principles.

The Restatement process contains four principal elements. The first is to ascertain the nature of the majority rule. If most courts faced with an issue have resolved it in a particular way, that is obviously important to the inquiry. The second step is to ascertain trends in the law. If 30 jurisdictions have gone one way, but the 20 jurisdictions to look at the issue most recently went

the other way, or refined their prior adherence to the majority rule, that is obviously important as well. Perhaps the majority rule is now widely regarded as outmoded or undesirable. If Restatements were not to pay attention to trends, the ALI would be a roadblock to change, rather than a "law reform" organization. A third step is to determine what specific rule fits best with the broader body of law and therefore leads to more coherence in the law. And the fourth step is to ascertain the relative desirability of competing rules. Here social-science evidence and empirical analysis can be helpful.

A Restatement consists of an appropriate mix of these four elements, with the relative weighing of these considerations being art and not science. The Institute, however, needs to be clear about what it is doing. For example, if a Restatement declines to follow the majority rule, it should say so explicitly and explain why.

An excellent common-law judge is engaged in exactly the same sort of inquiry. In the words of Professor Wechsler, which are quoted on the wall of the conference room in the ALI headquarters in Philadelphia:

> We should feel obliged in our deliberations to give weight to all of the considerations that the courts, under a proper view of the judicial function, deem it right to weigh in theirs.

But in the quest to determine the best rule, what a Restatement can do that a busy common-law judge, however distinguished, cannot is engage the best minds in the profession over an extended period of time, with access to extensive research, testing rules against disparate fact patterns in many jurisdictions.

Like a Restatement, the common law is not static. But for both a Restatement and the common law the change is accretional. Wild swings are inconsistent with the work of both a common-law judge and a Restatement. And while views of which competing rules lead to more desirable outcomes should play a role in both inquiries, the choices generally are constrained by the need to find support in sources of law.

An unelected body like The American Law Institute has limited competence and no special authority to make major innovations in matters of public policy. Its authority derives rather from its competence in drafting precise and internally consistent articulations of law. The goals envisioned for the Restatement process by the Institute's founders remain pertinent today:

It will operate to produce agreement on the fundamental principles of the common law, give precision to use of legal terms, and make the law more uniform throughout the country. Such a restatement will also effect changes in the law, *which it is proper for an organization of lawyers to promote* and which make the law better adapted to the needs of life. [emphasis added]

RESTATEMENT OF THE LAW, LIABILITY INSURANCE

COUNCIL DRAFT NO. 2

REPORTERS' MEMORANDUM

Tom Baker and Kyle Logue
December 20, 2015

This Council Draft No. 2 contains (1) a complete draft of Restatement Chapter 3, which addresses general principles regarding the risks insured by liability insurance policies, and (2) revisions to §§ 13, 18, and 19 from Chapter 2, which address certain aspects of the duty to defend.

Like Chapters 1 and 2, Chapter 3 addresses topics that are common to most forms of liability insurance, consistent with the organizing principle that the Restatement address the most significant, general topics in liability insurance. There are three Topics covered in Chapter 3: (1) rules regarding coverage provisions, (2) rules regarding conditions, and (3) rules regarding the application of limits, retentions, and deductibles. Our hope is that the Restatement's treatment of these Topics regarding the risks insured, along with the framework Topics addressed in Chapters 1, 2, and 4, will provide guidance to courts that will also be useful in addressing more specialized issues that arise in the context of the many specific lines of liability insurance.

The coverage Topic contains (1) rules regarding insuring clauses and exclusions that, to a substantial extent, consist of applications of the general principles regarding interpretation from Chapter 1; (2) rules regarding the timing of events that trigger coverage; and (3) rules regarding insurance of liabilities involving aggravated fault. Because the aggravated-fault Section addresses the insurability of these liabilities and, hence, the enforceability of insurance-policy terms that provide that coverage, it is possible that this Section may be moved to Chapter 4, which will contain a Topic addressing the enforceability of liability insurance policy terms more generally.

The conditions Topic begins with a special, insurance-law definition of "condition" that is narrower than the usual contract-law definition. Generalizing from established insurance case law, the first Section in this Topic articulates a general, condition-precedent rule that represents an important insurance-law application of the

disproportionate-forfeiture principle stated in the Restatement Second of Contracts. The conditions Topic then addresses two kinds of exceptions to this condition-precedent rule: conditions that are enforced without regard to prejudice and conditions that are not enforceable.

The final Topic contains rules regarding the application of policy limits, retentions, and deductibles: the number of accidents or occurrences, exhaustion and drop down, indemnification from multiple policies (allocation), and contribution. These rules affect the amount of coverage that is available for large claims, including under liability insurance policies sold in the past and, thus, beyond anyone's ability to alter. Accordingly, these rules will be controversial no matter what position the ALI takes.

Council Draft No. 2 also contains revisions of §§ 13, 18, and 19 from Chapter 2, which the Council discussed at the October meeting. At that meeting, the Council approved all of Chapter 2, except § 13(3) and § 19. We have revised § 13(3) so that it now articulates a more general, but still narrow, exception to the "complaint allegation" rule governing the duty to defend, and we have revised the Comments to § 13 to further clarify the application of the core, duty-to-defend rules. The revisions to § 18, which addresses the termination of the duty to defend, align that Section with the change to § 13(3). In § 19 we have not made any substantive changes to the black letter, but we have thoroughly revised the Comments, especially regarding the loss of coverage defenses when an insurer denies a defense without a reasonable basis.

RESTATEMENT OF THE LAW, LIABILITY INSURANCE
COUNCIL DRAFT NO. 2

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CHAPTER 2

MANAGEMENT OF POTENTIALLY INSURED LIABILITY CLAIMS

TOPIC 1

DEFENSE

§ 13. Conditions Under Which the Insurer Must Defend

(1) An insurer that has issued an insurance policy that includes a duty to defend must defend any legal action brought against an insured that is based in whole or in part on any alleged facts that, if proven, would be covered by the policy, without regard to the merits of those allegations or any associated legal theory.

(2) For the purpose of determining whether an insurer must defend, the legal action is deemed to be based on:

(a) Any allegation contained in the complaint or comparable document stating the legal action; and

(b) Any additional allegation that a reasonable insurer would regard as an actual or potential basis for all or part of the legal action.

(3) An insurer is not required to defend a legal action brought against an insured if undisputed facts that are not at issue in the legal action for which defense is sought establish as a matter of law that the legal action is not covered. Unless such undisputed facts establish as a matter of law that the legal action is not covered, the insurer must defend until its duty to defend is terminated under § 18.

Comment:

a. The duty to defend and the complaint-allegation rule. When evaluating whether to defend a legal action that is brought against an insured, the insurer must take as true all of the facts alleged in the complaint or comparable document that favor coverage. An allegation in a complaint that, if true, would subject the insured to a covered liability conclusively establishes that the insurer has a duty to defend, subject to the exception permitted by subsection (3). When an insurer has the duty to defend, it must do so until that duty terminates in one of the ways enumerated in § 18. As a consequence of this widely accepted "complaint allegation" rule, the insurer typically must defend the legal action all the way through final adjudication of the action, unless the action is settled, the insurer prevails in a declaratory-judgment action establishing that

the action is not covered by the liability insurance policy, or one of the other subsections of § 18 applies.

b. Duty to defend is independent of the merits of the legal action. The insurer's duty to defend does not depend on the probability of the claimant's success in the legal action. The weaker a potentially covered claim is on the merits, the more valuable the defense coverage is in relation to the indemnity coverage. This is a central rationale underlying the long-established liability insurance principle that the duty to defend is broader than the duty to indemnify a claim. In almost every case in which an insured is named as a defendant in a lawsuit, the insured will need a lawyer to provide a defense—to investigate the plaintiff's factual assertions, to determine the credibility of the evidence, and to evaluate the legal theory on which the legal claim is based. Only in a subset of cases will payment of a judgment be required. In the absence of a defense from the insurer, the insured could be forced by a non-meritorious lawsuit either to pay an out-of-pocket settlement or to incur large legal bills to defend against the suit.

c. Information beyond the complaint: the potential-basis rule. If the complaint or comparable document does not contain an allegation that triggers the duty to defend a legal action, the insurer has a duty to defend the action if the insurer knows or reasonably should know of information that, under flexible modern pleading rules, could reasonably be expected to be added as an allegation and that, if so added, would require the insurer to defend. Except as provided in subsection (3), this rule works in one direction only: facts or circumstances not alleged in the complaint or comparable document may not be used to justify a refusal or failure to defend. Such information may be used, however, in a declaratory-judgment action seeking to terminate the insurer's duty to defend the action. See § 18, Comment *j*. The complaint-allegation rule is followed in most jurisdictions, and the "potential basis" rule is followed in the majority of jurisdictions that have addressed the issue. These rules are two important ways in which the duty to defend is broader than the duty to indemnify.

Illustrations:

1. Insured is sued for assault arising out of an altercation following an auto accident. The insurer denies coverage on the grounds that the complaint alleges that the insured intentionally assaulted the plaintiff and, thus, the suit is excluded under a provision stating that the insurance policy does not apply to "bodily injury . . . caused intentionally by or at the direction of the insured." The insured acknowledges striking the

plaintiff, but alleges that he acted in self-defense. According to the insured, he reasonably feared for his personal safety, because the plaintiff approached the insured's car in a menacing manner and jerked open the door. On these facts, the plaintiff has the potential to recover from the insured on a negligent self-defense theory that would be covered. Thus, the insurer has the duty to defend.

2. Insured is sued for bodily injury sustained during a fight in a bar. The complaint contains two counts. In the first count, the plaintiff alleges that the insured intentionally assaulted the plaintiff. In the second count, the plaintiff alleges that the insured negligently struck the plaintiff on the head. The insurer investigates the claim and determines, based on reliable witnesses, that the insured attacked the plaintiff with a wooden club. The insurer refuses to defend based on a provision stating that the insurance policy does not apply to "bodily injury . . . caused intentionally by or at the direction of the insured." The insurer has breached the duty to defend because count two in the complaint sets forth a covered legal theory.

d. Coverage questions that turn on facts not at issue in the legal action against the insured. The general rule is that an insurer may not refuse to defend an insured based on facts outside of the complaint or comparable document that serves as the basis for the legal action for which a defense is sought. Many courts have identified narrow, specific exceptions to this rule. Three exceptions of this sort are: (1) when undisputed facts demonstrate that the defendant in the action is not an insured under the insurance policy pursuant to which the duty to defend is asserted, (2) when undisputed facts demonstrate that the automobile involved in the accident at issue was not a covered automobile under the policy pursuant to which the duty to defend is asserted, and (3) when undisputed facts demonstrate that a claim was reported late under a claims-made-and-reported policy in circumstances in which the notice-prejudice rule does not apply. See § 37. Subsection (3) adopts an emerging general approach to these exceptions: an insurer may refuse to defend a legal action when undisputed facts, not at issue in that action, demonstrate that the action is not covered by the policy at issue. An undisputed fact is a fact about which there is no genuine dispute, such that summary judgment would be available if the fact were at issue in a civil proceeding. When there is a genuine dispute regarding a coverage-relevant fact, as distinguished from a disputed legal issue, the insurer must defend; it may contest

coverage only by reserving its rights under § 15; and it may terminate the duty to defend only through a declaratory-judgment action or other manner specified in § 18.

e. The distinction between factual and legal uncertainty. There are two different types of coverage uncertainty that an insurer may face in deciding whether to provide a defense: factual uncertainty and legal uncertainty. Factual uncertainty pertains to what happened in the world, in relation to the incident or series of incidents that gave rise to the underlying legal action or other events that affect insurance coverage for that action. Legal uncertainty has to do with what the insurance law of the relevant jurisdiction is and how it will be applied to the facts. In determining whether to undertake the defense of an insured, an insurer must resolve any factual uncertainty in favor of the duty to defend. For example, any factual assertion in the complaint or comparable document favoring coverage is to be treated as if true, except to the extent that there are inconsistencies between or among assertions, in which case the assertions favoring coverage are to be treated as if true. If there is evidence outside of the complaint that favors coverage, that evidence should be treated as true for purposes of resolving factual uncertainty with respect to whether coverage exists. Similarly, subsection (3) requires that all factual uncertainty regarding matters not at issue in the underlying claim must also be resolved in favor of the duty to defend.

In determining whether to undertake the defense of an insured, an insurer is not required to resolve legal uncertainty in favor of the duty to defend, though it will often be prudent for the insurer to do so. For example, the courts of the relevant jurisdiction may not have yet determined the meaning of an insurance-policy term or there may be uncertainty regarding the application of the policy term to the facts as alleged in the complaint. An insurer facing such legal uncertainty has two options. First, the insurer may deny the claim. If the insurer's legal position is correct, the insurer will not have breached the duty to defend and it will have avoided incurring the costs of defense. If the insurer's legal position turns out to be incorrect, it will have breached the duty to defend, with the consequences stated in § 19. Second, the insurer may defend the claim while reserving the right to contest coverage under § 15, in which case it retains control over the claim. If the insurer defends the claim under a reservation of rights, the adjudication of the insurer's obligation to indemnify the insured for a judgment will be based on all of the facts and circumstances, and the insurer's obligation to indemnify the insured for a settlement will be determined according to the rules stated in § 25.

Illustrations:

3. Nursing Home is sued by a nurse alleging negligence and intentional injury arising out of an altercation between the plaintiff nurse and a physician who worked at the home. The complaint alleges that, upon learning that the nurse had decided to transfer a patient to the hospital, the doctor began screaming at the nurse, leading the nurse to back forcefully into the edge of a table, causing bodily injury. Nursing Home's general liability insurer refuses to defend the suit on the grounds that the claim is excluded by the "professional services" and "intentional injury" exclusions in the policy. Nursing Home files a breach-of-contract action against the insurer. In that action, the insurer's duty to defend is determined in a manner that gives the insured the benefit of the doubt with regard to all disputed facts, both the facts alleged in the complaint and any additional factual information outside of the complaint that is favorable to the Nursing Home's demand for coverage. This means that, as long as there is any evidence indicating that the doctor did not intend to cause the bodily injury to the nurse, the insurer breached the duty to defend.

4. Same facts as Illustration 3, except the insurer defends under a reservation of rights and files a declaratory-judgment action seeking to terminate the duty to defend. In that declaratory-judgment action, the insurer's duty to defend is determined upon all the facts and circumstances including factual information not contained in the complaint showing that the doctor intentionally injured the plaintiff nurse.

5. Driver is sued by pedestrian alleging injuries from an automobile accident. Driver does not provide notice of the claim to Liability Insurer until shortly before trial in the suit. Insurer refuses to defend based on late notice. Driver files a breach of contract action against the insurer. In that action, because there is a dispute about whether the late notice prejudiced the insurer, the insurer is unable to demonstrate on the basis of undisputed facts that there is not coverage for the claim. Accordingly, the insurer has breached the duty to defend.

6. Law firm is sued by client for malpractice. The law firm does not provide notice of the suit to the insurer on the risk until six months after the end of the applicable claims-made-and-reported insurance policy. The policy contains a condition in the insuring agreement that requires the law firm to report the claim to the insurer in no event

later than 120 days after the conclusion of the policy period. The insurer refuses to defend based on breach of the claim-reporting condition. Provided that the law of the jurisdiction follows the rule that the insurer need not prove that the late report prejudiced the insurer, the insurer did not breach the duty to defend. The timing of the report is an undisputed fact that is not at issue in the malpractice claim for which coverage is sought.

7. Homeowner is sued by Guest alleging injuries from slip and fall. Homeowner provides notice to Liability Insurer. Insurer investigates and determines that Homeowner had falsely answered "no" to a question regarding prior convictions on the application for the policy. Insurer refuses to defend based on this misrepresentation. Homeowner files a breach-of-contract action against Insurer. In that action, Homeowner demonstrates that there are disputed facts as to whether a reasonable homeowners' insurer would have used inexpensive and easily available public sources to verify whether an applicant's statement regarding prior convictions was correct (see Comment *d* to § 9) and, thus, the § 13(3) exception does not apply. Accordingly, the insurer has breached the duty to defend.

f. The all-the-facts-and-circumstances approach distinguished. Some commentators have advocated an all-the-facts-and-circumstances approach that goes well beyond the exception recognized in subsection (3). Under this approach, when deciding whether to provide a defense of a claim, the insurer may take into account any and all circumstances that bear on whether the claim is covered. In other words, under this approach, there would be no requirement that the factual basis for the insurer's decision to deny a defense be undisputed. Moreover, the insurer could refuse to defend on the basis of facts that were at issue in the legal action for which the insured sought a defense. Thus, for example, even if a complaint were filed that alleged facts that, if proven, would give rise to a covered claim, the insurer could decline to defend the case under the facts-and-circumstances approach, without resort to a declaratory-judgment action, if the insurer decided that facts outside of the complaint demonstrated that the claim was not covered. Under this approach, a breach of the duty to defend would be found only if it were subsequently determined that the insurer was wrong about the true facts and circumstances.

The problem with this broad application of the facts-and-circumstances approach is the uncertainty it would create for insureds, who would in a wider range of situations be put in a position of having to finance their own defense and then to bring a separate breach-of-contract

action against their insurers to recoup those costs. The possibility of such an after-the-fact remedy would be of little comfort to insureds, who would find such litigation expensive and daunting. By contrast, under the approach adopted in this Section, there is substantially less uncertainty borne by insureds regarding when they can expect to receive a defense from their insurer. So long as the complaint contains allegations that if proven true would be covered, or the insured can offer evidence outside of the complaint that supports coverage, the insured can be confident of receiving a defense, except in the limited circumstances permitted by subsection (3).

g. The "suit" requirement. Many standard-form liability insurance policies contain a provision that limits the insurer's duty to defend to matters that qualify as a "suit." This Section states rules regarding when an insurer must defend a legal action, using the term "legal action" in a generic sense that refers to a demand for redress of the kind that fits within the usual framework of insured liabilities but that is subject to more specific requirements or definitions in the liability insurance policy in question, such as the "suit" requirement. This Section does not address the separate question of when in the course of the procedural events attending the assertion and litigation of the legal action the insurer must begin the defense. This means, for example, that this Section does not affect the common requirement in policies that there must be a "suit" before the insurer is obligated to defend. If the liability insurance policy does contain such a suit requirement, this Section may be used to determine which suits the insurer is required to defend. In that case the insurer must defend any "suit" that is based in whole or in part on any alleged facts that, if proven, would be covered by the policy, without regard to the merits of those allegations or any associated legal theory.

REPORTERS' NOTE

a. The duty to defend and the complaint-allegation rule. The majority of jurisdictions follow "[the] 'eight corners rule' (that is, a comparison of the 'four corners' of the complaint with the 'four corners' of the policy)." Stevens v. United Gen. Title Ins. Co., 801 A.2d 61, 66 n.4 (D.C. 2002). As one commentator has explained,

> Courts are in accord that a determination of whether a suit against an insured is "seeking" covered damages, thereby triggering the duty to defend, is based on a review of the potentially applicable insurance policy and the allegations in the underlying complaint . . . . The duty to defend arises if any of the allegations in the complaint, if proven true, create the potential that the insured can be held liable for damages covered by the policy.

3 Jeffrey E. Thomas, New Appleman on Insurance Law Library Edition § 17.01[2][a] (Lexis 2011). See also Seven Signatures General Partnership v. Irongate Azrep BW LLC, No. 11-00500 JMS/RLR, 2012 WL 1656972 at *5 (D. Hawai'i May 9, 2012), quoting Pancakes of Haw. v. Pomare Props. Corp., 944 P.2d 83, 89-91 (Haw. Ct. App. 1997) ("Under the complaint allegation rule, the duty to defend is construed broadly and is triggered when 'any of the allegations in the complaint potentially include conduct that is covered by the indemnity contract'.").

The rule that "the insurer must defend any suit whose allegations would fall within coverage if the allegations were proved to be true" has become "hornbook law." Kenneth S. Abraham, Insurance Law and Regulation 631 (5th ed. 2010) (noting that the rule "is often called the 'scope of the pleadings,' or 'four corners of the complaint' rule," as well as "the 'eight corners' rule, referring to the comparison between the four corners of the complaint and what is contained in the four corners of the policy"). See also Ellen S. Pryor, The Tort Liability Regime and the Duty to Defend, 58 Md. L. Rev. 1, 23 (1999) ("The almost universally-used approach is the eight-corners rule: one takes the allegations in the plaintiff's complaint, assumes the truth of those allegations without resorting to evidence extrinsic to the complaint, and then asks whether these allegations, if true, would establish a liability covered under the policy."); C. T. Drechsler, Allegations in third person's action against insured as determining liability insurer's duty to defend, 50 A.L.R.2d 458 § 4 (Originally Published 1956) ("It appears to be well settled that, generally speaking, the obligation of a liability insurance company under a policy provision requiring it to defend an action brought against the insured by a third party is to be determined by the allegations of the complaint in such action."). For a useful 50-state survey of court decisions regarding the use of extrinsic evidence see Randy Maniloff and Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State at 111 et seq. (2015).

For cases finding the insurer had a duty to defend based on the allegations in the complaint, see, e.g., Capitol Indem. Corp. v. Elston Self Service Wholesale Groceries, Inc., 559 F.3d 616, 619 (7th Cir. 2009) ("In order to determine whether an insurer has a duty to defend its insured, we must compare the allegations in the underlying complaint to the language in the insurance policy."); Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co., 876 A.2d 1139, 1144 (Conn. 2005) ("[T]he insurer's duty to defend is measured by the allegations of the complaint . . . Hence, if the complaint sets forth a cause of action within the coverage of the policy, the insurer must defend."), quoting Board of Education v. St. Paul Fire & Marine Ins. Co., 801 A.2d 752, 755 (Conn. 2002). Cf. Susan Randall, Redefining the Insurer's Duty to Defend, 3 Conn. Ins. L.J. 221 (1997) (arguing for rejection of the complaint-allegation rule because the rule leads to conflicts of interest).

Once triggered by the allegations in the underlying complaint, "an insurer's duty to defend . . . lasts until the conclusion of the underlying lawsuit, or until it has been shown that there is no potential for coverage. When multiple alternative causes of action are stated, the duty continues until every covered claim is eliminated." 14 Lee R. Russ with Thomas F. Segalla,

Couch on Insurance § 200:47 (3d ed. 2011). Thus, an insurer who initially "failed to establish . . . that it had no duty to defend" the insured because one of the allegations fell within the scope of the policy could later terminate its defense when the insured was absolved of liability for that claim. City of Niagara Falls v. Merchants Ins. Group, 824 N.Y.S.2d 841, 842-843 (App. Div. 2006).

b. Duty to defend is independent of the merits of the legal action. In contracts that provide a duty to defend, the insurer "is contractually obligated to defend even meritless suits that fall within coverage." Miller v. Westport Ins. Corp., 200 P.3d 419, 423 (Kan. 2009), quoting Jerry & Richmond, Understanding Insurance Law, § 111[a] at 826-827 (4th ed. 2007). See also Abouzaid v. Mansard Gardens Associates, LLC, 23 A.3d 338, 347 (N.J. 2011) ("Notably, the potential merit of the claim is immaterial: the duty to defend 'is not abrogated by the fact that the cause of action stated cannot be maintained against the insured either in law or in fact—in other words, because the cause is groundless, false or fraudulent'."), quoting Danek v. Hommer, 100 A.2d 198 (N.J. App. Div. 1953).

Not all policies provide for a duty to defend: "the insured may prefer to pick up the tab for his defense rather than pay a higher premium for the policy." Scottsdale Ins. Co. v. Subscription Plus, Inc., 299 F.3d 618, 622 (7th Cir. 2002). But when an insured buys a policy that includes defense coverage, "the insured's desire for immediate defense is likely to have been a strong motive in purchasing the policy." Travelers Indem. Co. of Illinois v. Insurance Co. of North America, 886 F. Supp. 1520, 1525, 1526 (S.D. Cal. 1995) (rejecting the insurer's claim that it could recoup defense costs by showing that the allegations against the insured were ultimately unsubstantiated). Therefore,

> any other rule would have the paradoxical effect that the less meritorious the suit, the less protection a liability insurance policy would give the defendant . . . . The insured who has bought a liability policy that entitles him to defense as well as indemnification wants to be defended against claims of liability regardless of their merit. He doesn't want to be stuck with the lawyer's bill just because he wins and therefore doesn't need to look to the insurer for indemnification. If he wanted that he would just buy indemnification and not defense.

Scottsdale Ins. Co., 299 F.3d at 622-623. Although the insurer will be liable for the costs of defense, "[p]resumably, the plaintiff's claims in meritless suits will be defeated, and the insurer will therefore not incur any obligation to provide indemnification." *Miller*, 200 P.3d at 423, quoting Richmond & Jerry, § 11[a] at 826-827.

c. Information beyond the complaint: the potential-basis rule. The law is "almost equally clear that the insurer must defend even when the complaint does not allege facts within coverage, if the insurer possesses extrinsic information that the claim probably does fall within coverage." Kenneth S. Abraham, Insurance Law and Regulation 631 (5th ed. 2010). See, e.g., Pennzoil Co. v. U.S. Fidelity and Guar. Co., 50 F.3d 580, 583 (8th Cir. 1995) ("[T]he rule that has evolved in most jurisdictions is that, if the insurer acquires actual knowledge of additional facts [beyond the

complaint] that establish a reasonable possibility of coverage, the duty to defend is triggered, even if the insurer made an appropriate initial decision not to defend"). See also 14 Lee R. Russ with Thomas F. Segalla, Couch on Insurance § 200:17 (3d ed. 2011) ("[A] liability insurer's duty to defend is not necessarily limited to what is set forth in the complaint. A modern trend is for insurers to conduct reasonable investigation of the claims prior to making a determination on the duty to defend a particular lawsuit. Consequently, some jurisdictions look to actual knowledge of facts or extrinsic facts, in addition to the allegations of the complaint, when determining an insurer's duty.").

Thus, "[d]etermination of the duty to defend depends, in the first instance, on a comparison between the allegations of the complaint and the terms of the policy. But the duty also exists where extrinsic facts known to the insurer suggest that the claim may be covered." Hyundai Motor America v. National Union Fire Ins. Co., 600 F.3d 1092, 1097-1098 (9th Cir. 2010), quoting Scottsdale Ins. Co. v. MV Transp., 115 P.3d 460, 466 (Cal. 2005). See also Fitzpatrick v. American Honda Motor Co., 575 N.E.2d 90, 93-94 (N.Y. 1991):

> The conclusion we reach here flows naturally from the fact that the duty to defend derives, in the first instance, not from the complaint drafted by a third party, but rather from the insurer's own contract with the insured *(see, e.g.,* 7C Appleman, *op. cit.,* § 4682, at 27 [and authorities cited therein]). While the allegations in the complaint may provide the significant and usual touchstone for determining whether the insurer is contractually bound to provide a defense, the contract itself must always remain a primary point of reference *(see also,* Technicon Elecs. Corp. v. American Home Assur. Co., supra, at 73 [duty to defend arises from complaint *and* insurance contract]). Indeed, a contrary rule making the terms of the complaint controlling 'would allow the insurer to construct a formal fortress of the third party's pleadings . . . thereby successfully ignoring true but unpleaded facts within its knowledge that require it . . . to conduct the . . . insured's defense' (Associated Indem. Co. v. Insurance Co., 68 Ill. App. 3d 807, 816-817, 386 N.E.2d 529, 536).

Accord, National Indem. Co. v. Flesher, 469 P.2d 360, 367 (Alaska 1970); Loftin v. US Fire Insurance, 127 S.E.2d 53, 59 (Ga. Ct. App. 1962); Gray v. Zurich Insurance Co., 419 P.2d 168, 171 (Cal. 1966). For other cases adopting the rule that the insurer may have a duty to defend based on information it obtains, "even if the allegations of the complaint themselves would not give rise to such a duty," see 1 Allan D. Windt, Insurance Claims and Disputes § 4:3 & n.1 (5th ed. 2012) (collecting cases). A minority of jurisdictions continue to look only to the allegations in the complaint, and not facts extrinsic to the complaint, when determining an insurer's duty. See, e.g., Board of Educ. of City of Bridgeport v. Fire and Marine Ins. Co., 261 Conn. 37, 41 (2002) ("[T]he insurer's duty to defend is measured by the allegations of the complaint . . . Hence, if the complaint sets forth a cause of action within the coverage of the policy, the insurer must defend."); Am. Registry of Pathology v. Ohio Cas. Ins. Co., 461 F. Supp. 2d 61, 67 (D.D.C.

2006) ("[T]he eight-corners rule focuses solely on the documents at issue; facts outside the complaint and policy are irrelevant.")

Although extrinsic evidence known to the insurer may give rise to a duty to defend, most courts have specified that "[t]he insurer may not rely on facts extrinsic to the complaint to deny the duty to defend—it may do so only to trigger the duty." Woo v. Fireman's Fund Ins. Co., 164 P.3d 454, 459 (Wash. 2007). This rule reflects the principle that the duty to defend should be construed more broadly than the duty to indemnify; as explained by one court:

> [The insurer] has offered no persuasive authority in support of its proposed rule that an insurer may rely on extrinsic facts to deny its duty to defend when the Eight Corners Rule would otherwise require it to defend. Allowing an insurer to point to facts outside the pleadings to demonstrate that it would ultimately have no duty to *indemnify* as proof that it has no duty to *defend* would render the two duties indistinguishable and thus effectively depreciate the duty to defend.

Capital Environmental Services, Inc. v. North River Ins. Co., 536 F. Supp. 2d 633, 642 (E.D. Va. 2008). See also York Ins. Group of Maine v. Lambert, 740 A.2d 984, 985-986 (Me. 1999) (holding that the court could not consider extrinsic evidence to allow the insurer to avoid its duty to defend). See also Robert H. Jerry, II, and Douglas R. Richmond, Understanding Insurance Law at 834 (4th ed. 2007) ("Insurers are not allowed to refuse to defend when the complaint makes allegations within coverage simply because the insurer has knowledge of extrinsic evidence showing that the complaint's allegations are incorrect or untrue"). Illustration 1 is based on Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966). Illustration 2 is based on Thornton v. Paul, 384 N.E.2d 335 (Ill. 1978).

d. Coverage questions that turn on facts not at issue in the legal action against the insured. See Pompa v. American Family Mutual Insurance Co., 520 F.3d 1139 (10th Cir. 2008) (permitting insurer to refuse to defend based on "an indisputable fact that is not an element of either the cause of action or a defense in the underlying litigation"); Farm Family Mutual Ins. Co. v. Whelpley, 54 Mass. App. Ct. 743, 747, 767 N.E.2d 1101 (2002) ("this case falls within one of the rare exceptions to the rule that an insurer has a duty to defend as long as the complaint states or adumbrates a claim within the coverage [citation omitted] that exception being the existence of an undisputed extrinsic fact that takes the case outside the coverage and that will not be litigated at the trial of the underlying action."). See also Robert H. Jerry, II, & Douglas R. Richmond, Understanding Insurance Law at 829 (4th ed.) ("the insurer is not obligated to provide a defense if the insurer can establish through extrinsic evidence that the defendant is not the insurer's insured"); Rowell v. Hodges, 434 F.2d 926, 929-930 (5th Cir. 1970) (automobile insurer is not required to defend a claim when the undisputed evidence showed that the defendant was not driving a covered automobile). As explained by one court,

> [C]ontractual provisions generally impose an obligation to defend against any suit alleging the occurrence of risks against the insured even if the suit is groundless, false, or fraudulent . . . . However, these contractual provisions do not purport to

> obligate the insurer to defend a complete stranger to the contract. A Sine qua non to the existence of any obligation to defend, or pay, whether the suit be groundless or otherwise, is the pre-existing relationship of the insurer-insured.

Navajo Freight Lines, Inc. v. Liberty Mut. Ins. Co., 471 P.2d 309, 315 (Ariz. Ct. App. 1970).

e. The distinction between factual and legal uncertainty. "Any doubt as to whether the facts establish the existence of the defense duty must be resolved in the insured's favor." Montrose Chemical Corp. v. Superior Court, 861 P.2d 1153, 1160 (Cal. 1993). Therefore, so long as factual allegations in the complaint create the potential for coverage, "[f]acts merely tending to show that the claim is not covered, or may not be covered, but are insufficient to eliminate the possibility that resultant damages (or nature of the action) will fall within the scope of coverage," will not relieve the insurer of a duty to defend. Id. at 1161. See also Frontier Ins. Co. v. State, 662 N.E.2d 251, 253 (N.Y. 1995) (holding that an insurer may demonstrate no duty to defend "only if it can be concluded as a matter of law that there is no possible factual or legal basis on which the insurer will be obligated to indemnify the insured."). The influential California appellate judge Walter Croskey articulated the significance of the difference between factual and legal uncertainty in the context of the duty to defend as follows:

> First, if a *potential* for coverage exists (i.e., there is a *factual* dispute over coverage) then the insurer has a duty to defend and its failure to do so, *whatever its reason*, will result in bad faith liability. Or, to put it another way, the failure or refusal to provide a defense when a potential for coverage exists constitutes bad faith as a matter of law. And, if the facts in dispute are also at issue in the underlying action, then an insurer may not even utilize a declaratory relief action to effect an early termination of the defense burden. . . .
>
> Secondly, when a coverage dispute turns on a legal issue, then there is no issue as to a *potential* for coverage. That potential can only exist in the presence of a *factual* dispute as to the existence of coverage. A legal dispute necessarily involves undisputed facts and/or a question of policy construction and a "potential for coverage" would be oxymoronic. There either is coverage or there is not and, if it turns out there is coverage, the insurer's liability for bad faith can be evaluated under . . . the genuine dispute doctrine . . . .

Walter Croskey, Genuine Dispute Doctrine in Third Party Bad Faith Cases, 23 California Litigation 10 (2010).

For further support, see 3 Jeffrey E. Thomas, New Appleman on Insurance Law Library Edition § 17.01[2][a] (Lexis 2011) ("If any of the facts pleaded in the complaint establishes the potential for covered liability the insurer must defend. Any doubt as to whether a defense obligation exists must be resolved against the insurer and in favor of the insured . . . ."); 14 Lee R. Russ with Thomas F. Segalla, Couch on Insurance § 200:11 (3d ed. 2011) ("When coverage under the duty to defend depends on an outstanding factual dispute, the disputes must be resolved in favor of coverage until the insurer conclusively establishes that there is not potential

for coverage."); David L. Leitner et al., Law and Prac. of Ins. Coverage Litig., § 4:14 (July 2012) ("For an insurer to avoid the obligation to defend, it must be concluded *as a matter of law* that there is no possible factual or legal basis on which the insurer might eventually be held obligated to indemnify the insured under any provision of the insurance policy. . . . The insurer is not obligated to defend a suit only when there is no potential for coverage.") (emphasis added). Illustrations 3 and 4 are based on the facts in Records v. Aetna Life & Cas. Ins., 683 A.2d 834 (N.J. Super. Ct. App. Div. 1996).

f. The all-the-facts-and-circumstances approach distinguished. For an example of a commentator advocating a broader application of the facts-and-circumstances rule, see Ellen S. Pryor, The Tort Liability Regime and the Duty To Defend, 58 Md. L. Rev. 1, 52 (1999), concluding that, except when the facts that matter for coverage are at issue in the underlying claim:

> On balance, the actual facts approach seems preferable. It delivers the appropriate level of defense insurance in theory, and the usual breach of contract and extracontractual remedies would be available for mistakes or abuses in the application of the approach. Indeed, as just noted, it appears that many courts have been applying something akin to this approach by allowing the actual facts to govern, from the outset, with respect to questions such as the identity of the insured or the insured vehicle.

See also 1 Rowland H. Long, The Law of Liability Insurance, § 5.02[2][b][ii] (2006) ("When the extrinsic facts relied on by the insurer are relevant to the issue of coverage, but do not affect the third party's right of recovery, courts have held that the insurer may refuse to defend third-party actions even though the allegations in the complaint indicate coverage."). The counter-argument is that a defense is so important to the insured, and the insured is so vulnerable at the point of claim, that the potential additional administrative costs associated with requiring the insurer to pursue a declaratory-judgment action are worth incurring because of the greater certainty that this rule brings to the insured's right to a defense.

g. The "suit" requirement. See generally Mark Bradford, What Constitutes a Suit, in DRI, Insurer's Duty To Defend: A Compendium of State Law at 59 (2005), which provides a useful explanation of the different understandings of suit. States can generally be subdivided into those states that define a suit solely as an action against the insured in a court of law initiated by filing a complaint and those states that find suit to be an ambiguous term possibly incorporating other administrative proceedings and claims. Jurisdictions with a broader definition of suit may define it more along the lines of an attempt to gain a particular end through legal process or find that there are other types of proceedings which are the functional equivalent of a case or suit. For those jurisdictions, there are four main types of claims that may be covered: a potentially-responsible-party notification letter, a regulatory-compliance order, administrative-enforcement proceedings, and demand for arbitration. Bradford also identified a demand for mediation as a possible triggering occurrence, but located no cases where the insured made the argument that it

should trigger an insured's duty to defend. Compare, e.g., Foster-Gardner, Inc. v. National Union & Fire Ins. Co. of Pittsburgh, 959 P.2d 265, 77 Cal. Rptr. 2d 107 (1998) (declining to require insurer to defend based on a governmental demand letter), Lapham-Hickey Steel Corp. v. Protection Mutual Ins. Co., 655 N.E.2d 842 (1995) (same), with Compass Ins. Co. v. City of Littleton, 984 P.2d 606 (Colo. 1999) (holding that coercive actions begun by government demand letters are "suits"), Hazen Paper v. USF&G, 65 N.E.2d 576 (Mass. 1998) (same). See also Steven Plitt and Jordan Ross Plitt, 1 Practical Tools for Handling Insurance Cases § 2:8 (stating that the broader interpretation of suit is the significant majority view).

§ 18. Terminating the Duty to Defend a Claim

An insurer's duty to defend a legal action terminates only upon the occurrence of one or more of the following events:

(1) An explicit waiver by the insured of its right to a defense of the action;

(2) Final adjudication of the action;

(3) Final adjudication or dismissal of part of the action that eliminates any basis for coverage of any remaining components of the action;

(4) Settlement of the claim that fully and finally resolves the entire action;

(5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining components of the action;

(6) If so stated in the insurance policy, exhaustion of the applicable policy limit;

(7) A correct determination by the insurer based on undisputed facts not at issue in the legal action for which the defense is sought, as permitted under § 13(3); or

(8) Final adjudication that the insurer does not have a duty to defend the action.

Comment:

a. Only upon the occurrence of the enumerated events. Because of the importance of the insurer's duty to defend and the possibility of irreparable harm if an insurer prematurely withdraws from the defense of a legal action, insurance law requires judicial supervision over withdrawals except in the situations enumerated in subsections (1) to (7). In all other cases in which the insurer has a duty to defend under § 13, the insurer must continue to defend the action until relieved of that duty by adjudication. This is a mandatory rule for duty-to-defend policies. See Comment *k*.

b. Explicit waiver by the insured. An insured may require the insurer to withdraw from the defense of an action, in which case the insured waives any rights to further defense or indemnification of the action. The insured does not waive its rights, however, to recover from the insurer for a prior breach of the duty to defend, the damages for which may include future indemnification and defense costs. See § 19(1) (an insurer that breaches the duty to defend loses the right to assert any control over the defense).

c. Final adjudication of the action. Final adjudication of an action terminates the duty to defend. Final adjudication means that a court has entered a judgment finally disposing of the action and the time for taking an appeal from that judgment has expired, or any available appeals have been resolved. An insurer with discretion to settle may terminate its duty to defend before final adjudication by settling the case or by paying the full amount of a judgment rather than pursue an appeal.

d. Final adjudication of part of the action. Partial adjudication of an action may end the duty to defend in circumstances in which an action is based on covered and noncovered counts. Adjudication eliminating any covered count from the action ends the insurer's duty to defend the action, provided that the time for taking an appeal from that adjudication has expired, any appeals have been resolved, or the claimant has relinquished its appeal rights. It is expected that because of the rules governing the professional responsibilities of defense lawyers and the ordinary status of the insurer as a nonparty to the litigation, any motion seeking such partial adjudication would require the consent of the insured. To the extent that it is possible for the insurer to seek such partial adjudication without the consent of the insured, the insurer's actions will be subject to the duty of good faith and fair dealing.

Illustration:

1. Insured homeowner is sued for defamation and negligent infliction of emotional distress. Insurer agrees to defend the suit under the "personal injury" coverage part, which provides coverage for claims of defamation, but reserves the right to contest coverage for the negligent-emotional-distress claim on the grounds that the suit does not allege any bodily injury. The policy provides coverage for negligent-infliction-of-emotional-distress claims only if such claims allege bodily injury. With the consent of the insured, the defense lawyer moves to dismiss the defamation count. The motion to dismiss is granted with prejudice. Provided that the plaintiff agrees to relinquish any appeal rights, the insurer may withdraw from the defense. Neither the complaint nor the results of the insurer's reasonable investigation reveal any allegations of bodily injury. Thus, after the dismissal of the defamation count, the suit no longer satisfies the conditions under which the insurer must provide a defense under § 13.

e. Final full or partial dismissal. In some cases, adjudication will result in a full or partial dismissal of an action. In other cases, a party may voluntarily dismiss all or part of an action. Only a partial dismissal with prejudice eliminates the plaintiff's right to reassert the dismissed component of the action. If the component of the action that triggered the duty to defend is dismissed with prejudice, the insurer's duty to defend is terminated. A partial dismissal without prejudice does not provide the same certainty regarding the scope of the action. Accordingly, a partial dismissal without prejudice should be treated for purposes of the duty to defend as if that component of the action had never been included in the complaint, with the insurer's continuing duty to defend analyzed under the rules stated in § 13. Depending on the circumstances, the ability of the plaintiff to bring that component back into the lawsuit may mean that the insurer will have a continuing duty to defend, unless and until it establishes through a declaratory-judgment action that there is no duty to defend.

f. Settlement. A settlement that fully and finally establishes the insured's responsibilities with regard to an action terminates the duty to defend. Just as a partial adjudication may fully resolve all of the insured portions of the action, a partial settlement that resolves all of the components of the action that are covered by the liability insurance policy may also terminate the duty to defend. Such a partial settlement requires the consent of the insured after being informed

of the consequences thereof. Otherwise, insurers would have an incentive to avoid their obligation to defend the whole legal action by settling the covered portions of the action in a manner that would disadvantage the insured.

Illustration:

2. Insured is sued for defamation and sexual harassment. The insurer agrees to defend, reserving the right to deny coverage for damages assessed against the insured for sexual harassment, which was specifically excluded by the liability insurance policy. With the informed consent of the insured, the insurer settles the defamation portion of the suit. Because there are no other aspects of the suit that are potentially covered by the policy, the insurer's duty to defend is terminated.

g. Exhaustion of the policy limit. Liability insurance policies generally contain terms explicitly terminating the insurer's obligation to defend after the policy limits are paid and accepted. The payment of the limits is said to "exhaust" the policy limits, relieving the insurer of further responsibility for the action in question, and, in some cases, other actions. The rule terminating the duty to defend upon the exhaustion of the applicable policy limit is subject to the insurer's duty of good faith and fair dealing, such that an insurer may not prematurely settle or otherwise pay one action in order to avoid the obligation to defend or continue to defend another. See § 26 (regarding the effect of multiple claimants on the insurer's duty to make reasonable settlement decisions).

h. Exhaustion through payment of defense costs. Under the default rule stated in § 14(3), the costs of the defense do not count against the policy limits when an insurer has issued a liability insurance policy with a duty to defend. Insurance law permits insurers to modify this default rule. An insurer may offer a policy that subjects defense costs to the limits of the policy but does not disclaim the duty to defend. In that event, the payment of sufficient defense costs ordinarily exhausts the policy and terminates the insurer's duty to defend.

i. Withdrawal pursuant to a § 13(3) determination. Section 13(3) states an exception to the complaint-allegation rule that permits insurers to deny coverage based on undisputed facts that are not at issue in the action for which a defense is sought. Subsection (7) to this Section is a corollary to § 13(3). An insurer that starts to defend an action is permitted to withdraw from the defense if it subsequently determines, correctly, that there are undisputed facts that demonstrate

that the action is not covered. This clarifies that an insurer that promptly defends an action does not lose the opportunity to avoid coverage on this narrow ground and, thus, increases the likelihood that an insurer will undertake the defense in a case in which it is uncertain about the application of the § 13(3) exception to the complaint-allegation rule. Note that the insurer's determination there are undisputed facts that demonstrate that the action is not covered must be correct. An incorrect determination is a breach of the duty to defend that is subject to the consequences of the breach of the duty to defend under § 19.

j. Adjudication that there is no duty to defend. An insurer that is providing a defense after adequately reserving the right to contest coverage may avoid the continued duty to defend through a declaratory-judgment action seeking to prove that the action is not covered, subject to any applicable rules of the jurisdiction regarding the scope and timing of declaratory-judgment actions. For example, in some jurisdictions courts stay a coverage proceeding when it involves the determination of facts that are also at issue in the underlying action. In the declaratory-judgment action, the insurer's continuing duty to defend is adjudicated on the basis of all the relevant facts and circumstances, without a presumption that the facts set forth in the complaint or comparable document that concern coverage are true. For example, the insurer may prove that the action is excluded because the insured's conduct falls within the scope of an exclusion in the policy, the insured breached a sufficiently important condition in the policy in a manner that substantially prejudiced the insurer, the insured obtained the policy based upon a misrepresentation that meets the requirements of § 7, or any other valid, complete defense to coverage. The lack of merit or invalidity of one or more causes of action included in the underlying action, however, is not a defense to the duty to defend. The duty to defend obligates an insurer to defend a covered action even if the action is without merit. See § 14, Comment *a*.

Illustrations:

3. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. The complaint alleges that the child negligently caused the fire while playing with matches. An investigation by the family's homeowner's insurer reveals cause for the insurer to believe that the child may have started the fire on purpose. The insurer denies coverage for the suit based on the intentional-harm exclusion in the policy. The insured hires a lawyer to defend the suit, settles the suit for a reasonable amount within the limits of the homeowner's policy, and brings a breach-of-contract

action against the insurer. At trial in the breach-of-contract action, the insurer's liability is determined solely on the basis of whether the insurer had the duty to defend. Because the complaint alleged that the child negligently caused the fire, the insurer had the duty to defend regardless of the child's mental state. Therefore, the insurer is obligated to pay damages for breach of the duty to defend, and, depending upon the application of the rule in § 19(2), the insurer may not be able to rely upon the intentional-harm exclusion to avoid coverage for the settlement of the claim.

4. When investigating a serious but otherwise routine "slip and fall" involving a repair person at the home of an insured, the homeowner's insurer discovers information indicating that the insured has been conducting business at the home, despite having answered "no" to a question in the policy application regarding business at the home. The company defends the action subject to a reservation of rights to contest coverage on the grounds of misrepresentation. The insurer files a declaratory-judgment action seeking to rescind the policy and avoid coverage for the claim. At a trial in the declaratory-judgment action, which takes place while the action is pending, the insurer proves that the insured intentionally provided false information in order to avoid being required by the insurer to purchase business-pursuits coverage from the insurer. The insurer is entitled to rescind the policy and withdraw from the defense of the claim.

k. Mandatory or default rules. Courts have not addressed the question of whether to enforce an insurance-policy term that provides an additional way for an insurer to terminate the duty to defend. Unless the insurance policy also contains a mechanism protecting the insured's right to a defense comparable to that provided by the rules stated in this Section, a court likely would not and should not enforce such a term. The rules stated in this Section, like much of the law governing the insurer's defense duties, were developed to manage the conflicts of interest that are present whenever the insured bears some judgment risk. Thus, these rules can be understood as specific applications of the more general duty of good faith and fair dealing. See § 14, Comments *b* (explaining judgment risk) and *h* (regarding the mandatory nature of legal rules related to the duty to defend).

REPORTERS' NOTE

a. Only upon the occurrence of the enumerated events. See United Enterprises, Inc. v. Superior Court, 183 Cal. App. 4th 1004, 1011 (Ct. App. 2010) ("Normally, an insurer must defend until the underlying action is resolved by settlement or judgment, but circumstances may change such that there is no longer a potential for coverage by, for example, (1) the discovery of new or additional evidence, (2) a narrowing or partial resolution of claims in the underlying action, or (3) the exhaustion of the policy. When any such circumstances exist, an insurer may bring a declaratory relief action, in order to conclusively establish that there is no longer a duty to defend.") (internal citations omitted); Montrose Chemical Corp. v. Superior Court, 6 Cal. 4th 287, 295 (Cal. 1993) ("The defense duty is a continuing one, arising on tender of defense and lasting until the underlying lawsuit is concluded or until it has been shown that there is no potential for coverage . . . ."); Lee v. Aetna Casualty & Surety Company, 178 F.2d 750 (2d Cir. 1949) ("if the plaintiff's complaint against the insured alleged facts which would have supported a recovery covered by the policy, it was the duty of the defendant [insurer] to undertake the defence until it could confine the claim to a recovery that the policy did not cover").

This rule is supported by a public policy of protecting the insureds' expectation of a meaningful defense. See, e.g., *Montrose,* 6 Cal. 4th at 295-296 ("The insured's desire to secure the right to call on the insurer's superior resources for the defense of third party claims is, in all likelihood, typically as significant a motive for the purchase of insurance as is the wish to obtain indemnity for possible liability. As a consequence, California courts have been consistently solicitous of insureds' expectations on this score."); Continental Ins. Co. v. Burr, 706 A.2d 499, 502 (Del. 1998) ("A reasonable policy holder would expect to be defended until claims arising under the policy are resolved, either by settlement or judgment. To read the policy otherwise would be to nullify the duty to defend in those situations where the insured most needs that protection.").

b. Explicit waiver by the insured. See Cincinnati Companies v. West American Ins. Co., 701 N.E.2d 499, 503-504 (Ill. 1998) ("[A]n insured may knowingly forgo the insurer's assistance by instructing the insurer not to involve itself in the litigation. The insurer would then be relieved of its obligation to the insured with regard to that claim."); Richard Marker Associates v. Pekin Ins. Co., 743 N.E.2d 1078, 1083 (Ill. App. Ct. 2001) (holding that the "right to forgo coverage" with insurer "included an ability to deactivate the coverage" even after settlement of the underlying dispute).

c. Final adjudication of the action. What constitutes final adjudication will depend on the law of the relevant jurisdiction. In general, final adjudication requires the entry of judgment and the expiration of all appeal rights. See, e.g., Bruce v. Junghun, 912 N.E.2d 1144, 1148 (Ohio Ct. App. 2009) ("The duty to defend does not automatically cease when the trial court enters judgment."); Meadowbrook, Inc. v. Tower Ins. Co., Inc., 559 N.W.2d 411, 416-417 (Minn. 1997) (duty to defend did not terminate until plaintiffs had no further right to appeal their claims); Klamath Pac. Corp. v. Reliance Ins. Co., 950 P.2d 909, 916 (Or. Ct. App. 1997)

(concluding that an intermediate order from a trial court dismissing a claim does not relieve an insurer of its duty to defend because such an order is not a final resolution of the claim).

d. Final adjudication of part of the action. "As a general rule, a liability insurer's duty to defend continues until the claims giving rise to coverage have been eliminated from the suit." Wackenhut Serv., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 15 F. Supp. 2d 1314, 1324 (S.D. Fla. 1998) (holding that the insurer's duty to defend ended when the only claim arguably falling within coverage was dismissed and not reinstated). See also City of Niagara Falls v. Merchants Ins. Group, 824 N.Y.S.2d 841, 842-843 (N.Y. App. Div. 2006) (an insurer who initially "failed to establish . . . that it had no duty to defend" the insured because one of the allegations fell within the scope of the policy could later terminate its defense when the insured was absolved of liability for that claim); City of Sandusky, Ohio v. Coregis Ins. Co., 192 F. App'x 355, 362 (6th Cir. 2006) (holding that the duty to defend remained when the covered claims had been dismissed in nonfinal order of summary judgment); Commerce & Industry Ins. Co. v. Bank of Hawaii, 832 P.2d 733, 737 (Haw. 1992) (holding that the insurer could not withdraw from its duty to defend after a partial summary judgment until either a "Rule 54(b) certification was granted and the appeal period had expired or a final judgment had disposed of the entire case"); C.A. Fielland, Inc. v. Fidelity & Casualty Co. of New York, 297 So. 2d 122, 127 (Fla. Dist. Ct. App. 2d Dist. 1974) ("Even though only a portion of a claim made against an insured is within the liability coverage, the insurance carrier has the duty to defend the entire action, at least until such time as the covered portions of the claim have been eliminated from the suit."); Frankenmuth Mut. Ins. Co. v. Beyer, 395 N.W.2d 36, 38 (Mich. App. Ct. 1986) (holding that the insurer was not required to defend the insured after negligence count against the insured was dropped, with prejudice, and all that remained was a tortious assault-and-battery charge for which coverage was not provided under the insurance policy).

e. Final full or partial dismissal. An original complaint that "has been superseded by an amended complaint [that no longer contains potentially covered allegations] . . . can no longer furnish a basis for determining the insurer's duty to defend." Baron Oil Co. v. Nationwide Mut. Fire Ins. Co., 470 So. 2d 810, 815 (Fla. Dist. Ct. App. 1st Dist. 1985), citing Alabama Farm Bureau Mutual Casualty Insurance Co. v. Harris, 279 Ala. 326 (1966). Moreover, "where an amended complaint alleges facts that clearly bring the entire cause of action within a policy exclusion, and the amended complaint contains no additional counts or causes of action which show coverage, the allegations in the amended complaint control and the insurer's duty to defend comes to an end." Id. Accord, National Union Fire Ins. Co. of Pittsburgh Pennsylvania v. Starplex Corp., 188 P.3d 332, 336 n.1 (Or. Ct. App. 2008) (holding that the duty to defend may be extinguished by the filing of a subsequent amended complaint).

f. Settlement. When "the potential for covered liability has ended by settlement," the duty to defend expires. 1 Steven Plitt & Jordan R. Plitt, Practical Tools for Handling Insurance Cases § 2:19 (2012). See, e.g., Great American Ins. Co. v. Superior Court, 100 Cal. Rptr. 3d 258, 269 (Cal. Ct. App. 2009) ("Normally, the insurer must defend until the underlying action is resolved by settlement or judgment."); Kocse v. Liberty Mut. Ins. Co., 387 A.2d 1259, 1262 (N.J. Super.

Ct. 1978) ("Certainly, if [the insurer] could have effected settlement of the claim and it saw fit to dispose of it in that fashion, there would be no duty to defend the action."). See also Jeffrey E. Thomas and Francis J. Mootz III, 3 New Appleman on Insurance Law Library Ed. § 17.06[2][a] (Lexis 2012) ("Courts . . . have held an insurer cannot extinguish its duty to defend by tendering its limits without obtaining a complete release for its insured in the underlying action . . . ."). But, "payment of policy limits pursuant to a partial settlement of claims brought against the insured may not terminate the duty to defend." 1 Steven Plitt & Jordan R. Plitt, Practical Tools for Handling Insurance Cases § 2:19 (2012). In Levenfeld v. Clinton, for instance, the insurer attempted to settle only the covered claims in order to avoid the cost of defending the remaining noncovered claims. 674 F. Supp. 255 (N.D. Ill. 1987). Holding that the settlement was unenforceable because the insurer had acted in bad faith, the court noted that

> There is no question that the settlement proposed by [the insurers] harms [the insureds] severely. While [insureds] insist they do not fear the outcome of the malicious prosecution suit, they rightly fear the cost of litigating those issues . . . . [The insurers] freely concede that they are offering [the plaintiff] $500,000 rather than face the expense of seeing this case through.

Id. at 258. But see Meadowbrook, Inc. v. Tower Ins. Co., Inc., 559 N.W.2d 411, 417 (Minn. 1997) ("Even though the insurer agreed to defend the entire claim against the insured, its duty extended only to those claims arguably covered by the policy. Once the insurer settled and paid those claims, it had completely performed its contractual duty. . . . Regardless of the insurer's motivation in settling the defamation claims, the fact remains that the insurer's action relieved the insured of any liability resulting from those arguably coverable claims").

g. Exhaustion of the policy limit. The principle stated in subsection (6) is the majority approach. See Commercial Union Ins. Co. v. Pittsburgh Corning Corp., 789 F.2d 214, 219 (3d Cir. 1986) ("Although a few such cases do appear to hold that the insurer is required to defend the insured even after exhaustion of coverage through settlement or judgment . . . the predominant weight of authority is to the contrary."). For an example of a case holding that exhaustion of the applicable policy limit terminates the duty to defend, see Zurich Ins. Co. v. Raymark Industries, Inc., 514 N.E.2d 150, 163 (Ill. 1987) ("Where the insurer has exhausted its indemnity limits, . . . the insurer cannot ultimately be obligated to indemnify the insured. . . . [W]hen . . . the insurer has no potential obligation to indemnify, it has no duty to defend."). Courts uphold provisions terminating the insurer's duty to settle or defend upon the exhaustion of the policy limit if such provisions are unambiguous. Zurich Ins. Co. v. Northbrook Excess and Surplus Ins. Co., 494 N.E.2d 634, 645 (Ill. App. Ct. 1986) (holding that policy language—limiting the insurer's duty to the limits of liability—clearly evinced the intent of the parties to extinguish the insurer's duty to defend upon exhaustion by judgment or settlement); American States Ins. Co. of Texas v. Arnold, 930 S.W.2d 196, 200-201 (Tex. Ct. App. 1996) (holding that policy language—providing that the insurer's "duty to settle or defend ends when [its] limit of liability for [the] coverage has been exhausted"—is unambiguous and terminates the insurer's

duty to defend when the policy limits are exhausted). However, provisions that are ambiguous are construed in favor of the insured so as to require the insurer to continue defending the insured until settlement or judgment, despite having paid the policy limit. See, e.g., Brown v. Lumbermens Mut. Cas. Co., 390 S.E.2d 150, 154 (N.C. 1990) ("Given the ambiguity, the provision relating to the insurer's duty to defend must be interpreted favorably to the insured. So interpreted, it means that the insurer's duty to defend continues until its coverage limits have been exhausted in the settlement of a claim or claims against the insured or until judgment against the insured is reached."); St. John's Home of Milwaukee v. Continental Cas. Co., 147 Wis. 2d 764, 786-787 (Wis. Ct. App. 1988) (construing policy language continuing the duty to defend to the "maximum potential liability" to require the insurer to continue to defend up to the insured's maximum potential liability even though the insurer had tendered its maximum policy limit).

This rule is subject to a good-faith requirement so that an insurer does not rescind its tender of defense to the prejudice of the insured. See, e.g., Weimer v. Ypparila, 504 N.W.2d 333, 335 (S.D. 1993) (holding that the duty to defend continued, even though the insurer had offered its policy limits, until it had obtained a judgment or settlement and a release in favor of the insured, in order to protect the insured from prejudice); Continental Cas. Co. v. Farmers Ins. Co. of Arizona, 883 P.2d 473, 476 (Ariz. Ct. App. 1994) (holding that the policy—which read in relevant part: "[w]e will not defend any suit or make additional payments after we have paid the limit of liability for the coverage"—terminated the insurer's duty to defend once the insurer had paid its policy limits and obtained a covenant not to execute that protected the insured); Maguire v. Ohio Cas. Ins. Co., 602 A.2d 893, 896 (Pa. Super. Ct. 1992) (holding that an insurer may not tender its policy limit into the court pending a determination of liability in order to avoid its duty to defend because such actions are not taken in good faith as is required to be excused from the duty to defend once it has paid its policy limits).

Where a dispute arises over whether an insurer has exhausted its policy limits, the insurer has a continuing duty to defend until adjudication determines that it has exhausted its policy limits. Hartford Accident & Indemnity Co. v. Superior Court, 23 Cal. App. 4th 1774, 1779 (Cal. Ct. App. 1st 1994). However, the primary insurer would be entitled to reimbursement for the defense costs incurred during the interim period from an excess carrier upon a determination that it had exhausted its policy limit. *Hartford Accident*, 23 Cal. App. 4th at 1780.

An insurer does not exhaust its policy limit by tendering that limit to an excess insurer, an underlying claimant, or the court. See Anderson v. United States Fidelity & Guar. Co., 339 S.E.2d 660, 661 (Ga. Ct. App. 1986):

> There is no intimation in an insurance policy that its duty to defend may be satisfied by merely paying into court the applicable policy limits. To read the policy otherwise would render a near nullity a most significant protection afforded by the policy, that of defense. The term "exhaust" encompasses, not the paying into court of the policy limits, but the payment either of a settlement or of a judgment wholly depleting the policy amount.

Accord, Continental Ins. Co. v. Burr, 706 A.2d 499, 502 (Del. 1998). See also Samply v. Integrity Ins. Co., 476 So. 2d 79 (Ala. 1985) (holding that an insurer, when it obligated itself to defend, could not avoid its duty to defend against an insured's contingent liability by tendering its policy limits into court without effectuating a settlement or obtaining consent of insured); Conway v. Country Cas. Ins. Co., 442 N.E.2d 245, 247 (Ill. 1982) (holding that an insurer is not discharged from its duty to defend its insured by the payment of the policy limits); John and Jean Appleman, 7C Appleman, Insurance Law and Practice, § 4682 (1979) ("[T]he primary insurer may not walk away from the insured by paying relatively low limits into court and abandon the insured with a substantial judgment simply because the cost of appeal or other handling may be formidable. The insured's interests may demand continued protection despite threatened exhaustion of the primary limits."); 14 Lee R. Russ et al., Couch on Insurance § 200:50 (3d ed. 2011) ("Generally, without settlement or the insured's consent, an insurer cannot avoid its duty to defend by simply tendering payment, since an insurer's duty to defend is separate and distinct from its obligation to pay a judgment rendered against its insured.").

h. Exhaustion through payment of defense costs. See, e.g., Gabarick v. Laurin Maritime (America), Inc., 650 F.3d 545, 553-554 (5th Cir. 2011) (interpreting policy to count defense costs towards policy limits); Carlson Mktg. Group, Inc. v. Royal Indem. Co., 517 F. Supp. 2d 1089, 1114 (D. Minn. 2007) (noting, in dispute over excess insurance, that underlying insurance policy provided that defense costs eroded policy limits). However, New York Insurance Department Regulation (11 NYCRR) § 60–1.1(b) has been interpreted as requiring an automobile liability insurer to pay all defense costs until a case ends and not excusing it from providing a full defense by payment of its policy limit. See Matter of East 51st St. Crane Collapse Litig., 84 A.D.3d 512, 513 (N.Y. App. Div. 2011); Haight v. Estate of DePamphilis, 5 A.D.3d 547, 548 (N.Y. App. Div. 2004); Delaney v. Vardine Paratransit, 132 Misc. 2d 397, 398 (N.Y. Sup. Ct. 1986); see also People v. ELRAC, Inc., 192 Misc. 2d 78, 80 (N.Y. Sup. Ct. 2002) (holding that N.Y. Vehicle and Traffic § 370 (McKinney 2011) disallowed insurer from including defense costs in policy limits).

j. Adjudication that there is no duty to defend. See American and Foreign Ins. Co. v. Jerry's Sport Center, Inc., 2 A.3d 526, 542 (Pa. 2010) (holding that an insurer is relieved of the duty to defend if it is successful in a declaratory-judgment action to determine whether a claim is covered under an insurance policy); Baumann v. Elliott, 704 N.W.2d 361, 366 (Wis. Ct. App. 2005) ("The insurer breaches its duty to defend if it refuses to provide a defense before the court decides the issue of coverage, but the duty to defend ends once the court resolves the coverage issue in favor of the insurer") (citing Elliott v. Donahue, 485 N.W.2d 403, 406 (Wis. 1992)).

§ 19. Consequences of Breach of the Duty to Defend

(1) An insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action.

(2) An insurer that lacks a reasonable basis for its failure to defend a legal action also loses the right to contest coverage for the action.

Comment:

a. Breach of the duty to defend. Breach of the duty to defend includes a failure to defend when required, a provision of an inadequate defense, a failure to provide an independent defense when required, and a withdrawal of a defense when the duty to defend has not terminated.

b. Damages for breach of the duty to defend. The general topic of damages for breach of the liability insurance contract is addressed in Chapter 4. In general, these damages include the foreseeable consequences of a breach of the insurer's contractual obligations. When an insurer breaches the duty to defend, those consequences include the reasonable costs of defense, any amount by which a noncovered settlement or judgment entered in the case is larger than it otherwise would have been as a result of the breach of the duty to defend, and any other damages recoverable for breach of a liability insurance contract. The insurer is also obligated to pay any covered judgment or the reasonable amount of any covered settlement, subject to the policy limits, but that obligation is part of the insurer's ordinary duty to pay covered claims, not part of the damages for breach of the duty to defend.

c. Loss of control over defense and settlement. An insurer that breaches the duty to defend loses its right to control the defense and settlement of the action. In that event, the insured, or another insurer acting on behalf of the insured, may undertake the defense and settlement of the action and obtain reimbursement from the insurer of the reasonable costs of defense. If the breach of the duty to defend occurs while the insurer is defending an action, the insured may demand that the insurer withdraw from the defense. This is the prevailing legal rule.

d. Additional consequences when an insurer lacks a reasonable basis for a failure to defend. There are two opposing rules in the case law regarding the consequences of an insurer's breach of the duty to defend. Under the more insured-protective rule, an insurer that breaches the duty to defend must pay any judgment entered in the action, or the reasonable amount of a settlement of the action, without regard to any coverage defenses that the insurer would have been able to assert if it had defended the claim under a reservation of rights. Under the less insured-protective rule, which is the majority rule, an insurer that breaches the duty to defend retains the right to contest coverage for a settlement or judgment. For example, an insurer that refused to defend a claim that includes a potentially covered negligence count would be

obligated to pay the insured's defense costs as damages in the breach-of-contract action, but it would have the right to contest the obligation to pay for the judgment or settlement on the grounds that the insured intended the harm. (Of course, the insurer would be likely to face counter-arguments by the insured, for example, that the insurer's breach of the duty to defend caused the judgment, or that the settlement was a reasonable settlement of the potentially covered portions of the claim, alone).

The arguments in favor of the minority rule center on the strong insurance law norm in favor of the duty to defend and the desire to prevent insurers from unilaterally converting a duty-to-defend policy into a defense-cost-reimbursement policy. In addition, supporters of the minority rule point to an inconsistency between the majority rule and the rule in § 15 regarding the reservation of rights. Under the rule in § 15, an insurer that defends under a reservation of rights loses any coverage defenses that it does not promptly identify, while an insurer that refuses to defend can, under the majority rule, wait until the insured files a breach-of-contract action to identify its coverage defenses.

The arguments in favor of the majority rule center on the contract-law origins of insurance law and the extra-compensatory nature of the forfeiture remedy. In addition, supporters of the majority rule observe that there are already strong incentives for the insurer to defend in most cases. These incentives come from the defense-cost savings that may be realized when the insurer controls the defense, the reduction in settlement or judgment amounts attributable to an insurer-controlled defense, and the avoidance of the costs of an action for breach of the duty to defend, in addition to whatever incentives are provided by the insurance market. Finally, supporters of the majority rule observe that the courts in a substantial majority of the states follow this rule.

Subsection (2) articulates an intermediate rule that limits the extra-compensatory consequences of the minority rule to cases in which the insurer lacks a reasonable basis for the failure to defend. A "reasonable basis" means that the insurer has a reasonable legal theory pursuant to which, giving the insured the benefit of the doubt with regard to any and all disputed facts, the insurer has no duty to defend as a matter of law. This intermediate rule gains support from courts holding that an insurer that breaches the duty to defend in bad faith must pay the judgment or settlement without regard to whether the insurer had other coverage defenses and, under the principle that the greater includes the lesser, from the respectable minority of

jurisdictions that have adopted the more insured-protective rule pursuant to which any breach of the duty to defend leads to the loss of coverage defenses. The intermediate rule provides greater protection for insureds than the majority rule and it may provide greater protection than the bad-faith rule, because there is no need to prove the malign intent that is sometimes required for bad faith.

e. Justifying the no-reasonable-basis, intermediate rule: striking a proper balance between the advantages and disadvantages of a forfeiture-of-coverage-defenses rule. Although insurers generally have significant incentive to undertake the defense of a potentially covered claim, an insurer that breaches the duty to defend without a reasonable basis has demonstrated the insufficiency of this ordinary incentive. An insurer that could refuse to defend without a reasonable basis, while still preserving its coverage defenses, would be less willing to provide the promised defense. If the breaching insurer could preserve its coverage defenses, all that it would be required to pay in the event of a successful challenge is the amount that it should have paid at the time the insured needed the defense. This possibility is particularly troubling in situations in which the complaint-allegation rule clearly requires the insurer to defend, but the insurer believes that it has a strong coverage defense on the basis of disputed facts. In such situations, the ability to control the defense and settlement of the claim does not provide a strong incentive for the insurer to provide a defense that it clearly owes.

On the other hand, it might be argued that even the more limited rule stated in subsection (2) harms insureds as a group by increasing premiums because insurers are required to pay claims that are not covered, thereby unjustly enriching insureds that prevail in an action for breach of the duty to defend. This argument is not persuasive. An insurer can preserve its coverage defenses and refuse to defend as long as it has a reasonable basis for that refusal. Subsection (2) reflects the principle that the promise to defend is a promise to perform, not simply a promise to decide whether to perform or to pay ordinary contract damages.

It might also be argued that there is no need for any forfeiture-of-coverage-defenses rule because a refusal to defend does not really harm the insured. According to this argument, either the insured will have adequate assets to manage the defense on its own and then bring an action for reimbursement, so that all that is at stake is the timing of the insurer's payment of the defense costs or, because the insured does not have adequate assets, the claimant will settle with the insured and accept an assignment of the insured's rights against the insurer, so that the insured is

not harmed at all. If the claimant refuses to agree to such a settlement, then, at worst, the claimant will have an unenforceable judgment against the insured.

This argument also is not persuasive. A refusal to defend deprives insureds of one of the main benefits of the duty-to-defend bargain: a timely, insurer-funded defense. Reimbursement is a poor substitute for the expert litigation services provided when an insurer fulfills the duty to defend, not only for consumers and small businesses, but also for larger commercial entities that, in contrast to liability insurance companies, are not in the business of managing litigation. Moreover, the intermediate rule adopted in this Section discourages insurers from treating a duty-to-defend policy as if it were a duty-to-reimburse-defense-cost policy. There are both duty-to-defend and duty-to-reimburse insurance policies available on the insurance market, with prices and other terms reflecting that there is a real difference between these forms of coverage. Furthermore, even if a rational claimant would agree to settle and accept assignment from a judgment-proof defendant, not all claimants are rational, and civil judgments have consequences even for judgment-proof defendants: for example, harming their credit rating and interfering with the enjoyment of money that they may come to possess in the future. It would be highly unusual, at best, for liability-insurance-law rules to be crafted as if liability did not matter.

Finally, it might also be argued that the reasonable-basis standard in subsection (2) will be overly difficult for courts to apply. This argument also is not persuasive. It is true that the rule in subsection (2) will require more work on the part of courts than either the automatic forfeiture-of-coverage-defenses rule or the no-forfeiture-of-coverage-defenses rule, just as a negligence rule requires more work on the part of courts than either an absolute-liability rule or a no-liability rule. This analogy to competing tort-law standards is not perfect, but the trade-offs are similar. Courts have substantial experience applying reasonableness tests precisely because such tests so often are preferable to the all-or-nothing alternatives. In the case of an insurer that breaches the duty to defend, the majority never-a-forfeiture rule is insufficiently protective of insureds because it permits insurers to transform a duty-to-defend policy into a defense-cost-reimbursement policy in every case, subject only to the less than fully compensatory contract-damages rules and contrary to the strong liability insurance law principles supporting the insurer’s duty to defend. The minority, automatic-forfeiture is superior to the no-forfeiture rule on public-policy grounds, but it is more protective than necessary, because it will lead to a forfeiture of coverage defenses in situations in which a reasonable insurer would have declined

to defend. Accordingly, the intermediate rule stated in subsection (2) is preferable, notwithstanding the greater difficulty of adjudication.

f. Practical applications of subsection (2). In explaining the operation of the rule in subsection (2), it is helpful to consider the distinction between legal and factual uncertainty introduced in the context of the core duty-to-defend rules in § 13. As noted in Comment *e* to § 13, "an insurer is required to resolve factual uncertainty in favor of the duty to defend" and, thus, an insurer may not refuse to defend because of its belief that the resolution of uncertain facts will demonstrate that there is no covered cause of action. An insurer that refuses to defend because of its beliefs about disputed facts does not have a reasonable basis for that refusal and, therefore, is subject to loss of coverage defenses. The same result holds if an insurer refuses to defend based on a coverage defense that applies to only part of the legal action at issue (unless that part is the only potentially covered part of the legal action, in which case the insurer would not be subject to the loss of coverage defenses as long as that coverage defense met the reasonable-basis standard). Because the insurer is obligated to defend the entire legal action as long as any part of the action is covered, a coverage defense that applies to just part of the action cannot provide a reasonable basis for a refusal to defend that action. See § 13(1).

By contrast, as stated in Comment *f* to § 13, "an insurer is not required to resolve legal uncertainty in favor of the duty to defend." Thus, an insurer that accepts as true all of the alleged and reasonably potentially alleged facts that favor coverage and denies coverage based on a reasonable legal theory does not forfeit its other coverage defenses if it does not prevail on that legal theory and is therefore found to have breached the duty to defend. For example, an insurer that refuses to defend a claim involving bodily injury from lead paint on the grounds that such claims are excluded by the absolute-pollution exclusion, in a policy governed by the law of a jurisdiction in which that question has not yet been answered, has a reasonable basis for the refusal to defend even if the court subsequently determines that the exclusion does not apply to lead-paint claims, because this was an open issue upon which courts had disagreed. Accordingly, that insurer could also contest its obligation to indemnify the insured based on defenses such as late notice, intentional harm, misrepresentation, or the duty to cooperate, even when such defenses involve disputed facts and, therefore, cannot serve as the basis for a refusal to defend under the rules stated in § 13. See § 13, Comment *e*.

Illustrations:

1. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. The complaint alleges that the child negligently caused the fire while playing with matches, a claim that if true would indisputably fall within coverage of the liability portion of the family's homeowners' insurance policy. An investigation by the insurer reveals facts making it reasonable for the insurer to believe that the child started the fire on purpose. There is no dispute in this jurisdiction that if the child is proven to have caused the fire intentionally, there would be no coverage under the policy because of the intentional-harm exclusion. The insurer denies coverage and refuses to defend the claim for the sole reason that the child intentionally intended to damage the building and therefore that the claim is excluded by the intentional-harm exclusion in the policy. The insured defends the claim and settles with the claimant for a reasonable amount that is within the policy limits. The insured then brings a breach-of-contract action against the insurer seeking to require the insurer to reimburse the costs of defense and pay the settlement amount. Because prior law in the jurisdiction established that an insurer's duty to defend is governed by the complaint-allegation rule, and the complaint indisputably alleges a covered cause of action, the insurer had no reasonable basis for the refusal to defend. The insurer forfeits the opportunity to prove that the child in fact intentionally caused the property damage and therefore is obligated to reimburse the insured for the costs of defense and to pay the settlement in addition to any other compensable damages.

2. Same facts as Illustration 1, except the insurer reserved its rights to deny the claim based on the intentional-harm exclusion and provided a defense under a reservation of rights. The insured, nevertheless, settled with the claimant for a reasonable amount under the procedure authorized in § 25(3). Because the insurer did not breach the duty to defend, the insurer may refuse to pay the settlement and defend a breach-of-contract action on the basis of the reserved coverage defense. That breach-of-contract action will be decided on the basis of all of the facts and circumstances available to the insurer at the time of its decision not to defend.

3. Insured doctor is sued by a patient for sexual molestation that allegedly occurred during a medical exam. Insurer denies coverage and refuses to defend solely on

the grounds that the claim did not arise out of "professional services," as required by the policy. In the relevant jurisdiction the application of the professional-services requirement to a sexual-molestation claim brought by a patient against a doctor under the circumstances alleged in the complaint is an open question of law, and courts in other jurisdictions are divided on this issue. The insured defends the claim and settles with the claimant for a reasonable amount that is within the policy limits. The insured then brings a breach-of-contract action against the insurer seeking to require the insurer to reimburse the costs of defense and pay the settlement amount. The insurer asserts that it is not obligated to pay those costs on two grounds: (1) the "professional services" requirement and (2) the application of the intentional-harm exclusion in the policy. Because the application of the professional-services requirement to a sexual-molestation claim was an open question in the law of the jurisdiction, the insurer had a reasonable basis for the refusal to defend. Accordingly, the insurer may also contest coverage for the settlement on the basis of the intentional-harm exclusion in the policy, taking all of the facts and circumstances into account, even if the court determines that the insurer's denial of coverage was a breach of the duty to defend.

g. Liability in excess of the policy limit. A breach of the duty to defend does not obligate the insurer to indemnify the insured for amounts in excess of the policy limit. An insurer that breaches the duty to defend may become obligated to pay such amounts only as a result of the breach of some other obligation, such as the duty to make reasonable settlement decisions or the duty of good faith and fair dealing.

h. Mandatory rules. Because insurers have not attempted to draft around the rules regarding the consequences of the breach of the duty to defend, there is no authority on point. Nevertheless, the rules regarding remedies for breach of the duty to defend should be regarded as mandatory because of their importance to maintaining the integrity of the litigation-insurance aspect of liability insurance.

REPORTERS' NOTE

a. Breach of the duty to defend. An insurer can breach its duty to defend in multiple ways. An insurer breaches simply by refusing to defend where it has a duty to do so. See, e.g., Francis C. Amendola et al., Insurer's Liability for Wrongful Failure or Refusal to Defend, 46 C.J.S.

Insurance § 1641 (2012) ("When an insurance company wrongfully refuses to defend on the ground that the claim is not within policy coverage, the company is guilty of breach of contract, rendering it liable to the insured for all damages resulting to him or her because of such breach."); 14 Lee R. Russ with Thomas F. Segalla, Couch on Insurance § 202:6 (3d ed. 2011) (same). Similarly, an insurer breaches if it initially defends, but withdraws its defense before the duty to defend has terminated. See, e.g., City of Sandusky v. Coregis Ins. Co., 192 F. App'x 355, 361 (6th Cir. 2006) (insurer "breached its duty to defend by withdrawing its defense . . . before a final order was entered or an appeal pursued."); Arceneaux v. Amstar Corp., 66 So. 3d 438, 450 (La. 2011) (insurer "breached its duty to defend by withdrawing its defense" before "petitions . . . unambiguously exclude[d] coverage.").

An insurer also breaches if it defends, but fails to provide an adequate defense. See, e.g., Carrousel Concessions, Inc. v. Florida Ins. Guar. Ass'n, 483 So. 2d 513, 517 (Fla. Ct. App. 1986) ("If [the insured] is able to establish that the defense supplied by [the insurer] was inadequate," the insurer has breached its duty to defend and the insured could recover "all reasonable costs and attorney's fees."); Sierra Pacific Industries v. American States Ins. Co., No. 2:11-cv-00346-MCE-JFM, 2011 WL 2935878 at *6 (E.D. Cal. July 18, 2011) (denying summary judgment to the insurer in part because the insured had "alleged facts sufficient to establish that Defendant may have breached its duty to employ competent counsel and provide counsel with adequate funding, in breach of Defendant's duty to defend."). Finally, an insurer may breach its duty to defend if it fails to provide adequate independent counsel when obligated to do so. See, e.g., Great Divide Ins. Co. v. Carpenter ex rel. Reed, 79 P.3d 599, 609-610 (Alaska 2003) (holding that failure to notify the insured of his right to have independent counsel paid for by the insurer constituted a breach of the insurer's duty to defend); Travelers Indem. Co. of Ill. v. Royal Oak Enterprises, Inc., 429 F. Supp. 2d 1265, 1273 & n.32 (M.D. Fla. 2004) (finding that a claim of breach of duty to defend could survive because "allegations that an insurer failed to provide mutually agreeable independent counsel when a conflict of interest arose during the defense of an insured are sufficient for purposes of a motion to dismiss."); Lloyd v. State Farm Mut. Auto. Ins. Co., 860 P.2d 1300, 1301 (Ariz. Ct. App. 1992) (holding "that an insurer's voluntary assumption of the duty to defend may give rise to a cause of action for derelictions in that defense even when there is no actual coverage"); BellSouth Telecommunications, Inc. v. Church & Tower of Florida, Inc., 930 So. 2d 668, 673 (Fla. Dist. Ct. App. 2006) (labeling "meritless" an insurer's attempted distinction that a case relied on by the insured "involved a failure to provide an adequate defense, rather than a refusal to provide a defense at all"); 14 Couch on Insurance § 205:27 ("An insurer who accepts a duty to defend an insured under a reservation of rights, but then performs the duty in bad faith, is no less liable than an insurer who accepts but later rejects its duty."); 2 California Ins. Law Dictionary & Desk Ref. § I14 (2011 ed.) ("inadequate or perfunctory defense is tantamount to an insurer's refusal to defend").

b. Damages for breach of the duty to defend. An insurer that wrongfully refuses to defend "becomes liable for all damages which flow naturally from the breach." MCO Environmental, Inc. v. Agricultural Excess & Surplus Ins. Co., 689 So. 2d 1114, 1116 (Fla. Dist. Ct. App. 1997).

See also Burgett, Inc. v. American Zurich Ins. Co., 830 F. Supp. 953, 964 (E.D. Cal. 2011) ("[W]here an insurer wrongfully 'refuses to defend an action against its insured . . . the insurer is liable for the total amount of fees unless the insurer produces undeniable evidence that it is not liable for all of the attorney's fees.'"); Chandler v. Doherty, 702 N.E.2d 634, 640 (Ill. Ct. App. 1998) ("When an insurance company unjustifiably refuses to defend its insured, the measure of damages is (1) the amount of the judgment against its insured up to the policy limits . . . (2) expenses incurred by the insured in defending the suit; and (3) any additional damages traceable to its refusal to defend."). For a discussion of the factors courts may take into account in considering the reasonableness of attorney's fees, see 3 Jeffrey E. Thomas & Francis Mootz III, New Appleman on Insurance Law Library Ed. § 17.07[1] (2011).

For cases requiring an insurer to pay the reasonable amount of an unreasonable settlement, see State Farm Fire & Cas. Co. v. Farmers Alliance Mut. Ins. Co., 96 P.3d 1179, 1184-1185 (N.M. 2004) (holding that "the primary insurer . . . is bound by the settlement reached between" an additional insurer and the plaintiff but that in reimbursing the other insurer who settled the claim, the primary insurer was only responsible for "$250,000, out of the total $375,000 settlement, because a reasonable settlement should not have exceeded $250,000"); Copeland v. Assurance Co. of Am., 2005 WL 2487974 (W.D. Wash. 2005) ("A party whose liability insurer has acted in bad faith by denying coverage may proceed to make his own settlement with an injured plaintiff, and then seek reimbursement from the insurer. However, the insurer is only liable for the amount of the settlement that is reasonable and paid in good faith."); Zurich Ins. Co. v. Killer Music, Inc., 998 F.2d 674, 680 (9th Cir. 1993) (remanding action "for a determination of the damages attributable to a reasonable settlement"); New Hampshire Ins. Co. v. Mendocino Forest Products, Co., LLC, 2007 WL 2875683 (N.D. Cal. 2007) (interpreting *Zurich* as "stand[ing] for the proposition that an insurer is liable for a 'reasonable settlement of the claim in good faith,' but is not obligated beyond the reasonable value of the settlement"). See also Lynn Haggerty King & Heidi Loken Benas, The Duty to Defend: When Does It Exist and What Damages Are Recoverable for Its Breach?, 7 U.S.F. Mar. L.J. 245, 267 (1994) ("If the insurer can show that the agreement to settle is unreasonable, it will not be responsible for payment of the full amount.").

c. Loss of control over defense and settlement. C. T. Drechsler, Consequences of liability insurer's refusal to assume defense of action against insured upon ground that claim upon which action is based is not within coverage of policy, 49 A.L.R.2d 694 § 18 (Originally Published 1956) ("It appears well settled that an insurer cannot deny liability as against the insured and refuse to defend an action brought against the latter . . . and at the same time insist on controlling the defense."). See, e.g., Burgett, Inc. v. American Zurich Ins. Co., 830 F. Supp. 2d 953, 965 (E.D. Cal. 2011), quoting Intergulf Devel. v. Super. Ct., 107 Cal. Rptr. 2d 162, 165 (Cal. Ct. App. 2010); Willcox v. American Home Assur. Co., 900 F. Supp. 850, 855 (S.D. Tex. 1995) ("[O]nce an insurer has breached its duty to defend, as in the instant case, the insured is free to proceed as he sees fit; he may engage his own counsel and either settle or litigate at his option."); MCO Environmental, Inc. v. Agricultural Excess & Surplus Ins. Co., 689 So. 2d 1114, 1116

(Fla. Dist. Ct. App. 1997) ("If an insurance company breaches its contractual duty to defend, the insured can take control of the case, settle it, and then sue the insurance company for damages it incurred in settling the action."); Krenitsky v. Ludlow Motor Co., 96 N.Y.S.2d 102, 104 (N.Y. App. Div. 1950) ("By refusing to defend, it has forfeited to the defendant the right to control its defense of the actions."). Following a breach of duty to defend, an insurer is bound by the judgment of the underlying case in terms of both liability and damages and thus cannot reopen or relitigate the underlying liability or damages once judgment has been entered or the case has settled. See, e.g., Garamendi v. Golden Eagle Ins. Co., 116 Cal. App. 4th 694 (2004); Matychak v. Security Mut. Ins. Co., 181 A.D.2d 957 (N.Y. Sup. Ct. App. Div. 1992) (holding the same for default judgments).

With respect to settlements, "[i]t appears well settled that an insurer cannot breach its contract by unjustifiably refusing to defend an action against the insured . . . and at the same time take advantage of a policy provision prohibiting the insured from settling any claim except at his own cost without the consent of the insurer." Drechsler, 49 A.L.R.2d 694 at § 22[a]. See, e.g., Risely v. Interinsurance Exchange of Auto. Club, 107 Cal. Rptr. 3d 343, 350 (Cal. Ct. App. 2010) ("[w]here the insurer denies its insured a defense for covered claims, the insured may make reasonable, noncollusive settlement with the third party, without the insurer's consent."); Guillen ex rel. Guillen v. Potomac Ins. Co. of Illinois, 751 N.E.2d 104, 114 (Ill. Ct. App. 2001), aff'd as modified and remanded, 785 N.E.2d 1 (Ill. 2003) ("In cases such as this one, however, where there has been a breach of duty to defend, the insured may enter into a settlement without the insurer's approval."); Isadore Rosen & Sons, Inc. v. Sec. Mut. Ins. Co. of New York, 291 N.E.2d 380, 382 (N.Y. 1972) ("[W]here an insurer 'unjustifiably refuses to defend a suit, the insured may make a reasonable settlement or compromise of the injured party's claim, and is then entitled to reimbursements from the insurer, even though the policy purports to avoid liability for settlements made without the insurer's consent'."), quoting Matter of Empire State Sur. Co., 108 N.E. 825 (N.Y. 1915). See generally 3 Jeffrey E. Thomas & Francis Mootz III, New Appleman on Insurance Law Library Ed. § 17.07[1] (2011) ("If an insurer breaches its duty to defend, however, the insured may enter into a reasonable, non-collusive settlement without the consent of the insurer and without forfeiting coverage.")

d. Additional consequences when an insurer lacks a reasonable basis for a failure to defend. For a statement in support of the automatic-forfeiture rule, see Robert H. Jerry, II, and Douglas R. Richmond, Understanding Insurance Law at 861 (4th ed. 2007):

> At first glance, it might seem that estopping the insurer to deny coverage when it unjustifiably refuses to defend puts the insurer in an impossible dilemma . . . The answer is that the insurer is not on the horns of a dilemma because . . . [t]here are mechanisms that enable an insurer to perform its duty to defend without giving up the right to contest coverage later. . . . Indeed it is the availability of these procedural alternatives that provides the best reason for estopping the insurer to deny coverage when it breaches the duty to defend.

For cases adopting the automatic-forfeiture rule, see Twin City Fire Ins. Co. v. City of Madison, Miss., 309 F.3d 901 (5th Cir. 2002) (applying Mississippi law and ruling on the basis of estoppel); Valley Imp. Ass'n, Inc. v. U.S. Fid. & Guar. Corp., 129 F.3d 1108, 1125 (10th Cir. 1997) (holding under New Mexico law that an insurer that breaches the duty to defend "will not be heard to complain that the claims might not have been within coverage"); Farmers Union Mut. Ins. Co. v. Staples, 90 P.3d 381 (Mont. 2004) ("the court should have ended the analysis and concluded that since FUMIC breached that duty, it was estopped from denying coverage and Staples was entitled to summary judgment"); Employers Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122, 1135 (Ill. 1999) ("Once the insurer breaches its duty to defend . . . . the estoppel doctrine has broad application and operates to bar the insurer from raising policy defenses to coverage, even those defenses that may have been successful had the insurer not breached its duty to defend."); Ames v. Cont'l Cas. Co., 79 N.C. App. 530, 538, 340 S.E.2d 479, 485 (1986); Conanicut Marine Servs., Inc. v. Insurance Co. of N. Am., 511 A.2d 967, 971 (R.I. 1986) (holding that an insurer that breaches the duty to defend cannot later contest coverage); Missionaries of Company of Mary, Inc. v. Aetna Casualty & Surety Co., 230 A.2d 21, 26 (Conn. 1967) ("The defendant having, in effect, waived the opportunity which was open to it to perform its contractual duty to defend under a reservation of its right to contest the obligation to indemnify the plaintiff, reason dictates that the defendant should reimburse the plaintiff for the full amount of the obligation reasonably incurred by it.") limited in part by Capstone Bldg. Corp. v. Am. Motorists Ins. Co., 67 A.3d 961 (Conn. 2013) (limiting the earlier *Missionaries* rule by holding that an insurer forfeits coverage defenses only for those causes of action "contained in the complaint or fairly discernible from the demand for defense, when considered independently" that it had a duty to defend, not for causes of action that it would not have had a duty to defend had they not been combined in the same action); Prof's Office Bldgs., Inc. v. Royal Indem. Co., 145 Wis. 2d 573, 586, 427 N.W.2d 427 (Ct. App. 1988). Note that the courts in Illinois and Wisconsin permit an insurer to suspend its duty to defend by filing a declaratory-judgment action, so that the duty to defend can be conclusively determined before the insurer is obligated to defend a claim that it believes it should not have to defend.

The famous California case Gray v. Zurich Ins. Co., 65 Cal. 2d 263, 280, 419 P.2d 168 (1966) held that "an insurer that wrongfully refuses to defend is liable on the judgment against the insured," but other cases cast doubt on whether that remains the law in all cases in California. See, e.g., Hogan v. Midland Nat'l Ins. Co., 3 Cal. 3d 553, 566, 476 P.2d 825 (1970) ("*Gray* therefore stands for the proposition that the insurer is liable whenever the trial in the underlying action involved a theory of recovery within the coverage of the policy and it was not clear whether the jury's verdict was based upon that theory"); Pruyn v. Agric. Ins. Co., 36 Cal. App. 4th 500, 514, 42 Cal. Rptr. 2d 295 (1995) as modified (July 12, 1995), as modified on denial of reh'g (July 27, 1995) ("However, where the issues upon which coverage depends are not raised or necessarily adjudicated in the underlying action then the insurer is free to litigate those issues in the subsequent action and present any defenses not inconsistent with the judgment against its insured").

For cases permitting the insurer to contest coverage notwithstanding a breach of the duty to defend, see, e.g., Employers Cas. Co. v. Block, 744 S.W.2d 940, 943-944 (Tex. 1988) (permitting the insurer to litigate the factual question of the timing of the damage notwithstanding having breached the duty to defend), overruled on other grounds by State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696, 714 (Tex. 1996); Sentinel Ins. Co., Ltd. v. First Ins. Co. of Haw., Ltd., 875 P.2d 894, 912 (Haw. 1994) (loss of coverage defenses is too great a penalty in the absence of bad faith); Servidone Const. Corp. v. Security Ins. Co. of Hartford, 64 N.Y.2d 419, 423, 477 N.E.2d 441 (1985) (recently reaffirmed on stare decisis grounds in K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co., 22 N.Y.3d 578 (2014), a decision that reversed after rehearing an earlier Court of Appeals opinion in the same case that had adopted the forfeiture-of-coverage rule apparently in ignorance of the prior *Servidone* opinion).

For cases supporting forfeiture of coverage defenses as a consequence of a bad-faith refusal to defend, see, e.g., Truck Ins. Exch. v. Vanport Homes, 58 P.3d 276 (Wash. 2002) (insurer forfeits coverage defense because of bad-faith breach of the duty to defend); Amato v. Mercury Cas. Co., 53 Cal. App. 4th 825, 833, 61 Cal. Rptr. 2d 909, 914 (1997) (holding that an insurer that breaches the duty to defend in bad faith is liable for a default judgment, even if the claims are not covered, on a theory that the refusal to defend caused the judgment). Courts in Alaska have taken an approach that is similar to a bad-faith rule, preventing the insurer from debating coverage when it has breached the duty to defend in a particularly unfair way. Compare Afcan v. Mut. Fire, Marine & Inland Ins. Co., 595 P.2d 638, 647 (Alaska 1979) (permitting an insurer who clearly states that it is not providing a defense to later litigate whether there was coverage of the settled claims) with Sauer v. Home Indem. Co., 841 P.2d 176, 183 (Alaska 1992) ("Where, as here, the insurer does not communicate its decision to withdraw or explain the basis for its decision but simply denies coverage, it should be precluded from later arguing that coverage under the policy did not exist.").

Note that the standard for subsection (2) is substantially similar to the standard for bad-faith breach in many jurisdictions. See, e.g., Kirk v. Mt. Airy Ins. Co., 951 P.2d 1124 (Wash. 1998):

> In order to establish bad faith, an insured is required to show the breach was unreasonable, frivolous, or unfounded. Wolf v. League Gen. Ins. Co., 85 Wash.App. 113, 122, 931 P.2d 184 (1997). Bad faith will not be found where a denial of coverage or a failure to provide a defense is based upon a reasonable interpretation of the insurance policy. Transcontinental Ins. Co. v. Washington Pub. Utils. Dists.' Util. Sys., 111 Wash.2d 452, 470, 760 P.2d 337 (1988).

Accord, e.g., Campbell v. Superior Court, 52 Cal. Rptr. 2d 385 (Cal. App. Dep't Super. Ct. 1996) ("[I]f an insurer unreasonably fails to defend, it has breached the implied covenant of good faith and fair dealing."); State Farm Mut. Auto. Ins. Co. v. Smith, 757 N.E.2d 881 (Ill. 2001) ("where a bona fide dispute concerning coverage exists, costs and sanctions are inappropriate"); Rumford

Prop. & Liab. Ins. Co. v. Carbone, 590 A.2d 398 (R.I. 1991) ("'There cannot be a showing of bad faith when the insurer is able to demonstrate a reasonable basis for denying benefits.' . . . 'If a claim is "fairly debatable," no liability in tort will arise.'"). For cases imposing an additional, subjective requirement for bad faith, see, e.g., Freidline v. Shelby Ins. Co., 774 N.E.2d 37 (Ind. 2002) ("To prove bad faith, the plaintiff must establish, with clear and convincing evidence, that the insurer had knowledge that there was no legitimate basis for denying liability."); Adamski v. Allstate Ins. Co., 738 A.2d 1033 (Pa. Super. Ct. 1999) ("To establish bad faith under section 8371, our Court has utilized a two-part test, both elements of which must be established by clear and convincing evidence: (1) the insurer lacked a reasonable basis for denying coverage; and (2) the insurer knew or recklessly disregarded its lack of a reasonable basis.").

Because an insurer who breaches the duty to defend may be bound to reasonable settlements of the action that it refused to defend, including the reasonable allocation of those settlements to covered claims, the ability to contest coverage may not in practice be as valuable as it might appear to be in theory. See H. Walter Croskey et al., California Practice Guide: Insurance Litigation 7:697 ("absent evidence that a settlement was unreasonable or the product of fraud or collusion, the parties' allocation of settlement proceeds solely to covered claims will not be set aside, even where the insured has been found liable for noncovered damages") (citing Howard v. American Nat'l Fire Ins. Co., 187 Cal. App. 4th 498, 532-533 (2004) (insurer liable for entire post-judgment settlement characterized as compensating plaintiffs for "physical injuries and sickness" even though judgment included punitive-damages award)). See also Liberty Mut. Ins. Co. v. Metzler, 586 N.E.2d 897 (Ind. Ct. App. 1992) (insurer is collaterally estopped to deny coverage if underlying claim is resolved on the basis of facts bringing the result within the scope of coverage).

e. Justifying the no-reasonable-basis, intermediate rule: striking a proper balance between the advantages and disadvantages of a forfeiture-of-coverage-defenses rule. See cases and materials cited in the Reporters' Note to Comment *d*.

f. Practical applications of subsection (2). For support for the proposition that, in any case in which coverage turns on disputed facts, the insurer lacks a reasonable basis for a refusal to defend, see Walter Croskey, Genuine Dispute Doctrine in Third Party Bad Faith Cases, 23 California Litigation 10 (2010):

> [W[hile there are no cases applying the genuine dispute doctrine in duty to defend cases, the application of general principles does permit some reasonable conclusions. *First*, if a potential for coverage exists (i.e., there is a factual dispute over coverage) then the insurer has a duty to defend and its failure to do so, whatever its reason, will result in bad faith liability. Or, to put it another way, the failure or refusal to provide a defense when a potential for coverage exists constitutes bad faith as a matter of law. . . .

The environmental-cleanup-action examples are based on Polaroid Corp. v. The Travelers Indem. Corp., 610 N.E.2d 912 (Mass. 1992) (Wilkins, J.) (permitting insurer to litigate whether pollution was sudden and accidental as a matter of fact after having refused to defend based on

multiple open legal issues such as the "damages" issue; leaving open the question whether forfeiture of coverage would be appropriate in the case of a bad-faith breach). Illustration 1 is loosely based on Parsons v. Continental Nat'l Am. Group, 550 P.2d 94 (Ariz. 1976). For a discussion of cases regarding the issues in Illustration 3, see David M. Lang, Sexual Malpractice and Professional Liability: Some Things They Don't Teach in Medical School – A Critical Examination of the Formative Case Law, 6 Conn. Ins. L.J. 151 (1999-2000).

g. Liability in excess of the policy limit. "The liability of the insurer is ordinarily not increased beyond policy limits because it wrongfully refuses to defend the insured." 1 Allan D. Windt, Insurance Claims and Disputes § 4:36 & n.1 (6th ed. 2013) (collecting cases). See, e.g., State Farm Mut. Auto. Ins. Co. v. Paynter, 593 P.2d 948, 954 (Ariz. Ct. App. 1979) ("The general rule, however, is that such a refusal to defend in and of itself does not expose the insurance carrier to greater liability than contractually provided in the policy."); George Winchell, Inc. v. Norris, 633 P.2d 1174 (Kan. Ct. App. 1981) (finding that the insurer had not refused to defend in bad faith and the insured therefore could not recover the judgment amount in excess of the policy limits); Conway v. Country Cas. Ins. Co., 442 N.E.2d 245, 249 (Ill. 1982) ("'The mere failure to defend does not, in the absence of bad faith, render the insurer liable for that amount of the judgment in excess of the policy limits.'"), quoting Reis v. Aetna Cas. and Sur. Co. of Illinois, 387 N.E.2d 700 (Ill. App. 1st Dist. 1978).

CHAPTER 3
GENERAL PRINCIPLES REGARDING THE RISKS INSURED

TOPIC 1
COVERAGE

§ 31. Insuring Clauses

(1) An "insuring clause" is a term in a liability insurance policy that grants insurance coverage.

(2) Whether a term in a liability insurance policy is an insuring clause does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Insuring clauses are interpreted broadly.

Comment:

a. Purpose. Classification of a term as an insuring clause is to be made on a functional rather than a formal basis. In contemporary liability insurance policies insuring clauses most commonly appear in sections of the policy with the label "insuring agreement" or similar labels, but they also appear in other parts of a liability insurance policy.

b. Insuring agreements. Contemporary insurance policies commonly contain a section labeled "insuring agreement" that specifies what will be covered under the policy provided that all of the conditions in the policy are met and no exclusions apply. Insuring agreements always contain insuring clauses, but they may also contain exclusions and conditions. An exclusion or condition that appears in an insuring agreement is subject to the ordinary rules governing exclusions and conditions. See §§ 32 and 35.

c. Insuring clauses in endorsements. Contemporary insurance policies commonly consist of one or more standard-form parts that could function as complete insurance policies, along with additional parts, known as "endorsements," that modify the coverage. Typically, the endorsements are also standard forms. Whether a term in an endorsement is an insuring clause, an exclusion, a condition, or none of these is to be determined on the same basis as if it were in the main body of the policy.

d. Exception clauses in exclusions. Contemporary insurance policies commonly contain a section labeled "exclusions" that includes a set of terms that restrict the coverage that otherwise would be provided by the policy. See § 32. Exclusions may contain exceptions that narrow the application of the exclusion. While such exceptions are insuring clauses, they operate only to narrow the exclusions in which they appear, not to expand coverage beyond that stated by other insuring clauses in the policy. See § 32(5).

e. Relation between broad interpretation of insuring clauses and contra proferentem. Judicial opinions issued in insurance-coverage cases commonly state that grants of coverage are to be interpreted broadly. This statement does not represent an independent, analytically distinct canon of construction but rather an application of the ordinary insurance-policy interpretation rules stated in §§ 3 and 4.

f. Burden of proof. The insured bears the burden of proving that a claim falls within the scope of an insuring clause in the policy. This is the prevailing legal rule.

REPORTERS' NOTES

a. Purpose. Appleman notes that an "insuring clause . . . sets forth the basic scope of the insured risk and represents the requirements that must be satisfied for a covered loss to be present." 3-16 *Appleman on Insurance* § 16.09. See, e.g., Liberty National Enterprises, L.P. v. Chicago Title Ins. Co., 217 Cal. App. 4th 62, 77 (Cal. App. 2013) ("Before considering whether any exclusions apply, we examine the insuring clause to determine whether coverage exists at all").

b. Insuring agreements. See, e.g., Clemco Industries v. Commercial Union Ins. Co., 665 F. Supp. 816, 820 (N.D. Cal. 1987) ("The placement of the phrase, however, in no way changed the effect or character of the phrase; "expected or intended" remained an exclusion of the coverage grant by the very operation of its terms. The testimony of both Clemco's and Commercial's insurance experts supported this conclusion. Clemco's expert, Professor Temple, stated very convincingly that "while [the phrase] does not appear under a heading of 'exclusion' it's not uncommon in policies to have exclusions within insuring clauses. So, yes, it serves as a way of excluding coverage for claims that would fall within that language. . . . In our industry, we construe that to be an exclusion.").

c. Insuring clauses in endorsements. See, e.g., Couch, 2 Couch on Ins. § 21:21 ("Endorsements, riders, marginal references, and other similar writings are a part of the contract of insurance and are to be read and construed with the policy proper."). See also Adams v. Explorer Ins. Co., 107 Cal. App. 4th 438, 451 (Cal. App. 2003) ("An endorsement is an amendment to or modification of an existing policy of insurance. It is not a separate contract of

insurance. Standing alone, an endorsement means nothing."); Haynes v. Farmers Ins. Exchange, 32 Cal. 4th 1198, 1204 (Cal. 2004) ("Coverage may be limited by a valid endorsement and, if a conflict exists between the main body of the policy and an endorsement, the endorsement prevails."); Hart Constr. Co. v. American Family Mut. Ins. Co., 514 N.W.2d 384, 391 (N.D. 1994) ("When there is a conflict between the provisions of an insurance policy and an attached endorsement, the provisions of the endorsement prevail").

d. Exception clauses in exclusions. See, e.g., K & L Homes, Inc. v. Am. Family Mut. Ins. Co., 2013 ND 57, ¶ 9 (N.D. 2013) ("Likewise, although an exception to an exclusion from coverage results in coverage, an exception to an exclusion is incapable of initially providing coverage; rather, an exception may become applicable if, and only if, there is an initial grant of coverage under the policy and the relevant exclusion containing the exception operates to preclude coverage"); Sheehan Constr. Co. v. Cont'l Cas. Co., 935 N.E.2d 160, 162 (Ind. 2010) ("Exceptions to exclusions narrow the scope of the exclusion and, as a consequence, add back coverage. However, it is the initial broad grant of coverage, not the exception to the exclusion, that ultimately creates (or does not create) the coverage sought."); Nav-Its, Inc. v. Selective Ins. Co., 183 N.J. 110, 127 (N.J. 2005) ("We interpret that exception to limit the reach of the pollution clause, i.e. if the environmental pollution occurs within a building within a single forty-eight hour period, and the other conditions are met, then the insured may receive coverage for that environmental pollution claim. Simply put, if the pollution exclusion is not applicable, neither is the exception to the pollution exclusion."); Sikirica v. Nationwide Ins. Co., 416 F.3d 214, 228 (3d Cir. Pa. 2005) ("The Contractual Liability provision broadens the definition of 'incidental contract' as used in the exception to the exclusion provision, but it does not extend coverage of the Policy to injury or damages that are not the result of an 'occurrence' or 'accident.'"). For an example of a court using an exception to an exclusion as a guide to interpretation of coverage, see Panfil v. Nautilus Ins. Co., No. 12 C 6481, 2014 WL 52774, at *2 (N.D. Ill. Jan. 7, 2014), aff'd, 799 F.3d 716 (7th Cir. 2015):

> Defendant correctly notes that, under Illinois law, "an exception to an exclusion does not create coverage or provide an additional basis for coverage, but, rather, merely preserves coverage already granted in the insuring provision." [citation omitted] I do not suggest that this exception to an exclusion has "created" coverage. But by "preserving coverage already granted in the insuring provision," an exception to an exclusion does offer some indication as to what the policy itself is meant to cover.

See also Architex Ass'n, Inc. v. Scottsdale Ins. Co., 27 So. 3d 1148, 1160 (Miss. 2010) ("The policy exclusions and exceptions thereto can be (and often are) valuable in determining the parameters of coverage, generally, and the meaning of 'accident' within the definition of 'occurrence,' specifically.")

e. Relation between broad interpretation of insuring clauses and contra proferentem. Miller v. Continental Ins. Co., 40 N.Y.2d 675, 678 (N.Y. 1976) ("The hornbook rule [states] that

policies of insurance, drawn as they ordinarily are by the insurer, are to be liberally construed in favor of the insured."); Richards v. Std. Acc. Ins. Co., 200 P. 1017, 1020 (Utah 1921) ("Insurance policies should be construed liberally in favor of the insured and their beneficiaries so as to promote and not defeat the purpose of insurance."); La. C.C. Art. 2056 ("In case of doubt that cannot be otherwise resolved, a provision in a contract must be interpreted against the party who furnished its text. A contract executed in a standard form of one party must be interpreted, in case of doubt, in favor of the other party."). See also Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368, 1376 (E.D.N.Y. 1988) ("At this stage, 'after it has exhausted every effort to derive the meaning of the terms that accurately reflects the intent of the parties,' the court must follow the rule of contra proferentem to construe any ambiguity against the insurer as drafter."). For a discussion how the maxim of construing an insuring clause broadly represents an application of the ambiguity principle, see Woodson v. Manhattan Life Ins. Co., 743 S.W.2d 835, 838 (Ky. 1987).

§ 32. Exclusions

(1) An "exclusion" is a term in an insurance policy that identifies a category of claims that is not covered by the policy.

(2) Whether a term in an insurance policy is an exclusion does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Exclusions are interpreted narrowly.

(4) Unless otherwise stated in the insurance policy, words in an exclusion regarding the expectation or intent of the insured refer to the subjective state of mind of the insured.

(5) An exception to an exclusion narrows the application of the exclusion; the exception does not grant coverage.

Comment:

a. Exclusions can appear anywhere in an insurance policy. Insurance law takes a functional approach to determine whether an insurance-policy term is an exclusion. Under the prevailing conventions of insurance-policy drafting, exclusions typically appear in a part of the insurance policy with the specific heading "Exclusions." But exclusions can appear in almost any part of an insurance policy: the insuring agreement, the definitions section, endorsements, and even in the conditions section.

Illustration:

1. The 1966 edition of the Commercial General Liability Insurance policy defines "occurrence" as follows:

> "occurrence" means an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

The clause "neither expected nor intended from the standpoint of the insured" is an exclusion despite the fact that it is included in a term that is contained in a section of the policy labeled "Definitions" and not in the section of the policy labeled "Exclusions."

b. Interpretation. Courts regularly state that exclusions in insurance policies are to be interpreted narrowly. This statement does not represent an independent, analytically distinct canon of construction but rather an application of the ordinary insurance-policy interpretation rules stated in §§ 3 and 4.

c. Severability of exclusions. Liability insurance policies often contain exclusions whose application depends upon specified conduct of the insured that serves as the basis for the alleged liability. Examples include exclusions for liability arising out of expected-or-intended injury, criminal or malicious acts, the use of intoxicating substances, sexual molestation, corporal punishment, physical or mental abuse, fraud, wrongful profit or advantage, and knowing violation of rights. The default rule is that such exclusions are severable, meaning that they apply only to insureds whose conduct meets the requirements of the exclusion. This rule is an application of the general rule regarding the narrow interpretation of exclusions. In addition, this rule reflects the underlying purposes of such exclusions: limiting the impact of liability insurance on incentives to engage in highly wrongful conduct, and preventing those who in fact engage in such conduct from making claims on the resources of those in the insurance pool. Applying these exclusions to insureds who did not engage in the wrongful conduct does not promote these purposes of the exclusions. Because these insureds did not engage in the wrongful conduct, there is less concern that the presence of insurance changed their incentives to engage in that conduct, nor is there the same concern about using the resources of the insurance pool on their behalf.

d. The default rule in favor of a subjective standard for expectation and intent. Many liability insurance policies contain an exclusion for claims arising out of injuries that are

"expected or intended from the standpoint of the insured." Courts have articulated different standards governing the application of this expected-or-intended exclusion. This Section adopts a subjective standard that is the majority rule, while making clear that this standard is a default rule. Under the subjective standard, an insured intends harm when such harm is the object of the insured's action, and an insured expects harm when the insured knows that the harm will occur as the result of the insured's intentional act, even if that harm was not the object of the action. This default rule is an application of the general rule in favor of the narrow interpretation of exclusions. Because the traditional expected-or-intended exclusion is silent regarding the subjective or objective nature of the standard, it is ambiguous in that regard. As demonstrated by the many judicial opinions adopting the subjective standard as the proper interpretation of the expected-or-intended exclusion, the subjective standard is a reasonable interpretation of the exclusion. Of course subjective intent can only be determined on the basis of objective evidence, as even an insured's admission of intent to harm is subject to cross-examination and the jury's assessment of credibility. Moreover, courts at times have determined that intent to harm can be inferred as a matter of law, for example in cases involving sexual abuse. Subject to any restrictions that may be imposed on public-policy or other grounds through the procedures governing the approval of liability insurance policy forms, insurers may draft around the subjective standard (as has occurred through the criminal-acts exclusion now included in many homeowners' insurance policies).

Illustrations:

2. Insured shoots a pistol at A but hits B. B files a suit against Insured, who tenders the claim to his homeowners' insurer. Insured has a standard homeowners' insurance policy that excludes coverage for claims arising out of bodily injury that is expected or intended from the standpoint of the insured. The claim is not excluded by the expected-or-intended exclusion because Insured did not intend to injure B.

3. Insured shoots a pistol at A, believing that person to be his wife. A was not in fact his wife. Insured has a standard homeowners' insurance policy that excludes coverage for claims arising out of bodily injury that is expected or intended from the standpoint of the insured. The claim is excluded by the expected-or-intended exclusion

because the Insured intended to injure A even though he was mistaken about the identity of A.

4. Manager deliberately fires a worker in violation of the Age Discrimination in Employment Act, causing emotional distress that is sufficiently severe that it leads to bodily injury. The fired worker files suit against Manager's Company, which has a standard commercial general-liability insurance policy that excludes coverage for claims arising out of bodily injury that is expected or intended from the standpoint of the insured. The claim is not excluded by the expected-or-intended exclusion because Manager did not expect or intend to cause bodily injury.

e. Burden of proof. The insurer bears the burden of proving that a claim falls within the scope of an exclusion in the policy. This is the prevailing legal rule. This burden of proof reflects the basic structure of liability insurance policies, which generally contain a relatively broad grant of coverage and a set of narrower exclusions from coverage. Each exclusion represents an insurer's efforts to identify a class of claims that differs in some material way from the broad class of claims that are covered by the policy. It is the insurer that has identified the excluded classes of claims and will benefit from being able to place a specific claim into an excluded class. Thus, assigning the insurer the burden of proving that the claim fits into the exclusion is appropriate.

f. An exception to an exclusion. The rule in subsection (5) regarding exceptions to exclusions is a straightforward application of logic to the interpretation of a liability insurance policy. An exception to an exclusion narrows the application of the exclusion; it does not extend the coverage provided by the insuring clauses in the policy. See also § 31, Comment *d.*

REPORTERS' NOTES

a. Exclusions can appear anywhere in an insurance policy. See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1205 (2d Cir. 1995), op. modified on other grounds, 85 F.3d 49 (2d Cir. 1996) ("[U]nder New York law, the exclusionary effect of policy language, not its placement, controls allocation of the burden of proof."); Borough of Moosic v. Darwin Nat. Assur. Co., 556 F. App'x 92, 97 (3d Cir. 2014) ("While the Related Claims provision appears in the section titled 'Conditions,' rather than the section titled 'Exclusions,' the location of the provision in the policy is not determinative."); United P. Ins. Co. v. McGuire Co., 281 Cal. Rptr. 375, 378 (Cal. App. 1st Dist. 1991) ("It does not matter that the [provision

limiting coverage] appears in the 'definitions' section of the policy rather than the 'exclusions' section; in either case it performs the function of an exclusion."); Jones v. Philip Atkins Const. Co., 371 N.W.2d 508, 512 (Mich. App. 1985) (holding that an exclusion that appeared on a separate endorsement to the policy barred coverage for plaintiff's injuries).

b. Interpretation. Courts regularly state that exclusions should be narrowly construed. See, e.g., 7A Couch on Ins. § 108:6 ("Exclusions from coverage in insurance policies are to be strictly construed."); Snell v. Stein, 259 So. 2d 876, 879 (La. 1972) ("Construing the exclusionary clause strictly, as we must, . . . we cannot conclude it applies here."); Reserve Ins. Co. v. Pisciotta, 640 P.2d 764, 770 (Cal. 1982) (holding that the policy's family exclusion did not apply by reasoning that "[b]ecause the word 'family' is susceptible of several reasonable definitions, the most appropriate resolution is to construe the term narrowly, i.e., in favor of the insured"); Seaboard Sur. Co. v. Gillette Co., 476 N.E.2d 272, 275 (N.Y. 1984) ("[Exclusions] are to be accorded a strict and narrow construction."); Gore Design Completions, Ltd. v. Hartford Fire Ins. Co., 538 F.3d 365, 370 (5th Cir. 2008) (applying Texas law) ("Exclusions are narrowly construed."); First Ins. Co. of Hawaii, Ltd. v. Contl. Cas. Co., 466 F.2d 807, 809 (9th Cir. 1972) ("Insurance exclusions are narrowly construed against the insurer."); Eyler v. Nationwide Mut. Fire Ins. Co., 824 S.W.2d 855, 859 (Ky. 1992) ("Kentucky law is crystal clear that exclusions are to be narrowly interpreted."); An-son Corp. v. Holland-Am. Ins. Co., 767 F.2d 700, 703 (10th Cir. 1985) ("An insurance policy's words of exclusion are to be narrowly viewed.") (citing Conner v. Transamerica Insurance Co., 496 P.2d 770, 774 (Okla. 1972)).

c. Severability of exclusions. See generally 7A Couch on Ins. § 103:37 ("Liability insurance policies employ any number of exclusions that attempt to describe certain types of behavior, liability for the consequences of which the insurer intends to exclude from coverage.") For cases determining the applicability of exclusions by examining whether the insured engaged in the excluded conduct, see, e.g., Worcester Mut. Ins. Co. v. Marnell, 398 Mass. 240, 496 N.E.2d 158 (1986) (finding that severability clause in policy created separate insurable interests and did not exclude parents from coverage for damage caused by son, who was also an insured under the policy); Unigard Mut. Ins. Co. v. Argonaut Ins. Co., 579 P.2d 1015 (Wash. App. 1978) (holding that intentional-act exclusion did not apply to other insureds who did not engage in excluded conduct); Aetna Cas. and Sur. Co. v. Dow Chem. Co., 28 F. Supp. 2d 421, 431 (E.D. Mich. 1998) ("It should also be noted that it is important to focus on whether the insured engaged in culpable conduct in order to enforce the important public policies at issue."); Arenson v. Nat'l. Auto. & Casualty Ins. Co., 45 Cal. 2d 81, 286 P.2d 816 (1955) (concluding that intentional-act exclusion did not exclude coverage for parents for intentional act of vandalism committed by son, who also was an insured under policy); Catholic Diocese of Dodge City v. Raymer, 840 P.2d 456 (Kan. 1992) (holding that intentional-act exclusion did not apply to parents who had been found to have been negligent in supervising their minor child.). For cases holding that a policy's exclusion applies only if it applies with respect to the specific insured seeking coverage see, e.g., Float–Away Door Co. v. Continental Casualty Co., 372 F.2d 701 (5th Cir. 1966); Phoenix Assur. Co. v. Hartford Ins. Co., 29 Colo. App. 548, 488 P.2d 206 (1971);

Shelby Mut. Ins. Co. v. Schuitema, 183 So. 2d 571 (Fla. Dist. Ct. App. 1966), aff'd per curiam, 193 So. 2d 435 (Fla. 1967); Pennsylvania Nat'l Mut. Casualty Ins. Co. v. Bierman, 266 Md. 420, 292 A.2d 674 (1972); American Nat'l Fire Ins. Co. v. Estate of Fournelle, 472 N.W.2d 292 (Minn. 1991); Travelers Ins. Co. v. Auto–Owners Ins. Co., 1 Ohio App. 2d 65, 203 N.E.2d 846 (1964); Commercial Standard Ins. Co. v. American General Ins. Co., 455 S.W.2d 714 (Tex. 1970); Bankers & Shippers Ins. Co. v. United States Fire Ins. Co., 216 Va. 807, 224 S.E.2d 312 (1976).

In general, the reasoning in the severability cases employs an ambiguity-centric analysis that is consistent with a default-rule approach. The following statement from the Kansas Supreme Court in Catholic Diocese v. Raymer is representative:

> The Court of Appeals noted that the general rule is that exceptions, limitations, and exclusions to insuring agreements require a narrow construction on the theory that the insurer, having affirmatively expressed coverage through broad promises, assumes a duty to define any limitations on that coverage in clear and explicit terms. . . . In Kansas, the general rule is that exceptions, limitations, and exclusions to insuring agreements require a narrow construction on the theory that the insurer, having affirmatively expressed coverage through broad promises, assumes a duty to define any limitations on that coverage in clear and explicit terms.

840 P.2d 456, at 462 (Kan. 1992). Dicta from the Massachusetts Supreme Judicial Court in Worcester Mut. Ins. Co. v. Marnell suggests that, at least in the homeowners'-insurance context, severability may be a mandatory rule, not just a default rule:

> Finally, our decision is in keeping with the long-standing rule of construction that the favored interpretation of an insurance policy is one which "best effectuates the main manifested design of the parties." [citation omitted] Clearly, the manifest design of homeowners' insurance is to protect homeowners from risks associated with the home and activities related to the home. Contrary to the position taken by Worcester Mutual, negligent supervision, unlike negligent entrustment, is a theory of recovery that is separate and distinct from the use or operation of an automobile. Thus, the negligent supervision theory advanced by Alioto and the cause of action pertaining to the negligent failure of the Marnells to prevent their son from drinking relate only to activities that are alleged to have taken place within the Marnells' home. Therefore, the Marnells could reasonably expect to be protected by their homeowners' policy in an action based on those activities.

496 N.E.2d 158, at 161 (Mass. 1986).

d. The default rule in favor of a subjective standard for expectation and intent. The expected-or-intended exclusion originally appeared as part of the definition of occurrence, as

part of the shift from accident- to occurrence-based coverage, see Donald F. Farbstein and Francis J. Stillman, Insurance for the Commission of Intentional Torts, 20 Hastings L.J. 1219, 1220-1221 & 1236-1237 (1969) (describing the two ambiguities of the term "accident" in relation to gradual events and the perspective from which to consider whether an event is accidental and explaining that "[b]y replacing the term 'accident' with that of 'occurrence,' and by supplying the definition [of occurrence] quoted above, the new policy seeks to eliminate the major ambiguities noted earlier"). Most courts have held that liability insurance uses the subjective expected-or-intended standard to determine if an accident took place. See, e.g., SL Indus. v. Am. Motorists Ins. Co., 128 N.J. 188, 212 (N.J. 1992) ("[If the insured] subjectively intends or expects to cause some sort of injury, that intent will generally preclude coverage. If there is evidence that the extent of the injuries was improbable, however, then the court must inquire as to whether the insured subjectively intended or expected to cause that injury. Lacking that intent, the injury was 'accidental' and coverage will be provided."); Hecla Mining Co. v. New Hampshire Ins. Co., 811 P.2d 1083, 1088 (Colo. 1991) ("What make injuries or damages expected or intended rather than accidental are the knowledge and intent of the insured. It is not enough that an insured was warned that damages might ensue from its actions, or that, once warned, an insured decided to take a calculated risk and proceed as before. Recovery will be barred only if the insured intended the damages, or if it can be said that the damages were, in a broader sense, 'intended' by the insured because the insured knew that the damages would flow directly and immediately from its intentional act."); Brooklyn Law School v. Aetna Casualty & Surety Co., 849 F.2d 788, 789 (2d Cir. N.Y. 1988) ("Ordinary negligence does not constitute an intention to cause damage; neither does a calculated risk amount to an expectation of damage. To deny coverage, then, the fact finder must find that the insured intended to cause damage."); S. Macomb Disposal Auth. v. Am. Ins. Co., 225 Mich. App. 635, 655 (Mich. Ct. App. 1997) ("The subjective test applies where an insurance policy uses the term 'accident' but is otherwise silent with respect to from whose perspective the event is to be deemed an accident."); In Am. Family Ins. Co. v. Walser, 628 N.W.2d 605, 612 ("Where there is specific intent to cause injury, conduct is intentional for purposes of an intentional act exclusion, and not accidental for purposes of a coverage provision. . . . [W]here there is no intent to injure, the incident is an accident, even if the conduct itself was intentional."); State Farm Fire & Cas. Co. v. Ctc Dev. Corp., 720 So. 2d 1072, 1076 ("Uzdevenes did not expect or intend for damages to result from his act of constructing the home. He did not openly defy the setback requirements; he mistakenly believed that he had received a variance for the construction. Therefore, the fact that he intentionally constructed the house knowing that it was outside of the setback line does not preclude a finding of coverage under his liability policy for this occurrence."); Physicians Insurance Co. of Ohio v. Swanson, 569 N.E.2d 906 (Ohio 1991) (adopting subjective standard); Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815 (Cal. App. 1993) (adopting subjective standard for expected). But see Carter Lake v. Aetna Casualty & Surety Co., 604 F.2d 1052 (8th Cir. 1979) ("For the purposes of an exclusionary clause in an insurance policy, the word 'expected' denotes that the actor knew or should have known that there was a substantial probability that

certain consequences will result from his actions."). For an example of a case from a jurisdiction with an objective standard adopting an exception see Amco Ins. Co. v. Haht, 490 N.W.2d 843 (Iowa 1992) (finding an exception to an intentional tort-like standard in a case in which a young boy killed a friend by throwing a baseball bat at him).

For an example of a case involving the broader exclusion for intentional harm contained in a criminal-acts exclusion, see Allstate Ins. Co. v. Peasley, 932 P.2d 1244 (Wash. 1997) (excluding losses from "any bodily injury which may reasonably be expected to result from the intentional or criminal acts of an insured person or which are in fact intended by an insured person"). Cf. Eric Knutsen, Fortuity Victims and the Compensation Gap: Re-envisioning Liability Insurance Coverage for Intentional and Criminal Conduct, 21 Conn. Ins. L.J. 209, 243 (2014) (proposing that the subjective standard should also be applied to the criminal-acts exclusion).

Illustration 2 is based on Smith v. Moran, 209 N.E.2d 18, 21 (Ill. App. 1965).

e. Burden of proof. A majority of courts require the insurer to bear the burden of proving that a claim falls within the scope of an exclusion in the policy. See, e.g., 17A Couch on Ins. § 254:12 ("The insurer bears the burden of proving the applicability of policy exclusions and limitations in order to avoid an adverse judgment after the insured has sustained its burden and made its prima facie case."); Intl. Paper Co. v. Contl. Cas. Co., 320 N.E.2d 619, 622 (N.Y. 1974) ("The insurer is cloaked with the burden of proving that the incident and claim thereunder came within the exclusions of the policy."); Ment Bros. Iron Works Co., Inc. v. Interstate Fire & Cas. Co., 702 F.3d 118, 121 (2d Cir. 2012) ("Under New York law . . . an insurer bears the burden of proving that an exclusion applies."); Great American Ins. Co. v. Gaspard, 608 So. 2d 981, 984 (La. 1992) ("As with any exclusion in an insurance policy, the insurer bears the burden of proving that the intentional injury provision is applicable."); Capital Envtl. Services, Inc. v. N. River Ins. Co., 536 F. Supp. 2d 633, 640 (E.D. Va. 2008) ("The insurer bears the burden of proving that any coverage exclusion applies."); HLTH Corp. v. Clarendon Nat. Ins. Co., CIV.A.07C-09-102RRC, 2009 WL 2849779, at *22 (Del. Super. Aug. 31, 2009), aff'd sub nom. Axis Reinsurance Co. v. HLTH Corp., 993 A.2d 1057 (Del. 2010), as corrected (May 10, 2010) ("Under Delaware law, because the Plaintiffs have established, and the parties do not dispute, that their loss is within the terms of the policies, Defendants, as insurers, bear the burden of establishing that the Prior Notice Exclusion bars coverage."); Madison Constr. Co. v. Harleysville Mut. Ins. Co., 557 Pa. 595, 735 A.2d 100, 106 (1999) ("Where an insurer relies on a policy exclusion as the basis for its denial of coverage and refusal to defend, the insurer has asserted an affirmative defense and, accordingly, bears the burden of proving such defense."); New Hampshire Ins. Co. v. Martech USA, Inc., 993 F.2d 1195, 1199 (5th Cir. 1993) ("[U]nder . . . Texas law, the burden is on the insurer to prove the applicability of policy exclusions.").

f. An exception to an exclusion. See, e.g., K & L Homes, Inc. v. Am. Family Mut. Ins. Co., 2013 ND 57, ¶ 9 (N.D. 2013) ("Likewise, although an exception to an exclusion from coverage results in coverage, an exception to an exclusion is incapable of initially providing

coverage; rather, an exception may become applicable if, and only if, there is an initial grant of coverage under the policy and the relevant exclusion containing the exception operates to preclude coverage."); Sheehan Constr. Co. v. Cont'l Cas. Co., 935 N.E.2d 160, 162 (Ind. 2010) ("Exceptions to exclusions narrow the scope of the exclusion and, as a consequence, add back coverage. However, it is the initial broad grant of coverage, not the exception to the exclusion, that ultimately creates (or does not create) the coverage sought."); Nav-Its, Inc. v. Selective Ins. Co., 183 N.J. 110, 127 (N.J. 2005) ("We interpret that exception to limit the reach of the pollution clause, i.e. if the environmental pollution occurs within a building within a single forty-eight hour period, and the other conditions are met, then the insured may receive coverage for that environmental pollution claim. Simply put, if the pollution exclusion is not applicable, neither is the exception to the pollution exclusion."); Sikirica v. Nationwide Ins. Co., 416 F.3d 214, 228 (3d Cir. Pa. 2005) ("The Contractual Liability provision broadens the definition of 'incidental contract' as used in the exception to the exclusion provision, but it does not extend coverage of the Policy to injury or damages that are not the result of an 'occurrence' or 'accident.'").

§ 33. Timing of Events That Trigger Coverage

(1) When a liability insurance policy provides coverage based on the timing of a harm, event, wrong, loss, activity, occurrence, claim, or other happening, when that harm event, wrong, loss, activity, occurrence, claim, or other happening took place is a question of fact.

(2) A liability insurance policy may deem a harm, event, wrong, loss, activity, occurrence, claim, or other happening that triggers coverage under a liability insurance policy to have taken place at a specially defined time, even if it would otherwise be determined as a matter of fact to have taken place at a different time.

Comment:

a. Trigger of coverage. Liability insurance policies typically contain a requirement that a covered claim must arise out of a specified class of events that take place during a specified time period. Such requirements are sometimes referred to as the "trigger of coverage" for a liability insurance policy. An insurance policy is "triggered" when certain events take place that activate the coverage, subject to any applicable exclusions or other terms in the policy. In most liability situations, it is clear whether the relevant events took place within the relevant policy period. For example, automobile liability insurance policies generally contain an accident trigger of coverage

that is linked to the policy period. Thus, if an insured driver has an auto liability claim brought against her, only an auto liability insurance policy in effect at the time of the accident may be obligated to provide coverage for the claim. A determination that a particular policy is triggered does not necessarily mean that the policy covers that claim. For example, there may be exclusions that prevent the triggered policy from providing coverage.

Illustrations:

1. The insured owns and operates a car that is covered under a standard auto liability policy, which contains the following language as part of its insuring agreement: "The company will pay damages which an insured becomes legally obligated to pay because of bodily injury, sustained by a person, and damage to or destruction of property, arising out of the ownership, maintenance or use of the owned auto." In the "conditions" section of the policy, there is a term stating that "this policy applies only to bodily injury or property damage that occurs during the policy period." The declarations page of the policy contains the following term: "Policy period: 01/01/Year 1 – 01/01/Year 2." On April 25, Year 1, the insured, while driving his covered car, accidentally but negligently runs into the rear of another vehicle at a traffic light. The driver of the other car suffers neck and head injuries, and her car sustains damage to its rear bumper and to the trunk, all as a result of the accident. She files a personal-injury suit against the insured in May of Year 2 seeking recovery for these losses, as well as for damages for pain and suffering. The insured's Year 1 auto liability policy is triggered by these events. Therefore, the insurer issuing that policy may owe a duty to defend and a duty to indemnify the insured with respect to any bodily-injury and property-damage claims brought by the other driver, depending on other terms in the insured's policy.

2. The insured is an orthopedic surgeon who purchased an occurrence-based medical-malpractice liability policy that contains the following term in the insuring agreement:

> The company will pay on behalf of the insured all sums which the insured shall be legally obligated to pay as damages because of injury arising out of the rendering of or failure to render, during the policy period, professional services in the practice of the named insured's profession as a physician or surgeon by the named

> insured or by any person for whose acts or omissions the named insured is legally responsible, and the company shall have the right and duty to defend any suit against the insured seeking damages, even if any of the allegations of the suit are groundless, false, or fraudulent, and may make such investigation and such settlement of any claim or suit as it deems expedient.

The declarations page of the policy contains the following term: "Policy period: 01/01/Year 4 – 01/01/Year 5."

On November 5, Year 5, a medical-malpractice suit is filed against the insured alleging that the insured, while performing routine back surgery on the claimant, negligently severed a nerve that left the claimant, who is a professional violinist, permanently unable to play the violin. The insured's Year 4 medical-malpractice policy is triggered because the bodily injury in question allegedly arose out of the rendering, or failure to render, services during that policy period.

b. Categories of coverage triggers. Because all liability insurance policies are issued for a defined policy period, all liability insurance policies have some trigger of coverage. Most triggers of coverage fall into one of three categories: harm-based, cause-based, and claims-based. A harm-based trigger of coverage is a requirement that a specified form of harm must take place during the specified period. Common harm-based triggers are bodily injury and property damage. A cause-based trigger of coverage is a requirement that a specified causal act must take place during the specified period. Examples of cause-based triggers include professional services, accident, and wrongful act. A claims-based trigger of coverage is a requirement that a claim be first made against the insured during the specified period.

c. Dual triggers of coverage. Some liability insurance policies have more than one timing requirement. For example, errors-and-omissions policies frequently contain both claims-made and caused-based triggers of coverage, requiring that the claim be first made during the policy period or during a defined additional period (typically referred to as an "extended reporting period") and that the claim arise out of a wrongful act that occurred after a specified date (typically referred to as the "retroactive date"). Similarly the claims-made form of general-liability insurance contains both claims-made and harm-based triggers of coverage, requiring that

the claim be first made during the policy period or during an extended reporting period and that the claim arise out of bodily injury or property damage that occurred after the retroactive date.

d. A question of fact. Determining when a triggering harm, event, wrong, loss, activity, occurrence, or other happening takes place involves distinct questions of law and fact. Determining what particular event the liability insurance policy requires to take place, and when, involves the interpretation of the policy, which is a question of law. Determining whether the required event took place during the required period involves the application of the policy, as interpreted by the court, to the facts. When there is no dispute about the relevant facts, courts may decide as matter of law whether or not an insurance policy is triggered.

e. The use of deemer clauses. Some liability insurance policies contain terms that deem a triggering event to take place during a designated period, even when that event did not in fact take place during that period. For example, many claims-made policies contain a "notice of circumstances" clause that grants the policyholder the option of providing the insurer with notice of circumstances that may lead to a claim. Such clauses typically provide that, if such circumstances do result in a claim, that claim will be deemed to have been first made at the time of the notice of circumstances. Such clauses protect policyholders by providing them the option to secure coverage under an existing policy for a legal action that may be brought in the future, after the period for reporting claims under the policy has ended.

f. Trigger theories in long-tail-harm cases involving occurrence-based policies. Liability claims for "long-tail" (or continuous-injury, progressive or latent) harms present difficult issues of contract interpretation and application for commercial general-liability insurance policies as well as for other similarly worded insurance policies. The term "long-tail harms" describes a series of indivisible harms, whether bodily injury or property damage, that are attributable to continuous or repeated exposure to the same or similar substances or conditions that take place over multiple years or have a long latency period. The paradigmatic examples of long-tail harms are asbestos-related bodily injuries and environmental property damage. These two classes of long-tail harms have together, over the past several decades, produced more payments by liability insurers than any other source of liability in history.

In the context of long-tail harms, the "trigger of coverage" question can be especially problematic. In such cases, it is difficult, sometimes impossible, to determine precisely when bodily injury and property damage occurs. Reflecting this difficulty, courts in long-tail-harm

cases have developed many different approaches to the question of when bodily injury or property damage occurs. Under the "exposure theory," bodily injury or property damage is said to occur during the years in which the claimants are exposed to the harm-causing circumstance, irrespective of when the harm is made manifest. Under the "manifestation theory," bodily injury or property damage occurs in the first year in which such injury or damage either is or reasonably can be detected by the claimant. The manifestation theory, therefore, could result in a single year's policy being triggered, even though the exposure occurs over many years. Under the "continuous trigger theory," by contrast, bodily injury or property damage is presumed to occur over the course of the entire period of exposure and manifestation, subject to proof by the insurer to the contrary. Under the "double trigger" theory, courts have held that the injury occurs both at the time of exposure and at the time of manifestation, though not necessarily during the intervening period. Finally, under the "injury in fact" or "actual injury" trigger theory courts make the effort—even in these difficult latent-harm cases—to determine in which years the injury or damage in fact occurs.

Just as for harm-based triggers in general, this Section adopts the injury-in-fact approach to determining the trigger of coverage for long-tail harms under standard-form occurrence-based liability insurance policies. A liability insurance policy with a harm-based trigger provides coverage for a claim only if the specified harm in fact occurred during the policy period, unless the policy states otherwise. Consistent with the general rule regarding defense duties stated in § 13, the duty to defend is triggered by an allegation that the harm occurred during the policy period or, if there is no allegation, a factual basis for the insured's assertion that the harm occurred during the policy period. This default rule is consistent with the language in the standard-form commercial general-liability insurance policies, as well as other occurrence-based liability-insurance policies, and is consistent with the intuition that "coverage follows injury." If a court concludes that the injury or property damage in question is the result of a continuous process that takes place over the course of time, the injury-in-fact approach can produce results that are indistinguishable from the exposure and continuous-trigger approaches. Thus, when the available scientific evidence is not able to determine the precise amount of harm attributable to a particular year or to particular years, most courts have concluded either that the continuous-trigger rule applies or, applying the injury-in-fact trigger, that the bodily injury or property damage actually takes place continuously from the moment of first exposure to asbestos or

environmental contaminants. In such cases there is little ultimate difference between the injury-in-fact trigger and the continuous trigger. This is true, for example, in cases involving asbestos-related bodily injuries or certain types of environmental property damage.

By contrast, for other types of long-tail risks, where the available scientific evidence provides more information as to the particular timing of actual injuries, there can be a distinct difference between the injury-in-fact trigger and the continuous trigger. Some courts, for example, have held that if a "discrete and identifiable event" that initially gave rise to the continuing harm can be identified, the year in which that event took place will be considered the single year of the actual injury, and therefore the only triggered year. This rule has been applied in some breast-implant liability cases, for example, where the damage could be traced back to the initial implant, as well as in some environmental cases, where the progressive damage could be traced back to a single, discrete original spill. Under the injury-in-fact approach, the breast implant and environmental injuries would not be limited to the policy period in which the discrete and identifiable event took place unless, in fact, all the injuries took place during that policy period.

g. When the facts cannot be determined. When it is not possible to determine whether or when a triggering event took place, the question whether a liability insurance policy is triggered is resolved through the allocation of the burden of proof. Ordinarily, the insured has the burden of proving that a liability insurance policy is triggered; but there may be circumstances in which the court assigns to the insurer the burden of proving that its policy is not triggered. For example, in long-tail-harm cases, especially those involving asbestos exposure, it may be enough for the insured simply to demonstrate that potential claimants were exposed to the risk prior to the relevant policy period, and then each insurer will be given an opportunity to prove that there was no injury during its policy period.

REPORTERS' NOTES

a. Trigger of coverage. Trigger-of-coverage concepts have been used to help define when a policy goes into effect and what effects are covered. See Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1042 (D.C. Cir. 1981) ("Trigger of Coverage; The first step in the analysis of this problem is to determine what events, from the point of exposure to the point of manifestation, trigger coverage under these policies. In the language of the policies, the question is when did 'injury' occur?"); Owens-Illinois, Inc. v. Aetna Casualty & Surety Co., 597 F. Supp. 1515, 1518 (D.D.C. 1984) ("Under that decision O-I asserts that the 'trigger' of coverage, the

events or conditions that determined that the insurance policies apply to the asbestos claims, were the exposure of the claimants to asbestos fibers, or the continuing development of the disease after exposure, or manifestation of the injury."); Eli Lilly & Co. v. Home Ins. Co., 482 N.E.2d 467, 468 (Ind. 1985) ("The basic dispute concerns what must happen during a particular policy period to invoke insurance coverage for that period, described by the insurers as the trigger of coverage."); and Montrose Chemical Corp. v. Admiral Ins. Co., 913 P.2d 878, 880 n.2 (Cal. 1995) (defining trigger of coverage as "what must take place within the policy's effective dates for the potential of coverage to be 'triggered.'"). In run-of-the-mill personal-injury and property-damage cases, which policies are triggered is obvious. Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State 537 (3d ed. 2015). The issue can be much more difficult in long-tail-harm cases, such as those involving progressive asbestos or environmental harms. Id. The trigger issue also arises in construction-defect cases. See, e.g., Pepperell v. Scottsdale Ins. Co., 62 Cal. App. 4th 1045, 1053 (Cal. App. 1998) ("[T]he continuous injury trigger of coverage should be applied to third party claims of continuous or progressively deteriorating damage or injury."); Rando v. Top Notch Properties, L.L.C., 879 So. 2d 821, 827 (La. Ct. App. 2004); see also Maniloff & Stempel, supra, chapter 17 (surveying construction defect and other non-latent-harm trigger cases). Courts have also had to select among trigger theories in the first-party property context. See Prudential-LMI Com. Ins. v. Superior Court, 789 P.2d 1230, 1246 (Cal. 1990) ("[W]e conclude that in first party progressive property loss cases, when, as in the present case, the loss occurs over several policy periods and is not discovered until several years after it commences, the manifestation rule applies.").

b. Categories of coverage triggers. For an example of a harm-based coverage trigger see Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1188 (2d Cir. 1995) ("Because the policies are triggered by injury or damage that occurs during the policy period, the trials focused extensively on when asbestos-related bodily injury and property damage occurs for purposes of these policies."); 7 Couch on Ins. § 102:25 ("Coverage is triggered when the harm first manifests, and the insurer on the risk at the time of first manifestation is liable for the entire loss even if the damage progresses after the policy expires."). For an example of a cause-based coverage trigger, see President v. Jenkins, 180 N.J. 550, 554 (N.J. 2004) ("Generally, an 'occurrence' policy provides coverage for any asserted misconduct that occurs during the policy period, even if the claim is asserted after the policy expires."); 7 Couch on Ins. § 102:23 ("The peril insured is the occurrence itself, and once the occurrence takes place, coverage attaches even though the claim may not be made for some time thereafter."). For an example of a claims-based coverage trigger see St. Paul Fire & Marine Ins. Co. v. House, 315 Md. 328, 333 (Md. 1989) ("The ordinary meaning of 'claim made' refers to the assertion of a claim by or on behalf of the injured person against the insured. In this case Platzer's claim was made, in the ordinary meaning, during the policy period. St. Paul reads the policy specially to define 'claim made' as the reporting of a claim or potential claim by the insured to the insurer. On that basis the claim was not made until after the policy had expired. Reading the policy as a whole leaves St. Paul's interpretation far from clear."); 7 Couch on Ins. § 102:30 ("Insurers may be held responsible for

losses caused by defects created before issuance of policy, in light of existence of 'manifestation rule' under which insurer is responsible for claims on loss manifesting during policy period even though cause may have been present, and damage begun, before inception of policy.").

c. Dual triggers of coverage. For examples of dual triggers of coverage see Rotwein v. General Acci. Group, 103 N.J. Super. 406, 421 (Law Div. 1968) ("This policy applies only to errors, omissions or acts which occur within the United States of America, its territories or possessions, or Canada during the policy period and then only if claim is first made against the insured during the policy period."); T.H.E. Ins. Co. v. P.T.P., Inc., 331 Md. 406, 408 (Md. 1993) ("The policy acquired by P.T.P. from T.H.E. was written on a claims made basis. The policy period was from April 2, 1987, to April 2, 1988, with a retroactive date of April 2, 1987. Injuries occurring before the retroactive date are not covered by the policy."); Ballow v. Phico Ins. Co., 875 P.2d 1354, 1366 (Colo. 1993) ("Some insurers offer policies that have a retroactive date identical to the beginning of the coverage with the insurer. This type of policy is a combination of claims-made and occurrence policies. This type of claims-made coverage (hybrid claims-made policy) covers negligent acts or omissions which occur and are the subject of a claim during the policy period."); Stine v. Continental Casualty Co., 349 N.W.2d 127, 134 (Mich. 1984) ("The insurance afforded by this policy applies to errors, omissions or negligent acts which occur on or after the date stated in item 6 of the declarations (the effective date of the first policy issued and continuously renewed by the Company) provided that claim therefor is first made against the insured during this policy period and reported in writing to the Company during this policy period or within 60 days after the expiration of this policy period.").

d. A question of fact. Whether a liability insurance policy is triggered with respect to a particular claim ordinarily is a question of fact to be determined by the factfinder. See Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1195-1196 (2d Cir. 1995) ("[T]he New York Court of Appeals had considered the triggering issue in the property damage context . . . [T]he Court noted that 'application of the term accident in such contexts as that before us provides a question of fact.'") (citing McGroarty v. Great Am. Ins. Co., 329 N.E.2d 172, 174 (N.Y. 1975)); Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 888 (Cal. 1995) ("[T]he proper resolution of a trigger of coverage issue in any given case may turn on whether the court is addressing underlying facts involving a single event resulting in immediate injury (e.g., an explosion causing instantaneous bodily injuries and destruction of property), a single event resulting in delayed or progressively deteriorating injury (e.g., a chemical spill), or a continuing event (referred to in CGL policies as 'continuous or repeated exposure to conditions') resulting in single or multiple injuries (e.g., exposure to toxic wastes or asbestos over time)."); Towns v. N. Sec. Ins. Co., 964 A.2d 1150, 1165, 1165 n.6 (Vt. 2008) ("The record here also supports the trial court's application of the continuous-trigger test to conclude that environmental damage occurred during the policy period. . . . Under the facts presented here . . . the evidence leaves no doubt that both exposure and injury-in-fact occurred while the Northern policy was in effect."); Mayor & City Council of Baltimore v. Utica Mut. Ins. Co., 802 A.2d 1070, 1095 (Md. 2002)

("According to the Michigan Supreme Court, reference to specific trigger paradigms 'can be deceiving,' because in the final analysis the court must apply policy language in particular factual contexts.") (citing Gelman Sciences, Inc. v. Fidelity & Casualty Co., 572 N.W.2d 617, 622 (Mich. 1998)); Domtar, Inc. v. Niagara Fire Insurance Co., 563 N.W.2d 724, 733 (Minn. 1997) ("The proper scope of coverage also will depend on the facts of the case."); see 7 Couch on Ins. § 102:23 ("In order to trigger coverage under occurrence clause in comprehensive general liability insurance policy, damage must be sustained during policy period."); E.R. Squibb & Sons, Inc. v. Lloyd's & Cos., 241 F.3d 154, 164 (2d Cir. N.Y. 2001) ("In general, a liability insurer's 'duty to indemnify is "triggered" by a determination that fortuitous bodily injury or property damage took place during the policy period.'" quoting Barry R. Ostrager & Thomas R. Newman, Handbook on Insurance Coverage Disputes § 9.01, at 408 (9th ed. 1998)).

e. The use of deemer clauses. The purpose of a deemer clause is to limit an insurer's risk from a single harm or series of harms to the policy limits of a single policy. See United Technologies Corp. v. Liberty Mut. Ins. Co, No. 877172, 1993 WL 818913, at *19 (Mass. Super. Aug. 3, 1993) ("The purpose of the 'deemer' clause, according to Liberty, is to limit the insurer's risk to the coverage limit of one policy."); Liberty Mut. Ins. Co. v. Black & Decker Corp., 383 F. Supp. 2d 200, 212 (D. Mass. 2004) ("The purpose of the deemer clause was to prevent 'stacking' of claims, by assigning a claim to a single policy—not by completely excluding coverage. The clause's effect is to limit each individual accident to a single policy year."); Endicott Johnson Corp. v. Liberty Mut. Ins. Co., 928 F. Supp. 176, 182 (N.D.N.Y. 1996) ("The Court notes that the clause was included in policies before there was a general awareness of environmental pollution problems. . . . As a result, just as the Court held in its previous summary judgment decision, coverage for property damage caused by gradual pollution is afforded by the policy or policies in force when the property damage occurred."). Application of a deemer clause is also a fact-intensive question. See Cincinnati Ins. Co. v. ACE INA Holdings, Inc., 886 N.E.2d 876, 887 (2007) ("The question we must answer is whether the multiple exposures constituted the 'same general conditions' under the deemer clause."). Deemer clauses are applied in a number of different contexts, and courts in different jurisdictions often apply the clauses differently, even when the context is the same. For example, some courts will enforce a deemer clause that limits damage caused by sexual abuse to the first encounter. See TIG Ins. Co. v. Smart Sch., 401 F. Supp. 2d 1334, 1349 (S.D. Fla. 2005) ("The first encounter rule may apply where the parties agree that all damage occurred at the time of the first sexual encounter."). But see Roman Catholic Diocese of Joliet, Inc. v. Interstate Fire Ins. Co. (State Report Title: Roman Catholic Diocese v. Lee), 685 N.E.2d 932, 939 (Ill. Ct. App. 1997) ("[W]e conclude that in the event of ongoing sexual abuse spanning multiple policy periods, application of the first encounter rule is both inappropriate and inequitable.").

A deemer clause usually states the particular facts that must be provided by the insured to the insurer to properly give notice, facts including dates, persons, and entities involved. Whether the policyholder has provided sufficient information to put its insurer on notice is normally a

question of fact. See Chatz v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 372 B.R. 368, 372 (N.D. Ill. 2007); Sigma Fin. Corp. v. Am. Int'l Specialty Lines Ins. Co., 200 F. Supp. 2d 710, 718 (E.D. Mich. 2002) ("The Court is mindful, however, that notice under a 'claims made' policy must be made with sufficient specificity. . . . Relaxing the notice requirement, allowing coverage to be triggered by broadly phrased, innocuous, or non-specific statements, would permit an unbargained-for expansion of the policy, undermining the key distinguishing characteristic of a claims made policy."). The burden of proof is on the policyholder. See Brown Daltas & Associates, Inc. v. Gen. Acc. Ins. Co. of Am., 48 F.3d 30, 37 (1st Cir. 1995) ("Put in concrete terms, it was the insureds' burden to prove that they *first* became aware during the policy period of the circumstances subsequently giving rise to the . . . claim.").

In claims-made policies, a "notice of circumstances" clause allows the policyholder to provide its insurer with notice of circumstances that may lead to a claim. See KPFF, Inc. v. California Union Ins. Co., 56 Cal. App. 4th 963, 973 (1997) ("[I]f the pleadings contain material relevant both to the reporting of a claim and to circumstances covered by the awareness provision, they can serve the dual purpose of both reporting a claim and giving written notice of circumstances which may subsequently give rise to other claims."); City of Sterling Heights v. United Nat'l. Ins. Co., 2004 WL 252091, at *6 (E.D. Mich. Feb. 11, 2004) ("[B]ecause all the claims in the State and Federal Actions are claims asserting losses to the same person or organization as a result of wrongful acts, they are all deemed under United's policy to have been made at the time the first of them was made. . . . [A]rguments that the State and Federal Actions state several claims . . . miss the point. There is no dispute that Plaintiffs were aware of and gave notice of circumstances that might give rise to claims . . . during the 9/1/00 to 9/1/01 policy period. . . . In light of the deemer clause . . . all claims asserted . . . are to be deemed first made during the earlier . . . policy period.").

f. Trigger theories in long-tail-harm cases involving occurrence-based policies. In the context of long-tail, progressive-harm cases, such as those involving asbestos or environmental harm, there are five types of trigger theories: the exposure theory, the manifestation theory, the continuous-trigger theory, the double- or triple-trigger theory, and the injury-in-fact trigger theory. See Atchinson, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co., 71 P.3d 1097, 1135 (Kan. 2003) (listing all five trigger theories) (citing to Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994)); see also Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 893-895 (Cal. 1995) (listing and describing four trigger theories—all of those listed above, except for the double/triple trigger theory).

For examples of courts applying the exposure-trigger theory, see Hancock Labs. v. Admiral Ins. Co., 777 F.2d 520, 523 (9th Cir. 1985) ("Under the exposure theory, which applies to diseases that are cumulative and progressive, bodily injury occurs when an exposure causing tissue damage takes place and not when physical symptoms caused by the disease manifest themselves."); and Cole v. Celotex Corporation, 599 So. 2d 1058 (La. 1992); Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980). For examples of courts applying

the manifestation theory, see Clutter v. Johns-Manville Sales Corp., 646 F.2d 1151, 1157 (6th Cir. Ohio 1981) ("Ohio products liability cases implicitly use the date a latent defect manifests itself by causing injury, this Court concludes that it should continue to adhere to Brush Beryllium and hold that Ohio would apply a manifestation rule for determining when the cause of action from asbestosis should accrue under Ohio law."); Eagle-Picher Industries, Inc. v. Liberty Mut. Ins. Co., 682 F.2d 12, 20 (1st Cir. Mass. 1982) (The manifestation theory holds that insurance kicks in when a disease "becomes 'manifest or active'"; coverage is not defeated by a showing that the disease previously lay dormant in the body."). For examples of courts applying the continuous-trigger theory, see Lac D'Amiante Du Quebec, Ltee. v. American Home Assurance Co., 613 F. Supp. 1549, 1556 (D.N.J. 1985) (footnote omitted) ("[C]overage is triggered by a claim that a victim was either exposed to asbestos products, suffered exposure in residence, or manifested an asbestos-related disease during the policy period. Because the policies' 'trigger'—the occurrence of injury—is a continuing process beginning with the inhalation of asbestos fibers and ending years later with the manifestation of an asbestos-related disease, any insurer whose policy was in effect at any point in this process would be, under this theory, jointly and severally liable for the whole of this single injury with the insurers to determine amounts of contribution among themselves."); Carey Canada, Inc. v. California Union Ins. Co., 748 F. Supp. 8, 12 (D.D.C. 1990) (Citing to Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981), "continuous trigger applies because bodily injury caused by asbestos begins with inhalation of fibers and ends with manifestation."). For courts applying the double-trigger theory, a combination of the manifestation and exposure theories, see Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150, 160 (Ill. 1987) ("[A]n insurer whose policy was in force at the time a claimant was exposed to asbestos . . . [W]e agree that the evidence supports the conclusion that disease occurs, and therefore triggers coverage, when it becomes manifest . . . a 'sickness,' . . . would also trigger coverage under the policies."); John Crane, Inc. v. Admiral Ins. Co., 991 N.E.2d 474 (Ill. Ct. App. 2013) (reaffirming *Zurich*). For courts applying the injury-in-fact approach, see American Home Products Corporation v. Liberty Mut. Ins. Co., 748 F.2d 760 (2d Cir. 1984); Emhart Indus., Inc. v. Century Indem. Co., 559 F.3d 57 (1st Cir. 2009); Olin Corp. v. Certain Underwriters at Lloyd's London, 221 F.3d 307 (2d Cir. 2000); Domtar, Inc. v. Niagra Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997).

Minnesota follows its own version of the actual-injury or injury-in-fact trigger theory to long-tail harms. First, courts in such cases determine if there was a "discrete and identifiable event" that caused or began the long-tail harm. If so, only the policy in force in that year is triggered, even if the harm continues over multiple years. See, e.g., Northern States Power Co. v. Fidelity & Casualty Co. of N.Y., 523 N.W.2d 657 (Minn. 1994) (adopting actual-injury trigger theory); SCSC Corp. v. Allied Mutual Ins. Co., 536 N.W.2d 305 (Minn. 1995) (applying actual-injury trigger to environmental case and finding that trigger occurred in single year in which the original spill took place, even though harm continued over multiple policy periods); In re Silicone Implant Ins. Coverage Litig., 667 N.W.2d 405, 415 (Minn. 2003) (applying *SCSC Corp* ruling on actual-injury trigger to breast-implant context and finding that if "discrete originating

event" can be identified, it will be deemed the sole trigger). Even in Minnesota, however, if no discrete and identifiable event can be found, multiple policies can be triggered. Wooddale Builders, Inc. v. Maryland Casualty Co., 722 N.W.2d 283, 295 (Minn. 2006).

g. When the facts cannot be determined. Ordinarily, the insured has the burden of proving that a liability insurance policy is triggered. See 17A Couch on Ins. § 254:11 ("Generally speaking, the insured bears the burden of proving all elements of a prima facie case including the existence of a policy, payment of applicable premiums, compliance with policy conditions, *the loss as within policy coverage*, and the insurer's refusal to make payment when required to do so by the terms of the policy.") (emphasis added); 17A Couch on Ins. § 254:37 ("[T]he insured must prove that the policy at issue in the case at hand was in force at the time of the loss, by a preponderance of the evidence."); N. States Power Co. v. Fid. & Cas. Co. of New York, 523 N.W.2d 657, 663-664 (Minn. 1994) ("Consistent with long-standing principles of insurance law, the insured bears the burden of proving the policy was 'triggered' and therefore that coverage is available."); Tillman v. Lincoln Warehouse Corp., 72 A.D.2d 40, 43 (N.Y. App. Div. 1979) (same); Banco Nacional De Nicaragua v. Argonaut Ins. Co., 681 F.2d 1337, 1340 (11th Cir. Fla. 1982) (same); Carey Canada, Inc. v. California Union Ins. Co., 748 F. Supp. 8, 12 (D.D.C. 1990) (same). In cases involving long-tail risks, especially asbestos cases, some jurisdictions have determined that fairness and efficiency require that the burden of proof be shifted to insurers. See, e.g., Keene Corp. v. Insurance Co. of North America, 667 F.2d 1034 n.42 (1981) ("We recognize that the insured generally bears the burden of proving coverage. The injuries at issue in these cases, however, are unique and traditional procedural rules cannot be allowed to defeat Keene's or its insurers' substantive rights under the policies. We recognize that burdens of proof are matters of state law. . . . We believe, however, that this case is so different from the cases in which the insured's burden of proof developed, that those cases provide no authority for this case. Reversal of the ordinary burden of proof will be more equitable for all parties and will prevent unnecessary litigation."); and Insurance Co. of North America v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1225 n.27 (1980) ("If an insurance company can show that a certain manufacturer's products were not or could not have been involved for certain years, it will be absolved from paying its pro-rata share for those years. Given the impossibility in most cases of ascertaining which company provided asbestos products in different years, we think that this is the fairest way to apportion liability. Thus, we simply reverse the ordinary burden of proof and place it on the insurer. We are keenly aware of the need to apply a straightforward formula and not one which will lead to additional litigation.").

§ 34. Insurance of Liabilities Involving Aggravated Fault

(1) It is not against public policy for a liability insurance policy to cover defense costs incurred in connection with any claim, including but not limited to a criminal prosecution; an action seeking fines, penalties, or punitive damages; and a claim alleging intentionally caused harm, fraud, criminal acts, or other conduct involving aggravated fault.

(2) It is not against public policy for a liability insurer to pay damages to a third-party claimant for the civil liability of the insured for intentionally caused harm, punitive damages, fraud, criminal acts, or other conduct involving aggravated fault. If insulating the insured from the financial consequences of such liability would contravene the public purpose of the imposition of liability, the insurer may seek indemnification from the insured for any amounts the insurer paid to or on behalf of the claimant.

Comment:

a. Scope. This Section addresses the insurability of defense costs and liability for damages incurred in claims involving aggravated fault. It does not address the question whether a particular insurance policy contains terms that would provide such coverage. This latter question is one of interpretation that is addressed using the rules of insurance-contract interpretation set forth in §§ 3 and 4. The rules in this Section apply only if the application of the ordinary rules of insurance-contract interpretation determines that the insurance policy provides the coverage in question. A term in an insurance policy excluding such coverage is enforceable.

b. Defense coverage for criminal proceedings. Payment of the costs of defending criminal proceedings brought against an insured is among the forms of defense coverage that are permissible for liability insurers to provide. Whether such defense costs are insured under any particular liability insurance policy is a question of interpretation. There are no public-policy-based restrictions on such defense coverage under prevailing insurance law. Courts generally hold that such coverage does not violate public policy, among other reasons because such insurance promotes the presumption of innocence and other constitutionally protected aspects of a criminal defense.

c. Defense coverage for uninsurable civil remedies. Just as courts generally enforce defense coverage for criminal proceedings, courts also generally enforce defense coverage for civil actions seeking uninsurable remedies. To the extent that there are public-policy objections to insurance for certain liabilities, the objection is based upon the premise that the insured is liable for the wrong upon which the remedy is based. Defense coverage provides the means for the insured to contest liability, not to avoid the financial consequences of liability actually assessed. There are no public-policy-based restrictions on such defense coverage.

d. Insurance of civil liability arising out of criminal acts. There is no blanket, public-policy-based objection in insurance law to insuring a civil liability that arises out of a criminal act, even in jurisdictions with public-policy-based restrictions on the insurability of certain kinds of liabilities. In such jurisdictions, the insurability of civil liability arising out of a criminal act generally depends on whether the insured intended to injure the victim or whether punitive damages are assessed. To the extent that public-policy-based limits on insurance coverage are based on a concern about moral hazard, the fact that a wrong is also a crime should reduce that concern, because the presence of criminal penalties will increase whatever deterrence is provided by liability. A wrongdoer whose conduct is not affected by potential criminal liability is unlikely to be affected by the presence or absence of liability insurance for civil liability.

e. Insurance of vicarious liability. Courts generally permit insurance coverage of liabilities that are assessed vicariously, even in situations in which the liability of the primary actor would be uninsurable in the jurisdiction, for example punitive damages.

f. Insurance of direct punitive damages. Courts in nearly all states that have considered the issue permit liability insurance for punitive damages assessed against defendants who are subject to vicarious liability for the outrageous conduct of another. This position necessarily implies that the term “damages” in a liability policy in which the insurer promises to pay “all sums that the insured shall be liable to pay as damages” includes punitive damages. Courts in nearly half the states have held that liability insurance for directly assessed punitive damages contravenes the public policy of the state, in effect adopting an implied-in-law, immutable exclusion for directly assessed punitive damages. This Section follows the courts in those states in which the question of whether a liability insurance policy provides coverage for punitive damages, both vicarious and direct, is answered solely through interpretation of the insurance policy.

Courts that adopt an implied-in-law exclusion for direct punitive damages provide both deterrence- and retribution-based justifications for this decision. Both sets of justifications are overbroad. Under the deterrence justification, punitive damages are sometimes necessary to create incentives for parties to take reasonable care to avoid accidents. On this view, courts applying liability insurance policies to cases involving punitive damages sometimes hold that providing insurance for such damages is a violation of public policy because of the potential for such coverage to dampen the incentive effect of such awards. However, punitive damages can be assessed in situations in which there is little or no reason to believe that the presence of liability insurance for punitive damages will have any effect on behavior, for example in the drunk-driving context, or other contexts in which there are widely known criminal penalties.

Under the retributivist justification for the implied-in-law exclusion for punitive damages, punitive damages are sometimes necessary to express a public commitment to the value of persons. However, the availability of insurance for punitive damages may promote the retributive objectives of punitive damages, especially when defendants cannot be made to pay a substantial punitive-damages judgment, because the availability of insurance coverage for punitive damages helps to motivate the plaintiff to bring an action against the wrongful actor.

If in a specific case the insured-defendant is not judgment proof, and if insulating the insured from the financial consequences of punitive damages would contravene the purposes of assessing punitive damages, the rule in subsection (2) would allow the insurer to subrogate against the insured, preserving the deterrence and retributive functions of the punitive damages. Declaring coverage for punitive damages to be a violation of public policy often turns out to have little or no effect, other than to force insureds to find the coverage elsewhere. Specifically, large organizations and wealthy individuals are able to procure, and regularly do procure, insurance that covers direct punitive damages even when those damages are assessed in jurisdictions in which direct punitive damages supposedly are uninsurable. Such insurance is purchased using insurance-policy forms with favorable choice-of-law and venue clauses and, often, arbitration clauses. Sometimes this insurance is purchased in offshore jurisdictions.

g. Insurance of liabilities based on morally offensive acts. Some have suggested that liability insurance law should limit coverage for morally offensive acts, without regard to the presence of applicable exclusions or absence of incentive effects created by insurance. Such a prohibition would have the unfortunate consequence that the victims of some of the most

offensive wrongs would be least likely to be able to obtain civil recourse for those wrongs. That such a situation presently obtains for certain liabilities as a result of exclusions in liability insurance policies (exclusions for sexual-molestation claims provide a ready example) does not provide a basis for a common-law prohibition of such coverage.

h. Insurance of liability for intentional harm. Insurance law recognizes the potentially deleterious consequences that could result from the incentives created by liability insurance for intentional harm. Because intentional harm is ordinarily under the conscious control of the insured, and because such harm may even be part of the objective of the insured's wrongful act, insurance for the liabilities arising out of those wrongful acts poses a potential threat to the deterrence and retribution purposes of the liability. As with insurance of punitive damages, however, the deterrence- and retribution-based objections to insurance of intentional harm are overbroad. In many cases the presence or absence of insurance has no effect on the behavior of the wrongdoer, for example an assault that occurs in the heat of passion. Moreover, the presence of liability insurance can promote, rather than hinder, the objectives of tort law, by providing compensation for the victim as well as the means to employ the civil-justice system to name, blame, and shame the defendant.

Indeed, the compensation justification distinguishes insurance of intentional harm from insurance of punitive damages. In addition, the retribution justification for the insurance of intentional harms is stronger in many cases than that for the insurance of punitive damages. The availability of compensatory damages in an ordinary punitive-damages case, drunk driving for example, may allow the victim to find a lawyer who is willing to take the case. By contrast, a blanket rule against insurance of liability for intentional harm will prevent the victim from being able to obtain a lawyer in the many instances in which the defendant is an individual without substantial assets that can be reached in a civil action. Accordingly, the rule stated in subsection (2) is more closely tailored to the compensation, deterrence, and retribution objectives of the underlying liability regime than a blanket prohibition against insuring punitive damages.

i. Cases enforcing liability insurance coverage of intentional harm. The contemporary liability insurance market includes a variety of coverages that are explicitly crafted to cover intentional wrongs, for example: defamation, disparagement, trademark infringement, unfair competition, false imprisonment, employment discrimination, wrongful termination, malicious prosecution, and invasion of privacy. Courts regularly enforce insurers' promises to provide

these coverages, typically without any mention of the tension between these coverages and the traditional public-policy-based concern about insurance for intentional harm. Those relatively few cases that do discuss the insurability issue generally resolve that issue by explaining that providing liability insurance (a) does not undercut the purpose of the underlying liability and (b) by providing compensation to the injured victim promotes the compensation purpose of that liability.

j. When insulating the insured from financial consequences would contravene the public purpose of the liability. Subsection (2) generalizes a rule that is developing through the cases enforcing liability insurance policies that explicitly provide coverage for intentional harms. These cases permit the insurance of liability for intentional harm provided that there is a public policy in favor of compensation of the victim and there is no evidence that the existence of the insurance entered into the motivation of the defendant in committing the wrong. Further support for this rule can be found in cases enforcing the "final adjudication" language in certain intentional harm or misconduct exclusions, pursuant to which the exclusion only applies if there has been final adjudication of liability that takes place in the litigation for which coverage is sought. The practical impact of this language is that even a post-trial settlement of the underlying claim prevents the exclusion from being applied, because the intentional harm or misconduct cannot be established in the litigation between the insurer and insured. These two sets of cases signal a rejection of the blanket public-policy-based prohibition of liability insurance of intentional injuries. Subsection (2) combines this emerging rule with a rule adopted by the New Jersey Supreme Court in a decision requiring a liability insurer to pay a judgment in an arson-death case, in an unusual situation in which there was no expected or intended exclusion in the general-liability policy at issue, but allowing the insurer to obtain indemnification against the insured.

Further support for this development can be seen in the law regarding vicarious liability, which permits an injured plaintiff to recover from a third party for harm caused by bad actors. By allowing injured persons to recover from third parties, vicarious liability could be seen as insulating tortfeasors from the consequences of their conduct. Yet the law permits vicarious liability in order to promote compensation and because the relationships between the tortfeasors and the vicariously liable parties are such that there is less concern that vicarious liability will undercut the deterrence and retributive objectives of tort law. Indeed, there are reasons to believe

that vicarious liability will promote those objectives, and the ability of vicariously liable parties to seek indemnification from tortfeasors provides a means for ensuring that when such actors have sufficient means that they do not escape the financial consequences of their actions. So, too, in the case of liability insurance for claims that are based on aggravated fault. See Comments *f*, *g*, and *h*. If the insured does not have the capacity to pay, or cannot be made to pay, then enforcing a liability insurance policy that provides coverage for intentional harm does not insulate the insured from the financial consequences of the liability. If the insured does have the capacity to pay, then the insurer's indemnification right will ensure that the insured is subject to the financial consequences of his or her wrongful conduct.

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b. Defense coverage for criminal proceedings. Directors and Officers liability insurance regularly provides coverage for criminal-defense costs. See Tom Baker & Sean Griffith, The Missing Monitor in Corporate Governance: The Directors' and Officers' Liability Insurer, 95 Georgetown L.J. 1795, 1805 (2009). For a discussion of criminal-defense coverage provided by the National Rifle Association, see Tom Baker, Liability Insurance at the Tort-Crime Boundary, in *Fault Lines: Tort Law as Cultural Practice* (David M. Engel and Michael McCann eds., Stanford U. Press 2009).

c. Defense coverage for uninsurable civil remedies. See Sean W. Gallagher, The Public Policy Exclusion and Insurance for Intentional Employment Discrimination, 92 Mich. L. Rev. 1256, 1326 (1994) ("Courts are generally willing to enforce insurance to cover defense costs even in cases in which the underlying liability might be uninsurable as a matter of public policy.") For cases allowing coverage of defense costs see, e.g., Andover Newton Theological Sch., Inc. v. Continental Cas. Co., 930 F.2d 89, 95 (1st Cir. 1991) ("Although an argument can be made that a public policy is to some extent subverted by insurance against defense costs, the basic fact is that this is not insurance against liability."); B&E Convalescent Ctr. v. State Compensation Ins. Fund, 9 Cal. Rptr. 2d 894, 903 (Ct. App. 1992) ("[E]ven though public policy . . . precludes an insurer from indemnifying an insured in an underlying action the duty to defend still exists so long as the 'insured reasonably expect[s] the policy to cover the types of acts involved in the underlying suit."' (quoting Republic Indem. Co. v. Superior Ct., 273 Cal. Rptr. 331, 335 (Ct. App. 1990)).

d. Insurance of civil liability arising out of criminal acts. Driving under the influence is likely to be the modal crime tort that is regularly insured. See Tom Baker, Liability Insurance at the Tort-Crime Boundary, in *Fault Lines: Tort Law as Cultural Practice* (David M. Engel and Michael McCann eds., Stanford U. Press 2009); Sean W. Gallagher, The Public Policy Exclusion and Insurance for Intentional Employment Discrimination, 92 Mich. L. Rev. 1256, 1325 (1994)

("Courts do not necessarily void insurance for civil liability arising out of criminal misconduct, and several courts have even enforced insurance to cover civil liability for criminal sexual assault.") Careful examination of opinions stating that a liability is uninsurable because it arises out of a criminal act reveals that these cases fall into one of two categories: (1) the insurance policy contains an exclusion for liabilities arising out of criminal acts; (2) the criminal act involved an intentional injury. For cases finding that the insurability of liability arising out of a criminal act depends on whether the insured intended to injure the victim or whether punitive damages are assessed see, e.g., Nielsen v. St. Paul Companies, 283 Or. 277, 280-281 (1978) (explaining that the public policy against insurability does not attach to all unlawful acts or even all intentional acts but attaches only in the specific scenario where the actor's purpose is to inflict harm); Penzer v. Transp. Ins. Co., 545 F.3d 1303, 1310-1311 (11th Cir. 2008) (explaining that Florida public policy against insuring for intentional misconduct does not apply where liability is not predicated on intent); Nationwide Mut. Ins. Co. v. Machniak, 74 Ohio App. 3d 638, 641, 600 N.E.2d 266, 268 (Ohio Ct. App. 1991) (holding that intentional-injury exclusion did not apply to insured's conviction for felonious assault because the crime is not statutorily defined as a specific-intent crime.

e. Insurance of vicarious liability. See Catherine M. Sharkey, Revisiting the Noninsurable Costs of Accidents, 64 Md. L. Rev. 409 (2005) (discussing insurability of vicariously assessed punitive damages); Sean G. Gallagher, The Public Policy Exclusion and Insurance for Intentional Employment Discrimination, 92 Mich. L. Rev. 1256 (1994) (discussing insurance coverage for intentional discrimination by an employee that is imputed to an employer).

f. Insurance of direct punitive damages. Some courts refuse on public-policy grounds to enforce contracts that cover punitive damages, while other courts leave the question of liability insurance coverage for all punitive damages, both vicarious and direct, to the insurance contract. See Catherine M. Sharkey, Revisiting the Noninsurable Costs of Accidents, 64 Md. L. Rev. 409 (2005) (discussing jurisdictions' differing approaches to the insurability of punitive damages). For a discussion of why a deterrence- and retribution-based justification for an implied-in-law exclusion for direct punitive damages is overbroad see Tom Baker, Reconsidering Insurance for Punitive Damages, 1998 Wis. L. Rev. 101 (1998). See also Catherine M. Sharkey, Revisiting the Noninsurable Costs of Accidents, 64 Md. L. Rev. 409 (2005) (noting how underwriters and insurance brokers have begun to circumvent public-policy objections to insuring punitive damages by including "most favorable venue" language, "a kind of 'choice-of-law' provision that specifies, for example, that if an issue arises regarding punitive damages, the carrier will apply the law and public policy of an applicable state with the 'most favorable' view of insurance coverage for punitive damages.") Acknowledgment that the common law is, as a practical matter, unable to prevent the sale or purchase of such insurance could have the salutary effect of prompting action by regulatory authorities, which have greater powers than courts to

detect and prevent the sale or purchase of, or payment under, such policies, and greater expertise in the determination of when such insurance is likely to have undesirable consequences.

g. Insurance of liabilities based on morally offensive acts. See generally Christopher French, Debunking the Myth That Insurance Coverage Is Not Available or Allowed for Intentional Torts or Damages, 8 Hastings Bus. L.J. 65 (2012); Tom Baker, Liability Insurance at the Tort-Crime Boundary, in *Fault Lines: Tort Law as Cultural Practice* (David M. Engel and Michael McCann eds., Stanford U. Press 2009). For cases demonstrating a concern for victim compensation see, e.g., Aetna Life & Cas. Co. (Cas. & Sur. Div.) v. McCabe, 556 F. Supp. 1342, 1353 (E.D. Pa. 1983) (holding that physician's intentional malpractice would be covered under insurance policy because nothing suggested that the physician bought the insurance in contemplation of committing malpractice, there was no basis to believe denying coverage would have a deterrent effect, and Pennsylvania's interest in compensating victims of malpractice outweighed Pennsylvania's recognized interest in deterring intentional torts); Yousuf v. Cohlmia, 741 F.3d 31 (10th Cir. 2014) ("ANPAC's policies covering Dr. Cohlmia specifically provide indemnification for certain intentional conduct, and there is no evidence that the availability of insurance coverage induced Dr. Cohlmia to engage in intentional conduct. Furthermore, the interest in compensating an innocent third party, Dr. Yousuf, outweighs the concern that Dr. Cohlmia would unjustly benefit from the coverage."); Grinnell Mutual Reinsurance Co. v. Jungling, 654 N.W.2d 530, 541 (Iowa 2002) ("the ultimate and primary beneficiaries of coverage [for intentional wrongdoing] will be innocent third parties"); Burd v. Sussex Mut. Ins. Co., 56 N.J. 383, 398-399 (1970) (noting that the public interest in victim compensation and the insured's interest in maximum protection under the contract weigh against an overly broad reading of the public-policy exclusion); Vigilant Insurance Company v. Kambly, 114 Mich. App. 683, 685-686 (1982) (Finding coverage for malpractice where a doctor induced his patient to engage in a sexual relationship with him as part of her therapy, the court reasoned, "coverage does not allow the wrongdoer unjustly to benefit from his wrong. It is not the insured who will benefit, but the innocent victim who will be provided compensation for her injuries."); Grinell Mutual Insurance Co. v. Jungling, 654 N.W.2d 530, 538 (Iowa 2002) (noting that the interest in victim compensation was found to "outweigh[ ] the public interest in forcing the willful wrongdoer to pay the consequences of the wrongdoing."); Ambassador Ins. Co. v. Montes, 76 N.J. 477, 484 (1978) (allowing the insurer to be subrogated to the victim's rights so that the insurer could collect from the insured, thereby advancing the interest in victim compensation and maintaining financial responsibility for the insured). For cases finding that a liability insurance policy, absent a pertinent exclusion, covers morally offensive acts see, e.g., Bailer v. Erie Insurance Exchange, 344 Md. 515, 517, 535 (1997) (finding coverage for an invasion-of-privacy claim where an insured surreptitiously videotaped an au pair while she was showering); S. Carolina State Budget & Control Bd., Div. of Gen. Services, Ins. Reserve Fund v. Prince, 304 S.C. 241, 248 (1991) (determining that it would be unreasonable to exclude coverage for defamation when the insurance policy specifically provided for that coverage); Illinois Farmers Ins. Co. v. Keyser, 956 N.E.2d 575 (Ill. 2011) (finding coverage for malicious-prosecution claim

because "it is . . . a fundamental policy in Illinois that when an insured pays a premium and an insurance company accepts it and promises coverage based on the premium paid, the insurer should be required to fulfill its obligation.").

h. Insurance of liability for intentional harm. For cases finding intentional harm uninsurable, see, e.g., Thomas v. Benchmark Ins. Co., 285 Kan. 918, 922, 179 P.3d 421, 425 (2008) ("Kansas public policy prohibits insurance coverage for intentional acts: '[A]n individual should not be exempt from the financial consequences of his own intentional injury to another.'") (citations omitted); Regence Grp. v. TIG Specialty Ins. Co., 903 F. Supp. 2d 1152, 1161 (D. Or. 2012) ("Oregon has long recognized the principle that 'a clause in a contract of insurance purporting to indemnify the insured for damages recovered against him as a consequence of his intentional conduct in inflicting injury upon another is unenforceable by the insured on the ground that to permit recovery would be against public policy.'") (citations omitted); see also Nat'l Fire Ins. Co. of Hartford v. Lewis, 898 F. Supp. 2d 1132, 1146 (D. Ariz. 2012) (holding that policy provisions extending to intentional acts are prohibited by public policy under Arizona law); Chiquita Brands International, Inc. v. National Union Insurance Co., 988 N.E.2d 897, 900 (Ohio Ct. App. 2013) (citations omitted) ("Ohio public policy generally prohibits obtaining insurance to cover damages caused by intentional torts.") For a discussion of how the justifications for the "public policy exception" are overbroad, see generally Christopher French, Debunking the Myth That Insurance Coverage Is Not Available or Allowed for Intentional Torts or Damages, 8 Hastings Bus. L.J. 65 (2012). For cases demonstrating a concern for victim compensation, see Reporters' Note to Comment *g*, supra. On the difficulty of collecting money from an uninsured defendant, see Steven G. Gilles, The Judgment Proof Society, 63 Wash. & Lee L. Rev. 603 (2006).

For the purposes of the public-policy exception, intent is often defined in a very restrictive manner that severely constrains the scope of the exception. Nielsen v. St. Paul Companies, 283 Or. 277, 280-281 (1978) (explaining that the public policy against insurability does not attach to all unlawful acts or even all intentional acts but attaches only in the specific scenario where the actor's purpose is to inflict harm). As a result, actions taken in self-defense, which are intentional but are not taken for the purpose of injuring another, are often covered by insurance policies. Fire Ins. Exch. v. Berray, 143 Ariz. 361, 363 (1984) ("[A]n act committed in self-defense should not be considered an 'intentional act' within the meaning of the exclusion." (citation omitted)). The breadth of the definition of intent therefore has an important effect on insurability. Further, even intentional harm may not fall within an intentional-act exclusion if the underlying violation does not require intent. Penzer v. Transp. Ins. Co., 545 F.3d 1303, 1310-1311 (11th Cir. 2008) (explaining that Florida public policy against insuring for intentional misconduct does not apply where liability is not predicated on intent); see also Nationwide Mut. Ins. Co. v. Machniak, 74 Ohio App. 3d 638, 641, 600 N.E.2d 266, 268 (Ohio Ct. App. 1991) (holding that intentional-injury exclusion did not apply to insured's conviction for felonious assault because the crime is not statutorily defined as a specific-intent crime).

i. Cases enforcing liability insurance coverage of intentional harm. Couch describes this emerging case law as follows:

> Even though it may be against public policy to insure for an insured's intentional or willful conduct, some jurisdictions may find coverage for the conduct when the policy language specifically provides coverage for that conduct; a statute allows insurance for intentional conduct; or the court finds that the public interest in having victims compensated for their injuries, outweighs public interest in forcing the willful wrongdoer to pay the consequences of the misconduct.

Couch § 101:24. For cases finding coverage under liability insurance provisions that cover intentional wrongs see, e.g., South Carolina State Budget & Control Board, Division of General Services, Insurance Reserve Fund v. Prince, 304 S.C. 241, 243 (1991) (holding that an insurer had a duty to indemnify under a policy that explicitly provided coverage for defamation); North Bank v. Cincinnati Insurance Companies, 125 F.3d 983, 984 (6th Cir. 1997) (finding coverage for employment discrimination under a policy that explicitly covered discrimination); Illinois Farmers Ins. Co. v. Keyser, 956 N.E.2d 575 (Ill. 2011) (finding coverage for malicious prosecution under a homeowner's policy that explicitly covered "false arrest, imprisonment, malicious prosecution, and detention."); Bailer v. Erie Insurance Exchange, 344 Md. 515, 517, 521 (1997) (finding coverage for an invasion-of-privacy claim under a personal-catastrophe liability policy); Cincinnati Insurance Co. v. Zen Design Group, Ltd., 329 F.3d 546, 549 (6th Cir. 2003) (enforcing a business liability policy that covered "slander," "libel," "misappropriation of advertising ideas or style of doing business," and "infringement of copyright, title, or slogan."); Dixon Distributing Co. v. Hanover Ins. Co., 161 Ill. 2d 433, 435 (1994) (concluding that providing coverage for an allegedly intentional wrongful termination did not violate the public policy of Illinois). For cases finding coverage for intentional conduct and demonstrating a concern for victim compensation, see Reporters' Note to Comment *g*, supra.

For sources noting that covering intentionally caused harm does not undercut the purpose of the underlying liability, see, e.g., St. Paul Fire & Marine Ins. Co. v. Jacobson, 826 F. Supp. 155, 157 (E.D. Va. 1993), aff'd, 48 F.3d 778 (4th Cir. 1995) (enforcing insurance against intentionally caused harm, noting that the existence of criminal sanctions for the doctor's behavior served as a greater deterrent than civil liability and that no evidence suggested the presence of insurance encouraged his behavior); Aetna Life & Cas. Co. (Cas. & Sur. Div.) v. McCabe, 556 F. Supp. 1342, 1353 (E.D. Pa. 1983) (holding that physician's intentional malpractice would be covered under insurance policy because nothing suggested that the physician bought the insurance in contemplation of committing malpractice, there was no basis to believe denying coverage would have a deterrent effect, and Pennsylvania's interest in compensating victims of malpractice outweighed Pennsylvania's recognized interest in deterring intentional torts); Illinois Farmers Ins. Co. v. Keyser, 956 N.E.2d 575 (Ill. 2011) ("there is nothing inherently unreasonable or inconsistent with Illinois public policy in allowing an individual to insure himself against damages caused by certain intentional acts, except to the

extent that the insured wrongdoer may not be the person who recovers the policy proceeds."); see also Christopher French, Debunking the Myth That Insurance Coverage Is Not Available or Allowed for Intentional Torts or Damages, 8 Hastings Bus. L.J. 65, 94 (2012) (noting that other deterrents, including the threat of jail time or concern with injuring oneself, loom much larger than any concern with civil liability that the presence of insurance may alleviate).

j. When insulating the insured from financial consequences would contravene the public purpose of the liability. See, e.g., Ambassador Ins. Co. v. Montes, 76 N.J. 477, 477 (1978) (permitting liability insurance in an arson-death case, but allowing the insurer to obtain indemnification against the insured); North Bank v. Cincinnati Insurance Companies, 125 F.3d 983, 988 (6th Cir. 1997) (enforcing insurance against intentional discrimination, noting that high premiums, bad publicity for businesses, and the "trauma of litigation" likely eliminated any effect that insurance may have in encouraging an insured to commit intentional torts); St. Paul Fire & Marine Ins. Co. v. Jacobson, 826 F. Supp. 155, 157 (E.D. Va. 1993) (enforcing insurance against intentional harm, noting that the existence of criminal sanctions for the doctor's behavior served as a greater deterrent than civil liability and that no evidence suggested the presence of insurance encouraged his behavior), aff'd, 48 F.3d 778 (4th Cir. 1995); cf. Ranger Ins. Co. v. Bal Harbour Club, Inc., 549 So. 2d 1005, 1005-1006 (Fla. 1989) (refusing to enforce insurance coverage for intentional religious discrimination based on a two-part test that would permit insurance for intentional injuries in other contexts: (1) whether the conduct of the insured is the type that will be encouraged by insurance and (2) whether the purpose of the imposition of liability is to deter wrongdoers or to compensate victims); see also Donald F. Farbstein & Francis J. Stillman, Insurance for the Commission of Intentional Torts, 20 Hastings L.J. 1219, 1254 (1969) (suggesting that uninsurability could be roughly limited to areas of civil damages intended to deter the wrongdoer rather than compensate the victim); James M. Fischer, The Exclusion from Insurance Coverage of Losses Caused by the Intentional Acts of the Insured: A Policy in Search of a Justification, 30 Santa Clara L. Rev. 95, 171 (1990) (arguing that the intentional-act exclusion should only activate when the insured "harbors a preconceived design to injure"). For discussion of the practical impact of the final-adjudication language based on field research, see Tom Baker & Sean Griffith, Ensuring Corporate Misconduct at ---- (2010). [cases enforcing the final-adjudication language to be inserted]

TOPIC 2
CONDITIONS

§ 35. Conditions in Liability Insurance Policies

(1) A "condition" in a liability insurance policy is an event under the control of an insured, policyholder, or insurer that, unless excused, must occur, or must not occur, before performance under the policy becomes due under the policy.

(2) Whether a term in a liability insurance policy is a condition does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Subject to § 37, the failure of an insured to satisfy a condition in a liability insurance policy does not relieve the insurer of its obligations under the policy unless the failure caused prejudice to the insurer.

Comment:

a. Conditions in insurance policies as compared to contract-law conditions generally. The concept of "condition" in contract law is a very broad one that includes any event that must occur, or that must not occur, before performance under a contract becomes due. See Restatement Second, Contracts § 224. Under this broad definition, almost all insurance-policy provisions would be understood to contain conditions. For example, insuring clauses commonly require that a specified event must take place within the policy period in order to trigger coverage under the policy, and exclusions commonly apply only when a specified event has taken place. In insurance law and practice, however, the term "condition" typically is employed only in connection with events that are under the control of insureds or insurers. (Note that this Restatement follows the terminology of the Restatement Second, Contracts, which does not distinguish between conditions precedent and subsequent. In jurisdictions that retain that distinction, the conditions that are specifically addressed in this Section would generally be regarded as conditions precedent. Thus, when applying the rules stated in §§ 35 to 38 in such jurisdictions, the term "condition precedent" can generally be substituted for the term "condition" as it appears in this Restatement.)

Illustrations:

1. The standard 2004 ISO Commercial General Liability insurance policy states:

> We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" . . . to which this insurance applies . . .
>
> This insurance applies to "bodily injury" . . . only if . . . the "bodily injury" . . . is caused by an "occurrence" that takes place in the "coverage territory."

The requirements that there be "damages," "bodily injury," and "an occurrence" that takes place in the "coverage territory" are not conditions because those requirements do not concern events under the control of the insured, policyholder, or insurer.

2. The standard 2004 ISO Commercial General Liability insurance policy states:

If a claim is made or "suit" is brought against any insured, you must:

(1) Immediately record the specifics of the claim or "suit" and the date received and

(2) Notify us as soon as practicable.

Because recording and notification of a claim are in the control of the insured, these requirements are conditions.

b. Interpretation of conditions. Because the nonoccurrence of a condition may lead to a forfeiture, contract law has developed a special canon of construction stated in Restatement Second, Contracts § 227, pursuant to which, in case of doubt, a term in a contract should be construed to impose a duty upon a party, rather than a condition. See Restatement Second, Contracts § 227, Comment *d*. Because the application of the ordinary rules of insurance-policy interpretation stated in §§ 3 and 4 of this Restatement should reach the same result, there is no need for a similar special canon of construction in liability insurance law. If the plain meaning of the policy makes a requirement a condition, then it will be treated as such under § 3 of this Restatement unless the circumstances clearly indicate to the contrary. If the policy does not have a plain meaning in this regard, then under § 4 of this Restatement the term should not be treated as a condition unless the circumstances clearly indicate that to be the only reasonable approach.

c. Notice-of-claim conditions. Liability insurance policies commonly contain terms that make the timely provision of a notice of claim a condition of the insurer's obligations under the policy. The purpose of such conditions is to allow insurers to obtain the information that they need to investigate and defend claims. Notice-of-claim conditions are the most frequently excused conditions in liability insurance policies. The vast majority of jurisdictions have recognized the notice-prejudice rule, which excuses the failure to provide timely notice of claim unless the insurer can show that the failure caused substantial prejudice.

d. The prejudice requirement. The conceptual source of the notice-prejudice rule lies in the disproportionate-forfeiture principle articulated in Restatement Second, Contracts § 228. Under that principle, the failure of the insured to satisfy a notice-of-claim condition relieves the

insurer of its obligations under the policy only if the insured's failure caused substantial harm to the insurer. Courts generally take a case-by-case approach to evaluating the substantiality of the asserted harm. What is required is that the late notice prevented the insurer from protecting its interests in a significant way. An increase in the cost or other burden of defense or investigation is not sufficient. Examples of harm that meets the prejudice requirement include: the loss of a defense in the underlying claim, a significant increase in the amount of damages or the settlement value of the claim, the destruction of evidence needed for the insurer to prove that the claim is not covered, and the extinction of the insurer's subrogation rights in a context in which the insurer would have had a meaningful possibility of recovery pursuant to those rights.

e. Reasons for the notice-prejudice rule. The notice-prejudice rule addresses several problems with strict enforcement of notice-of-claim conditions. First, as just described, strict enforcement exposes insureds to a substantial risk of disproportionate forfeiture of insurance coverage, because the value of the coverage to the insured often substantially exceeds the harm to the insurer from the breach of the notice condition. The notice-prejudice rule allows the insurer to avoid coverage if, in fact, the delay caused significant harm, while preserving coverage for the insured in those cases in which the delay did not. Second, strict enforcement of notice-of-claim conditions rewards insurers whose policies contain unreasonable, difficult-to-satisfy conditions, thereby encouraging the drafting of such conditions. The notice-prejudice rule allows the insurer to avoid coverage only when the delay caused material prejudice, thereby providing no encouragement for unreasonable notice conditions. Third, strict enforcement of the condition interferes with the objectives of the underlying liability regime, which depend in many instances on the presence of liability insurance. Because the notice-of-prejudice rule is more closely tailored to the objective of the notice condition—access to the information needed to investigate and defend claims—it interferes less with the objectives of the liability regime.

f. Voluntary-payment conditions. Liability insurance policies commonly contain terms that make the insurer's approval a condition of payment of any expense. Terms requiring the insurer's consent to settle are a specialized example of such conditions. Commonly referred to as "voluntary payment" provisions, such conditions are sometimes held not to be subject to the prejudice requirement. Nevertheless, careful analysis of the facts in such cases reveals that the results in the cases are generally consistent with the underlying disproportionate-forfeiture principle. For example, courts commonly enforce the voluntary-payments condition in cases

involving "pre-tender defense costs," which are defense costs incurred by the insured before providing notice of the claim. In such cases, the insured typically receives an insurer-funded defense after providing that notice, and thus the only loss to the insured from enforcing the condition is the cost of the defense that the insured incurred prior to providing notice of the suit to the insurer. In such situations, the forfeiture of pre-tender defense costs would generally be a proportionate consequence of depriving the insurer of the opportunity to manage the defense costs in the pre-tender period.

The results of cases involving settlements by the insured, without the consent of the insurer, can similarly be reconciled with the general prejudice requirement for conditions in liability insurance policies. Among the courts that have addressed this issue, a majority have either required the insurer to prove prejudice or have explained why the insurer was prejudiced as a matter of law in the circumstances, for example because prejudice was obvious based on undisputed facts.

g. Cooperation conditions. Liability insurance policies commonly contain terms that make the insured's cooperation a condition of the insurers' obligations under the policy. Such conditions are subject to the prejudice requirement stated in § 30.

h. When an insured's failure to satisfy a condition relieves an insurer of its obligations under a liability insurance policy. Based on the courts' treatment of notice, cooperation, and voluntary-payment conditions, it is appropriate to conclude that the prejudice requirement is the general rule for conditions in liability insurance policies, as defined in subsection (1), subject to exceptions. The prejudice must be material. What is material depends on the balance of (a) the harm to the insurer from excusing the performance of the condition and (b) the harm to the insured and the underlying claimant from not excusing the performance. This balance should take into account both the severity of the harm and the certainty that it would be suffered.

This condition-prejudice rule is an application of the more general contract-law principle of disproportionate forfeiture, pursuant to which a nonmaterial breach of a condition by an insured does not excuse the insurer from performance because the harm to the insurer from the breach is so much less than the value of the coverage to the insured. There are both efficiency and fairness considerations for this principle that have special force in the liability insurance context. The principle is efficient in the sense that it applies insurance-policy terms in a manner that most insureds would be willing to pay for, if they had the information and bargaining power,

because the principle protects insureds from the same kinds of risks for which they buy liability insurance: their own negligence. The principle is fair because it is consistent with widely accepted proportionality norms as well as the public policy in favor of compensation of underlying claimants.

The exceptions to the condition-prejudice rule consist, on the one hand, of conditions that are not enforceable at all in certain circumstances, even if the insurer has suffered prejudice, and, on the other hand, of conditions that are strictly enforced in certain circumstances, even if the insurer has not suffered prejudice. The anti-assignment conditions addressed in § 38 are the examples of the former for which the law is best developed. The claim-reporting condition in a claims-made-and-reported policy is the example of the latter for which the law is best developed. See § 37. Whether other conditions, as defined in subsection (1), should be subject to the general condition-prejudice rule, or to exceptions, is determined on a case-by-case basis by comparison to the conditions for which the law is well developed.

i. Burden of proof of prejudice. The majority rule places the burden of proving prejudice on the insurer. This burden of proof is appropriate because the insurer is in the best position to identify what it would have done differently had the insured satisfied the condition and to prove the harm that it suffered as a result of being unable to take those actions.

REPORTERS' NOTES

a. Conditions in insurance policies as compared to contract-law conditions generally. Regarding the narrow, insurance-law use of "condition," it is difficult to prove that courts never use the term in a broader sense in insurance-law cases. All of the insurance-law citations to the conditions Sections in the Restatement Second of Contracts involve events that are under the control of the insurer or insured. The monumental article on claims-made insurance by Professor Works demonstrates some of the analytical complications that would result from applying disproportionate-forfeiture analysis to insurance-policy requirements that are not under the control of an insurer or insured. See Bob Works, Excusing Non Occurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case, 5 Conn. Ins. L.J. 505 (1999). As Works's discussion illustrates, the "conditions" (in the broad, contract-law sense of that term) in exclusions and insuring agreements are strictly enforceable under the Restatement's disproportionate-forfeiture analysis because they are a "material part of the agreed exchange," as that term is used in the Restatement Second of Contracts. Thus, there is no point in going through the disproportionate-forfeiture analysis.

b. Interpretation of conditions. See Beckenheimer's v. Alameda, 327 Md. 536, 611 A.2d 105, 113, 114 (Md. Ct. Spec. App. 1992) (citing § 227 of the Restatement Second of Contracts to support the conclusion that a proof-of-loss requirement was a covenant rather than a condition).

c. Notice-of-claim conditions. For cases adopting the notice-prejudice rule, see, e.g., PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008); Alcazar v. Hayes, 982 S.W.2d 845 (Tenn. 1998); Johnson Controls, Inc. v. Bowes, 381 Mass. 278 (Mass. 1980); Brakeman v. Potomac Ins. Co., 371 A.2d 193 (Pa. 1977); Allstate Floridian Ins. Co. v. Farmer, 104 So. 3d 1242 (Fla. Dist. Ct. App. 5th Dist. 2012).

d. The prejudice requirement. When deciding whether an insurer can deny coverage as a result of late notice, courts generally require the insurer to show that it suffered actual prejudice that caused an impairment or loss of the insurer's substantial rights. 13 Couch on Ins. § 193:68. For cases finding that the insurer met the prejudice requirement see, e.g., Atlantic Cas. Ins. Co. v. Value Waterproofing, Inc., 918 F. Supp. 2d 243 (S.D.N.Y. 2013) (concluding that CGL insurer was prejudiced by six-month delay in receiving notice because the delay prevented insurer from being able to ascertain potential causes of the loss); Martin v. Fireman's Fund Ins. Co., A-4206-09T1, 2011 WL 1584333, at *2 (N.J. Super. App. Div. Apr. 28, 2011) (holding that insurer was appreciably prejudiced after insured waited four years to notify insurer of injuries he sustained in an accident, resulting in insurer's inability to intervene in insured's lawsuit against the tortfeasor); West Bay Exploration Co. v. AIG Specialty Agencies of Texas, Inc., 915 F.2d 1030 (6th Cir. 1990) (finding insurers prejudiced by delay where evidence that might have proved that the claim was not covered was destroyed prior to the insurers receiving notice); Hyde Athletic Industries, Inc. v. Continental Cas. Co., 969 F. Supp. 289 (E.D. Pa. 1997) (finding prejudice where insured did not notify insurer of claim until after insured decided to proceed to trial and incurred $1.3 million in legal costs for $100,000 in liability); Maryland Cas. Co. v. American Home Assur. Co., 277 S.W.3d 107 (Tex. App. Houston 1st Dist. 2009) (finding prejudice where delay in notice caused insurer to lose its ability to defend the suit and rights to subrogation); Port Services Co. v. General Ins. Co. of America, 838 F. Supp. 1402 (D. Or. 1993) (finding prejudice where delay deprived insurer of the opportunity to investigate possible claims against third parties). See also 13 Couch on Ins. § 193:71 ("[I]nsurers have been found prejudiced where the delay [k]ept the insurer from an opportunity to conduct an investigation of the damage or the witnesses; [d]id not allow the insurer an opportunity to conduct an investigation; [c]ompromised the insurer's ability to defend the action when notice was being given shortly before trial or after judgment entered; [k]ept the insurer from an opportunity to participate in remedial efforts; [k]ept the insurer from having an opportunity to play a meaningful role in negotiations and strategy; [and] [i]mpaired the insurer's opportunity to protect its subrogation rights."). For cases finding that an increase in the cost or other burden of defense is not sufficient to show prejudice see, e.g., Republic Ins. Co. v. Underwriters Safety & Claims, Inc., 2010 WL 3069066 (W.D. Ky. Aug. 2, 2010) (Prejudice resulting from late notice cannot be proven by the insurer merely disclosing that it was not able to partake in any of the judicial proceedings; the insurer must demonstrate that

there was "some reasonable possibility that the outcome would have been different had it received notice."); Franco v. Selective Ins. Co., 184 F.3d 4 (1st Cir. 1999) (holding that entry of default judgment does not constitute prejudice unless insurer can demonstrate that it would not have been able to have the default set aside if it had intervened and petitioned to have the default removed).

f. Voluntary-payment conditions. Courts differ in the application of the prejudice rule to voluntary-payment conditions. For cases holding that there is a prejudice requirement and the insurer failed to satisfy it, see, e.g., Southeastern Fidelity Ins. Co. v. Earnest, 378 So. 2d 787 (Fla. Dist. Ct. App. 3d Dist. 1979) (holding that the insured's unauthorized settlement did not result in a forfeiture of coverage because "[a] judgment against Mrs. Bradwell would not have been worth the paper it was printed on and no reasonable person would have expended the costs, let alone the attorney's fees, it would have required to get it. … Under our law, a technical and illusory 'loss' of this kind cannot result in the forfeiture of insurance coverage."); Roberts Oil Co., Inc. v. Transamerica Ins. Co., 833 P.2d 222 (N.M. 1992) (denying summary judgment in case in which the insured made payments to abate environmental contamination, because there were issues of material fact as to whether insurers were prejudiced by insured's breach of voluntary-payment provision); Griffin v. Allstate Ins. Co., 29 P.3d 777, 783 (Wash. App. Div. 1 2001) ("But even assuming Allstate could prove breach of the voluntary payment provision, Allstate must also prove actual prejudice."), opinion modified on denial of reconsideration, 36 P.3d 552 (Wash. App. Div. 1 2001); Coastal Refining & Mktg., Inc. v. U.S. Fid. and Guar. Co., 218 S.W. 3d 279, 296 (Tex. App. 2007) (granting summary judgment for the insured, because the insurer failed to meet its burden of showing that it had sustained prejudice—monetary or otherwise—from the insured entering into a settlement without its consent); Columbia Cas. Co. v. Gordon Trucking, Inc., 758 F. Supp. 2d 909, 916 (N.D. Cal. 2010) (concluding that under Washington law, an insurer must show actual prejudice before it can enforce a voluntary-payment provision); Bond/Tec, Inc. v. Scottsdale Ins. Co., 622 S.E.2d 165, 168-169 (N.C. App. 2005) (denying insurer's motion for summary judgment because insurer failed to show it was prejudiced by the insured's violation of the policy's voluntary-payment provision).

For cases holding that there is a prejudice requirement but the insurer satisfied it as a matter of law in the circumstances, see, e.g., Perini/Tompkins Jt. Venture v. Ace Am. Ins. Co., 738 F.3d 95, 105 (4th Cir. 2013) (holding that the insurer was prejudiced as a matter of law because the insured's authorized settlement "cut . . . off the insurer's right to investigate, defend, control, or settle a suit") (internal quotations omitted); Maryland Casualty Co. v. American Home Assurance Co., 277 S.W.3d 107 (Tex. App. – 2009); Augat, Inc. v. Liberty Mut. Ins. Co., 410 Mass. 117, 571 N.E.2d 357, 361 (1991) (enforcing the policy's voluntary-payment provision because the court concluded that the insurer suffered prejudice as a matter of law); W. Bend Co. v. Chiaphua Industries, Inc., 112 F. Supp. 2d 816, 826 (E.D. Wis. 2000), aff'd, 11 F. App'x 616 (7th Cir. 2001) (same).

For cases holding that there is no prejudice requirement, see, e.g., Low v. Golden Eagle Ins. Co., 2 Cal. Rptr. 3d 761, 770-771 (Cal. App. 1st Dist. 2003) (internal quotations omitted) ("The no-voluntary-payment provision is based on the equitable rule that the insurer is invested with the complete control and direction of the defense, and is thus not liable for any voluntary payments . . . assumed by the insured without the insurer's consent.") (citation and quotation marks omitted); Travelers Ins. Companies v. Maplehurst Farms, Inc., 953 N.E.2d 1153, 1160-1161 (Ind. App. 2011) ("[W]here an insured enters into a settlement agreement without the insurer's consent in violation of a voluntary payment provision, that obligation cannot be recovered from the insurer, and prejudice is irrelevant."); New Jersey Eye Ctr., P.A. v. Princeton Ins. Co., 928 A.2d 25, 33 (N.J. Super. App. Div. 2007) (denying coverage for a medical-malpractice claim because the insured failed to obtain his insurer's consent when he settled the malpractice claim); Champion Spark Plug Co. v. Fid. & Cas. Co. of New York, 687 N.E.2d 785, 792 (Ohio App. 6th Dist. 1996) (in Ohio "there is no burden to show that a voluntary payment or settlement made by the insured in violation of a term in the insurance contract prejudiced the insurer before a ruling can be made that a material breach of the contract occurred which relieves the insurer of the obligation to make payment.")

The reasoning in cases both for and against a prejudice requirement is consistent with the disproportionate-forfeiture principle that underlies the general rule; the courts simply disagree about the materiality of the condition in question. Compare, e.g., Bond/Tec, Inc. v. Scottsdale Ins. Co., 622 S.E.2d 165 (N.C. App. 2005) (holding that, as a matter of first impression, an insurer must show prejudice in order to be relieved of liability where the insured has breached the voluntary-payments clause of the policy) with, e.g., W. Bend Co. v. Chiaphua Industries, Inc., 112 F. Supp. 2d 816, 826 (E.D. Wis. 2000) ("West Bend deprived Royal of its contractual right to control the settlement process by presenting the settlement as a fait accompli, after failing for years to even alert Royal to the existence of the claim. The Court believes that such a flagrant breach of the voluntary payments clause is inherently prejudicial . . . To saddle Royal with the cost of the settlement, when it was kept in the dark throughout the investigation, defense and settlement of the claim, would be the 'antithesis of equity.'") aff'd, 11 F. App'x 616 (7th Cir. 2001). See also Jamestown Builders, Inc., 77 Cal. App. 4th 341, 346, 91 Cal. Rptr. 2d 514 (1999) (In allowing the insurer to deny coverage for the insured's voluntarily incurred expenses, the court stated that "[no-voluntary-payments provisions] are designed to ensure that responsible insurers that promptly accept a defense tendered by their insureds thereby gain control over the defense and settlement of the claim . . . In short, the provision protects against coverage by fait accompli.").

g. Cooperation conditions. See § 30, Reporters' Note to Comment *b*.

h. When an insured's failure to satisfy a condition relieves an insurer of its obligations under a liability insurance policy. Almost all of the case law regarding liability insurance conditions involves conditions that are specifically addressed in this Restatement: notice-of-claim conditions, cooperation conditions, voluntary-payment and settlement conditions, and anti-

assignment conditions. Not surprisingly, most of the reasoning in the recent cases relies entirely on precedent-based justifications that do not shed light on the rule-exception framework noted in Comment *f*. See the Reporters' Notes to Comment *a* of § 36 and to Comment *b* of § 30. The reasoning in published decisions in cases in which there was no prior controlling authority in the jurisdiction, however, is generally consistent with the proposition that the prejudice requirement is the general rule, subject to exceptions. See, e.g., PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008) (applying the notice-prejudice rule to notice-of-claim conditions); Alcazar v. Hayes, 982 S.W.2d 845 (Tenn. 1998) (same); Johnson Controls, Inc. v. Bowes, 381 Mass. 278 (Mass. 1980) (same); Brakeman v. Potomac Ins. Co., 371 A.2d 193 (Pa. 1977) (same); Allstate Floridian Ins. Co. v. Farmer, 104 So. 3d 1242 (Fla. Dist. Ct. App. 5th Dist. 2012) (same); State Farm Mut. Auto. Ins. Co. v. Fennema, 110 P.3d 491, 492 (N.M. 2005) ("For the first time we consider whether an insurance company must demonstrate substantial prejudice from the breach of a consent-to-settle provision before it can be relieved from paying underinsured motorist benefits. We answer this question in the affirmative."); Nationwide Mut. Ins. Co. v. Lehman, 743 A.2d 933, 940 (Pa. Super. 1999) ("We hold that in order for an insurer to deny UIM coverage to an insured, where the insured settles with a tortfeasor for the limits of available liability insurance, and in contravention of the insurance policy's consent-to-settle clause, the insurer must show that its interests were prejudiced."); Bond/Tec, Inc. v. Scottsdale Ins. Co., 622 S.E.2d 165 (N.C. App. 2005) (holding that, as a matter of first impression, an insurer must show prejudice in order to be relieved of liability when the insured has breached the voluntary-payments clause of the policy).

i. Burden of proof of prejudice. For cases placing the burden of proving prejudice on the insurer see, e.g., Arrowood Indem. Co. v. Pendleton, 304 Conn. 179, 39 A.3d 712 (Conn. 2012) (adopting majority rule that assigns burden of proof to the insurer and overruling Aetna v. Murphy, 538 A.2d 219 (Conn. 1988) to that limited extent); Fox v. Nat'l Sav. Ins. Co., 424 P.2d 19, 25 (Okla. 1967) ("[I]t is in accord with the public policy of this State . . . to place the burden upon the insurer to show prejudice from noncompliance with the policy's provisions concerning written notice."); Cooper v. Gov't Employees Ins. Co., 237 A.2d 870, 874 (N.J. 1968) (holding that the burden to prove prejudice is on the insurer); Brakeman v. Potomac Ins. Co., 371 A.2d 193, 196 (Pa. 1977) ("[T]he insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position."); Hardwick Recycling & Salvage, Inc. v. Acadia Ins. Co., 869 A.2d 82 (Vt. 2004) (holding that insurer was not relieved of its obligations under policy because insurer failed to prove that it suffered prejudice as a result of the delay); Felice v. St. Paul Fire & Marine Ins. Co., 711 P.2d 1066, 1070 (Wash. App. 1985) (insurer asserting prejudice has burden of demonstrating prejudice); Ingalls Shipbuilding v. Fed. Ins. Co., 410 F.3d 214 (5th Cir. 2005) (placing burden to prove prejudice on insurer); BEI Sensors & Sys. Co. v. Great Am. Ins. Co., 2011 WL 835769 (N.D. Cal. Mar. 4, 2011) (determining that insurer failed to meet its burden of proving that late notice resulted in prejudice); Falcon Steel Co. v. Md. Cas. Co., 366 A.2d 512 (Del. Super. Ct. 1976) (concluding the insurer must provide coverage because insurer could not show prejudice

because of delay); Best v. W. Am. Ins. Co., 270 S.W.3d 398, 405 (Ky. Ct. App. 2008) ("[A]n insurer may not deny coverage because the insured failed to provide prompt notice of loss unless the insurer can prove that it is reasonably probable that it suffered substantial prejudice from the delay in notice."); Michoud v. Mut. Fire, Marine & Inland Ins. Co., 505 A.2d 786, 787 (Me. 1986) (concluding the insurer failed to demonstrate prejudice).

§ 36. Consent or Approval of the Insurer as a Condition

When a liability insurance policy makes the consent or approval of the insurer a condition of the insurer's duty under the policy, the condition is satisfied if the insured seeks to obtain the consent or approval of the insurer and a reasonable insurer would consent or approve in the circumstances.

Comment:

a. Consent or approval of a reasonable insurer. Under the rule adopted in this Section, a condition that requires consent of the insurer is satisfied if the insured seeks to obtain consent and an objectively reasonable insurer would consent in the circumstances. For example, many liability insurance policies forbid the insured from making voluntary payments in settlement of a claim without the consent or approval of the insurer. Under the rule adopted in this Section, if an insured presents a settlement offer to its insurer for approval and a reasonable insurer would approve the settlement, the consent-to-settlement condition is satisfied even if the insurer does not in fact grant its approval. Consistent with this rule, if an insurer that is presented by the insured with a request for approval of a settlement does not provide a definitive response to this request within a reasonable time, the consent is deemed granted if a reasonable insurer in the circumstances would have consented to the settlement.

In contract law generally, there is a strong preference for objective, commercial-reasonableness standards regarding satisfaction of conditions, especially when the satisfaction at issue is that of a party to the contract. Among other reasons for the objective standard, there is a concern that the party has selfish reasons not to agree. See Restatement Second, Contracts § 228, Comment *b*. Because of the aleatory nature of insurance contracts and the resulting power imbalance at the point of claim, insurance contracts present an especially strong case for a commercial-reasonableness standard. A commercial-reasonableness standard reduces the opportunity for insurers to misuse that power imbalance. Applying such a standard to insurer-

consent provisions is one of the ways that insurance law protects the objectively reasonable expectations of insureds. In addition, a commercial-reasonableness standard provides better guidance to the parties negotiating the settlement of a liability action than a subjective standard, because the parties have access to all of the information needed to assess the commercial reasonableness of a settlement. By contrast, only the liability insurer knows whether it is proceeding on a subjectively reasonable or good-faith basis. The same can be said when an insured seeks to retain a defense lawyer or to incur some other expense for which the consent of the insurer is required. In either case, a commercial-reasonableness standard provides greater guidance to the professionals with whom the insured is interacting than a subjective standard, which could vary among insurers and even within insurers depending on the personnel involved. Finally, a commercial-reasonableness standard promotes settlement, furthering the objectives of the underlying liability regime as well as the uncertainty-reducing objectives of insurance law.

b. A mandatory rule. Whether the commercial-reasonableness standard is a mandatory rule for liability insurance conditions has not been addressed in the case law. Based on the absence of published opinions regarding the enforceability of liability insurance policy provisions that attempt to specify a different standard for the insurer's withholding of consent, such as an honest-satisfaction standard that is analogous to the "honesty in fact" approach to good faith in the Uniform Commercial Code, it appears that insurers have not attempted to contract around the commercial-reasonableness standard. Especially in the consumer and small-business context, there would seem to be few, if any, benefits from allowing an insurer to specify a standard other than commercial reasonableness for the insurer's consent to a settlement, an independent-defense cost, or other aspect of the management of a claim reasonably undertaken by an insured in the circumstances. It is not credible that ordinary policyholders will choose among competing insurance policy forms on that basis, nor is it credible that such policyholders could be well informed about insurers' claims practices in relation to consent. Thus, there is little likelihood of a market constraint on the potential for opportunism presented by an honest-satisfaction standard for consent outside of the large-commercial-policyholder market.

Some support for insurers' acceptance of the mandatory nature of this rule in the consumer and small-business context can be drawn from the lack of reported cases involving personal lines or small-business insurance-policy provisions that attempt to create an honest-satisfaction or similar standard for insurer consent or approval. While there is a similar paucity of

such cases involving large commercial insureds, such insureds have less need for protection, and there is a greater likelihood that the purchase of a liability insurance policy that grants the insurer such discretion would be the result of a considered choice. The honesty-in-fact standard, pursuant to which the insurer's refusal to consent to a settlement precludes coverage for the settlement as long as the insurer honestly believed that the settlement was not reasonable in the circumstances, is an intelligible one in the context of a consent-to-settle provision in a commercial defense-cost-indemnification policy, as insurers likely differ in their approach to settlement and it is at least conceivable that insurers' reputations in this regard may be known in the market and, thus, form the basis for a sophisticated policyholder to choose one insurer over another. Accordingly, although the rule stated in this Section is a mandatory rule for consumer and small-business insureds, it may be appropriate to treat the rule as a default rule for a sophisticated insurance purchaser that chose to purchase a policy with an honest-satisfaction or similar standard for when an insurer may withhold consent.

REPORTERS' NOTES

a. Consent or approval of a reasonable insurer. For authority regarding the objective reasonableness of an insurer withholding consent, see, e.g., Paul Koepff, New Appleman New York Insurance Law 2nd, § 16.12 (2015) ("The reasonableness of an insurer withholding consent will be judged objectively based on the facts known to the insurer at the time of the settlement, taking into account the totality of the relevant circumstances surrounding the insurer's decision."); National Mut. Ins. v. Fincher, 428 N.E.2d 1386 (Ind. Ct. App. 1981) (holding that the insurer had acted unreasonably in withholding consent, since the insurer had sent a letter to the insured's counsel encouraging the insured to settle); Matter of CNA Ins. Companies, 170 A.D.2d 794 (N.Y. App. Div. 1991) (holding on the basis of an objective inquiry that an insurer is entitled to withhold its consent when there is no protection of its subrogation rights provided that it intended or expected, in good faith, to exercise those rights against the individual whose insurance was being exhausted by the settlement); First Fidelity Bancorporation v. National Union Fire Ins. Co. of Pittsburgh, Pa., 1994 WL 111363 (E.D. Pa. 1994) (applying New Jersey law) (concluding that the insurer had unreasonably withheld its consent to settlement of the underlying claims). For authority regarding the consequences of insurer delay, see Murriel v. Alfa Ins. Co., 697 So. 2d 370 (Miss. 1997) (holding that an insurer may lose the right to a no-consent defense if the insurer does not respond within a reasonable time to the insured's request for consent); Matter of Allstate Ins. Co. v. Sullivan, 646 N.Y.S.2d 359 (N.Y. App. Div. 1996); Randy Sutton, Conduct or Inaction by Insurer Constituting Waiver of, or Creating Estoppel to Assert, Defense of Consent to Settle Provision Under Insurance Policy, 16 A.L.R. 6th 491 § 6 (2006). For authority regarding insurer consent to payment of defense expenses, see Mitchell F.

Dolin, Excess Defense Coverage and Long-Tail Liabilities, 32 Tort & Ins. L.J. 875 (1997) ("Where the act requiring consent is the policyholder's incurring of defense costs, the insurer should be permitted to withhold consent in situations only where the underlying lawsuit should not be defended at all or where the insured, without prior consultation with the excess insurer, incurs patently unreasonable expenses.")

For cases applying objective, commercial-reasonableness standards regarding the insured's satisfaction of conditions generally, see, e.g., Matter of Prudential Prop. and Cas. Ins. Co., 604 N.Y.S.2d 136, 137 (N.Y. App. Div. 2d Dept. 1993) (holding that "the [insured] satisfied the conditions precedent to arbitration by advising [the insurer] of the settlement offer, by requiring [the insurer's] right of subrogation be preserved, and by requesting [the insurer's] consent to settle the claim on numerous occasions); Tri-State Consumer Ins. Co. v. Hundley, 618 N.Y.S.2d 41, 42 (N.Y. App. Div. 2d Dept. 1994) ("Because the respondent advised the appellant of the settlement offer, sought its consent, and cooperated with the appellant's investigation, we conclude that she satisfied the conditions precedent to arbitration.

b. A mandatory rule. Although courts apply an objective-reasonableness standard when a liability insurance policy requires the insured to seek the consent of an insurer, the decisions do not indicate whether this is a mandatory rule or a default rule that insurers can change by redrafting their policies. See authority cited in the Reporters' Note to Comment *a*, supra.

§ 37. The Exception for Claim-Reporting Conditions in Claims-Made-and-Reported Policies

Unless otherwise stated in the insurance policy, the notice-prejudice rule does not apply when a claim is first reported to the insurer after the end of the reporting period of a claims-made-and-reported policy, provided that the insured was afforded a reasonable time in which to report the claim.

Comment:

a. Claim-reporting conditions in claims-made-and-reported policies. A claims-made-and-reported policy is a claims-made policy that includes a special notice condition—typically referred to as a reporting requirement—in the insuring agreement section of the policy that requires the claim to be reported before the end of the reporting period in the policy. Typically, contemporary claims-made-and-reported policies contain reporting periods that extend at least 60 days beyond the end of the policy period. Courts generally conclude that putting the reporting requirement in the insuring agreement makes that condition sufficiently material to the contract

that the ordinary prejudice rule does not apply. This exception to the ordinary prejudice rule is based on the conclusion that this special notice-of-claim condition in a claims-made-and-reported policy has additional purposes beyond the traditional purpose of providing insurers with the information that they need to investigate and defend covered claims: (a) simplifying insurers' reserving practices and (b) reducing the amount of uncertainty in insurance pricing. It is important to note that claims-made-and-reported policies also generally contain a second, traditional notice-of-claim condition in the policy. A claims-made policy that contains only this traditional notice condition, and not the special reporting condition in the insuring agreement, is not a claims-made-and-reported policy.

b. The reserving justification for the claims-made-and-reported exception to the notice-prejudice rule. A notice-of-claim condition in a claims-made policy has the potential to affect liability insurance reserving practices more significantly than a similar condition in an occurrence policy. A "reserve" is an accounting entry in the financial statements of an insurer that represents the insurer's estimate of the losses that it will have to pay in the future for a defined set of claims or under a defined set of policies. Insurance accounting distinguishes between "case reserves"—which are reserves for specific claims that have been reported to the insurer—and reserves for losses that are "incurred but not reported" (IBNR). An insurer's IBNR loss reserve is supposed to reflect the insurer's best estimate of the amounts that it will have to pay on claims that have not yet been reported under the class of policies for which the insurer is setting the IBNR loss reserve. If there is a date certain after which no new claims can be asserted under a group of policies issued during a specific time, the insurer would be able to set a zero dollar IBNR reserve at that time for that group of policies. A notice-of-claim condition that sets an outside limit on the date by which all claims under a policy must be reported allows the insurer to have a date certain on which it can reduce its IBNR reserves on that policy to zero.

It is not possible for an insurer to use a notice-of-claim condition to achieve a zero dollar IBNR reserve goal under an occurrence policy. Occurrence policies are triggered by harms or activities that take place during the policy period, and there is the possibility of claims being reported many months or even years after the policy period. With the passage of time, the likelihood of new claims generally declines, but asbestos liability under commercial general-liability insurance policies serves as the cautionary counter-example. This means that strict application of a notice-of-claim condition in occurrence or accident policies could not have as

material an effect on insurers' IBNR reserving practice as would the strict application of the same condition in claims-made policies.

The significance of this IBNR difference can be overstated, however. The uncertainty attendant to liability insurance reserving is not eliminated when the insurer is able to set a zero-dollar IBNR reserve. There is ample room for uncertainty with regard to the case reserves set on the claims for which the insurer has received notice. Moreover, modest extensions of the time before the insurer can set the zero-dollar IBNR reserve are unlikely to have a material impact on the insurer's financial condition. Put another way, it is the ability of the insurer to set an enforceable deadline on when a claim may be reported that is important, not the precise date of the deadline. Moreover, there is no particular reason that the deadline needs to be coterminous with the end of the policy period, especially because the practice of setting that deadline at the end of the policy period virtually guarantees that there will be a disproportionate forfeiture in some cases in which the insured learns of the claim very close to the end of the policy period.

c. The pricing-uncertainty justification for the claims-made-and-reported exception to the notice-prejudice rule. The second justification for the claims-made-and-reported policy exception to the notice-prejudice rule is the potential increase in pricing uncertainty that could result from allowing notice to be reported too long after the end of the policy period. All other things being equal, the further into the future the insurer needs to estimate its losses, the more uncertainty there will be in that estimate. Because occurrence policies expose insurers to potential claims quite far into the future, even extensive delay in receiving notice of claims is unlikely to materially increase the uncertainty involved in pricing an occurrence policy. By contrast, a delay in receiving notices under claims-made policies that regularly goes well beyond the end of the policy period could lead to a meaningful increase in pricing uncertainty for those claims-made policies, because one of the main objectives of the claims-made form of coverage was to shorten the period between the payment of premiums for a policy and the payment of claims under that policy in order to reduce that uncertainty.

It is important to note, however, that this potential increase in pricing uncertainty does not provide adequate justification for strict enforcement of an unreasonable claims-reporting condition. As with the reserving benefit, the reduction in pricing uncertainty comes from the presence of an enforceable deadline on receiving notices. The insurer receives substantially the same reduction in pricing uncertainty from a claim-reporting condition that provides the insured

with a reasonable time to report a claim. Accordingly, the application of an unreasonable deadline for reporting a claim creates a disproportionate forfeiture.

d. Granting the insured a reasonable time to report a claim does not materially harm the insurer, even when that time extends beyond the policy period. Relaxing the requirement that a claim must be reported during the policy period does not pose a material increase in risk to the insurer. An insurer that grants the insured a reasonable time to report a claim receives all of the legitimate benefits of strict enforcement of a claim-reporting condition that is included in the insuring agreement of a claims-made policy. While there are undoubted benefits to prompt reporting, the modest delay needed to allow the insured a reasonable time to report a claim should rarely, if ever, harm the insurer. And, if the delay does harm the insurer, the ordinary prejudice rule would protect the insurer. The only additional benefit that an insurer receives from a reporting condition that does not grant the insured a reasonable time to provide notice is an illegitimate one: cost savings attributable to non-payment of claims forfeited by insureds because there was insufficient time to report those claims. Contemporary claims-made-and-reported policies commonly provide for an additional period of time, after the end of the policy period, during which the insured may report a claim that was first made during the policy period. This additional period of time is generally referred to as an "extended reporting period." Typically, claims-made-and-reported policies include an extended reporting period of at least 60 days, often longer. Some states have statutes requiring the inclusion of such an extended reporting period in a claims-made-and-reported policy. Claims-made-and-reported policies often grant the policyholder the option of paying an additional fee to further extend the reporting period.

e. The reasonable-time requirement in the case law. Published opinions rarely address the situation in which an insured did not have a reasonable time in which to report a claim. The vast majority of published opinions that strictly enforce claims-reporting conditions in claims-made-and-reported policies involve claims in which the policy contained a reasonable extended reporting period or the insured reported the claim sufficiently long after the end of the policy period. Published opinions often describe claims that are reported over a year after the policy period ended, and there are relatively few published opinions, especially in recent years, that involve claims that are reported less than three months after the end of the policy period. This is likely the result of the fact that most insurers wisely choose not to press to judgment denials of coverage that are based on unreasonable claim-reporting requirements. Among the few published

opinions to address this situation, the majority strictly enforce an unreasonable claim-reporting condition, but recent, more persuasive authority concludes that the loss of coverage due to the failure of the insurer to provide the insured with a reasonable time to report the claim is a disproportionate forfeiture. That is the approach adopted in this Section.

f. Prejudice is required when notice is late but given before the end of the reporting period. Typically, the second, more traditional notice-of-claim conditions in claims-made-and-reported policies require the insured to provide notice "as soon as practicable." For a claim that is made early in the policy period, the "as soon as practicable" requirement could mean that a notice should be provided well before the end of the reporting period under the policy. In that circumstance, the notice-prejudice rule applies, meaning that the insurer can avoid its obligations under the policy only if it demonstrates substantial prejudice. The notice-prejudice rule applies to claims filed before the end of the reporting period under the policy because the justifications for the claims-made-and-reported exception to the notice-prejudice rule do not apply until that period is over. Until that time, the insurer remains subject to additional claims and, thus, subject to uncertainty about the number and severity of the claims that will be reported under the policy as well as the IBNR reserve.

REPORTERS' NOTES

a. Claim-reporting conditions in claims-made-and-reported policies. For cases in which courts declined to apply the notice-prejudice rule to claims-made-and-reported policies, see, e.g., Anderson v. Aul, 361 Wis. 2d 63 (2014) (holding that the Wisconsin notice-prejudice statute did not apply to reporting requirements of claims-made and reported professional-liability insurance policies; more than one year delay in reporting); Zuckerman v. National Union Fire Ins. Co., 495 A.2d 395 (N.J. 1985) (strictly enforcing provision in claims-made-and-reported policy that limited coverage to claims filed within the policy period; more than one year delay in reporting); Slater v. Lawyers' Mutual Ins. Co., 227 Cal. App. 3d 1415 (Cal. Ct. App. 2d Dist. 1991) (same; claim reported six months after end of the policy period); Gulf Ins. Co. v. Dolan, 433 So. 2d 512 (Fla. 1983) (same; claim reported nearly three months after end of policy period). See also Craft v. Phila. Indem. Ins. Co., 343 P.3d 951 (Colo. 2015) (declining to apply notice-prejudice rule to claims-made-and-reported policies; reported more than one year after end of the policy period). Cf. Sherlock v. Perry, 605 F. Supp. 1001 (E.D. Mich. 1985) (declining to strictly enforce a traditional notice-of-claim condition in a claims-made policy that was not a claims-made-and-reported policy).

b. The reserving justification for the claims-made-and-reported exception to the notice-prejudice rule. See, e.g., Hasbrouck v. St. Paul Fire & Marine Ins. Co., 511 N.W.2d 364, 368

(Iowa 1993) ("the 'claims made' policy reporting provision serves a different purpose. It provides a certain date after which an insurer knows that it is no longer liable under the policy. So the insurer can more accurately fix its reserves for future liabilities and compute premiums with greater certainty.")

c. The pricing-uncertainty justification for the claims-made-and-reported exception to the notice-prejudice rule. Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 406 Mass. 862, 865 (Mass. 1990) (holding that the purpose of a claims-made policy is "to minimize the time between the insured event and the payment . . . If a claim is made against an insured, but the insurer does not know about it until years later, the primary purpose of insuring claims rather than occurrences is frustrated"). See also Anderson v. Aul, 361 Wis. 2d 63 (2014) (adopting the reasoning of *Chas. T. Main* and concluding that notice-prejudice statutes do not apply to the reporting requirements in claims-made policies).

d. Granting the insured a reasonable time to report a claim does not materially harm the insurer, even when that time extends beyond the policy period. See Stacey Kalberman, Director and Officer Liability: An Overview of Corporate and Insurance Indemnification, 16 Andrews Off. & Dir. Liab. Litig. R. 16 (2001) ("Many [D&O claims-made] policies also contain a 30- or 60-day automatic extended reporting period which does not require any additional premium.") For sources noting that claims-made-and-reported policies often grant the policyholder the option of paying an additional fee to further extend the reporting period see California Practice Guide: Insurance Litigation Ch. 7A-C ("To extend the time within which the claim may be made, the insured may purchase 'tail coverage' or a separate 'extended reporting period' endorsement (e.g., six months) for a particular claims-made policy year. This provides insurance protection *if* the wrongful act took place during that policy year and the claim is made before expiration of the extended reporting period."); Joseph P. Monteleone, Notice-Prejudice Requirements in D&O Policies: Diverse Trends in Contract Language and Case Law, The D&O Diary, November 23, 2015 (reporting that D&O policies commonly contain 180-day extended reporting periods and, increasingly, include language explicitly requiring the insurer to prove prejudice in order to avoid coverage on the basis of late notice). For a compilation of statutes requiring the inclusion of extended reporting periods, see Ostrager & Newman, Handbook on Insurance Coverage Disputes (17 ed. 2015) § 4.02[b][E], Survey of Jurisdictions on Issue Whether Public Policy Requires Claims-Made Policies to Include an Extended Reporting Provision.

e. The reasonable-time requirement in the case law. See 13 Couch on Ins. § 186:13 ("[T]he 'prompt' requirement [appearing in claims-made policies] may be deemed to allow coverage for claims of which the insurer receives notice 'promptly' even if that notice is given a short time after the policy period ended."). Among the few published opinions to address this situation, a majority strictly enforce an unreasonable notice-of-claim condition contained in the insuring agreement of a claims-made policy, but recent, more persuasive authority concludes that the loss of coverage due to the failure of the insurer to provide the insured with a reasonable time

to provide notice is a disproportionate forfeiture. See Root v. American Equity Specialty Ins. Co., 30 Cal. Rptr. 3d 631 (Cal. App. 4th Dist. 2005) (finding coverage under a claims-made-and-reported policy despite the insured's failure to notify insurer of claim during the policy period because the policy did not provide the insured a reasonable time to report the claim.) That is the approach adopted in this Section. Two of the standard citations courts provide when explaining the difference between claims-made-and-reported policies and occurrence policies in a manner that justifies strict enforcement of the reporting condition are law-review articles written by a prominent insurance attorney, Sol Kroll (who served, for example, as U.S. General Counsel to Lloyd's of London and director of the New York Insurance Federation), in the 1970s, before courts had substantial experience with claims-made policies; these articles do not reflect the more nuanced explanation of the potential impact of a reporting condition on pricing and reserving provided in the Comments to this Section. See, e.g., Anderson v. Aul, 862 N.W.2d 304 (Wis. 2014) (citing Sol Kroll, "Claims Made"—Industry's Alternative: "Pay as You Go" Products Liability Insurance, 1976 Ins. L.J. 63, 64 (1976)), Zuckerman v. National Union Fire Ins. Co., 495 A 2d 395 (N.J. 1985) (citing Sol Kroll, "The Professional Liability Policy 'Claims Made,'" 13 Forum 842, 850 (1978) and Sol Kroll, " 'Claims Made'-Industry's Alternative: 'Pay as You Go' Products Liability Insurance," 637 Ins. L.J. 63, 64 (Feb., 1976)).

f. Prejudice is required when notice is late but given before the end of the reporting period. 13 Couch on Ins. § 186:13 notes that "promptness" provisions are "directed at ensuring promptness of notice, maximizing the insurer's opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured." For cases applying the notice-prejudice rule to an insured's breach of a claims-made policy's prompt-notice provision, see, e.g., Fin. Indus. Corp. v. XL Specialty Ins. Co., 285 S.W.3d 877, 879 (Tex. 2009) ("an insurer must show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is given within the policy's coverage period"); Fulton Bellows, LLC v. Fed. Ins. Co., 662 F. Supp. 2d 976 (E.D. Tenn. 2009) (same).

§ 38. Circumstances in Which Anti-Assignment Conditions are Unenforceable

(1) Rights under an insurance policy relating to a specific claim that has been made against an insured may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments.

(2) A right under an insurance policy relating to a class of claims or potential claims may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments, provided the following requirements are met:

(a) The assignment accompanies the transfer of financial responsibility for the underlying liabilities insured under the policy as part of a sale of corporate assets or similar transaction;

(b) The assignment takes place after the end of the policy period; and

(c) The assignment of the right does not materially increase the risk borne by the insurer.

Comment:

a. Assignment of a right to payment for a specific claim. It is generally accepted that the insured's rights under a liability insurance policy relating to a specific claim that has already been made against the insured is a "chose in action" that is freely assignable by the insured, notwithstanding any provision in an insurance policy prohibiting or conditioning such assignment.

b. Assignment of liability insurance rights in mergers and acquisitions. The question of what rights under a liability insurance policy can be assigned as part of corporate sale or reorganization has proved controversial in some contexts in light of the presence of an anti-assignment condition in most liability insurance policies. When there is a corporate merger, the law treats the resulting entity as the continuation of each of the merged entities, with the result that the resulting entity retains the liability insurance rights of each of the merged entities. In that merger context, there is no assignment of rights under a liability insurance policy that could be subject to any conditions that might be present in the merged entities' liability insurance policies. By contrast, when one corporation acquires a business from another corporation through an asset sale, or when part of a business is placed into a newly formed corporation, the acquiring entity is a legally separate entity that is not ordinarily treated as the continuation of the entity transferring the assets. In that context, the liability insurance rights that have been associated with the business that is being transferred must be transferred to the acquiring entity through an assignment that is either express or implied.

Traditionally, liabilities and the associated rights under occurrence- or accident-based liability insurance policies issued in the past were routinely transferred as part of an asset purchase or the creation of a new corporation, apparently without significant challenge from liability insurers, at least as indicated by reported cases and the insurance trade literature, and in some cases even without an express assignment term in the asset-purchase documents. Such

transfers came under challenge in the late 20th century, however, as a violation of a liability insurance policy term that prohibits the assignment of rights under the policy without the consent of the insurer. Although some courts have concluded that the failure to obtain the insurer's consent does lead to a forfeiture of coverage, the majority rule is to the contrary.

Typically, courts on both sides of this debate have analyzed the question in relation to precedents regarding a chose in action. Under that approach, the outcome turns on whether liability insurance policy rights relating to future claims arising out of covered activities that took place in the past, during a policy period that has already ended, can be characterized as a chose in action. Most of the courts that have examined the question have determined that these rights are appropriately considered as a chose in action in light of the substantial insurance-law authority supporting the assignability of insurance rights regarding a loss that has already occurred, but for which no claim has yet been made. Insurance accounting treats future covered claims as a present loss, and requires insurance companies to set reserves for such "incurred but not reported" losses. The public policy in favor of facilitating corporate reorganizations and the sale of businesses provides further support for this conclusion.

This result is also consistent with the general rule that the insured's failure to satisfy a condition does not relieve the insurer of its obligations under the policy unless the insurer can demonstrate prejudice. Ordinarily there would not be any prejudice from the assignment because the liabilities are based on activity that occurred in the past and are not affected by the transfer of the liabilities and associated insurance rights.

c. Coverage for pre-merger or acquisition liabilities. The rule stated in this Section applies only to liabilities that were already insured under an insurance policy prior to a merger or acquisition. Companies do not have the right to coverage for their pre-acquisition or pre-merger liabilities under the policies of other companies that they acquire or with which they merge. Requiring the pre-merger insurer to cover the new, post-merger liabilities would substantially increase the risks under the policy of the pre-merger insurer, in marked contrast to the situation addressed in this Section. The rule stated in this Section simply preserves the right to insurance for the liabilities insured under the pre-merger or pre-acquisition insurance policy.

Illustrations:

1. In 2005 Widget Wrench Corp. purchases the assets and assumes the liabilities of Acme Hammer Corp. pursuant to a contract that expressly assigns to Widget Wrench all rights under Acme Hammer Corp.'s liability insurance policies. Acme Hammer Corp. dissolves and Widget Wrench renames itself Widget Tools Corp. In 2006 Widget Tools Corp. is the subject of a product-liability action alleging that an Acme hammer caused bodily injury to the plaintiff in 2002. Widget Tools is entitled to a defense under the standard-form, occurrence-based commercial general-liability insurance policy issued to Acme Hammer for the policy period January 1, 2002 to January 1, 2003, assuming that all other requirements for the defense coverage are satisfied. Widget Tools is not entitled to a defense under the standard-form, occurrence-based commercial general-liability insurance policy issued to Widget Wrench for the policy period January 1, 2002 to January 1, 2003.

2. Same facts as Illustration 1, except that the product-liability action alleges that a Widget wrench caused the bodily injury. Widget Tools is not entitled to coverage for this lawsuit under the liability insurance policy issued to Acme Hammer. Widget Tools is entitled to a defense for this lawsuit under the policy issued to Widget Wrench, assuming that all other requirements for the defense coverage are satisfied.

d. Assignment of liability insurance rights in other contexts is an open question. In specifying that liability insurance rights may be assigned in the context of mergers and acquisitions, this Restatement is not taking a position on whether liability insurance rights may be assigned without the consent of the insurer in other contexts in which there is no material increase in the risk borne by the insurer.

REPORTERS' NOTES

a. Assignment of a right to payment for a specific claim. For those jurisdictions following the majority rule and permitting post-loss assignment of payment for a specific claim, see Egger v. Gulf Insurance Co., 903 A.2d 1219, 1229 (Pa. 2006) (holding that "whether or not the assignment was made prior to the jury verdict is irrelevant, as the obligation . . . arose on the date of the occurrence…."); In re Ambassador Ins. Co., 965 A.2d 486, 490-491 (Vt. 2008) (holding that the post-loss assignment of a claim is permissible regardless of an anti-assignment clause because once the event triggering the claim occurs, the risk to the insurer does not change); Wehr

Constructors Inc. v. Assur. Co of Am., 384 S.W.3d 680, 683 (Ky. 2012) (stating that once the loss has occurred, the chose in action can be assigned, notwithstanding the existence of an anti-assignment clause, as such a clause would be void as against public policy); Ohio v. Baird, 567 F.3d 1207, 1214 (10th Cir. 2009) (finding under Utah law that an anti-assignment clause is no longer enforceable once the event giving rise to the claim has occurred); Colo. Cas. Ins. Co. v. Safety Control Co., 230 Ariz. 560, 565-566 (Ariz. Ct. App. 2012); Glenn v. Fleming, 247 Kan. 296 (Kan. 1990) ("[A]n insured's breach of contract claim for bad faith or negligent refusal to settle may be assigned.").

A few jurisdictions do not permit the assignment of claims post-loss if the policy contains an anti-assignment clause. See Holloway v. Republic Indemnity Co., 147 P.3d 329, 335 (Or. 2006) (holding that the anti-assignment clause in a workers'-compensation and employers'-liability policy prohibited the assignment of the "insured's rights or duties without regard to whether they arose pre-loss or post-loss"); ARM Props. Mgmt. Group v. RSUI Indem. Co., 642 F. Supp. 2d 592, 609 (W.D. Tex. 2009) (stating that an "anti-assignment provision applies to bar the post-loss assignment of claims"); In re Katrina Canal Breaches Litigation, No. 2010-CQ-1823, 63 So. 3d 955, 964 (La. May 10, 2011) ("There is no public policy in Louisiana which precludes an anti-assignment clause from applying to post-loss assignments. However, the language of the anti-assignment clause must clearly and unambiguously express that it applies to post-loss assignments, and thus it must be evaluated on a policy by policy basis."); Dillingham v. Tri-State Ins. Co., 214 Tenn. 592, 381 S.W.2d 914, 917-919 (Tenn. 1964) (holding that defendants may not assign choses in action against their insurers).

b. Assignment of liability insurance rights in mergers and acquisitions. The majority of jurisdictions have found that anti-assignment clauses are not enforceable against post-loss assignments of insurance rights through mergers and acquisitions. 3 Couch on Ins. § 35:8 (2004, updated 2014) ("[T]he great majority of courts adhere to the rule that general stipulations in policies prohibiting assignments of the policy, except with the consent of the insurer, apply only to assignments before loss, and do not prevent an assignment after loss…."); 3-16 New *Appleman on Insurance Law Library Edition* 2011 § 16.05(2)(c) ("This rule [that anti-assignment clauses do not preclude post-loss assignments] is generally applied to rights under liability insurance policies…."). See, e.g., Elliot Co. v. Liberty Mutual Insurance Co., 434 F. Supp. 2d 483, 491 (N.D. Ohio 2006) (holding that a purchase agreement could assign former subsidiaries coverage for pre-assignment occurrences, even when there was an anti-assignment clause in the policy); Viking Pump, Inc. v. Century Indem. Co., 2 A.3d 76, 82 (Del. Ch. 2009) (asserting that New York law treats a loss as occurring at the event where the liability arises, such that after that event it can be transferred); Arrwood Indem. Co. v. Atl. Mut. Ins. Co., 948 N.Y.S.2d 581, 582-583 (App. Div. 2011) (stating that the anti-assignment provision is not enforceable as the liabilities, the personal injuries from exposure to products, arose prior to the transfer of insurance benefits); Ill. Tool Works, Inc. v. Commerce & Indus. Ins. Co., 962 N.E.2d 1042, 1053 (Ill. App. Ct. 2011) (affirming that for third-party occurrence-based policies, anti-

assignment clauses do not prevent the assignment after the loss has occurred, and that the event giving rise to liability is the loss itself); Massachusetts Elec. Co. v. Commercial Union Ins., 20 Mass. L. Rptr. 145, *2, Mass. Super. (declaring that when the event giving rise to the loss occurred during the policy period, the right to recover could be transferred despite an anti-assignment clause); Century Indem. Co. v. Aero-Motive Co., 2004 U.S. Dist. Lexis 31180, at *10, *14 (W.D. Mich. 2004) (stating that anti-assignment clauses are inapplicable once a claim "amounts to an accrued cause of action against the insurer," which happens at the occurrence of the events leading to liability); N.H. MFG. Self Ins. Group Trust v. Cont'l Cas. Co., 2008 NH Super. Lexis 42 (finding that the accident insured against determines when the loss occurred such that a post-incident transfer was permitted); Pilkington North America, Inc. v. Travelers Casualty & Surety Co., 861 N.E.2d 121, 126 (Ohio 2006) (holding that the right to bring an action under an occurrence-based policy arises as soon as the injury occurs, which creates a chose in action, such that the duty to indemnify can be transferred even when there is an anti-assignment clause). California, the most significant jurisdiction to enforce an anti-assignment condition in an asset-purchase context, recently overruled its earlier opinion, adopting the majority rule. See Fluor Corporation v. Superior Court, 61 Cal. 4th 1175 (Cal. 2015) (overruling Henkel Corp. v. Hartford Accident & Indem. Co., 29 Cal. 4th 934, 945, 62 P.3d 69, 76 (2003)).

For jurisdictions that have enforced anti-assignment clauses against the post-loss assignment of benefits through an asset transfer, see Keller Foundations, Inc. v. Wausau Underwriters Ins. Co., 626 F.3d 871, 877 (5th Cir. 2010) (holding under Texas law that a non-assignment clause in an insurance agreement is enforceable even against a post-loss assignment of insurance benefits through an asset transfer); Travelers Casualty & Surety Co. v. U.S. Filter Corp., 895 N.E.2d 1172, 1180 (Ind. 2008) (upholding anti-assignment clauses in a liability policy as preventing the assignment of rights until the loss is "identifiable with some precision" and "fixed, not speculative," such that the transfer cannot be merely after the event leading to the loss under the occurrence-based policy) (internal citations omitted); Del Monte Fresh Produce (Hawaii), Inc. v. Fireman's Fund Ins. Co., 183 P.3d 734, 747 (Haw. 2007) (holding that an anti-assignment clause prevents the transfer of policy rights even post-loss, and recognizing that this is against the majority rule).

c. Coverage for pre-merger or acquisition liabilities. See, e.g., Total Waste Mgmt. Corp. v. Commercial Union Ins. Co., 857 F. Supp. 140, 150 (D.N.H. 1994) (holding the successor's policies "do not provide coverage for an entity which was acquired by the named insured after the expiration of the policies and which entity allegedly caused damage [ ] during the policies' periods"); see also Armstrong World Indus. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690, 723, 726 (Cal. App. 1996) (holding the policies did not provide coverage for the acts of the merged company prior to the merger and stating "a corporate acquisition taking place after the policy has expired can have no retroactive effect on the identity of the named insured during the policy period"); Caterpillar, Inc. v. Aetna Cas. & Sur. Co., 668 N.E.2d 1152 (Ill. App. Ct. 1996). See

generally Michael A. Kotula & Gary D. Centola, After-Acquired and After-Involved Liabilities in Insurance Coverage Disputes, 12-9 Mealey's Litig. Rep. Ins. 8 (Jan. 6, 1998).

TOPIC 3

APPLICATION OF LIMITS, RETENTIONS, AND DEDUCTIBLES

§ 39. Policy Limits

(1) A policy limit is a term in an insurance policy that identifies the maximum amount the insurer is obligated to pay for the claim or claims to which the policy limit applies.

(2) A per-occurrence, per-accident, per-claim, per-person, or other per-circumstance policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a single occurrence, accident, claim, person, or other specified circumstance.

(3) An aggregate policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a specified set of circumstances, regardless of the number of occurrences, accidents, claims, persons, or other specified circumstances. An insurance policy may have an aggregate limit that applies to all claims covered by the policy or it may have one or more aggregate limits that apply only to a defined set of claims. Not all liability insurance policies contain an aggregate limit.

Comment:

a. The function and effect of policy limits. Policy limits allow insurers to manage their exposure in a manner that reduces the cost of insurance by reducing the uncertainty faced by insurers. Policy limits also allow policyholders to choose the amount of liability insurance protection that they are buying. In addition, policy limits reduce the risk of insurer insolvency. These benefits come at a cost, however. The presence of a policy limit means that insureds, and, potentially, liability claimants, bear the risk of judgments in excess of those limits. This risk of excess judgments creates the potential for a conflict of interest between the primary insurer, who often has control over settlement decisions, and the insured and excess insurers. It is this conflict

of interest to which the duty to make reasonable settlement decisions is a response. See § 24, Comment *a*.

b. Types of policy limits. Liability insurance policies sold in the United States generally contain some form of policy limit, typically a policy limit that sets the maximum amount that the insurer may be obligated to pay under the policy for a defined circumstance, such as an "occurrence," "accident," "claim," or "bodily injury to a person." Automobile liability insurance policies typically have per-person and per-accident limits; commercial general-liability policies typically have per-occurrence limits; errors-and-omissions policies often have per-claim limits. This Restatement refers generically to all such policy limits as "per-circumstance policy limits." Many liability insurance policies, including most commercial liability insurance policies, contain some form of policy limit that specifies the maximum amount the insurer may be obligated to pay under the policy for a specified set of claims. The insurance trade practice is to refer to such limits as "aggregate limits." There may be an overall aggregate limit in a policy that specifies the total amount that the insurer may be obligated to pay for all claims covered by the policy. Alternatively, there may be an aggregate limit that applies only to specified types of claims. For example, for much of the 20th century it was common for commercial general-liability policies to have an aggregate limit for products-liability claims but not for other kinds of claims.

c. Default rule on policy limits and defense costs. Under the rule adopted in § 14(3), the costs of the defense of a claim are borne by the insurer in addition to the policy limits, unless otherwise stated in the policy.

REPORTERS' NOTES

a. The function and effect of policy limits. The amount of coverage provided by an insurance policy is its policy limits or limit of liability. This term sets an insurer's maximum obligation to pay under the policy. See Randy Maniloff & Jeffrey Stempel, *General Liability Insurance Coverage* 6 (2d ed. 2012); Paul E.B. Glad, et al., *Appleman on Insurance Law and Practice* § 16.09[3][a][i] (Lexis 2015). In some circumstances, however, an insurer may be liable for damages in excess of its policy limits, such as when it breaches its duty to defend and the excess amount arose from the breach. See Robert H. Jerry II, Douglas R. Richmond, *Understanding Insurance Law* 819-820 (5th ed. 2012).

Policy limits are an important term in insurance contracts that limit an insurer's total risk based on the premiums paid by the policyholder. See Brohawn v. Transamerica Ins. Co., 347

A.2d 842, 851 (Md. 1975) ("The promise to defend the insured, as well as the promise to indemnify, is the consideration received by the insured for payment of the policy premiums.") Policy limits are commonly written on a per-occurrence basis. In addition, a policy limit may have an "aggregate limit" that represents the total amount the company promises to pay for all occurrences or claims covered by a particular policy. See Tom Baker & Kyle D. Logue, Insurance Law and Policy 504-505 (3d ed. 2013); Cincinnati Ins. Co. v. Television Eng'g Corp., 265 F. Supp. 2d 1078, 1081 (E.D. Mo. 2003) ("An aggregate limit is [t]he maximum limit of coverage available under a liability policy during a specified period of time . . . regardless of the number of claims that may be made. . . . Its counterpart is the per occurrence limit, which expressly limits the amount to be paid under an insurance policy for liability arising out of each compensable occurrence.").

b. Types of policy limits. Ordinarily, the policy limit is a fixed term in an insurance contract. See Mesmer v. Maryland Auto. Ins. Fund, 725 A.2d 1053, 1061 (Md. 1999) ("Under the typical liability insurance policy, the insurer has a duty to indemnify the insured, up to the limits of the policy . . . The source of [the] dut[y] is solely the insurance contract."). See also *Couch on Insurance* § 172:3 (3d ed. 2013) ("[T]he liability of an insurer and the extent of the loss under a policy of liability and indemnity insurance must be determined, measured, and limited by the terms of the contract.") (citing Vrabel v. Scholler, 85 A.2d 858 (Pa. 1952); Miller v. Lewis, 21 Pa. D. & C. 684 (C.P. 1934); De Pasquale v. Union Indem. Co., 149 A. 795 (R.I. 1930)).

The policy language determines whether an insurer's defense costs contribute towards the policy limits. See generally Robert H. Jerry II, Douglas R. Richmond, *Understanding Insurance Law* 812-816 ("In sum, the question of whether an insurer can discharge its duty to defend by fulfilling its duty to indemnify is a confused one."). Most courts interpreting both the 1966 and 1980s CGL policy language have held the costs of defense do not count against the policy limits. Id.; see also Seth D. Lamden, 3-17 *Appleman on Insurance Law and Practice* § 17.03 (Lexis 2015) ("Under most general liability policies, defense costs are not subject to the policy limits."). However, some general-liability policies, referred to as "self-consuming" or "burning limits," reduce the policy limits by both the insurer's indemnity and defense payments. See Lamden, 3-17 *Appleman on Insurance Law and Practice* § 17.03 (Lexis 2015).

A policyholder may purchase multiple policies to insure the same risk. Second- and third-level excess policies "stack" additional coverage beginning at the preceding policy's policy limits. See Steven Plitt, et al, 1 *Couch on Insurance* § 6:35 (3d ed. 2015) ("In modern business practice, it is common to find that a single insured is covered under two or more different policies of liability insurance, each of which 'kicks in' at a different dollar value of liability, with the beginning coverage level of one policy designed to kick in at the maximum policy amount for the next lower level.").

Severability clauses do not increase policy limits, as they are not coverage provisions. Plitt, 2 *Couch on Insurance* § 23:1 (3d ed. 2014) (citing United Services Auto Ass'n v. Neary,

307 P.3d 907 (Alaska 2013)); Baker v. DePew, 860 S.W.2d 318, 320 (Mo. 1993) ("The severability clause applies to the meaning of the term 'insured' anywhere in the policy except in the provisions that specify the limits of liability; i.e., the severability clause does not operate to increase the limits of the policy.").

Per-person policy limits containing the words 'each person' only refer to the persons that have suffered direct harm or loss from the accident or occurrence. Plitt, 12 *Couch on Insurance* § 172:8; see Hutton v. Martin, 262 P.2d 202, 204 (Wash. 1953) ("[T]he words 'each person' refer to the person injured or killed and not to each person who may suffer damages from such injury or death."); Jones v. Zagrodnik, 600 So. 2d 1265, 1266 (Fla. Dist. Ct. App. 1992) ("The estate and the survivors suffered loss, not directly from the collision, but from the loss of the deceased who was killed in the accident.")

c. Default rule on policy limits and defense costs. See § 14(3).

§ 40. Retentions and Deductibles

(1) A self-insured retention is the amount specified in a liability insurance policy that the insured must pay for a covered loss before coverage under the policy begins to apply. Unless otherwise stated in the insurance policy, an insurer has no duty to defend or indemnify the insured until the insured has paid any applicable self-insured retention.

(2) A deductible is the amount specified in the liability insurance policy by which coverage under the policy is reduced after the coverage amount is finally determined.

(3) Unless otherwise stated in the insurance policy, none of the insurer's duties with respect to defense or indemnification are contingent upon the insured's payment of the deductible.

Comment:

a. The function and effect of deductibles and retentions. Deductibles and self-insured retentions in liability insurance policies leave some of the costs of covered losses on insureds, serving two main functions. First, they reduce moral hazard by preserving insureds' incentive to avoid loss and thereby more closely aligning the incentives of insurer and insured. Second, deductibles and retentions reduce costs by allowing policyholders to manage or absorb the loss of smaller claims themselves, so that policyholders incur the administrative costs associated with

risk transfer only for larger claims for which they benefit from the loss spreading provided by insurance. Both functions are more important in the commercial liability insurance market. Consumer and small commercial liability insurance policies often do not have a deductible, or have a very low deductible, because these insureds do not have the capacity to administer a liability claim on their own, and insurers have found that such policies do not create an unacceptable moral-hazard problem. Large commercial enterprises frequently arrange their insurance programs to include large self-insured retentions in order to reduce premiums, increase policy limits, or retain greater control over claims adjustment and defense.

b. The difference between deductibles and self-insured retentions. Generally, the primary difference between a deductible and a self-insured retention relates to the timing of the inception of the insurer's obligation. Under the typical wording of a self-insured retention provision, the insurer has no obligation to provide or pay for the defense or settlement until the insured has spent the amount of the retention. By contrast, under the typical wording of a deductible provision, a liability insurer has the standard duties to settle and defend from the first dollar of costs incurred, but has the right to recoup the amount of the deductible from the insured. Thus, under the standard wording of most deductible provisions, if the deductible in the policy is stated to be $10,000 per occurrence and the per-occurrence policy limit is $500,000, the insurer would typically defend the case, from the first dollar, and would pay up to $500,000 for settlements or judgments of a single occurrence, only then seeking $10,000 of reimbursement from the insured for the deductible. In practice, however, the insurer might simply pay the net amount of coverage owed ($490,000), subtracting the deductible from the coverage amount. By contrast, with the typically worded retention of the same amount, the insurer would have no defense or indemnity obligations until after the insured incurred costs of $10,000, at which point the insurer's defense obligations and indemnity obligations would apply up to $500,000 total.

Notwithstanding these typical differences between deductible and retention provisions in liability insurance policies, the effect of such provisions ultimately does not depend on their label as "deductible" or "retention" but rather on the particular wording of the insurance policy in question and the application of the normal rules of interpretation in §§ 3 and 4. Thus, if the language of a self-insured retention does not state that the duty to defend, or to pay for defense costs, applies only after the full retention is paid by the insured, such a term may be considered ambiguous and the insurer's duty may be triggered before the payment of the retention.

REPORTERS' NOTES

a. The function and effect of deductibles and retentions. Black's Law Dictionary defines a deductible as "the portion of the loss to be borne by the insured before the insurer becomes liable for payment" and defines a "self-insured retention" as "the amount of an otherwise-covered loss that is not covered by an insurance policy that usually must be paid before the insurer will pay benefits." Black's Law Dictionary at 1391 (8th ed. 2004). For a general discussion of deductibles and retentions and their functions and effects, see Robert H. Jerry II, Douglas R. Richmond, *Understanding Insurance Law* 36 (5th ed. 2012); Tom Baker & Kyle D. Logue, *Insurance Law and Policy* 349 (3d ed. 2013); and Richard J. Cohen, et al., 5-47 *Appleman on Insurance Law and Practice* § 47.03 (Lexis 2015).

b. The difference between deductibles and self-insured retentions. For a discussion of the differences between deductibles and self-insured retentions, see Glad, 3-16 *Appleman on Insurance Law and Practice* § 16.09[b][i]:

> Although some courts appear to view 'deductible' as synonymous with 'self-insured retention,' there are important distinctions between the two. First, it is generally accepted that the insurer in a deductible arrangement is primarily responsible for the loss starting from its first dollar, though entitled to reimbursement from the insured, so that in case of insured insolvency, for example, the insurer must pay amounts covered under the policy within the deductible for which the insured is held liable. Where the policy imposes on the insurer a duty to defend, furthermore, this duty attaches even for claims within the deductible in the absence of specific policy language to the contrary. Unlike a deductible-type policy, a self-insured retention does not constitute "other insurance" for purposes of an "other insurance" clause in the absence of specific policy language to the contrary.

(Internal footnotes omitted). Notwithstanding these general rules, the precise difference between deductibles and retentions depends on the exact wording of the policies themselves. Thus, for example, if an SIR does not clearly provide that an insurer's defense obligations do not apply until after the SIR is paid by the insured, courts have held in favor of insureds, finding a duty to defend on grounds of ambiguity in the policy language. See, e.g., Am. Safety Indem. Co. v. Admiral Ins. Co., 162 Cal. Rptr. 3d 699, 708 (Cal. Ct. App. 2013), review denied, 2013 Cal. LEXIS 10507 (Cal. Dec. 18, 2013) (holding that trial court did not err in determining that insureds were not required to satisfy the SIR as a condition of obtaining a defense, where the SIR did not expressly and unambiguously make the duty to defend subject to payment of the SIR). For a discussion on the rules regarding per-accident and per-occurrence deductible clauses, see Plitt, 12 *Couch on Insurance* § 172:12 ("Any analysis of these issues should start with an inquiry of how many claims are involved, the extent and nature of the injury, the number of causal

accidents involved and the continuity, if any, between the injury and accident. Once these factors are determined, the practitioner can turn to the application of the policy provisions to the facts.").

§ 41. Number of Accidents or Occurrences

For liability insurance policies that have per-accident or per-occurrence policy limits, retentions, or deductibles, the number of accidents or occurrences is determined by reference to the cause(s) of the bodily injury, property damage, or other harm that forms the basis for the claim, unless otherwise stated in the policy.

Comment:

a. Determining the number of accidents and occurrences. Liability insurance policies that contain per-accident or per-occurrence policy limits, deductibles, or self-insured retentions can give rise to controversies regarding the number of accidents or occurrences that have taken place during a particular policy period. The number of accidents or occurrences can have large implications for the total amount of coverage available. Arguably the most famous number-of-occurrences example is the attack on the World Trade Center in 2001. With roughly $3.6 billion at stake in that situation, insureds argued that there were at least two occurrences (two planes, two buildings), and insurers argued that there was no more than a single occurrence (one terror plot). The World Trade Center case involved first-party property insurance, but the same issue arises in connection with liability insurance, which also uses per-occurrence limits. As in many cases that raise the number-of-occurrences question, the result in the World Trade Center case turned on the relevant language in the contract. The court determined that the plain meaning of the language in one policy provided for a single occurrence and the relevant language in another policy was ambiguous, with the result that the two-occurrence interpretation that favored the non-drafting insured was applied.

The term "occurrence" itself is typically defined within a liability insurance policy to mean "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Determining the number of accidents or occurrences that have taken place during the policy period is notoriously difficult. From the perspective of the policy limits, the more occurrences there are, the better the result will be for the insured, because the larger the total amount of coverage there will be. However, the opposite is true from the perspective of deductibles or retentions: all else equal, the fewer the occurrences, the better the result for the

insured will be, because the smaller will be the share of a covered claim that must be borne by the insured. Unfortunately, the question how many "accidents" there were and the question whether all the losses at issue in a given claim were the result of "continuous or repeated exposure to substantially the same general harmful conditions" often has no clear answer. As a result, courts have developed two general doctrinal tests for determining the number of accidents or occurrences for purposes of calculating both the number of policy limits and the number of deductibles or retentions that will apply: the "effects test" and the "cause test."

b. The effects test. Under the effects test, each injured individual or piece of damaged property tends to be regarded as a separate occurrence. The "effects test" is a relatively old rule that has fallen out of favor with the courts. Most of the courts that originally adopted this approach have abandoned it, because treating each separate injured person or damaged property as a separate occurrence effectively converts a "per occurrence" policy into a "per claim" policy, which runs counter to the language of occurrence-based coverage. This effects test also conflicts with the reasonable expectations of the contracting parties, who would expect "an occurrence" to mean something akin to "an accident," expanded of course to also include "continuous or repeated exposure to substantially the same general harmful conditions." Considering for example the case of an explosion that injures many bystanders, the ordinary understanding of "accident" would refer to the explosion, not to each of the individual injuries.

c. The cause test(s). Consistent with the explosion example, a substantial majority of courts that have addressed the number-of-accidents-or-occurrences issue look to the cause of the loss rather than the effect. Under the "cause test," courts determine the number of accidents or occurrences by asking how many "causes," "liability-triggering events," or "unfortunate events" produced the injury or damage. If there is one cause, there is one accident or occurrence, and hence one per-accident or occurrence policy limit (and, if applicable, one deductible or retention) under each of the policies that is triggered. If there are five causes, there are five accidents or occurrences and five per-accident or occurrence policy limits, subject to any applicable aggregate limit (and, if applicable, five deductibles or retentions). Courts have concluded that the cause test fits more closely than the effects test with the language of the policies and also with the expectations of the parties. Application of the cause test tends to result in fewer occurrences than the effects test, all else equal.

The cause test itself takes a number of forms. Some courts and commentators have helpfully organized the various versions of the cause test into two different subtests: the "proximate cause" or "immediate cause" test, on the one hand, and the "liability event" test, on the other. Under the proximate-or-immediate-cause test, the court looks to the significant causal actions or events that are most proximate—closest in time and/or space—to the harm to determine the number of occurrences. By contrast, the liability-events test focuses on the cause that is within the control of the insured: the act or omission on the part of the insured that would constitute an alleged breach of a duty and thus give rise to a potential tort claim. These two versions of the cause test often result in the same number of occurrences, because the alleged negligence of the insured will often also be the most proximate (immediate) cause of the harm.

Although a majority of courts have adopted some version of the cause test for determining the number of occurrences, no single version of that test seems clearly to dominate. Moreover, no version of the cause test generates precise and predictable outcomes across the entire range of cases. Nevertheless, the cause test is generally considered more consistent with the reasonable expectations of both insurers and insureds. As with other issues of interpretation, if there are disputed facts, such questions will typically be decided by a jury. If the facts are not in dispute, the court can make as-a-matter-of-law determinations of the number of causes and thus the number of per-occurrence or per-accident policy limits or deductibles to apply in a given case. In making such determinations courts may take into account the structure of the overall insurance program to determine what number of causes is most consistent with the intent of the parties. In such cases, the court should follow the ordinary rules of insurance-policy interpretation, assuming the policy contains standard-form terms, and, to the extent that the policy is ambiguous as applied to the claim at issue, choose the interpretation that favors the insured, unless the insurer persuades the court that this interpretation is unreasonable. See § 3.

Illustrations:

1. A retail store owner has a commercial general-liability insurance policy with a per-occurrence policy limit of $1 million, a deductible of $50,000 per occurrence, and no aggregate limit. Wrongly believing that the store is being robbed, the owner takes out a gun and fires a shot over the head of each of the three individuals who the owner believes are involved in the robbery. Because the owner is a poor shot, each of the bullets strikes the individuals in question, who turn out not to

be involved in a robbery at all. Each of the three individuals files suit against the owner, alleging three separate negligence actions. There are three occurrences, corresponding to the three alleged acts of negligence by the owner. The maximum amount of potential coverage in this case is $2,850,000: ($3 million policy limits) – ($150,000 deductibles).

2. A retail store owner has a commercial general-liability insurance policy with a per-occurrence policy limit of $1 million, a deductible of $50,000 per occurrence, and no aggregate limit. An employee of the store comes into the store with a gun and shoots eight customers before being apprehended by the police. The victims each file suit against the owner alleging negligent supervision and negligent hiring. There is one occurrence, corresponding to the alleged negligent failure to exercise reasonable care in the hiring and supervision of the employee in relation to this single violent episode. The maximum amount of potential coverage in this case is $950,000: $1 million policy limit and $50,000 deductible.

3. The insured is a manufacturer of both cattle feed and a form of chemical flame retardant that is poisonous if eaten. The insured distributes the two products in nearly identical brown bags, with only a small, similar-appearing label distinguishing the two. The insured mistakenly ships four loads of the chemical flame retardant to four different cattle-food retailers, one shipment to each retailer. Each of the four retailers then ships the bags of the flame retardant to 25 different farmers. Each of those 100 farmers feeds the flame retardant to 200 cows. All 20,000 of the infected cows become sick from the flame retardant and eventually have to be destroyed. The insured has a standard general-liability insurance policy with coverage for product-liability claims that applies to the year in question, with a per-occurrence policy limit of $10 million, an aggregate limit of $50 million, and a deductible of $500,000 per occurrence. The policy defines an occurrence as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

There are two reasonable conclusions regarding the number of occurrences. First, one could reasonably conclude that there were four occurrences, corresponding to four acts of negligence: the four shipments of flame retardant. Under this interpretation, the losses associated with each of the four shipments would be

aggregated, and the insured would have $38 million of coverage: (4 x $10 million per-occurrence limit) – (4 x $500,000 per-occurrence deductible). Second, one could also reasonably conclude that there was one occurrence, corresponding to the negligent decision to package and distribute such dangerously different products in nearly identical bags. Under this interpretation, the insured would have $9.5 million of coverage: $10 million – $500,000. Because either of these interpretations is reasonable, the occurrence limit is ambiguous as applied. Therefore, in the absence of extrinsic evidence that persuades the court that the four-occurrence interpretation is unreasonable, the court should interpret the policy to identify four occurrences in this case.

REPORTERS' NOTE

a. Determining the number of accidents and occurrences. Determining the number of occurrences can have large implications for the amount of coverage available, both from the perspective of policy limits and deductibles. See generally Robert H. Jerry, III & Douglas Richmond, Understanding Insurance Law § 65 (5th ed. 2012); Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State ch. 9 (3d ed. 2015); Baker & Logue, Insurance Law and Policy 349-355 (3d ed. 2013); Michael Murray, Note, The Law of Describing Accidents: A New Proposal for Determining the Number of Occurrences in Insurance, 118 Yale L.J. 1484, 1499 (2009). As evidenced in the famous World Trade Center case, ultimately the number of occurrences often depends in part on the precise wording of the language in question. In cases before the Second Circuit, applying New York law with respect to number-of-occurrences issues, the court reached different conclusions for different insurers, because of the difference in the relevant wording of the binders. For one set of insurers, whose obligations were determined to be governed by the language of the policy form proposed by the insured's broker (the so-called "Wilprop" form), the court ruled that the insurers were entitled to summary judgment that there was a single occurrence. World Trade Ctr. Props., LLC v. Hartford Fire Ins. Co., 345 F.3d 154, 170 (2d Cir. 2003). The court "held that the WilProp form's definition of 'occurrence,' which aggregated and treated as a single occurrence all loses [sic] or damages 'attributable directly or indirectly to one cause or to one series of similar causes,' contemplated a single-occurrence treatment of the September 11 attacks." SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props., LLC, 467 F.3d 107, 114 (2d Cir. 2006), citing *World Trade Ctr. Props.*, 345 F.3d at 180. For another set of insurers, whose obligations were determined to be governed by the standard policy form definition of "occurrence," a jury, taking into account extrinsic evidence, determined that there were two occurrences. Both holdings were upheld on appeal. See *SR Int'l Bus. Ins. Co.*, 467 F.3d 107 (2d Cir. 2006).

b. The effects test. Most courts have taken to analyzing the number-of-occurrences issue in terms of the effects test and the cause test. Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State 256 (3d ed. 2015); Paul E.B. Glad, William T. Barker & Michael Barnes, 3-16 *Appleman on Insurance* § 16.09. The effects test, which is the older of the two approaches, instructs courts to view each injured individual or piece of property as a separate occurrence. Id. This view derives originally from Anchor Cas. Co. v. McCaleb, 178 F.2d 322 (5th Cir. 1949) (exploding oil well damaging many individual properties was an occurrence for each damaged property) and is widely regarded as the minority view. Courts frequently criticize the effects test for providing no limit on the number of occurrences and for effectively converting "per occurrence" policies into "per claim" policies. Glad, Barker & Barnes, supra. Most courts recognize that the effects rule does not reflect the contracting parties' expectations or intentions with respect to occurrence-based liability insurance policies, and some have gone so far to say it "violates common sense." State Auto Prop. & Cas. Co. v. Matty, 286 Ga. 611, 615 (2010).

Tennessee and Louisiana are among the few jurisdictions that still have an effects test. See, e.g., Am. Modern Select Ins. Co. v. Humphrey, 2012 WL 529576 (E.D. Tenn. Feb. 17, 2012); Kuhn's of Brownsville v. Bituminous Cas. Co., 197 Tenn. 60 (1954); Lexington Ins. Co. v. St. Bernard Parish Gov't, Civ. No. 11-1865, 2013 WL 55908 (E.D. La. 2013) motion for relief from judgment denied, Civ. No. 11-1865, 2013 WL 870365 (E.D. La. Mar. 7, 2013) and aff'd as modified and remanded, 548 F. App'x 176 (5th Cir. 2013) ("In cases in which the injuries at issue were discrete and occurred at different times, courts have followed the holding of [Lombard v. Sewerage and Water Board of New Orleans, 284 So. 2d 905 (La. 1973)] and assessed the number of occurrences from the point of view of the people who experienced damage, *i.e.*, the effects, not the cause, of the occurrence."). Even in Louisiana, however, the effects test, though frequently discussed, is rarely applied. Courts often use the effects test to determine whether there has been at least one occurrence, for purposes of determining whether a given policy is triggered. Keene v. Insurance Co. of N. America, 667 F.2d 1034, 1042 & n.12 (D.C. Cir. 1981); Eagle-Picher Indus., Inc. v. Liberty Mutual Ins. Co., 523 F. Supp. 110, 114 (D. Mass. 1981).

c. The cause test(s). By far the majority rule is that the number of occurrences is based on the relevant "cause" of the damage. See, e.g., Liberty Mut. Ins. Co. v. Pella Corp., 631 F. Supp. 2d 1125, 1135 (S.D. Iowa 2009). See generally Robert H. Jerry, III & Douglas Richmond, Understanding Insurance Law § 65 (5th ed. 2012); Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State ch. 9 (3d ed. 2015); Baker & Logue, Insurance Law and Policy 349-355 (3d ed. 2013); Michael Murray, Note, The Law of Describing Accidents: A New Proposal for Determining the Number of Occurrences in Insurance, 118 Yale L.J. 1484, 1499 (2009). The cause rule, however, has a number of variations. In fact, owing to the wide variety of circumstances in which the number-of-occurrences question can arise, a number of smaller sub-doctrines within the cause rule have also developed. Application of any

subcategory of the "cause" analysis, however, tends to result in fewer occurrences than application of the effects test. See generally Mitsui Sumitomo Ins. Co. of Am. v. Duke Univ. Health Sys., 509 F. App'x 233 (4th Cir. 2013).

The two major sub-doctrines of the cause test are the "proximate cause" and "liability event" theories. Under the proximate-cause theory, courts consider an event to constitute one occurrence when there was but one proximate, uninterrupted, and continuing cause that resulted in all of the injuries and damage. Mitsui Sumitomo Ins. Co. of Am. v. Duke Univ. Health Sys., 509 F. App'x 233, 239 (4th Cir. 2013) (citation omitted). It is notoriously difficult to predict how a court will come out under the proximate-cause approach, as the proximate-cause label is remarkably vague. Often, the proximate-cause test focuses on the causes that are the most immediate to the harms in question, irrespective of whether those causes were within the control of the insured. In contrast, courts employing the liability-event theory look to the actions or the omissions of the insured that gave rise to the event. Id. Unfortunately, judges can and do come to different conclusions despite plain language and apparently taking the same approach. See, e.g., Champion Int'l Corp. v. Cont'l Cas. Co., 546 F.2d 502, 506 (2d Cir. 1976) (dissent) ("We agree that the issue is whether in the circumstances indisputably established by the record there has been one or more than one "occurrence" within the meaning of the Liberty Mutual policy. We also agree that this issue can be resolved by the plain meaning of the words in the policy. We reach opposite conclusions as to that plain meaning."). Courts that take the proximate-cause view generally follow the lead of Appalachian Insurance Co. v. Liberty Mut. Ins. Co., in which the Third Circuit explicitly adopted the proximate-cause test and found a single occurrence when the insured company was sued for its discriminatory employment policies. 676 F.2d 56, 61 (3d Cir. 1982) ("As long as the injuries stem from one proximate cause there is a single occurrence."). These courts "tend to look to the direct, physical cause of the injuries as being the yardstick for measuring whether the claims had a common origin." Michael F. Aylward, Twin Towers: The 3.6 Billion Question Arising From the World Trade Center Attacks, 69 Def. Couns. J. 169, 172 (2002). Each occurrence must have its own unique proximate cause. Even within the proximate-cause view there is some inconsistency, as courts sometimes look to more "direct, immediate" causes other times looking deeper for "single, underlying" causes or more "remote" causes. Cf. Diocese of Winona v. Interstate Fire & Cas. Co., 858 F. Supp. 1407 (D. Minn. 1994) (finding a single occurrence when sexual abuse by a priest spanned 20 years and six victims, which parties agreed to) with State Farm Fire & Cas. Co. v. Elizabeth N., 9 Cal. App. 4th 1232, 1236 (1992) (finding a separate occurrence for each victim of sexual abuse in a day care, but not for each act of abuse).

Under the liability-events causal test, adopted in this Restatement, courts look at the insured's act or omission that allegedly constitutes a breach of a duty to the claimant, rather than at the most "direct" or "immediate" causes of the injury that are outside the insured's control. An example of this type of analysis, though one that does not use the term "liability event test," is Donegal Mutual Insur. Co. v. Baumhammers, 938 A.2d 286 (Pa. 2007). In this case the insureds'

son shot and killed a number of people in different locations over a two-hour period. Using the cause test, the court concluded that there was one occurrence, because the relevant cause was the insureds' negligent failure to confiscate the son's weapon or notify authorities of his unstable condition. Maniloff and Stempel characterize the *Baumhammers* case as "a typical example of a court adopting the 'cause' test." Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State 256-257 (3d ed. 2015). To illustrate the difference between the liability-event causal test and the proximate-cause test, contrast RLI Ins. Co. v. Simon's Rock Early Coll., 54 Mass. App. Ct. 286, 290 (2002) with Koikos v. Travelers Ins. Co., 849 So. 2d 263, 268 (Fla. 2003). In both cases the insured is sued for failing to prevent a third party from shooting multiple people in a single spree. *Simon's Rock* considers the liability of the insured and finds a single occurrence, while *Koikos* considers the immediate cause of the injury and finds each shot constituted a separate cause, and so a separate occurrence. Cf. id. at 290 ("We conclude that when the issue is the number of occurrences, we must look to the 'cause' of the injury by reference to the conduct of the insured for which coverage is afforded, and that 'cause' and 'occurrence' are indistinguishable for purposes of this analysis.") with *Koikos*, 849 So. 2d at 271 ("We conclude, consistent with the 'cause theory,' that in the absence of clear language to the contrary, when the insured is being sued for negligent failure to provide security, "occurrence" is defined by the immediate injury-producing act and not by the underlying tortious omission."). By this view, each "event" causing liability for the insured is a separate occurrence. Jurisdictions applying the liability-event causal test include Massachusetts and Pennsylvania. Cincinnati Ins. Co. v. Devon Int'l, Inc., 924 F. Supp. 2d 587 (E.D. Pa. 2013).

There is a substantial degree of overlap between the proximate-cause view and the liability-event view. For instance, Kansas recently adopted the proximate-cause view and rationalized that its prior decisions apparently considering the liability event all reached the result proximate cause would. See *Wilkins*, 285 Kan. at 1063 (2008). The liability-event view is often criticized as being suspiciously similar in outcome to the effects test. "The results of applying this theory often are the same as those from applying an effect theory. One commentator notes that in some cases a "court applie[s] an effect theory analysis and label[s] it causation theory." Michael Murray, The Law of Describing Accidents: A New Proposal for Determining the Number of Occurrences in Insurance, 118 Yale L.J. 1484, 1544 n.68 (2009) (quoting Sharon Abidor, Traveling Outside the Insurance Contract; the Problems with Maximizing Victim Compensation: *Koikos v. Travelers Insurance Company*, 10 Conn. Ins. L.J. 349, 366 (2004)). It is also inconsistent, as a court's analysis is highly dependent on the underlying claims brought: similar underlying facts can produce different outcomes based entirely on how the injured party frames their claims against the insured. See, e.g., Allstate Prop. & Cas. Ins. Co. v. McBee, Civ. No. 08-0534, 2009 WL 1124973 (W.D. Mo. 2009) (noting that there would likely be one occurrence had the injured party's suit relied on the insured's negligent harboring of a vicious dog rather than the specific negligent failure to secure the dog). As a result, the liability-event view fails to reflect the expectations of the parties and fails to produce predictable results.

Some jurisdictions apply approaches to the number-of-occurrence question that are difficult to characterize. New York, for example, applies the "unfortunate events" test, which determines the number of occurrences by viewing the number of "unexpected events" that result, seen from the standpoint of the ordinary person. The leading case is Arthur A. Johnson Corp. v. Indem. Ins. Co., 7 N.Y.2d 222 (1959), finding two occurrences when two walls on the same property collapsed during a single storm. Scholars have struggled to categorize this approach. Some view it is a variation of the liability-event view that simply employs different terminology. See, e.g., Murray, supra. Others consider it an entirely separate doctrine. New Appleman on Insurance: Critical Issues in Insurance Law, Issues as to Number of Occurrences under Comprehensive General Liability Policies (Lexis, Spring 2010). In any event, the analysis and usual outcome is substantially similar to the liability-event view, and it has not directly influenced many other jurisdictions. A more recent application of the unfortunate-events test was Appalachian Ins. Co. v. General Electric Co., 8 N.Y.3d 162 (2007). In that case, the New York Court of Appeals rejected arguments made by the policyholder that all claims arising out of exposure to any asbestos-containing product manufactured by the policyholder should be deemed a single occurrence. Rather, the court held that the definition of occurrence depends on the circumstances of each plaintiff's exposure to the policyholder's asbestos-containing products and that, in light of the highly individualized exposure histories of each plaintiff, each claim constituted a separate occurrence.

§ 42. Excess Insurance: Exhaustion and Drop Down

When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the excess insurance policy:

(1) The excess insurer is not obligated to provide benefits under its policy until the underlying policy is exhausted.

(2) The underlying policy is exhausted when an amount equal to the limit of that policy has been paid to claimants for a covered loss, or for other covered benefits whose payment is subject to that limit, by or on behalf of either the underlying insurer or the insured.

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide coverage in the place of the underlying insurer (drop down), unless otherwise stated in the excess policy. In the case of an underlying insurer that is unable

to perform because of insolvency, the excess insurer must provide benefits under its policy once the applicable limit of the underlying policy is paid without regard to any requirement in the excess policy that such payments must be made by the underlying insurer.

Comment:

a. Scope. This Section addresses true excess insurance policies, which are purchased as part of a layered insurance program. The rules in this Section do not apply to policies that are considered to be excess by virtue of the operation of "other insurance" clauses. See § 20 (setting forth rules governing circumstances in which multiple insurers have a duty to defend a claim); and § 45 (setting forth rules governing contribution among multiple insurers whose indemnification or defense obligations are triggered with respect to a claim).

b. The nature and function of excess liability insurance. Policyholders facing substantial liability risk often purchase multiple layers of liability insurance coverage. Such policyholders often purchase a layer of "primary" coverage from one insurer and one or more "excess" layers of coverage from other liability insurers. This structure of liability insurance coverage, sometimes referred to as a "tower" of coverage, permits policyholders to insure large amounts of liability risk without relying on the solvency of any single insurer. Structuring liability insurance in layered towers also permits insurance companies to specialize in particular levels of coverage and to manage their exposure to the risk of any single insured. When liability insurance is structured in layered towers, a lower level of insurance that must be paid out before a higher layer of coverage is obligated to pay is referred to as the "underlying insurance." Primary insurance is the term typically given to the lowest level of liability coverage. "Umbrella" insurance is a special type of excess insurance that, unlike generic excess insurance, drops down to fill gaps left by underlying insurance in specified circumstances. Umbrella insurance also sometimes covers risks not covered by the underlying policy.

Because excess insurance policies are expected to provide coverage only after the lower-level policies or underlying policies are exhausted, excess policies are priced differently from lower-level insurance policies. The company that issues the primary insurance policy is much more likely than the excess insurer to be called upon to defend a case brought against an insured or to settle a claim, simply because of the statistical regularity that small claims are more frequent than large claims. As a result, premiums for excess insurance are lower on average than

premiums for lower-level insurance. For this division of function among primary and excess insurers to work, however, excess insurers must know that their policies will not be called on to pay judgments, settlements, or defense costs until the underlying limits have been paid out, or will with certainty be paid out, by someone. In other words, the layered structure and pricing of insurance depends upon what are known in insurance trade practice as "exhaustion" requirements in excess policies.

c. The exhaustion default rule. Most, if not all, excess liability insurance policies contain some type of exhaustion clause. Such clauses typically provide that coverage under the excess policy is available only after the aggregate amount of all limits of underlying insurance has been exhausted by payment of judgments, settlements, and related costs associated with losses to which the policy applies. These clauses sometimes do not make clear, however, who needs to make the payments in order for them to count toward the exhaustion of the underlying limits. Subsections (1) and (2) accomplish two things. Subsection (1) adopts an exhaustion requirement as a default rule in all excess liability insurance policies. Subsection (2) specifies that the default exhaustion rule counts any payment to claimants for a covered loss, or for other covered benefits whose payment is subject to that limit, by or on behalf of the underlying insurer or the insured toward the exhaustion of the applicable underlying policy limit. Under this approach a policyholder may compromise a claim with an underlying insurer, pay the difference in that insurer's layer of coverage to the claimant, and then receive performance from the excess insurer. In an appropriate circumstance, such as when the insured lacks the capacity to make the payment, a credit from the third-party claimant can take the place of a payment by the insured, but in such cases the reasonableness of the settlement should be scrutinized so that the purpose of the exhaustion requirement is not thereby evaded.

d. Counting payments by insureds toward exhaustion is merely a default rule. The case law on this topic is largely consistent with the default rule adopted in subsection (2). This rule has become so associated with the famous Augustus Hand opinion in Zeig v. Mass. Bonding and Ins. Co., 23 F.2d 665 (2d Cir. 1928) that it is often called the *Zeig* rule even in the liability insurance context, despite the fact that *Zeig* was a first-party property-insurance case. This case law identifies two main reasons why payments made by the insured should be taken into account when determining whether the underlying policy limits have been exhausted.

First, as explained in Comment *c*, the exhaustion requirement protects insurers from being required to drop down to provide coverage for losses that are less severe, and therefore more frequent, than their policies have been priced to cover. This function of the exhaustion requirement is satisfied as long as someone, typically either the underlying insurer or the insured itself, is required to pay an amount equal to the policy limits in settlements or judgments. Second, the default rule adopted in this Section promotes settlement by permitting the underlying insurer and the insured to compromise without the insured losing access to its excess insurance. This is especially important in situations in which there is some dispute about coverage.

The most serious objection that excess insurers have expressed with respect to the *Zeig* rule is based upon the belief that only a payment-by-insurers requirement guarantees that the underlying claim will be fully vetted. On this view, insureds themselves are typically not as experienced or skilled at evaluating, settling, or litigating lawsuits as primary insurance companies are, and insureds may have reasons for settling that take into account consequences other than the potential for an adverse judgment. For these reasons, some excess insurers prefer that the primary insurance company be fully responsible for paying the underlying limit, so that, if the attachment point is ever reached, there is little doubt that the case has been fully and expertly vetted and that any settlements reflect only the risks of adverse judgments. Moreover, excess insurers prefer to have the primary insurer sort out coverage issues and bear the cost of any coverage litigation.

These are valid concerns. That is why the rule in this Section is merely a default rule. If policyholders and excess insurers determine that the "case vetting" benefits of tying exhaustion to the payment by the underlying insurers of the full policy limits, the parties can alter the default rule set forth in this Section simply by including a provision in the excess policy similar to the following: (1) "Liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits," or (2) "Coverage under this policy shall attach only after the full amount of the underlying limits have been paid by the underlying insurers." Some liability insurance policies already contain such language in their exhaustion clauses, and courts have typically enforced those terms. In light of the importance of such language, an insurance broker's duty of reasonable care may require the broker to advise a

customer of the presence of such a term and the consequences thereof and to present an alternative excess insurance program that does not contain such a term.[1]

Illustrations:

1. Insured Company is named in a class-action lawsuit. The suit seeks damages of $35 million. Company has claims-made liability insurance policies with Primary Insurer and Excess Insurer for the policy period in question that are triggered by the lawsuit. Primary's policy has a $10 million aggregate limit. Excess's policy has a $30 million aggregate limit, excess of the $10 million limit of the primary policy. The excess policy contains the following term: "Coverage under this policy shall attach only after all of the Underlying Limits of the policy issued by Primary Insurer have been fully exhausted by the actual payment of losses."

Primary and Excess reserve their rights based on an exclusion in their policies. Insured has the opportunity to settle the underlying suit with the claimants for $14 million. Company seeks consent from the insurers to settle the claim. The insurers refuse to grant consent but agree not to raise the failure to obtain their consent as grounds for non-payment. Company then settles for $14 million and seeks reimbursement from Primary for $10 million and from Excess for $4 million. (Assume that the defense costs paid by Company are equal to the amount of the Company's retention in the Primary policy.) Company settles with Primary for $7 million. Because the exhaustion term in the Excess policy is ambiguous with respect to whether payments must be made by insurer or whether instead payments made by insured also counts toward the exhaustion requirement, exhaustion is governed by the default rule in this Section. If Company prevails against Excess with respect to coverage, Excess will be obligated to pay $4 million of the settlement.

2. Same facts as Illustration 1, except that the exhaustion term in the Excess policy states as follows:

> Excess Insurer shall be liable to make payment under this policy only after the total amount of the Underlying Limit of Liability has been paid in

[1] Broker liability will be covered in Chapter 4. Appropriate cross-references will be inserted.

legal currency by the insurers of the Underlying Insurance as covered loss thereunder."

Excess Insurer is not obligated to pay the $4 million to reimburse Company for the portion of its settlement costs above the underlying limits because the plain language of the exhaustion term unambiguously states that only payments by Primary Insurer count toward the exhaustion of the underlying limits.

e. The no-drop-down default. Under the rule set forth in this subsection (3), the exhaustion requirement applies even if an underlying insurer becomes insolvent. Thus, if an underlying insurer becomes insolvent before it pays out the full underlying policy limit, the excess insurer has no obligation to pay until the insured or some other party pays the remaining amount of the policy limit in settlements, judgments, or related costs. The no-drop-down rule, implicit in subsection (1) and explicit in subsection (3), is consistent with the rule that has been adopted in the substantial majority of jurisdictions. In defense of this rule, courts often note that the alternative rule would make excess insurers, in effect, responsible for monitoring and insuring the solvency of underlying insurance carriers. This same observation is sometimes used in support of a drop-down rule, since excess insurers may be better at monitoring the business practices of another insurer than the average liability policyholder is; indeed, there is evidence that, when excess insurers price their policies, they take into account various facts about the underlying insurer, including the likelihood of insolvency. Nevertheless, the excess insurer does not choose the underlying insurer. In fact, the party most responsible for "assembling the tower" of liability coverage, at least in commercial settings, is the insurance broker. If the broker determines that the underlying insurer poses a serious risk of insolvency, then the insurance broker's duty of reasonable care may require the broker to advise the policyholder to purchase excess insurance from a different insurer or, alternatively, to insist that the excess policy include an express drop-down provision. In any event, the no-drop-down default rule adopted in this Section can be altered, and in some excess liability insurance policies is altered, by language in the excess policy expressly stating that the excess insurance drops down in the event of insolvency of the underlying insurer. For example, courts have generally held that, when excess polices are written specifically to be excess over "amounts collectible" or "amounts recoverable"

from the underlying policy, such language is sufficient to obligate the excess insurer to drop down in the event of the insolvency of the underlying insurer.

f. Payment-by-insurer requirements are not enforceable when the underlying insurer is insolvent. In circumstances in which the underlying insurer is not available to pay a claim or contribute to a settlement because of insolvency, this Section provides that a term in an excess policy requiring exhaustion through payments only by the underlying insurer will not be enforceable. The function of such terms is to make the underlying insurer responsible not only for a portion of the loss but also for providing the initial evaluation of the claim and defense and the resolution of any insurance-coverage issues. If, however, the underlying insurer is not available to perform these functions, enforcement of the payment-by-insurer condition would lead to a disproportionate forfeiture.

REPORTERS' NOTES

b. The nature and function of excess liability insurance. For a general discussion of the nature and function of excess liability insurance, see Steven Plitt, Daniel Maldonado, Joshua D. Rogers, and Jordan R. Plitt, *Nature of Excess and Umbrella Policies*, 15 Couch on Ins. 220:32. ("Both true excess and umbrella policies require the existence of a primary policy as a condition of coverage."); and Douglas R. Richmond, *Characterizing Liability Insurance Policies: Primary, Excess and Umbrella*, *New Appleman on Insurance Law Library Edition* § 24.02 (Lexis 2012). See also Fireman's Fund Ins. Co. v. Md. Cas. Co., 77 Cal. Rptr. 2d 296, 311 (Cal. Ct. App. 1998) ("'Excess' coverage means 'coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted.'"); United States Fid. & Guar. Co. v. Federated Rural Elec. Ins. Corp., 37 P.3d 828, 831 (Okla. 2001) ("An excess insurance policy is one which by its terms provides coverage that is secondary to the primary coverage; there is usually no obligation to the insured until after the primary coverage limits have been exhausted."); National Union Fire Ins. Co. v. Glenview Park Dist., 230 Ill. App. 3d 578, 588 (1st Dist. 1992) ("[T]he excess liability coverage obligated [excess insurer] 'to pay . . . all sums which the Insured shall become obligated to pay as . . . covered by the Primary Policy', but only in excess of the primary policy's limits. This type of coverage constitutes traditional 'excess' coverage."), aff'd in part, rev'd in part on other grounds, Nat'l Union Fire Ins. Co. of Pittsburgh, Pennsylvania v. Glenview Park Dist., 158 Ill. 2d 116 (1994); Archunde v. Int'l Surplus Lines Ins. Co., 905 P.2d 1128, 1129 (N.M. Ct. App. 1995) ("An excess liability insurance policy is a policy 'designed to protect against catastrophic loss and intended to "kick-in" only at large dollar-amounts of liability.'"), quoting Lisa K. Gregory, *"Excess" or*

"Umbrella" Insurance Policy as Providing Coverage for Accidents With Uninsured or Underinsured Motorists, 2 A.L.R.5th 922, 932 n.1 (1992).

c. The exhaustion default rule. For the idea that some sort of exhaustion requirement is typically found in an excess insurance policy, see *Couch on Insurance* § 220:32 (3d ed. 2014) ("[I]t is only after the underlying primary policy has been exhausted does the excess or umbrella coverage kick in."); Barrett v. Chin, 843 F. Supp. 783, 787 (D. Mass. 1994) ("[E]xcess policies, attach[] only in excess of underlying insurance. Liability commences only when all underlying insurance is exhausted."); State Farm Mut. Auto. Ins. Co. v. Cramer, 857 P.2d 751, 754 (Nev. 1993) ("An excess insurer becomes liable once the primary insurer's policy limits have been exhausted."); see also Occidental Fire and Cas. Co. of North Carolina v. Brocious, 772 F.2d 47, 54 (3d Cir. 1985) ("[P]rimary policies or policies with excess clauses must be exhausted before the carrier of an umbrella policy is required to pay."); Inst. for Shipboard Educ. v. Cigna Worldwide Ins. Co., 22 F.3d 414, 426 (2d Cir. 1994) ("[T]rue umbrella policy will be triggered only after all other excess policies have been exhausted."); Reliance Nat'l Indem. Co. v. Gen. Star Indem. Co., 85 Cal. Rptr. 2d 627, 638-639 (Cal. Ct. App. 1999) ("[A]n excess insurer does not accept premiums with the knowledge that it will be called upon to satisfy a full judgment."); C.B. Fleet Co. v. Aspen Ins. UK Ltd., 743 F. Supp. 2d 575 (W.D. Va. 2010) (in multi-layer insurance arrangement, any insurer that issued policy in "excess" of primary policy would only become liable after primary insurer's coverage, as well as that of any underlying excess insurers, was exhausted); Sharp Realty & Mgmt., LLC v. Capitol Specialty Ins. Corp., No. CV-10-AR-3180-S, 2012 U.S. Dist. Lexis 75353 (N.D. Ala. May 31, 2012) (true excess insurance carrier has no obligation to do anything for insured until such time as primary policy is exhausted).

d. Counting payments by insureds toward exhaustion is merely a default rule. The two major questions in exhaustion cases are whose payments count towards exhaustion of the underlying limit and what form that payment must take. Some commentators have concluded that the prevailing rule is one that is consistent with the rule adopted in this Section. See, e.g., Douglas R. Richmond, *New Appleman on Insurance Law Library Edition* § 24.02[2][b] (Lexis 2012) ("As a general rule, payments of the underlying limits from any sources count toward exhaustion."); see also Waste Mgmt. of Minn., Inc. v. Transcont'l Ins. Co., 502 F.3d 769, 773-774 (8th Cir. 2007). Many of the courts that have adopted *Zeig*-based interpretation of exhaustion terms have used some combination of *contra proferentem* and public-policy doctrine, including the *Zeig* court itself. That is, courts that have favored the *Zeig* interpretation have often relied both on the fact that the term is ambiguous (and thus likely to be construed in favor of the insured) and on the fact that, because counting insured payments towards exhaustion tends to favor settlement and usually does little harm to the excess insurer, public policy favors the insured's position. See, e.g., Zeig v. Massachusetts Bonding & Ins. Co., 23 F.2d 665, 666 (2d Cir. 1928) ("A result harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it."); Trinity Homes LLC v. Ohio Cas. Ins. Co., 629 F.3d 653, 658-659 (7th Cir. 2010) (adopting the *Zeig* approach and reasoning that

the excess insurer is not adversely affected by this construction of their ambiguous policy and Indiana's public policy favors an interpretation that encourages settlement); Reliance Ins. Co. v. Transamerica Ins. Co., 826 So. 2d 998, 999-1000 (Fla. Dist. Ct. App. 2001) (holding that public-policy interests require an interpretation of the ambiguous language that encouraged settlements). However, when unambiguous language in the exhaustion term in the policy clearly requires that policy limits be paid by the underlying insurer or insurers, courts have enforced that language, reasoning that the public-policy interest favoring settlements cannot override a contract's plain meaning. See, e.g., Citigroup Inc. v. Fed. Ins. Co., 649 F.3d 367, 372-374 (5th Cir. 2011) (relying on the plain language of the contracts); Comerica Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (observing that *Zeig* allowed for parties writing such a condition into the contract); Goodyear Tire & Rubber Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 694 F.3d 781, 782 (6th Cir. 2012) (holding a clear and unambiguous contract outweighed public-policy interests); Quellos Grp. LLC v. Fed. Ins. Co., 177 Wash. App. 620 (2013); Qualcomm, Inc. v. Certain Underwriters At Lloyd's, London, 73 Cal. Rptr. 3d 770 (Cal. App. 2008) (holding that explicit exhaustion clause meant that excess insurer was not obligated to pay if the insured settled with the underlying insurer for less than the policy limits); Ali v. Fed. Ins. Co., 719 F.3d 83, 94 (2d Cir. 2013) (interpreting the plain language of the relevant excess insurance policies reading "payment of losses" as requiring actual payment of losses, not merely the accrual of *liability*). See also Douglas R. Richmond, *New Appleman on Insurance* § 24.02[2][b] ("[C]ourts generally enforce an express requirement of *actual payment* of full underlying limits.").

Excess insurers, in cases in which they seek to enforce the exhaustion requirement, claim that they prefer that primary insurers pay the full limit of the underlying policy to prevent collusion between primary insurer and insured and to ensure claims that reach the excess layer have been processed fully through the underlying layers. See U.S. Fire Ins. Co. v. Lay, 577 F.2d 421, 423 (7th Cir. 1978) ("We can conceive of good reasons for an excess carrier to be unwilling to accept liability unless the amount of the primary policy has actually been paid. A settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty to represent the interests of the excess carrier).

e. The no-drop-down default. With most excess liability insurance policies, the drop-down question is addressed expressly in the excess policy, one way or the other. If there is a provision requiring the excess insurer to drop down under certain circumstances (such as if the underlying insurer should become insolvent), those terms are enforced. Compare Hocker v. N.H. Ins. Co., 922 F.2d 1476, 1481-1483 (10th Cir. 1991) (applying Wyoming law and holding that excess insurer had duty to drop down and defend), with Ticor Title Ins. Co. v. Employers Ins. of Wausau, 48 Cal. Rptr. 2d 368, 374 (Cal. Ct. App. 1995) (holding that excess insurer was not obligated to drop down and defend). However, in the absence of any policy language addressing the question, the majority rule, as mentioned in the Comment, is consistent with the rule adopted

in this Section: the excess insurer is not required to drop down. See, e.g., Vickodil v. Lexington Ins. Co., 587 N.E.2d 777, 780 (Mass. 1992) (holding that where the policy language says nothing about the excess-coverage lower limit dropping below the specified attachment point, there is no basis to hold that it drops down); and Hartford Accident & Indem. Co. v. Chicago Housing Auth., 12 F.3d 92, 95-96 (7th Cir. 1993) (same); Revco D.S., Inc. v. Gov't Employees Ins. Co., 791 F. Supp. 1254, 1264-1269 (N.D. Ohio 1991), quoting Wurth v. Ideal Mut. Ins. Co., 34 Ohio App. 3d 325, 518 N.E.2d 607 (1987) ("to adopt, due to public policy, a theory of 'drop down' liability would fundamentally alter the risk an excess coverage provider is obligated to provide by agreeing to issue excess liability insurance protection. Therefore, we hold 'drop down' liability protection should not be judicially imposed on Ohio excess insurance providers as a matter of public policy."); Highlands Ins. Co. v. Gerber Products Co., 702 F. Supp. 109, 112 (D. Md. 1988) ("[E]xcess carriers ordinarily are not required to provide drop-down coverage in the event of the insolvency of an underlying insurer."). See generally Douglas Richmond, *New Appleman on Insurance* § 24.06; and *Couch on Insurance* § 200:44 (3d ed. 2014).

f. Payment-by-insurer requirements are not enforceable when the underlying insurer is insolvent. This topic appears to be one that courts have not addressed. This Note will be expanded to explain how this rule fits into solvency-protection regimes.

§ 43. Indemnification from Multiple Policies: The General Rule

(1) When more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy, except as otherwise provided in subsection (2) or § 44.

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy and provided that there is no more allocation to the insured than there would have been under the applicable policy that is most favorable to the insured with regard to allocation.

(3) When multiple insurers have a duty to defend an insured for a claim, the insurers' defense obligations are governed by § 20.

Comment:

a. Multiple triggered policies. Multiple liability insurance policies can be triggered with respect to a single claim or underlying cause of action. See § 33 for a discussion of trigger. This can happen when multiple policies cover a particular loss or occurrence within a single policy

period. Such overlapping policies are sometimes referred to as "concurrent policies." Multiple policies also can be triggered by harm or activity that takes place over multiple policy periods. Such policies are sometimes referred to as "successive policies." This Section adopts joint and several liability as the general default allocation rule, subject to the exception in § 44 for claims in which multiple successive policies are triggered by continuing or repeated harm for long-tail claims. For the latter claims, the default allocation rule is pro rata by years, as stated in § 44.

b. Joint and several liability as the general default allocation rule. Joint and several liability is a commonly used and, in most situations, easily administrable solution to the problem of overlapping obligations. It has long been used in the tort context for indivisible harms. Joint and several liability is also used in contract law and in restitution. Under the joint-and-several liability rule adopted in this Section, an insured may seek indemnification for its liability costs from any or all of the triggered policies, subject to the limits of each policy. The qualification "subject to the limits of each policy" means that no insurer is obligated to pay more than the maximum amount authorized by the policy that it issued (unless there is a breach of the duty to make reasonable settlement decisions or a breach of the duty of good faith and fair dealing, both of which are outside the scope of this Section). The joint-and-several liability approach ensures that insureds are not worse off because they are eligible for coverage under more than one policy. Also, because joint and several liability allows insureds to recover from all of their insurers if necessary, it allows insureds to obtain the full benefits of all of the insurance policies that provide coverage. See also § 20 (adopting joint and several liability as the default rule for liability insurers' defense obligations).

Joint and several liability is the prevailing default rule across the United States in the case of concurrent policies. Courts uniformly analyze coverage from multiple concurrent policies by considering whether there are terms in the insurance policies that purport to create an order of priority of payment among the policies—typically referred to as "other insurance" clauses—and, if so, whether to enforce those terms. This approach treats joint and several liability as the default rule because that is the rule that applies unless there is a term in the insurance policy that provides to the contrary.

c. Joint and several liability for defense obligations. According to the rules set forth in § 20, joint and several liability is also the default rule when multiple insurers have duties to defend with respect to a given claim.

d. Altering the default joint-and-several rule. Allocation questions with respect to overlapping concurrent policies are often addressed by "other insurance" terms in the policies. If one policy that otherwise covers a claim contains an other-insurance clause and another concurrent policy that covers the same claim does not contain an other-insurance clause, the allocation approach stated in the other-insurance clause in the first policy applies to the claim. The difficulty arises when more than one concurrent policy that otherwise covers the same claim contains an other-insurance clause. This Section follows the majority rule that attempts to reconcile the language of multiple other-insurance clauses in overlapping concurrent policies. The outcomes of particular cases will depend on the specific language in the other-insurance clauses at issue. The goal is to give effect to the terms in the insurance policies while protecting the insured's reasonable expectation of coverage. An insured should not be worse off as a result of being the beneficiary of multiple policies.

Illustrations:

1. A nurse who is sued for medical malpractice is an insured under two separate liability insurance policies that provide coverage for the same policy period: the policy issued to the insured's employer, a healthcare corporation that provides nursing services to hospitals, and the policy issued to the hospital at which the insured had been working. Both policies contain the following other-insurance clause:

> The insurance afforded by this policy is primary insurance, except when otherwise stated. When this insurance is primary and the insured has other insurance that is also primary, the amount of the Company's liability under this policy shall be determined on a "pro rata by years" basis.

Because the two other-insurance terms are consistent with each other, both terms are enforced and the two insurers share indemnification responsibilities for the claim on a "pro rata by years" basis, subject to the policy limits.

2. Same facts as Illustration 1, except that the two insurance policies have different other-insurance terms. The employer's policy has a term that reads as follows:

> The insurance afforded by this policy is primary insurance, except when otherwise stated. If the insured has other insurance against a loss covered by this policy, the company shall not be liable under this policy for a

> greater proportion of such loss than the applicable limit of liability bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

The hospital's policy has the following term:

> The insurance afforded by this policy is primary insurance, except when otherwise stated. The insurance afforded by this policy shall be excess insurance over any other valid and collectible insurance.

To reconcile these two other-insurance clauses, the hospital's policy, owing to its excess clause, is interpreted as not being "valid and collectible" for purposes of the employer's other-insurance term. By contrast, the employer's policy, which contains only a pro rata allocation clause, is interpreted as being valid and collectible for purposes of the hospital's other-insurance clause. Thus, the employer's policy provides coverage, first, and the hospital's policy is excess insurance that is available to provide coverage once the employer's policy is exhausted.

e. When an allocation term in one policy cannot be harmonized with an allocation rule in another. Some allocation provisions contained in overlapping concurrently issued policies simply cannot be harmonized with each other. In such cases, if the allocation terms were read literally the result would be no coverage for the insured, violating the principle that an insured should not be worse off as a result of being the beneficiary of multiple policies. Courts confronted with such conflicting allocation terms typically hold such terms to be "repugnant," irreconcilable, or simply in violation of public policy and therefore unenforceable. In place of those conflicting terms the courts apply an equitable remedy, which usually entails some form of pro rata allocation among insurers. This Section adopts that rule as well.

Illustration:

3. A subcontractor is sued by an individual who was injured on one of the contractor's worksites. The subcontractor is an insured under two separate concurrently issued liability insurance policies: the policy issued to the subcontractor and the policy issued to the general contractor. Both policies contain the following escape clause:

> This insurance policy does not apply to any liability for such loss as is covered on a primary, contributory, excess, or any other basis by insurance issued by another insurance company.
>
> Because a literal interpretation of both allocation terms would leave the insured with no coverage for the liability in question, the terms are ignored and the two insurers share the indemnification obligations on a joint-and-several basis, up to the limits of the policies.

f. No additional allocation to the insured. Whatever allocation rule is adopted for overlapping concurrently issued policies, subsection (2) provides that the allocation rule may not make the insured worse off as a result of having multiple insurance policies. When parties to insurance contracts mean to allocate some portion of the liability to the insured for a given policy period, this is done expressly through deductibles and self-insured retentions. It is not done through the application of allocation terms such as other-insurance clauses.

REPORTERS' NOTE

a. Multiple triggered policies. For a general discussion of the circumstances in which concurrent coverage can arise, see 15 Couch on Ins. § 217:1 (3d ed. 2015) ("Circumstances may be such as to result in there being concurrent coverage of the insured by two [or more] different insurers. This may occur where the insured intentionally obtained more than one primary policy covering the same risk, where an insured inadvertently obtained more than one policy covering the same risk, as where he or she falsely believed that a policy terminated and purchased a 'replacement' policy, or where the insured is an 'other insured' under a policy issued to a different named insured."). Early cases confronting the issue of concurrently issued insurance policies include, e.g., E. Tex. Fire Ins. Co. v. Blum, 13 S.W. 572, 576 (Tex. 1890) ("To be concurrent, the insurance must operate at the same time, upon the same property, and look to the indemnity of the insured in case of its loss or destruction from casualty insured against."); Globe & Rutgers Fire Ins. Co. v. Alaska-Portland Packers' Ass'n, 205 F. 32, 34 (9th Cir. 1913) ("'Concurrent insurance is that which to any extent insures the same interest, against the same casualty, at the same time, as the primary insurance, on such terms that the insurers would bear proportionally the loss happening within the provisions of both policies. It is this last quality, of sharing proportionally in the loss, that distinguishes concurrent insurance from mere double insurance.'") (quoting New Jersey Rubber Co. v. Commercial Union Assur. Co. of London, 46 A. 777, 778 (N.J. 1900)).

Many recent cases deal with the problem of concurrent coverage. See, e.g., Penton v. Hotho, 601 So. 2d 762, 765 (La. Ct. App. 1992) ("[C]oncurrent insurance policies (i.e. two or

more primary policies or two or more excess policies) or non-concurrent policies (i.e. a primary policy and a true excess policy.)"); Nesheim v. Iowa Mut. Ins. Co., 305 N.W.2d 320, 321 (Minn. 1981) ("Insurance policies are not concurrent unless they are on the same property, the same interest in the property, in favor of the same party, and against the same risks.") (citing Nobbe v. Equity Fire Insurance Co., 297 N.W. 349 (Minn. 1941)).

b. Joint and several liability as the general default allocation rule. For courts recognizing joint and several liability for concurrent policies on the same level, see, e.g., Penton v. Hotho, 601 So. 2d 762, 764 (La. Ct. App. 1992) (recognizing two policies' joint-and-several liability obligations when there was "no question" that the policies were in effect and provided coverage at the same time); Ranallo v. Hinman Bros. Const. Co., 49 F. Supp. 920, 925 (N.D. Ohio 1942), aff'd sub nom. Buckeye Union Cas. Co v. Ranallo, 135 F.2d 921 (6th Cir. 1943) (holding that without contrary language, two policies that insure against the same loss "constitute co-insurance for the same liability"); Fid. & Cas. Co. of New York v. Fireman's Fund Indem. Co., 100 P.2d 364, 366 (Cal. 1st Dist. 1940) (recognizing that when two companies insure the same risk, they are cosureties to that risk); Commercial Cas. Ins. Co. v. Knutsen Motor Trucking Co., 173 N.E. 241, 242 (Ohio 1930) ("[W]here two or more parties become liable for the same obligation . . . as between themselves they are cosureties. . . . each or both are liable and may be sued . . . and a judgment against one does not bar the right to a judgment against the other."); Hanover Fire Ins. Co. v. Brown, 25 A. 989, 991 (Md. 1893) (explaining that when more than one insurer issues a policy to cover the same loss, each insurer owes indemnification that is equal and concurrent to the amount owed by the other insurers). See also Restatement Second, Contracts § 289 (1981) ("Where two or more parties to a contract promise the same performance to the same promisee, each is bound for the whole performance thereof.").

c. Joint and several liability for defense obligations. See generally sources cited in the Reporters' Note to § 20.

d. Altering the default joint-and-several rule. For a general overview of the case law dealing with "other insurance" clauses, see Robert H. Jerry, II & Douglas R. Richmond, *Understanding Insurance Law*, 700-716 (5th ed. 2012); and 3-22 *Appleman on Insurance* § 22.02 ("'Other insurance' situations arise where two or more insurers provide concurrent coverage for the same risk at the same level. . . . Other insurance issues arise only as to multiple policies on the same level, and not as to the relationship between, for example, a primary and excess policy."); Douglas R. Richmond & Darren S. Black, *Expanding Liability Coverage: Insured Contracts and Additional Insureds*, 44 Drake L. Rev. 781, 820 (1996) ("In order for courts or insurers to allocate liability according to other insurance clauses, concurrent policies must cover the same interest."); Contrans, Inc. v. Ryder Truck Rental, Inc., 836 F.2d 163, 166 (3d Cir. 1987) ("[T]here are three general types of 'other insurance' clauses—excess, pro rata and escape. Excess insurance 'kicks in' to provide additional coverage once the policy limits of other available insurance are exhausted. Pro rata provisions allocate financial responsibility between concurrent policies based upon the percentage of coverage each policy bears to the net

amount of coverage under all applicable policies. An escape clause attempts to release the insurer from all liability to the insured if other coverage is available."); Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1121 (N.J. 1998) ("'[O]ther insurance' clauses . . . are provisions typically designed to preclude a double recovery when multiple, concurrent policies provide coverage for a loss."); N. River Ins. Co. v. Am. Home Assurance Co., 210 Cal. App. 3d 108, 114, 257 Cal. Rptr. 129, 134 (Cal. Ct. App. 1989) ("An 'other insurance' dispute can only arise between carriers on the same level, it cannot arise between excess and primary insurers.") (citing Olympic Ins. Co. v. Employers Surplus Lines Ins. Co., 126 Cal. App. 3d 593, 598, 178 Cal. Rptr. 908, 911 (Cal. Ct. App. 1981)).

Other-insurance clauses do not apply to successive insurance policies. See Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613, 624 (Wis. 2009) ("The purpose of an 'other insurance' clause is to define which coverage is primary and which coverage is excess between policies.") (citing Arnold P. Anderson, *Wisconsin Insurance Law* § 11.2 (5th ed. 2004)) ("Whenever there are two polices that apply to the same insured at the same time, the issue of which policy must pay first—or which is primary and which is excess—is dealt with by other insurance clauses."); Alticor, Inc. v. Nat'l Union Fire Ins. Co. of Pennsylvania, 916 F. Supp. 2d 813, 828-829 (W.D. Mich. 2013) ("Federal courts have consistently held that successive or consecutively issued insurance policies do not implicate 'other insurance' provisions within those policies.") (collecting cases).

Most courts attempt to reconcile the language of multiple other-insurance clauses in overlapping concurrent policies. See generally Laura A. Foggan, 3-22 *Appleman on Insurance* § 3-22[3][a] "Majority View: Reconcile Language of Competing 'Other Insurance' Clauses in Order to Enforce Contract Terms, Where Possible" (2015) ("When 'other insurance' clauses first became prevalent in the 1940s, courts grappled with their application. . . . Courts increasingly rejected theories that were not tied to the language of the 'other insurance' clauses, resulting in a majority approach under which courts attempt to reconcile the applicable clauses of the conflicting policies to give effect to the intention of all parties.") (citing Putnam v. New Amsterdam Cas. Co., 269 N.E.2d 97, 101 (Ill. 1970)) ("Of the six possible combinations of the three basic clauses, three combinations find identical clauses in conflict. . . . [A]nd thus identical clauses are deemed incompatible. Most cases do not involve identical clauses, however; when the conflict between clauses is escape v. excess, Pro rata v. escape, or Pro rata v. excess, as here, the majority of jurisdictions reconcile the conflict by giving effect to one clause and finding the other to be inapplicable. . . ."). See also Jones v. Medox, Inc., 430 A.2d 488, 491 (D.C. 1981) ("Most courts attempt to reconcile dissimilar 'other insurance' clauses by giving effect to the intent of the parties through an examination of the language of the clauses whenever possible."); Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch., 444 S.W.2d 583, 587 (Tex. 1969) (collecting cases).

The minority view is that when any other-insurance clause comes into conflict with another, both should be rejected. See Laura A. Foggan, 3-22 *Appleman on Insurance*

§ 3-22[3][b] "Minority View: *Lamb-Weston* Doctrine" (2015); Lamb-Weston, Inc. v. Oregon Auto. Ins. Co., 341 P.2d 110 (Or. 1959); Werley v. U.S. Auto. Ass'n, 498 P.2d 112, 114 (Alaska (1972); Sloviaczek v. Estate of Puckett, 565 P.2d 564, 568 (Idaho 1977); Ky. Nat'l Ins. Co. v. Empire Fire & Marine Ins. Co., 919 N.E.2d 565 (Ind. Ct. App. 2010).

e. When an allocation term in one policy cannot be harmonized with an allocation rule in another. For a general discussion of how courts have handled conflicting allocation terms, see 7 Couch on Ins. § 98:19 (3d ed. 2015) ("In addressing the problem of conflicting other insurance clauses, the rule adopted by the majority of jurisdictions is that the 'other insurance' clauses are mutually repugnant. When this occurs, the courts disregard the clauses, and the claimant is entitled to recover up to the full coverage afforded by both policies. Some courts have held that where two policies cover the same occurrence and both contain 'other insurance' clauses, the clauses are mutually repugnant and must be disregarded. Each insurance company will then be liable for a pro rata of the settlement or judgment. This is the general rule throughout the country.") (internal citations omitted).

For courts finding unenforceable conflicting terms that, when read literally, purport to eliminate coverage entirely, see Fireman's Fund Ins. Co. v. Empire Fire & Marine Ins. Co., 155 F. Supp. 2d 429, 434 (E.D. Pa. 2001) ("Where two policies each purport to be excess over the other, such clauses are mutually repugnant; both must be disregarded and the insurers must share in the loss.") (quoting Nationwide Ins. Co. v. Horace Mann Ins. Co., 759 A.2d 9, 11-12 (Pa. Super. Ct. 2000)) (cautioning that the equal-shares method should be applied only where two clauses are truly irreconcilable, such that giving literal effect to both would result in neither policy covering the loss); State Farm Mut. Auto. Ins. Co. v. Union Ins. Co., 147 N.W.2d 760, 763 (Neb. 1967) ("The excess insurance provisions are mutually repugnant and as against each other are impossible of accomplishment. Each provision becomes inoperative in the same manner that such a provision is inoperative if there is no other insurance available. Therefore, the general coverage of each policy applies and each company is obligated to share in the loss."); Smith v. Wausau Underwriters Ins. Co., 977 S.W.2d 291, 294 (Mo. Ct. App. 1998) ("[T]he courts have adopted a rule that, when competing policies carry similar 'other insurance clauses,' the courts should disregard the clauses as being mutually repugnant and order insurers to share the loss."); Shelter Mut. Ins. Co. v. Mid-Century Ins. Co., 246 P.3d 651, 666 (Colo. 2011) (same); Reliance Ins. Co. v. St. Paul Surplus Lines Ins. Co., 753 F.2d 1288, 1290 (4th Cir. 1985) (same).

f. No additional allocation to the insured. See generally 15 Couch on Ins. § 219:1 (3d ed. 1999) ("'Other insurance' clauses govern the relationship between insurers, they do not affect the right of the insured to recover under each concurrent policy."); Susan Randall, Coordinating Liability Insurance, 1995 Wis. L. Rev. 1339, 1353 n.48 (1995) (explaining that "other insurance" clauses do not apply to policyholders and are included in insurance policies only because there is no contractual vehicle in which to define how to apportion liability among insurance

companies.); Douglas R. Richmond, Issues and Problems in "Other Insurance," Multiple Insurance, and Self-Insurance, 22 Pepp. L. Rev. 1373, 1380-1381 (1995):

> "Other insurance" clauses only affect insurers' rights among themselves; they do not affect the insured's right to recovery under each concurrent policy. Inter-insurer loss allocation by way of "other insurance" clauses never permits allocation of a loss to the insured. Payment of the insured's claim always takes priority over the allocation of the loss between concurrent insurers.

See also Am. Family Mut. Ins. Co. v. Regent Ins. Co., 846 N.W.2d 170, 188 (Neb. 2014) ("[C]ontribution in a concurrent insurer scenario is a right of the insurer flowing from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. It is a right independent of the rights of the insured.").

§ 44. Long-Tail Harms and Successive Policies

(1) When continuing or repeated harm triggers multiple insurance policies issued in successive policy periods, the insurers' indemnification obligations under the policies are subject to allocation according to the rule of pro rata by years, except as stated in subsection (2).

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

Comment:

a. The special case of long-tail harms. Liability claims for long-tail harms present difficult issues of contract interpretation and application for commercial general-liability insurance policies as well as for other similarly worded insurance policies. As discussed in Comment *f* of § 33, the term "long-tail harms" describes a series of indivisible harms, whether bodily injury or property damage, that are attributable to continuous or repeated exposure to the same or similar substances or conditions.

b. Divisible harms. The rule in this Section addresses indivisible harms. For liability claims involving divisible harms, even those occurring over long periods of time, courts generally will attempt to allocate among the policy periods according to actual injury or harm.

For example, in some toxic-tort cases, courts have allocated harm among policy periods and thus among multiple triggered insurers on the basis of the relative volume of the injuring substance that was released in each period.

c. Theories of allocation for indivisible long-tail harms. Once the trigger question has been decided with respect to a given set of indivisible long-tail harms (see § 33, Comment *f*), the question arises how to allocate indivisible harms among multiple triggered policies and, to the extent the insured does not have coverage for part of the period of the harm, to the insured. This allocation analysis determines how much of the total long-tail liability an insured is entitled to recover from each of the triggered policies, subject, of course, to the policy limits. Courts have developed two general approaches to this allocation question: the "pro rata" approach and the "all sums" approach.

Under the most common form of the pro rata approach, sometimes referred to as the "pro rata by years" or "time on the risk" approach, courts allocate the costs of long-tail liability claims across all triggered years equally. As a consequence, the maximum amount that an insured may recover from any triggered policy is the lesser of (a) the pro rata amount of the covered losses allocated to that policy period and (b) the coverage limits of that policy. Under pro rata by years, each year is assigned an equal fraction of the total loss as if that portion of the loss in fact occurred during that year. Therefore, the insured bears the financial responsibility for any uninsured or underinsured periods during which some portion of the long-tail harm occurred, without regard to the reason for the insured's lack of insurance in a given year. Therefore, even if no insurance was available in a given year, the insured would be assigned responsibility for its pro rata share of the overall harm. Under this "pro rata by years" approach, the insured is financially responsible for its decision in a given year not to purchase coverage as well as for the possibility of insurance unavailability or insurer insolvency. In addition, not only uninsured years but also uninsured levels of coverage are borne by the insured.

Under the all-sums approach, the insured may recover from any of the triggered policies for the full amount of that policy's coverage limits. This is also referred to as the joint-and-several liability approach, because it is analogous to joint and several liability in tort, with the obvious difference that, under the all-sums approach no insurer can be held responsible for more than the stated coverage limits in its policy (unless there is a breach of the duty to make reasonable settlement decisions or a violation of the duty of good faith and fair dealing). The

insurance case law uses the term "all sums" to refer to this approach because one of the justifications commonly provided for adopting this approach is the presence of the words "all sums" in the insuring agreement of the version of the standard commercial general-liability insurance policy that was at issue in the cases that first adopted this approach. (In general, the policies containing the all-sums language were issued prior to the 1986 policy year when the language in the standard ISO CGL policy was changed.)

Under the most common all-sums approach—sometimes called the all-sums-with-stacking approach—an insured may seek recovery from one triggered insurer until the limits of that policy are exhausted, then seek recovery from another triggered insurer until the limits of that policy are exhausted, and so on, until either the claim is fully paid or the limits of all the triggered policies are exhausted. Under this approach, the insured becomes responsible for the costs of covered claims only after all of the triggered policies have exhausted their policy limits (ignoring deductibles and self-insured retentions). This is true even for uninsured years. Therefore, the risk of uninsured years is borne by the triggered insurers, subject to those insurers' policy limits.

d. A division of authority on allocation for long-tail claims. In many jurisdictions, the highest courts have not addressed the long-tail-harm-allocation question. The jurisdictions that have addressed the allocation question in the context of successive policies triggered by long-tail claims have split among the various pro rata and the all-sums approaches. There is some debate over the precise number of jurisdictions that have adopted each position, in part because of variation in policy language and in part because of differing possible interpretations of particular courts' holdings. However, a clear majority of the jurisdictions that have addressed the question have adopted a pro rata approach. A minority of jurisdictions have adopted some version of the all-sums approach.

e. The default allocation rule for long-tail harms: pro rata by years. The split of authority reflects the fact that the liability risks presented by the rise of mass toxic-tort suits and environmental-cleanup and property-damage causes of action were not adequately anticipated and addressed in the standard general-liability insurance policies sold in the years before those risks were excluded from those policies. This Restatement adopts the "pro rata by years" approach as the default rule for allocation in the case of long-tail harms because it is the most consistent, simplest, and fairest solution to this problem. It is consistent because it provides the

same result for every triggered year. It is simple because it requires very little information to determine the pro rata percentage to be applied (only the number of triggered years), and it presents the fewest complications regarding exhaustion, deductibles, and settlement. It is fair because all triggered years, including the years in which the insured did not purchase insurance, share equally in the indivisible losses. In addition, this approach reflects the best effort to accommodate the language in insurance policies that links the coverage to harm that occurs during the policy period. Of all the alternative theories, this approach comes closest to allocating to each policy only those bodily injuries or property damage that occurred during each policy period, given the indivisibility of the harms at issue. For any occurrence-based general-liability insurance policies issued before the adoption of the allocation rule set forth in this Section, the allocation rule would in effect be mandatory rather than merely a default rule, as there would be no opportunity for the parties to contract around the rule.

f. Pro rata versus all sums as a matter of interpretation. A careful assessment of the standard-form comprehensive general-liability (CGL) policy must acknowledge that, except in some 21st-century versions of the CGL that contain express allocation terms, the relevant policy language is susceptible to both pro rata and joint-and-several interpretations. The earliest edition of the occurrence form of the CGL provides that the insurer will pay "all sums that the policyholder shall become legally obligated to pay as damages because of bodily injury or property damage to which the insurance applies caused by an occurrence." The term "occurrence" is then defined to mean "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage." In later versions of the CGL the language regarding bodily injury or property damage during the policy period moved out of the definition of occurrence, first into the bodily-injury and property-damage definitions and then into the insuring agreement.

In all three of these versions of the CGL, it is possible to read the during-the-policy-period requirement as applying only to the trigger of coverage and not to allocation, thus leaving open the possibility that the policy covers all of the damages awarded in a claim as long as any part of the harm upon which the damages are based occurred during the policy period. According to this interpretation, for a standard CGL policy to be potentially available to cover a given claim, there must at least be *some* bodily injury or property damage that occurs during the policy period. However, once it is determined that there is some bodily injury or property damage

during the policy period, and thus that the CGL policy issued to cover that policy period has been triggered, the during-the-policy-period language has no other effect. On this view, the during-the-policy-period language does not provide any justification for limiting an insurer's responsibility to harm that occurs during the policy period. At most, the during-the-policy-period language creates an ambiguity regarding the question of allocation, and such ambiguity should be construed against the drafter.

As the latter concession indicates, however, it is also possible to read the timing requirement as applying to both trigger of coverage and allocation, meaning that the policy covers only the damages that are attributable to the harm that occurred during the policy period. If the latter reading is correct, the "pro rata by years" approach provides the best method under the circumstances for achieving the goal of limiting the insurer's liability to the harms that occur during the policy period. Given the impossibility of knowing how much of the harm in fact occurred in each year in question, the best that can be done is to spread those costs evenly across all years. By contrast, adopting the all-sums approach creates the possibility that an insurer will be held responsible for a large amount of losses that did not occur during the policy period that the insurer agreed to cover.

Despite the fact that language in the standard-form CGL policies is susceptible to both interpretations, the majority of courts have not granted the insured the benefit of the more favorable all-sums (joint-and-several liability) approach. In effect, these courts have concluded that pro rata by years is the default allocation rule for long-tail claims and that ambiguous or uncertain terms that can be read in two ways—as consistent with the default rule or to the contrary—are insufficient to alter that default rule. By the same token, the results in most of the cases adopting the contrary, all-sums approach also can be reconciled conceptually with a pro-rata-by-years default rule, with the crucial difference that the courts in these cases differ from the majority in treating the "all sums" language as sufficient to alter that default rule.

g. The fairness argument in favor of pro rata. Proponents of the pro rata view contend that to hold an insurer that issued a policy to cover one year responsible for harms that occurred in other years not only runs counter to the language of the policy but also conflicts with commonsense expectations regarding the difference between buying and not buying insurance. A policyholder who does not buy insurance for liability attributable to harm that occurs during a given period should bear greater financial responsibility for harm that in fact occurs during that

period than a policyholder who does buy insurance for that liability. This argument can be seen in a simple hypothetical example. Insured A purchases a CGL policy with $1 million coverage limits in each of years one through five. Insured B purchases a CGL policy with $1 million coverage limits in each of years one through 10. Both Insured A and Insured B experience a liability claim totaling $5 million that results from continuous exposure to a long-tail harm over years one through 10. Under the majority all-sums approach, which includes stacking, both Insured A and Insured B would have, in effect, the same amount of coverage for the $5 million claim. Under the "pro rata by years" approach, however, the amount of coverage would be different: Insured A would have a total of $2.5 million of coverage, which results from $5 million of damages allocated over 10 years of exposure ($500,000 per year) times five years of coverage. Insured B would have a total of $5 million of coverage for the $5 million claim. The "pro rata by years" result makes the amount of total insurance coverage provided to the insureds over a given period of time a function of the number of years in which coverage was purchased.

h. The extrinsic evidence in favor of the all-sums approach. All-sums proponents contend that the available extrinsic evidence supports their argument. Specifically, on the basis of records from the drafting history of the standard CGL forms, as well as statements made by industry representatives who were involved in that process, they contend that (a) the insurance industry itself interpreted the CGL language consistently with the all-sums-with-stacking approach and (b) the industry considered several explicit allocation terms that were consistent with the pro rata approach and ultimately rejected them. On that basis they contend that it is reasonable to interpret the drafting history as supporting the conclusion that the insurance industry acknowledged and accepted, or at least acquiesced in, the all-sums interpretation of the CGL insuring agreement. Careful analysis of these materials reveals that many of the records and statements referenced by the all-sums proponents support the concept of stacking (i.e., the proposition that multiple per-occurrence policy limits are available in the event of harm that takes place over multiple years), which is consistent with a pro rata approach as well as an all-sums approach. Although some of the records and statements are inconsistent with the pro rata approach, these records and statements primarily serve to demonstrate that it is possible to interpret the policy language in favor of the all-sums approach. They cannot change the fact that the policy language is also susceptible to the pro rata interpretation. All things considered, the records and statements by the drafters simply corroborate the point made in Comment *e*: the

rules for allocating liability risks presented by the rise of mass toxic-tort suits and environmental-cleanup and property-damage causes of action were not adequately anticipated and addressed in the standard general-liability insurance policies sold in the years before those risks were excluded from those policies. If the outcome of the all-sums versus pro rata debate depended on the mechanical application of ambiguity rules, this kind of extrinsic evidence would be very persuasive. This Restatement adopts the pro rata rule for different reasons, however: consistency, simplicity, and fairness.

i. Pro rata by years versus pro rata by limits. A few courts have adopted a "pro rata by limits" rule, which is a common formula used for contribution among insurers in the context of concurrently overlapping policies with no or conflicting "other insurance" clauses. See § 45, Comment *b*. The "pro rata by limits" rule differs from the "pro rata by years" rule in two respects. First, the "pro rata by limits" approach uses policy limits in the calculation of the amount allocable to each of the relevant years, so that more of the indemnity obligation is allocated to policies with higher limits. Second, the "pro rata by limits" approach allocates long-tail losses to uninsured years only to the extent that the policyholder intentionally opted not to purchase coverage that was available—and then only to the extent of that available coverage.

Proponents of the "pro rata by limits" approach contend that it is more consistent with the pricing of those policies and thus with the parties' expectations. On this view, the larger the policy limit contained in a particular year's policy, the larger was the premium paid for the coverage in that year, and hence the greater the amount of the long-tail harm that should be allocated to that year. Further, it is argued that the "pro rata by limits" formula has the beneficial effect of encouraging the purchase of relatively high policy limits, because the higher the limits of coverage purchased for any year, the larger the fraction of total losses will be allocated to that year. In addition, this approach provides some relief to an insured—and to the claimants of the insured—who was unable to purchase coverage for reasons beyond its control. The insured bears the risk of long-tail harms in those years in which the insured opts not to purchase available coverage or decides to go bare; the other triggered insurers bear (proportionally) the risk of those harms allocated to years in which liability insurance was, for market or other reasons, unavailable.

The "pro rata by limits" approach is subject to several critiques. First, it is by no means certain that the "pro rata by limits" approach in fact does more to encourage the purchase of

insurance than any other allocation method. Any time an insured purchases greater policy limits, whatever the allocation method, there is more coverage available to pay claims. Moreover, by allocating more loss to years with higher limits, the rule fails to discourage an insured from reducing the amount of limits it purchases in any particular year. Second, there are fairness concerns about making insurers who, by assumption, expressly chose not to provide coverage in the years in which liability insurance was unavailable, responsible for those harms under policies that covered different policy periods, or making insurers that issued policies in one year more (or less) responsible because the policyholder purchased lower (or higher policy) limits in another year. Third, there is no textual basis for the "pro rata by limits" rule in the standard-form commercial general-liability insurance policies to which it is applied. Finally, the treatment of uninsured years in the "pro rata by limits" rule is complicated and information intensive.

Illustrations:

1. A series of asbestos-related lawsuits is brought against the insured involving $40 million of total liability costs. The bodily injuries that give rise to the liability claims occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the $40 million of harm occurred in each of the 10 years. During this 10-year period, the insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4 with annual policy limits of $500,000; Insurer B issued policies covering years 5-8 with annual policy limits of $5 million; and Insurer C issued policies covering years 9 and 10 with annual policy limits of $20 million.

Under the "pro rata by years" allocation method, 10 percent of the total $40 million liability cost ($4 million) would be allocated to each of the 10 years, as if that portion of the harm occurred in that year. Thus, in the absence of any deductibles or self-insured retentions in any of the policies, the insured would be entitled to a total of $26 million of liability coverage allocated as follows: $2 million from Insurer A (4 x $500,000 annual policy limit), $16 million from Insurer B (4 x $4 million annual allocation), and $8 million from Insurer C (2 x $4 million annual allocation). The insured would be responsible for the remaining $14 million in liability costs.

2. Same facts as Illustration 1, except that in years 5-8 Insurer B issued policies with annual limits of $10 million rather than $4 million, and the insured had no liability insurance policy for years 9 and 10 rather than coverage with Insurer C. Under the "pro rata by years" approach, again $4 million of the $40 million total costs would be allocated to each of the 10 years. As a result, Insurers A and B would again be responsible for $2 million and $16 million, respectively. The insured would be responsible for the remaining $24 million of losses. Note that the insured is responsible for the pro rata portion of liability attributable to years 9 and 10 without regard to why the insured lacked coverage in those years.

j. Exhaustion, deductibles, and settlement. In addition to the issues of trigger and allocation, long-tail harms raise related issues such as the application of deductibles, exhaustion, and the effect of settlements. The "pro rata by years" rule addresses each of these issues in a more straightforward and easier to administer manner than the all-sums rule. Under the pro rata rule, deductibles are easy to administer. Because a pro rata share of the liability is allocated to each policy year, the deductibles and self-insured retentions for each policy period are applied to that pro rata amount, just as they would apply to any other liability that occurred during the period. Moreover, because the amount allocated to each policy period is identical, no insurer needs to keep track of how much coverage remains under any other insurance policy. Under the all-sums approach, by contrast, the application of deductibles and self-insured retentions in one policy period can depend on the exhaustion of policies in another period. Further, under the pro rata rule, there need be no subsequent contribution action, as the allocation of responsibility among multiple triggered insurers is determined by the "pro rata by years" rule. (If an insurer pays more than its share under the "pro rata by years" rule, contribution is nevertheless ordinarily available under § 45.) This is the majority rule for the treatment of deductibles and SIRs in pro rata jurisdictions, and it is the rule that is most consistent with the rationale for the pro rata allocation approach. That is, the primary contractual justification for the pro rata approach is that, under circumstances in which it is equally likely that the harms occurred in any of the triggered years, the most sensible approach is to presume that the harm occurred equally in each triggered year. Once that assumption is made, the time-on-the-risk percentage is simply applied to the total liability costs, and then each triggered year is allocated its share of those costs, at

which point the deductible and SIR, as with the policy limit, for each year is applied straightforwardly to the amount allocated to that year.

Exhaustion is similarly straightforward under the "pro rata by years" rule. Long-term harms are allocated to each policy period as if the pro rata portion of the loss occurred in each triggered year. As soon as one policy in a given year is exhausted, the next-level policy takes over, and so on, until that tower of insurance is exhausted, at which point the insured is financially responsible for losses allocated to that policy period. Under the all-sums approach, by contrast, insureds exhaust the coverage available in one year before accessing the coverage available in another year, once again requiring all of the insurers that have not yet exhausted to track the payments. Moreover, the "vertical" approach to exhaustion under the all-sums approach puts some excess insurers in the position of paying long before primary insurers, which is inconsistent with the pricing of excess and primary coverage. One of the benefits of the pro rata allocation approach is that it avoids these problems as well.

The treatment of settlements under the pro rata approach is also simple. Because each year is allocated a pro rata portion of the overall liability, as if that amount of harm occurred during that policy period, settlements by insurers during one policy period have no effect on the liability of insurers in other policy periods. By contrast, under the all-sums approach, a complex and difficult decision must be made regarding how much to credit one insurer's settlement payment against the other insurers' overlapping liability taking into account exhaustion. Moreover, because the all-sums approach requires contribution actions to allocate among insurers, it is susceptible to collusion between the insured and one or more insurers to the disadvantage of other insurers.

Illustrations:

3. A series of asbestos-related lawsuits is brought against the insured involving $40 million of total liability costs. The bodily injuries that give rise to the liability claims occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the harm occurred in each of the 10 years. During this 10-year period, the insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4 with annual policy limits of

$500,000 and annual deductibles of $25,000, written as a standard deductible; Insurer B issued policies covering years 5-8 with annual policy limits of $5 million and annual deductibles of $100,000, written as a standard deductible; and Insurer C issued policies covering years 9 and 10 with annual policy limits of $20 million and annual self-insured retentions of $1 million.

Under the "pro rata by years" allocation method, 10 percent of the total $40 million liability cost ($4 million) would be allocated to each of the 10 years, as if that portion of the harm occurred in that year. Thus, Insured would be entitled to a total of $23.5 million, allocated as follows: $1.9 million from Insurer A for years 1-4 [(4 x $500,000 annual policy limit) – (4 x $25,000 annual deductible]); $15.6 million from Insurer B [4 x $4 million annual allocation) – (4 x $100,000 annual deductible)]; and $6 million from Insurer C [(2 x $4 million annual allocation) – (2 x $1 million retention)]. The insured would be responsible for the remaining $16.5 million ($40 million – $23.5 million) in liability costs.

4. A series of asbestos-related lawsuits is brought against Insured involving $100 million of total liability costs. The bodily injuries that give rise to the liability claims occurred continuously over a period of 10 years. During this 10-year period, the insured was covered under several different towers of CGL policies, as follows: For years 1-4, Insurer A issued primary policies with annual policy limits of $500,000, and Insurer B issued excess policies that attached at $500,000 with annual policy limits of $5 million; for years 5-8, Insurer C issued primary policies with annual policy limits of $5 million, and Insurer C issued excess policies attaching at $5 million with annual limits of $30 million; and for years 9 and 10, Insured was entirely self insured. There were no deductibles or retentions.

Under the "pro rata by years" allocation method, 10 percent of the total $100 million liability cost ($10 million) is allocated to each of the 10 years, as if that portion of the harm occurred in that year. For each of the policy years 1 through 4, all $500,000 of primary coverage is exhausted, as well as all $5 million of excess coverage, with the remaining $4.5 million of annual asbestos liability being borne by Insured. For each of the policy years 5 through 8, all $5 million of the primary coverage is exhausted, as well

as $5 million of the $30 million excess coverage. Insured bears no losses for those years. Insured bears all of the asbestos losses for years 9 and 10.

k. Other-insurance clauses. While some pro rata proponents have suggested, and a few courts have agreed, that the "other insurance" clauses found in most CGL policies should be understood as a sort of allocation provision for the long-tail-harm situation, the majority of courts that have addressed the question conclude that such other insurance clauses address a different situation: namely, the situation in which multiple insurance policies issued during the same policy period cover the same insured concurrently for a given loss. See § 43, Comment *d.*

l. Opting out of the default rule. The default rule of pro rata allocation can be altered by contractual terms that provide an alternative method of allocation or priority. For example, if an insurance policy contains a term that clearly adopts the all-sums approach to allocation (perhaps by eliminating the "during the policy period" language or by specifically stating that coverage will be provided even for harms that occur outside of the policy period, provided that they also occur in part during the policy period), such a term will be enforced. However, if such allocation terms conflict with each other, courts will apply the pro rata method of allocation as a matter of public policy. For example, if multiple policies contain allocation terms that purport to apply to the long-tail claim situation and that amount to escape clauses, such terms will not be enforced. Rather, the pro rata default rule will apply in such situations. This result is analogous to how courts have interpreted "other insurance" clauses. See § 43, Comments *d* and *e*.

REPORTERS' NOTE

a. The special case of long-tail harms. Long-tail harms, also known as "progressive injuries," are injuries or damages that are continuous and span over multiple policy periods. See 3-22 *Appleman on Insurance* § 22.01[1] ("In modern coverage litigation, many underlying claims are long-tail or delayed-manifestation claims where injury or harm takes place over a period of years."); State v. Cont'l Ins. Co., 281 P.3d 1000, 1005 (Cal. 2012) ("[A] 'long-tail' injury, is characterized as a series of indivisible injuries attributable to continuing events without a single unambiguous 'cause.' Long-tail injuries produce progressive damage that takes place slowly over years or even decades."); Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 Va. L. Rev. 85, 95 (2001) ("[A] 'long tail'—that is, coverage under a policy that was in effect at the time of injury or damage, even though a claim alleging liability for this injury or damage is not filed against the policyholder until many years later."); Rebecca M. Bratspies, *Splitting the Baby: Apportioning Environmental Liability Among Triggered*

Insurance Policies, 1999 B.Y.U. L. Rev. 1215, 1217 (1999) ("Long-tail injuries are progressive—that is, they take place slowly, over an extended period of time. Because these long-tail injuries occur gradually, PRPs often claim coverage under multiple insurance policies issued over the course of many years."). The most commonly litigated long-tail harms have been asbestosis, environmental damage, silicone implants, and construction defects. See 3-22 *Appleman on Insurance* § 22.01[2]; Jeff Hawkins, *Which Faultless Party Will Be Forced to Pay for Another's Failure? A Proposal for Legislatively Extending the Use of State Guaranty Funds to Absorb the Orphan Shares of Long-Tail Claims*, 37 Tex. Tech L. Rev. 215, 216 (2004).

When a long-tail harm is discovered, usually years after the triggering event, a policyholder may bring a "long-tail claim" to each of the insurers on the risk during the progressive injury. See 3-22 *Appleman on Insurance* § 22.01[2] ("[L]ong-tail claims where injury or damage takes place over multiple years, and which may trigger any responsive coverage during those years, almost invariably present difficult allocation issues."). Researchers estimate that long-tail environmental and asbestos claims cost insurance companies more than $1 billion every year. A significant percentage of those costs are spent defending, rather than indemnifying, the catastrophic social harms. See Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. Chi. L. Rev. 257, 259 (1997). For an overview of the history and costs of long-tail silicone-implant claims, see Deborah R. Hensler & Mark A. Peterson, *Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis*, 59 Brook. L. Rev. 961, 996-997 (1993).

b. Divisible harms. For an example of a court deciding that a long-tail harm was divisible, using volumes of a harmful agent released in each period, see Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368 (E.D.N.Y. 1998) (apportioning damages in proportion to the respective volumes of Agent Orange delivered by the insured to the military during each policy year).

c. Theories of allocation for indivisible long-tail harms. For a description of the "pro rata by years, time on the risk," allocation approach, see N. States Power Co. v. Fid. & Cas. Co. of New York, 523 N.W.2d 657, 664 (Minn. 1994); Pub. Serv. Co. of Colorado v. Wallis & Companies, 986 P.2d 924, 929 (Colo. 1999); Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1226 (6th Cir. 1980) (applying Illinois and New Jersey law) (adopting "pro rata by years" approach); Arco Indus. Corp. v. Am. Motorists Ins. Co., 594 N.W.2d 61, 71 (Mich. Ct. App. 1998) (adopting "pro rata by years" approach).

Under the "pro rata by years" method, courts always allocate losses incurred in years with no insurance coverage or insufficient coverage to the insured as a self-insurer. See, e.g., In re Wallace & Gale Co., 385 F.3d 820, 833 (4th Cir. 2004) (applying Maryland law) ("The allocation of risk to the insured is for periods for which there is no insurance in force or for which there is no coverage by an insurance policy which is in force."). Whether the policyholder made a calculated decision to self-insure, there was an unavailability of coverage in that year, an insurer became insolvent, or an exclusion was found to be applicable for at least one policy, under the "pro rata by years" approach insurers are never required to indemnify for losses

outside their policy periods. See S. M. Seaman & J. R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims § 4.3[c].

For a description of the "pro rata by years and limits" allocation approach, see Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 995 (N.J. 1994); Colon, *Pay it Forward: Allocating Defense and Indemnity Costs in Environmental Liability Cases in California*, 24 No. 2 Ins. Litig. Rep. 43, 60 (2002)). For explanations of the nine different pro rata methods adopted by courts, see S. M. Seaman & J. R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims § 4.3[b][1]-[9].

For a description of the "all sums" with stacking, or joint-and-several, approach to allocation, see State v. Cont'l Ins. Co., 281 P.3d 1000, 1008 (Cal. 2012); J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 509 (Pa. 1993); John Crane, Inc. v. Admiral Ins. Co., 991 N.E.2d 474, 491 (Ill. App. Ct. 2013).

For a description of the basic "all sums" approach to allocation, non-stacking, see Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 769 N.E.2d 835, 841 (Ohio 2002); Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1049-1050 (D.C. Cir. 1981); Lennar Corp. v. Markel Am. Ins. Co., 413 S.W.3d 750, 758-759 (Tex. 2013).

d. A division of authority on allocation for long-tail claims. The consensus among commentators and courts is that a majority of jurisdictions have adopted the "pro rata by years" method for allocating long-tail harms. See Shane R. Heskin, *Allocation of Latent Injury and Damage Claims*, in General Liability Insurance Coverage 597 (Maniloff and Stempel eds.) (3d ed. 2015); William P. Shelley, Fundamentals of Insurance Coverage Allocation (Jan. 5, 2000), Mealey's Litigation Reports (Insurance) 25; A. Hugh Scott, James E. DiTullio, *Boston Gas: Massachusetts Chooses "Pro Rata" Allocation for "Long Tail" Claims*, Boston B.J., Winter 2010, at 14.

Courts applying the law of 15 jurisdictions have adopted the "pro rata by years" approach for all long-tail-harm cases in which the triggered policies contain the standard 1976 CGL policy language. Specifically, in these 15 jurisdictions, either (1) The highest court in the state has stated all cases are pro rata, canceling out other cases that may have gone all sums before; or (2) lower courts in that state or federal courts applying that state's law have only gone pro rata. See, e.g., Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543, 1544-1546 (11th Cir. 1985) (applying Alabama law) (affirming the district court's conclusion that the defense and settlement costs be "prorated among those insurers that provided coverage during the periods of the plaintiff's exposure to asbestos hazards"); Pub. Serv. Co. of Colorado v. Wallis & Cos., 986 P.2d 924, 935 (Colo. 1999) ("We hold that . . . the damages must be allocated according to time-on-the-risk and the relative degree of risk assumed. Under this method, the 'ultimate net loss' sustained for each site must be reduced by one SIR per policy-year per site. . . ."); Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 826 A.2d 107, 121 (Conn. 2003) ("We are persuaded by the reasoning of the courts in *Forty-Eight Insulations, Inc.*, and *Owens-Illinois, Inc.*, and,

accordingly, adopt the pro rata approach to the allocation of defense costs in long latency loss claims that implicate multiple insurance policies."); Midamerican Energy Co. v. Certain Underwriters at Issue of Allocation Lloyd's London, 2010 WL 6726865 (Iowa Dist. Ct. Dec. 27, 2010) ("This court concludes, as did the Supreme Judicial Court of Massachusetts and the Supreme Court of New Hampshire, that the presence of the phrase 'during the policy period' in the contractual definition of 'occurrence' limits the promised 'all sums' or 'ultimate net loss' coverage in a way that requires proration of coverage. . . ."); Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co., 71 P.3d 1097, 1132, 1134 (Kan. 2003) ("If [insured] must exhaust only one self-insured retention before looking to Insurers for coverage, the claims must be allocated among the Insurers. . . . We cannot determine with certainty if the SIRs are sufficient to cover the damages for each year in question. Thus, this case must be remanded for the trial court to make that determination, and if the SIRs are not sufficient, to allocate the damages attributable to the excess coverage for that annual policy period."); Aetna Cas. & Sur. Co. v. Com., 179 S.W.3d 830, 842 (Ky. 2005) ("We adopt the reasoning of the Court of Appeal's opinion regarding this issue of pro-ration . . . when dealing with the instant case involving one insurer, a single liability policy . . . and a single excess policy. . . . As such, we affirm the Court of Appeal's decision on this issue."); Southern Silica of Louisiana, Inc. v. Louisiana Ins. Guar. Ass'n, 979 So. 2d 460, 469 (La. 2008) ("[Insured] is entitled to indemnity . . . but only after the pro rata shares of all insurers . . . are determined by judgment or settlement."); Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 314 (Mass. 2009) ("We are persuaded that the time-on-the-risk method of allocating losses is appropriate where the evidence will not permit a more accurate allocation of losses during each policy period. . . . [W]e conclude that the more reasonable fiction to adopt is that the progressive injuries took place evenly across all policy periods."); Pennsylvania Nat. Mut. Cas. Ins. Co. v. Roberts, 668 F.3d 106, 113 (4th Cir. 2012) (applying Maryland law) ("In lead paint or continuous trigger cases such as this one, Maryland courts engage in a 'pro rata by time-on-the-risk allocation' of liability."); Arco Indus. Corp. v. Am. Motorists Ins. Co., 594 N.W.2d 61, 69, 71, aff'd, 462 Mich. 896 (Mich. Ct. App. 1998) ("[W]e must reject any method of allocation that would require . . . coverage on a joint and several or 'all sums' basis . . . Accordingly, we remand for a recalculation of AMICO's liability applying the time-on-the-risk method."); Dutton-Lainson Co. v. Cont'l Ins. Co., 778 N.W.2d 433, 445 (Neb. 2010) ("Under the policies, the insurance companies were to provide coverage for property damage that occurred during the policy period. A pro rata, time-on-the-risk allocation satisfies the language of the policies, and the trial court did not err in using this method."); Olin Corp. v. Am. Home Assur. Co., 704 F.3d 89, 102 (2d Cir. 2012) (applying New York law) ("[B]oth this Court in *Olin I* and the New York Court of Appeals in *Consolidated Edison* have expressly rejected the conclusion that [all sums] language requires joint and several allocation of damages and instead have endorsed the pro rata allocation method for policies with that language."); Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co., 717 S.E.2d 589, 601 (S.C. 2011) ("[T]he proper method for allocating damages in a progressive property damage case is to assign each triggered insurer a pro rata portion of the loss based on

that insurer's time on the risk."); Sharon Steel Corp. v. Aetna Cas. & Sur. Co., 931 P.2d 127, 141-142 (Utah 1997) ("Thus, we remand the case with instructions to the trial court to fashion an equitable allocation scheme that takes into account the years when the insured was uninsured and to allocate that share to the insured."); Towns v. N. Sec. Ins. Co., 964 A.2d 1150, 1167 (Vt. 2008) ("[W]e conclude that the trial court here properly allocated defense and indemnity costs between [insurers] based on the percentage of each party's time on the risk."). See also Sentinel Ins. Co. v. First Ins. Co. of Hawai'i, 875 P.2d 894, 918-919 (Haw. 1994) ("When it is finally determined which policies were triggered, the liability for total loss, according to the continuous injury trigger, must be equitably apportioned between [insurers] . . . in proportion to the time periods their policies covered."); and Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724, 733-734 (Minn. 1997) ("It is only in those difficult cases in which property damage is both continuous and so intermingled as to be practically indivisible that ["pro rata by years"] properly applies. . . . [I]t offers a practical solution in the face of uncertainty.").

One jurisdiction has adopted the "pro rata by years" approach only for long-tail-harm cases with 1986 CGL policy language, specifically "those sums." See Thomson Inc. v. Ins. Co. of N. Am., 11 N.E.3d 982, 1020-1021 (Ind. Ct. App. 2014) ("We find the reasoning in *Trinity Homes* persuasive and agree with Judge Barker that *Dana II* is not controlling in cases involving the decisively different policy language at issue here. Judge Barker's interpretation gives effect to the plain meaning of the limiting phrases 'those sums' and 'during the policy period' and does not render any of the remaining language meaningless."). But see Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049, 1057 (Ind. 2001) ("['All-Sums'] policies require [insurer] to indemnify [insured] for all sums paid as a result of liability arising from any covered accident or event resulting in property damage or personal injury that occurs during the policy period."). Every court adjudicating a long-tail-harm case in which the policy language at issue contained the phrase "those sums" has allocated the loss pro rata. See, e.g., Ohio Cas. Ins. Co. v. Unigard Ins. Co., 268 P.3d 180, 182 (Utah 2012); Stryker Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 2005 WL 1610663 (W.D. Mich. July 1, 2005); Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co., 717 S.E.2d 589 (S.C. 2011); Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp., 1 F.3d 365 (5th Cir. 1993) (applying Texas law).

The "pro rata by years and limits" approach has been adopted by two jurisdictions for all long-tail-harm cases. See Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 995 (N.J. 1994); Spaulding Composites Co., Inc. v. Aetna Cas. And Surety Co., 819 A.2d 410, 423 (N.J. 2003) ("We take no position on . . . any other issue except to reaffirm the vitality of the *Owens-Illinois* approach and our commitment to its uniform application."); EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517, 527 (N.H. 2007) ("While we need not select a particular method of pro-ration in this case, we observe that in future cases, trial courts should, where practicable, apply the pro-ration by years and limits method described in *Owens–Illinois* for the reasons set forth in that case. If pro rating liability by years and limits is not feasible, trial courts should pro rate by years.").

The "all sums" with stacking, or joint-and-several, allocation approach has been adopted in all long-tail-harm cases by seven jurisdictions. See State v. Cont'l Ins. Co., 281 P.3d 1000, 1009 (Cal. 2012) ("In the present case, consistent with this court's precedent, principles of equity, and sound insurance policy interpretation considerations, we conclude that the all sums approach to insurance indemnity allocation applies to the State's liability for successive or long-tail property damage. In addition, we conclude that allocation of the cost of indemnification under these circumstances should be determined with stacking."); J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 509 (Pa. 1993) ("When the policy limits of a given insurer are exhausted, [insured] is entitled to seek indemnification from any of the remaining insurers which was on the risk during the development of the disease. Any policy in effect during the period from exposure through manifestation must indemnify the insured until its coverage is exhausted."); Cascade Corp. v. Am. Home Assur. Co., 135 P.3d 450, 457 (Or. 2006) ("[A]n insurer's liability to its insured is based on the insurer's direct obligation to its insured, not on what other insurers may owe or pay. . . . In all circumstances, an insurer must pay up to the limits of its policy."); John Crane, Inc. v. Admiral Ins. Co., 991 N.E.2d 474, 491 (Ill. App. Ct. 2013) ("We adhere to our supreme court's decision in *Zurich* and hold that where coverage for asbestos-related injury claims is triggered by bodily injury or sickness or disease, all triggered policies are jointly and severally liable"); Hercules, Inc. v. AIU Ins. Co., 784 A.2d 481, 494 (Del. 2001) ("Joint and several liability does not result in a 'windfall' to [insured] because of the continuing coverage [insured] purchased. Under the contract, [insured] is entitled to coverage for damages occurring after the insurer's time on the risk once a policy has been triggered."); Doe Run Res. Corp. v. Certain Underwriters at Lloyd's London, 400 S.W.3d 463, 474 (Mo. Ct. App. 2013) ("The plain language of the applicable insurance policies requires the adoption of the all sums allocation scheme in this case."); Am. Nat. Fire Ins. Co. v. B & L Trucking & Const. Co., 951 P.2d 250, 254 (Wash. 1998) ("[I]nsurers on the risk during the time of ongoing damage have a joint and several obligation to provide full coverage for all damages.").

The "all sums" rule without stacking has been adopted in all long-tail-harm cases in three jurisdictions. See Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1049-1050 (D.C. Cir. 1981); Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 769 N.E.2d 835, 841 (Ohio 2002); and Lennar Corp. v. Markel Am. Ins. Co., 413 S.W.3d 750, 758-759 (Tex. 2013).

Two jurisdictions have adopted the all-sums approach in a long-tail-harm case without answering the stacking question. See Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613, 627 (Wis. 2009); Emhart Indus., Inc. v. Century Indem. Co., 559 F.3d 57, 70-74 (1st Cir. 2009) (applying Rhode Island law). One jurisdiction has adopted the "all sums" without stacking rule in long-tail-harm cases requiring an injury-in-fact-trigger. See In re Silicone Implant Ins. Coverage Litig., 667 N.W.2d 405, 422 (Minn. 2003).

Oregon is the only state to require a specific allocation method by statute. In all environmental long-tail-harm cases, Oregon courts are required to apply the "all sums" with stacking approach to insurers on the risk. See Or. Rev. Stat. § 465.480(3)(a). But see Cascade

Corp. v. Am. Home Assur. Co., 135 P.3d 450, 457 n.9 (Or. 2006) ("Because of our conclusion that [insured] is entitled to prevail under a proper construction of the *Lamb–Weston* doctrine, we do not need to consider its argument that ORS 465.480 mandates the same result.").

f. Pro rata versus all sums as a matter of interpretation. For courts finding that the plain language of the 1976 CGL policy requires "pro rata by years" allocation, see Norfolk S. Corp. v. California Union Ins. Co., 859 So. 2d 167, 196 (La. Ct. App. 2003); Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co., 71 P.3d 1097, 1134 (Kan. 2003); and Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 306, 310 (Mass. 2009). Other courts have found that the "pro rata by years" approach is at least consistent with or satisfies the plain meaning of the 1976 CGL policy. See Consol. Edison Co. of New York v. Allstate Ins. Co., 774 N.E.2d 687, 695 (N.Y. 2002); Dutton-Lainson Co. v. Cont'l Ins. Co., 778 N.W.2d 433, 445 (Neb. 2010).

Courts adopting the "pro rata by years" approach rely on the legal fiction that the long-tail harm caused damage evenly during the triggered years. See N. States Power Co. v. Fid. & Cas. Co. of New York, 523 N.W.2d 657, 663 (Minn. 1994) ("This method assumes that the damages in a contamination case are evenly distributed (or continuous) through each policy period from the first point at which damages occurred to the time of discovery, cleanup or whenever the last triggered policy period ended."); Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 314 (Mass. 2009). These courts have also relied on their interpretation of the contracting parties' reasonable expectations to require "pro rata by years." See, e.g., Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co., 717 S.E.2d 589, 594 (S.C. 2011) ("In our view, the 'time on risk' approach best conforms to the terms of a standard CGL policy and to the parties' objectively reasonable expectations."); Pub. Serv. Co. of Colorado v. Wallis & Companies, 986 P.2d 924, 939 (Colo. 1999) ("We do not believe that these policy provisions can reasonably be read to mean that one single-year policy out of dozens of triggered policies must indemnify the insured's liability for the total amount of pollution caused by events over a period of decades, including events that happened both before and after the policy period.").

Courts adopting the "pro rata by years" approach also rely on the public-policy considerations of simplicity in administration, spreading the risk to the maximum number of insurers, and reduced subsequent litigation costs between insurers. See Towns v. N. Sec. Ins. Co., 964 A.2d 1150, 1166 (Vt. 2008) ("Courts and commentators have also recognized that the time-on-the-risk method offers several policy advantages, including spreading the risk to the maximum number of carriers, easily identifying each insurer's liability through a relatively simple calculation, and reducing the necessity for subsequent indemnification actions between and among the insurers.") (citing Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307, 323 (2d Cir. 2000)); N. States Power Co. v. Fid. & Cas. Co. of New York, 523 N.W.2d 657, 663 (Minn. 1994) ("[A] 'pro rata by time on the risk' allocation scheme could reduce the costs of litigation because it is more or less a per se rule."); EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517, 527 (N.H. 2007) ("[T]he joint and several allocation method is improvident. . . . This method divides the case into two separate suits: in the first suit, the insured

selects and sues one of the triggered insurers; in the second suit, the selected insurer then sues other triggered insurers for contribution. . . . In this way, despite its advocates' claims to the contrary, the joint and several method does not decrease litigation costs, does not give courts guidance as to how to allocate liability, and requires insurers to factor the costs of uncertain liability into their premiums.") (internal quotations omitted).

Another policy advantage relied upon by courts adopting the "pro rata by years" approach is that it promotes stability in the marketplace by creating a greater incentive for businesses to continue purchasing insurance in subsequent years. See Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co., 717 S.E.2d 589, 601 (S.C. 2011) ("Further, this interpretation forwards important policy goals. Specifically, it preserves the incentive for businesses to purchase sufficient insurance, which in turn promotes stability in the marketplace."); see also Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 306, 311 (Mass. 2009) ("[J]oint and several allocation . . .'creates a false equivalence between an insured who has purchased insurance coverage continuously for many years and an insured who has purchased only one year of insurance coverage.'") (quoting Public Serv. Co. of Colo. v. Wallis & Cos., 986 P.2d 924, 939-940 (Colo. 1999)).

For courts finding that the plain language of the CGL policy requires the "all sums" approach to allocation, see, e.g., Hercules, Inc. v. AIU Ins. Co., 784 A.2d 481, 494 (Del. 2001); Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co., 652 A.2d 30, 35 (Del. 1994) (applying Missouri law); State v. Cont'l Ins. Co., 281 P.3d 1000, 1005 (Cal. 2012); Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 769 N.E.2d 835, 841 (Ohio 2002).

Courts adopting the "all sums" allocation method recognize that the standard 1976 CGL policy does not reference periods of self-insurance nor contain mandatory proration provisions, and refuse to craft such terms into the insurance contract. See, e.g., Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1048-1049 (D.C. Cir. 1981) ("We have no authority upon which to pretend that Keene also has a 'self-insurance' policy that is triggered for periods in which no other policy was purchased. Even if we had the authority, what would we pretend that the policy provides? What would its limits be? There are no self-insurance policies, and we respectfully submit that the contracts before us do not support judicial creation of such additional insurance policies.

Other courts have relied on the principle of construing ambiguous insurance contracts in favor of coverage. See Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613, 626 (Wis. 2009); Am. Nat. Fire Ins. Co. v. B & L Trucking & Const. Co., 951 P.2d 250, 256 (Wash. 1998).

For a court finding the 1976 CGL policy's drafting history consistent with the "all sums" approach, see Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 990-991 (N.J. 1994). But see Arco Indus. Corp. v. Am. Motorists Ins. Co., 594 N.W.2d 61, 69, aff'd, 462 Mich. 896 (Mich. Ct. App. 2000).

j. Exhaustion, deductibles, and settlement. Under the "pro rata by years" allocation approach, an insured must fulfill every policy's deductible and/or SIR obligation before being

indemnified. See Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307, 324 (2d Cir. 2000) (applying New York law) ("To be sure, allocation has the effect of applying many years' deductibles to a single claim."); Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 303 n.28 (Mass. 2009) ("While most courts have held policyholders with occurrence-based policies responsible for a full per occurrence deductible or self-insured retention under each triggered policy, a minority of courts have prorated policyholders' deductibles.") (citing S.M. Seaman & J.R. Schulze, supra at § 4.3[c][2][A] at 4–29—4–32); Thomson Inc. v. Ins. Co. of N. Am., 11 N.E.3d 982, 1011 (Ind. Ct. App. 2014) ("We agree with XL and therefore reverse and remand with instructions to order Thomson to prove that the SIR for each 'occurrence' has been satisfied before any of XL's obligations under its 2003, 2004, and 2005 primary policies are triggered."); Norfolk Southern. Corp. v. California Union Ins. Co., 859 So. 2d 167, 198-199 (La. Ct. App.) ("In addition, [insured] must meet its SIR in every policy period . . . as required by the terms of the policy. It is clear, however, that the amount allocable to each of the policy periods is not sufficient to exceed even one SIR."); Pub. Serv. Co. of Colorado v. Wallis & Companies, 986 P.2d 924, 941-942 (Colo. 1999) ("Within each policy-year, the allocation of that $100,000 of liability depends on the structure of the insurance. Primary insurance, or alternatively, any SIRs, must first be exhausted. If liability remains after that, then policies in the first layer of excess for that year are required to respond, then policies in the second layer of excess, and so on. Where there are two or more policies within the same layer of excess, then liability is apportioned according to the degree of risk assumed by each policy.).

For courts adopting the "pro rata by years" approach and applying horizontal exhaustion, which is the majority rule, see, e.g., Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co., 71 P.3d 1097, 1132 (Kan. 2003); Cole v. Celotex Corp., 599 So. 2d 1058, 1080 (La. 1992); and Mayor & City Council of Baltimore v. Utica Mut. Ins. Co., 802 A.2d 1070, 1105 (Md. 2002).

The New Jersey Supreme Court, in adopting the "pro rata by limits" allocation method has rejected horizontal allocation. See Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1123 (N.J. 1998) ("[Insured] relies on its policy language that requires the underlying limits of coverage to be exhausted before liability attaches under its second-level excess policy. Fairly read, that provision requires the vertical depletion of the relevant policies in effect during the time of the excess policy's coverage; we are unpersuaded that the clause somehow applies to future policies that had not been written or signed at the time this second-layer excess policy was issued."). This rejection of horizontal exhaustion aligns with the "pro rata by limits" approach, which assigns a greater portion of indemnity costs to years with greater policy limits. Instead, courts adopting the "pro rata by limits" approach apply vertical exhaustion. See Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1123-1124 (N.J. 1998) (extending *Owens-Illinois*) (citing Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co., 978 F. Supp. 589, 609 (D.N.J. 1997)) (internal quotations omitted). For the rationale supporting vertical exhaustion under a pro rata approach, see Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1124 (N.J. 1998) ("[T]his approach makes efficient use of available resources because it neither minimizes nor

maximizes the liability of either primary or excess insurance, thereby promoting cost efficiency by spreading costs. . . . That method also promotes 'simple justice,' . . . by respecting the distinction between primary and excess insurance while not permitting excess insurers unfairly to avoid coverage in long-term, continuous-trigger cases."). Courts adopting the "all sums" without stacking approach necessarily require vertical exhaustion within the single policy year selected by the insured. For courts adopting the "all sums" with stacking approach applying vertical exhaustion, see, e.g., State v. Cont'l Ins. Co., 281 P.3d 1000 (Cal. 2012).

Under the "pro rata by years" approach, one insurer's settlement has no effect on other insurers' obligations to indemnify the insured for their respective policy periods. See Pub. Serv. Co. of Colorado v. Wallis & Companies, 986 P.2d 924, 942 (Colo. 1999) ("Wallis has conceded that if liability is allocated according to the time-on-the-risk method, then it is not also entitled to a set-off for the amounts that PSC received in settlement agreements with its other insurers. We agree."); Sharon Steel Corp. v. Aetna Cas. & Sur. Co., 931 P.2d 127, 139 (Utah 1997) ("We therefore conclude that it is more equitable to hold that an insurer who is on notice that another insurer has been paying significant defense costs should not be allowed to settle for a minimal sum to avoid having to contribute its fair share.")

l. Opting out of the default rule. Courts adopting both the "all sums" and pro rata allocation approaches have found that other-insurance clauses are meant to apply only to overlapping coverage among policies issued within a given policy year and should not be interpreted to apply to the allocation issue. See, e.g., Arco Indus. Corp. v. Am. Motorists Ins. Co., 594 N.W.2d 61 (1998) ("'Other insurance' clauses do not provide a solution to the allocation problem here because they were not meant to allocate liability among successive insurers. . . . Rather, they relate to the effect of concurrent coverages of a single occurrence.") (citing Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. Chi. L. Rev. 257, 278 (1997)); Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613, 624-625 (Wis. 2009); Ohio Cas. Ins. Co. v. Unigard Ins. Co., 268 P.3d 180, 184 (Utah 2012). But see Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1050 (D.C. Cir. 1981) ("When more than one policy applies to a loss, the 'other insurance' provisions of each policy provide a scheme by which the insurers' liability is to be apportioned. . . . These provisions of the policies must govern the allocation of liability among the insurers in any particular case.").

§ 45. Contribution

(1) An insurer that indemnifies an insured with respect to a claim has a right of contribution against any other insurer with an indemnification obligation to that insured for that claim to the extent that:

(a) The first insurer has paid more than its share of the indemnification costs;

(b) The other insurer has not settled with and been released by the insured; and

(c) The other insurer has not paid its share of the indemnification costs.

(2) In determining the insurers' share of indemnification costs, principles of restitution and unjust enrichment apply, following any consistent allocation terms contained in the liability insurance policies at issue.

Comment:

a. The basic rule. As discussed in § 43, sometimes multiple liability insurers have overlapping indemnification obligations. This can happen when multiple "concurrent" policies cover a particular loss or occurrence within a single policy period. This can also happen when a harm or activity that triggers liability insurance coverage takes place over multiple "successive" policy periods. When multiple liability insurers have indemnification obligations with respect to particular costs incurred by an insured, the insurers' indemnification obligations with respect to the insured are governed by § 43 and § 44. The contribution obligations that the insurers owe each other, however, are governed by this Section.

When an insurer makes a payment to indemnify particular costs of an insured and that payment is larger than the insurer's ultimate share of those costs relative to the share owed by the other insurers with overlapping indemnification obligations, then that insurer has a right of contribution against the other insurers even if there is no term in the contract granting such a right. This equitable right of contribution rests on principles of restitution and unjust enrichment. See generally §§ 23 and 24 of the Restatement Third, Restitution and Unjust Enrichment (governing performance of a joint obligation and equitable subrogation).

b. The role of allocation terms and the pro rata default contribution rule. When multiple insurance policies with overlapping indemnification obligations contain allocation terms that are consistent with each other, those allocation terms determine the appropriate amount of contribution owed to an insurer that has indemnified an insured's liability costs. For example, when multiple concurrently issued policies have consistent other-insurance terms, those terms determine the scope of the contribution obligation among the insurers. See § 43, Comment *d*. The same is true when multiple successively issued policies covering the same costs have

consistent allocation terms. See § 44, Comment *k*. In both settings, courts generally attempt to reconcile allocation terms.

When, however, the overlapping insurance policies contain no allocation terms or contain allocation terms that are inconsistent with each other, the contribution obligation among insurers depend on principles of restitution and unjust enrichment. See Restatement Third, Restitution and Unjust Enrichment § 24, Illustration 17 (illustrating a pro-rata contribution rule among primary insurers that "separately insured C in the same amount against identical risks"). Courts in such situations generally apply a pro rata contribution rule among insurers. In the context of concurrently overlapping policies, courts predominantly use a pro-rata-by-limits formula, pursuant to which the insurers' respective shares are a function of the percentage of the total available insurance represented by each of the policies. See § 44, Comment *i*. In the context of successively overlapping policies, courts often follow a pro-rata-by-years approach pursuant to which the insurers' respective shares are a function of the number of years in which the underlying harm occurred. In jurisdictions that have adopted pro rata by years as the method of allocation between insurers and insureds in cases of long-tail harm, which is the rule adopted as the default in § 44, the formula governing contribution among insurers is the same as the formula governing allocation and, thus, contribution actions should not be necessary (because no insurer is required to pay more than its pro rata share of the liability). Whatever contribution rule is applied, however, the contribution obligation of an insurer is limited by the amount of the policy limits contained in that insurer's policy. Once an insurer has exhausted its policy limits in the payment of costs insured under the policy, that insurer no longer has an indemnification obligation that could serve as the basis for a contractual or equitable contribution claim (except and to the extent that the insured has a special right against the insurer in the circumstances, for example for breach of the duty to make reasonable settlement decisions or for bad-faith breach of contract, both of which are beyond the scope of this Section).

c. The role of settlement in contribution. When the joint-and-several or all-sums method of allocation applies, one insurer can be compelled to pay for all of the insured's liability costs, subject to that insurer's policy limit. Consistent with the interests of fairness and efficiency that underlie the law of unjust enrichment and restitution, the paying insurer may seek contribution from the non-paying insurers. Those non-paying insurers do not include an insurer that has

settled with the insured, however, because a settling insurer has paid and been released by the insured and, thus, has already paid its agreed upon share of the liability.

To permit a non-settling insurer to recover in contribution from a settling insurer would undermine the incentive of insurers to settle by eliminating the finality of the settlement. Of course, denying the non-settling insurer a right of contribution against the settling insurer leaves the non-settling insurer bearing more than its equitable pro rata share of the overall liability costs. For that reason, some courts grant the non-settling insurer a "credit" against its liability to the insured for the pro rata portion of liability attributable to the settling insurer. [To be completed]

Illustrations:

1. Driver is sued by Daughter for injuries arising out of an auto accident in which the daughter was a passenger. Driver is the named insured under an auto liability insurance policy issued by Insurer A and an insured under the omnibus clause of an auto liability insurance policy issued by Insurer B. Neither policy contains an applicable "other insurance" clause. Because the policy issued by Insurer A contains a family-member exclusion, Driver requests a defense from Insurer B. Insurer B agrees to provide that defense. The case results in a verdict of $100,000, which is less than the applicable limit of the Insurer B policy. Driver directs Insurer B to pay the verdict. Subject to the exercise of any appeal rights, Insurer B must do so, but Insurer B may then seek contribution from Insurer A for half of the costs Insurer B incurred defending the suit, pursuant to § 20(5), and half of the verdict pursuant to this Section. In that contribution action, Insurer A may assert any coverage defenses that it has with regard to the claim.

2. Same facts as Illustration 1, except that, because of concerns about the enforceability of the family-member exclusion, Insurer A agrees to settle with Driver pursuant to an agreement in which Driver releases all rights against Insurer A in return for Insurer A's agreement to pay up to $25,000 toward any settlement of or judgment entered in Daughter's suit. Insurer B must pay $75,000 of the verdict and may not seek contribution from Insurer A.

3. [To be completed]

4. [To be completed]

REPORTERS' NOTE

a. The basic rule. For cases affirming and applying the general equitable right of contribution among insurers, see, e.g., Am. States Ins. Co. v. Nat'l Fire Ins. Co. of Hartford, 202 Cal. App. 4th 692, 702, 135 Cal. Rptr. 3d 177, 183 (4th Dist. 2011) ("[T]he reciprocal contribution rights of coinsurers who insure the same risk are based on the equitable principle that the burden of indemnifying or defending the insured with whom each has independently contracted should be borne by all the insurance carriers together, with the loss equitably distributed among those who share liability for it.") quoting from Fireman's Fund Ins. Co. v. Maryland Casualty Co., 65 Cal. App. 4th 1279, 1293, 1294-1295, 77 Cal. Rptr. 2d 296 (1st Dist. 1998) ("In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others."); Mutual of Enumclaw Ins. Co. v. USF Ins. Co., 191 P.3d 866 (Wash. 2008) (same); State Farm Mut. Auto. Ins. Co. v. Union Ins. Co., 147 N.W.2d 760, 763 (Neb. 1967) ("[W]e conclude that where both companies stand on an equal footing, equity requires an equal apportionment of the loss."); Cosmopolitan Mut. Ins. Co. v. Cont'l Cas. Co., 147 A.2d 529, 534 (N.J. 1959) (collecting cases) ("We therefore conclude that as both companies stand on an equal footing equity requires an equal apportionment of the amount of the settlement and expenses."); and Am. Emp. Ins. Co. v. Maryland Cas. Co., 218 F.2d 335, 338 (4th Cir. 1954) ("The doctrine of contribution does not rest upon contract but upon general principles of equity and natural justice.").

For a general discussion of the law of contribution and the related concept of subrogation in terms of restitution, see generally Restatement Third, Restitution and Unjust Enrichment § 23 (on indemnity and contribution) and § 24 (on equitable subrogation). For a general discussion of the rules governing contribution among insurance companies with overlapping coverage obligations, see *Couch on Insurance* Chapter 217 et seq. (3d ed. 2015). For a general discussion of the rules regarding subrogation as applied to insurance companies, and the relationship between these rules and the rules governing contribution, see 16 *Couch on Insurance* Chapter 222 (3d ed. 2015).

b. The role of allocation terms and the pro rata default contribution rule. Absent other-insurance terms in the respective policies, the majority default rule for overlapping concurrent policies is to apply a pro rata by limits contribution method among the insurers. See 15 *Couch on Insurance* § 217:9 (3d ed. 2015) ("The dominant view . . . appears to be that the insurance obligation should be shared by the various insurers pro rata in the proportion that their respective policy limits bear to the entire loss, even though the policies contain no provisions for such a pro rata allocation. Within this approach, proration has been computed based on the insurer's actual exposure for the accident, not on its maximum policy limits.") (Collecting cases). See also Great Am. Ins. Co. of New York v. N. Am. Specialty Ins. Co., 542 F. Supp. 2d 1203, 1212 (D. Nev. 2008) ("As a general rule, an insured's loss should be 'equitably distributed among those who share liability for it in direct ratio to the portion each insurer's coverage bears to the total

coverage provided by all the insurance policies.'") (quoting Fireman's Fund Ins. Co. v. Md. Casualty Co., 65 Cal. App. 4th 1279, 1294 n.4, 77 Cal. Rptr. 2d 296 (1st Dist. 1998)).

The minority rule is to allocate the loss equally among the insurers. See 15 *Couch on Insurance* § 217:9 (3d ed. 2015) (collecting cases). See also E.R. Squibb & Sons, Inc. v. Accident & Cas. Ins. Co., 860 F. Supp. 124, 127 (S.D.N.Y. 1994) ("The pro rata approach does not mean that an insurer's duty to pay another insurer takes priority over its obligation to pay the insured where other insurers are not responsible for a given claim because of exhaustion of policy limits or inapplicability of other policies to the time period involved."). In some jurisdictions, insurers' contribution requirements are prescribed by statute. See, e.g., Minn. Stat. Ann. § 65A.08 Subd. 4 ("If there are two or more policies upon the property, each shall contribute to the payment of the whole or partial loss in proportion to the amount specified."). Cf. Restatement Third, Restitution and Unjust Enrichment § 23, Comment *a* (where contracts specify how to divide the parties' joint obligations, "a claim to indemnity or contribution is governed by the parties' agreement, not by the law of restitution.") Although the R3RUE specifies that contribution rights among insurers in this situation derive from equitable subrogation, which is covered by § 24 of that Restatement, not by § 23, the underlying principle that equity should recognize the obligations that the parties agreed by contract to assume is the same. It is not unjust for an insurer with a pro rata allocation clause in its policy to be unable to obtain contribution for more than a pro rata share of the liability from another insurer.

c. The role of settlement in contribution. See generally Laura A. Foggan, 3-22 *Appleman on Insurance* § 22.05[2], *Issues That May Arise in Attempting to Seek Contribution or Subrogation* (2015) ("[C]ourts have dealt with situations in which a targeted insurer is seeking to spread the liability to insurers that had previously settled with the policyholder, requiring them to weigh competing policy concerns regarding the finality of insurer-insured settlements."); Steven Plitt, et al., 15 *Couch on Insurance* § 217:18 (citing Home Indem. Co. v. Mead Reinsurance Corp., 800 P.2d 46, 48 (Ariz. Ct. App. 1990)) (providing an insurer may "avoid being precluded from seeking indemnification" by bringing a declaratory action before settlement).

For courts holding that insurers do not have a contribution right against settled insurers, which is the rule adopted in this Section, see, e.g., Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1453 (3d Cir. 1996) (applying Pennsylvania law and providing a "set-off" of the settling insurers' apportioned share of liability instead of the right to contribution); GenCorp, Inc. v. AIU Ins. Co., 297 F. Supp. 2d 995 (N.D. Ohio 2003), aff'd, 138 F. App'x 732 (6th Cir. 2005) (providing non-settling insurers with settlement credits instead of contribution rights). See Randy Maniloff & Jeffrey Stempel, General Liability Insurance Coverage: Key Issues in Every State 601 (3d ed. 2015) ("The most equitable approach to reallocation is the 'apportioned share setoff' method recognized by the Third Circuit Court of Appeals in applying Pennsylvania law.") (citing *Koppers*). Most courts place the burden on the insurer to prove it is entitled to settlement credits only to prevent a policyholder's double recovery. See, e.g., Weyerhaeuser Co. v. Commercial Union Ins. Co., 142 Wash. 2d 654, 674 (2000) ("The burden of showing entitlement

to an exclusion of liability based upon the existence of other insurance is properly [the insurer]"); United Techs. Corp. v. Am. Home Assurance Co., 237 F. Supp. 2d 168, 173 (D. Conn. 2001) (insurer "bears the burden of establishing the existence of a double recovery"). But see Litho Color v. Pacific Employers Ins. Co., 991 P.2d 638 (Wash. 1999) (placing the burden on the insured, which it failed to meet, and thus off-setting non-settling insurer's liability by the full settlement amount). This set-off alternative to contribution in cases of settling insurers is considered by some commentators to be the fairest approach.

Some jurisdictions do permit non-settling insurers to maintain contribution actions against a settled insurer. See, e.g., Fireman's Fund Ins. Co. v. Maryland Cas. Co., 65 Cal. App. 4th 1279, 1289 (1998) ("[W]e hold that one insurer's settlement with the insured is not a bar to a separate action against that insurer by the other insurer or insurers for equitable contribution or indemnity."); Potomac Ins. Co. of Illinois ex rel. OneBeacon Ins. Co. v. Pennsylvania Mfrs. Ass'n Ins. Co., 41 A.3d 586, 598 (N.J. App. Div. 2012) (holding settlement between one insurer and insured did not extinguish another insurer's right to seek contribution). Other courts rely on a case-by-case analysis and equitable principles to determine contribution rights between settled and non-settled insurers. See Century Indem. Co. v. Liberty Mut. Ins. Co., 815 F. Supp. 2d 508, 512 (D.R.I. 2011) ("Most courts, in determining the effect of such settlements, have proceeded with a view toward upholding equity and preventing unjust enrichment."); Maryland Cas. Co. v. W.R. Grace & Co., 218 F.3d 204, 211 (2d Cir. 2000) ("[T]he contract of settlement an insurer enters into with the insured cannot affect the rights of another insurer who is not a party to it. Instead, whatever obligations or rights to contribution may exist between two or more insurers of the same event flow from equitable principles."); Clarendon Am. Ins. Co. v. Mt. Hawley Ins. Co., 588 F. Supp. 2d 1101, 1106 (C.D. Cal. 2008) ("[A]n insurer does not . . . waive its right to seek indemnification or contribution by participating in the settlement of a potentially covered claim.").

Appendix

Black Letter of Council Draft No. 2

§ 13. Conditions Under Which the Insurer Must Defend

(1) An insurer that has issued an insurance policy that includes a duty to defend must defend any legal action brought against an insured that is based in whole or in part on any alleged facts that, if proven, would be covered by the policy, without regard to the merits of those allegations or any associated legal theory.

(2) For the purpose of determining whether an insurer must defend, the legal action is deemed to be based on:

(a) Any allegation contained in the complaint or comparable document stating the legal action; and

(b) Any additional allegation that a reasonable insurer would regard as an actual or potential basis for all or part of the legal action.

(3) An insurer is not required to defend a legal action brought against an insured if undisputed facts that are not at issue in the legal action for which defense is sought establish as a matter of law that the legal action is not covered. Unless such undisputed facts establish as a matter of law that the legal action is not covered, the insurer must defend until its duty to defend is terminated under § 18.

§ 18. Terminating the Duty to Defend a Claim

An insurer's duty to defend a legal action terminates only upon the occurrence of one or more of the following events:

(1) An explicit waiver by the insured of its right to a defense of the action;

(2) Final adjudication of the action;

(3) Final adjudication or dismissal of part of the action that eliminates any basis for coverage of any remaining components of the action;

(4) Settlement of the claim that fully and finally resolves the entire action;

(5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining components of the action;

(6) If so stated in the insurance policy, exhaustion of the applicable policy limit;

(7) A correct determination by the insurer based on undisputed facts not at issue in the legal action for which the defense is sought, as permitted under § 13(3); or

(8) Final adjudication that the insurer does not have a duty to defend the action.

§ 19. Consequences of Breach of the Duty to Defend

(1) An insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action.

(2) An insurer that lacks a reasonable basis for its failure to defend a legal action also loses the right to contest coverage for the action.

§ 31. Insuring Clauses

(1) An "insuring clause" is a term in a liability insurance policy that grants insurance coverage.

(2) Whether a term in a liability insurance policy is an insuring clause does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Insuring clauses are interpreted broadly.

§ 32. Exclusions

(1) An "exclusion" is a term in an insurance policy that identifies a category of claims that is not covered by the policy.

(2) Whether a term in an insurance policy is an exclusion does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Exclusions are interpreted narrowly.

(4) Unless otherwise stated in the insurance policy, words in an exclusion regarding the expectation or intent of the insured refer to the subjective state of mind of the insured.

(5) An exception to an exclusion narrows the application of the exclusion; the exception does not grant coverage.

§ 33. Timing of Events That Trigger Coverage

(1) When a liability insurance policy provides coverage based on the timing of a harm, event, wrong, loss, activity, occurrence, claim, or other happening, when that harm event, wrong, loss, activity, occurrence, claim, or other happening took place is a question of fact.

(2) A liability insurance policy may deem a harm, event, wrong, loss, activity, occurrence, claim, or other happening that triggers coverage under a liability insurance policy to have taken place at a specially defined time, even if it would otherwise be determined as a matter of fact to have taken place at a different time.

§ 34. Insurance of Liabilities Involving Aggravated Fault

(1) It is not against public policy for a liability insurance policy to cover defense costs incurred in connection with any claim, including but not limited to a criminal prosecution; an action seeking fines, penalties, or punitive damages; and a claim alleging intentionally caused harm, fraud, criminal acts, or other conduct involving aggravated fault.

(2) It is not against public policy for a liability insurer to pay damages to a third-party claimant for the civil liability of the insured for intentionally caused harm, punitive damages, fraud, criminal acts, or other conduct involving aggravated fault. If insulating the insured from the financial consequences of such liability would contravene the public purpose of the imposition of liability, the

insurer may seek indemnification from the insured for any amounts the insurer paid to or on behalf of the claimant.

§ 35. Conditions in Liability Insurance Policies

(1) A "condition" in a liability insurance policy is an event under the control of an insured, policyholder, or insurer that, unless excused, must occur, or must not occur, before performance under the policy becomes due under the policy.

(2) Whether a term in a liability insurance policy is a condition does not depend on where the term is located in the policy or the label associated with the term in the policy.

(3) Subject to § 37, the failure of an insured to satisfy a condition in a liability insurance policy does not relieve the insurer of its obligations under the policy unless the failure caused prejudice to the insurer.

§ 36. Consent or Approval of the Insurer as a Condition

When a liability insurance policy makes the consent or approval of the insurer a condition of the insurer's duty under the policy, the condition is satisfied if the insured seeks to obtain the consent or approval of the insurer and a reasonable insurer would consent or approve in the circumstances.

§ 37. The Exception for Claim-Reporting Conditions in Claims-Made-and-Reported Policies

Unless otherwise stated in the insurance policy, the notice-prejudice rule does not apply when a claim is first reported to the insurer after the end of the reporting period of a claims-made-and-reported policy, provided that the insured was afforded a reasonable time in which to report the claim.

§ 38. Circumstances in Which Anti-Assignment Conditions are Unenforceable

(1) Rights under an insurance policy relating to a specific claim that has been made against an insured may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments.

(2) A right under an insurance policy relating to a class of claims or potential claims may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments, provided the following requirements are met:

(a) The assignment accompanies the transfer of financial responsibility for the underlying liabilities insured under the policy as part of a sale of corporate assets or similar transaction;

(b) The assignment takes place after the end of the policy period; and

(c) The assignment of the right does not materially increase the risk borne by the insurer.

§ 39. Policy Limits

(1) A policy limit is a term in an insurance policy that identifies the maximum amount the insurer is obligated to pay for the claim or claims to which the policy limit applies.

(2) A per-occurrence, per-accident, per-claim, per-person, or other per-circumstance policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a single occurrence, accident, claim, person, or other specified circumstance.

(3) An aggregate policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a specified set of circumstances, regardless of the number of occurrences, accidents, claims, persons, or other specified circumstances. An insurance policy may have an aggregate limit that applies to all claims covered by the policy or it may have one or more aggregate limits that apply only to a defined set of claims. Not all liability insurance policies contain an aggregate limit.

§ 40. Retentions and Deductibles

(1) A self-insured retention is the amount specified in a liability insurance policy that the insured must pay for a covered loss before coverage under the policy begins to apply. Unless otherwise stated in the insurance policy, an insurer has no duty to defend or indemnify the insured until the insured has paid any applicable self-insured retention.

(2) A deductible is the amount specified in the liability insurance policy by which coverage under the policy is reduced after the coverage amount is finally determined.

(3) Unless otherwise stated in the insurance policy, none of the insurer's duties with respect to defense or indemnification are contingent upon the insured's payment of the deductible.

§ 41. Number of Accidents or Occurrences

For liability insurance policies that have per-accident or per-occurrence policy limits, retentions, or deductibles, the number of accidents or occurrences is determined by reference to the cause(s) of the bodily injury, property damage, or other harm that forms the basis for the claim, unless otherwise stated in the policy.

§ 42. Excess Insurance: Exhaustion and Drop Down

When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the excess insurance policy:

(1) The excess insurer is not obligated to provide benefits under its policy until the underlying policy is exhausted.

(2) The underlying policy is exhausted when an amount equal to the limit of that policy has been paid to claimants for a covered loss, or for other covered benefits whose payment is subject to that limit, by or on behalf of either the underlying insurer or the insured.

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide

coverage in the place of the underlying insurer (drop down), unless otherwise stated in the excess policy. In the case of an underlying insurer that is unable to perform because of insolvency, the excess insurer must provide benefits under its policy once the applicable limit of the underlying policy is paid without regard to any requirement in the excess policy that such payments must be made by the underlying insurer.

§ 43. Indemnification from Multiple Policies: The General Rule

(1) When more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy, except as otherwise provided in subsection (2) or § 44.

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy and provided that there is no more allocation to the insured than there would have been under the applicable policy that is most favorable to the insured with regard to allocation.

(3) When multiple insurers have a duty to defend an insured for a claim, the insurers' defense obligations are governed by § 20.

§ 44. Long-Tail Harms and Successive Policies

(1) When continuing or repeated harm triggers multiple insurance policies issued in successive policy periods, the insurers' indemnification obligations under the policies are subject to allocation according to the rule of pro rata by years, except as stated in subsection (2).

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

§ 45. Contribution

(1) An insurer that indemnifies an insured with respect to a claim has a right of contribution against any other insurer with an indemnification obligation to that insured for that claim to the extent that:

(a) The first insurer has paid more than its share of the indemnification costs;

(b) The other insurer has not settled with and been released by the insured; and

(c) The other insurer has not paid its share of the indemnification costs.

(2) In determining the insurers' share of indemnification costs, principles of restitution and unjust enrichment apply, following any consistent allocation terms contained in the liability insurance policies at issue.

A Principled Approach to Coverage?—How Will Policyholders Respond To the Restatement?

Speakers:

John Buchanan (Covington & Burling — Washington, DC)

Lorie Masters (Perkins Coie — Washington, DC)

EXHIBIT 1 TO 11-18-2014 ALI LETTER

Lyman J. Baldwin, Jr., Secretary for Underwriting for the Insurance Company of North America, also recognized that more than one policy period could be liable to pay for a course of continuing or repeated injury: "[I]n some exposure types of cases involving cumulative injuries, it is possible that more than one policy will afford coverage."[540] In 1979, Mr. Baldwin explained that the "solution" used by the 1966 drafters to address this allocation issue "was essentially one of recognizing the impracticality of artificially forcing a long-term event into a single policy."[541]

Similarly, in 1966, E.R. Woodworth of the Insurance Company of North America also recognized that multiple insurance policies may be called upon to pay for a policyholder's liability for continuing injury or damage:

> The new policy will apply only to bodily injury or property damage which occurs during the policy period and within the policy territory. Coverage will no longer attach when the accident occurs, but rather when the injury or damage takes place, and will apply, regardless of when the accident took place. This is particularly true, for example, if the injury or damage is from waste disposal, or similar operations, [and] should continue after the waste disposal ceased or operations [are] completed, as it can happen. *It could produce losses on each side of a renewal date and, in fact, over a period of years with a separate policy period applying in each year.* Policy limits are renewed every year, and the underwriter may find a rather substantial pyramiding of his liability limits under the new contract for delayed action injuries.[542]

Richard Schmalz, one of the primary drafters of the 1966 Form, recognized that more than one policy period could be held liable to pay for a policyholder's liability "where the injury actually occurs over two or

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[540] Lyman J. Baldwin, Jr., Address to American Society of Insurance Management (Oct. 20, 1965) (on file with authors).

[541] Letter from Lyman J. Baldwin, Jr., to Daniel McNamara of Insurance Services, Inc. (Sept. 7, 1979) (on file with authors).

[542] E.R. Woodworth, New Comprehensive General Liability Policy: The Effect on Contracting Risks 9 (Apr. 14, 1966) (comments at Cleveland seminar) (emphasis added) (on file with authors).

more policy periods."[543] Mr. Schmalz recognized that the CGL policy contains no clause requiring pro rata allocation because of the difficulty of drafting such a provision: "[T]here is no pro-ration formula in the policy, as it seemed impossible to develop a formula which would handle every possible situation with complete equity."[544]

Similarly, Herbert P. Schoen, a participant in the drafting of the 1966 Form, confirmed in testimony in the 1980s that allocation issues were to be resolved among insurance companies, not between the policyholder and its insurance companies:

> Question: Was it your position in the 60's that the ultimate resolution of exposure-type cases extending over the policy periods of various insurance companies was for the insurance companies to get together and work it out amongst themselves?
>
> Question: I misspoke. I meant the best, the best resolution of exposure-type cases extending over the policy periods of several insurers was for the insurers to get together and work out allocation amongst themselves.
> Answer: Yes.[545]

In 1968, Richard H. Elliott, Secretary of the insurance industry association, the National Bureau of Casualty Underwriters, confirmed that, in cases involving a course of continuing or progressive injury, "more than one policy affords coverage."[546]

The insurance industry "discussion group," entitled the Enterprise Liability Study Group, convened in 1977[547] to discuss the insurance industry's response to potential asbestos-related liability in light of the *Borel* decision.[548] A memorandum of the April 21, 1977 meeting of the Enterprise Liability Study Group concluded that each insurance policy

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[543] Richard Schmalz, New Comprehensive General Liability and Automobile Program, Mutual Insurance Technical Conference (Nov. 15-18, 1965) (on file with authors).

[544] Richard Schmalz, New Comprehensive General Liability and Automobile Program, Mutual Insurance Technical Conference.

[545] Environmental Insurance Law Institute 53, Regarding Testimony of Herbert P. Schoen at 15, 898 (Mar. 6, 1986).

[546] Richard H. Elliott, *The New Comprehensive General Liability Policy, in* Liability Insurance Disputes 12-5 (S. Schreiber ed., 1968) (on file with the authors).

[547] *See* **§ 4.01[B]**.

[548] 493 F.2d 1076 (5th Cir. 1973).

triggered by continuing injury or damage may be liable in full to pay for the policyholder's liability:

> The majority view was that coverage existed for each carrier throughout the period of time the asbestosis condition developed—i.e., from the first exposure through the discovery and diagnosis. The majority also contended that each carrier on [the] risk during any part of that period could be fully responsible for the cost of defense and loss.[549]

In a memorandum discussing the meeting, Richard Hampton of Liberty Mutual Insurance Company confirmed the agreement of many insurance industry representatives that, once triggered, a general liability insurance policy is responsible for all of the policyholder's defense and indemnity, even that part of the liability applicable to uninsured periods:

> A large group representing primary and excess carriers as well as reinsurers including Zurich, Bituminous, CNA, Kemper and American RE take the position that all carriers [that] are on risk during the term of the exposure allegations are responsible for both indemnity and allocated [defense], subject to their percentage of coverage, including the policyholder's own percentage during any "bare" period.[550]

This "pyramiding" or "stacking," another term used in the contemporaneous insurance industry documents, was possible—even expected—under the CGL policy. The insurance industry drafting committees considered, and rejected, alternate language intended to prevent this "cumulation," or pyramiding, of policy limits.[551]

The issue emerged again in the late 1970s when a number of insurance companies concluded that the policy language was "not desirable because it pyramids the limits available to the insured for losses resulting

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[549] Charles Berryman & Richard Ingegnesi, Memorandum of Meeting of Discussion Group—Asbestosis 1 (May 20, 1977) (on file with authors).

[550] Memorandum from Richard Hampton to Ira Hall of Home Office Claims, Liberty Mutual Insurance Company 1 (Apr. 26, 1977) (on file with authors).

[551] *See* Explanatory Memorandum of the Joint Forms Committee to the Rating Committees of the National [NBCU] and Mutual Bureau [MIRB] 7 (June 7, 1961) (on file with authors).

from continuous or repeated exposures over multiple policy periods."[552] The insurance industry again declined to clarify the language to prevent the "pyramiding" of limits.[553]

[B] Enforcing the Promise to Pay "All Sums"

The insuring agreement in a standard-form CGL insurance policy promises to pay the policyholder "all sums," with no provision limiting that obligation in any way. Courts following this "joint and several" liability approach refuse to abrogate the insurers' contractual obligations by relying on the "during the policy period" language found in some policy definitions.

At least the following courts have ruled that standard-form CGL insurance policies must pay in full once triggered, subject to any rights that the insurance companies may have against one another: the United States Courts of Appeal for the Third[554] and District of Columbia Circuits,[555] the state supreme courts of California,[556] Delaware,[557]

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[552] ISO Memorandum to Members of the General Liability Rules and Forms Committee 1841 (Apr. 18, 1978) (enclosing minutes of Mar. 28, 1978 meeting) (on file with the authors).

[553] ISO Memorandum to Members of the General Liability Rules and Forms Committee at 1844.

[554] In *ACandS*, the United States Court of Appeals for the Third Circuit explained:

> The policies require the insurers to pay all sums which [the policyholder] becomes "legally obligated to pay" because of bodily injury during the policy period. . . . It follows that if a plaintiff's damages are caused in part during an insured period, it is irrelevant to [the policyholder's] legal obligations and, therefore, to the insurer's liability that they were also caused, in part, during another period.

764 F.2d 968, 974 (3d Cir. 1985) (citations omitted). *See also* Federal Ins. Co. v. Susquehanna Broadcasting Co., 727 F. Supp. 169, 175 (M.D. Pa. 1989), *on reconsideration, amended in part,* 738 F. Supp. 896 (M.D. Pa. 1990), *aff'd,* 928 F.2d 1131 (3d Cir. 1991) (*Susquehanna*).

[555] *Keene I, 667 F.2d 1034.*

[556] *See Aerojet, 17 Cal. 4th 38, 948 P.2d 909*, 770 Cal. Rptr. 2d 118.

[557] *Monsanto v. C.E. Heath*, 652 A.2d at 34-37. The Delaware Supreme Court later reaffirmed this ruling in Hercules Inc. v. AIU Ins. Co., 784 A.2d 481, 491 (Del. 2001) (*Hercules*), effectively overruling the pro-rata allocation result in E.I. duPont de Nemours & Co. v. Allstate Ins. Co., 686 A.2d 1015 (Del. 1997).

Illinois,[558] Indiana,[559] Ohio,[560] Pennsylvania,[561] Washington,[562] and Wisconsin.[562.1] Other courts also have adopted this rule of joint-and-several liability.[563] The Minnesota Supreme Court, although holding that proration is appropriate in some cases involving environmental injury, rejected

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[558] *Raymark*, 118 Ill. 2d at 57, 514 N.E.2d at 165. *See* Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's, London, 59 Mass. App. Ct. 646, 797 N.E.2d 434 (2003) (applying Illinois law to apply "all sums" allocation).

[559] Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049, 1057-58 (Ind. 2001) (*Allstate v. Dana*). An Indiana appellate court limited *Allstate v. Dana* to environmental coverage cases. Federated Rural Elec. Ins. Exch. v. National Farmers Union Prop. & Cas. Co., 805 N.E.2d 456 (Ind. Ct. App. 2004) (validity is questionable given subsequent history, 822 N.E.2d 973, *appeal vacated due to settlement*, 816 N.E.2d 1157 (Ind. 2004)).

[560] Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 95 Ohio St. 3d 512, 516-17, 769 N.E.2d 835, 840 (2002) (*Goodyear*); Pennsylvania Gen. Ins. Co. v. Park-Ohio Indus., Inc., 126 Ohio St. 3d 98, 102, 930 N.E.2d 800, 805-06 (2010) (following *Goodyear*) (*Park-Ohio*). The dissent in *Goodyear* referred to proration as the majority rule "in the context of continuing *environmental damage* from pollution." The dissent there cited no law, but instead an article written by attorneys from Cozen & O'Connor, a law firm that represents only insurance companies in insurance coverage disputes. 95 Ohio St. 3d at 521, 769 N.E.2d at 845 (citing an article by William P. Shelly, Fundamentals of Insurance Coverage Allocation, Mealey's Litig. Rep.—Ins., 25, 30 (Jan. 5, 2000)). *But see* GenCorp Inc. v. AIU Ins. Co., Nos. 04-3244, 04-3377, 2005 U.S. App. LEXIS 13669 (6th Cir. July 7, 2005) (unpublished) (refusing to apply *Goodyear* in a case involving excess insurance policies; in effect limiting *Goodyear* to primary insurance policies at issue in environmental coverage cases).

[561] *J.H. France,* 626 A.2d at 508. *See Viacom*, 138 S.W.3d 723, 726-27.

[562] *B&L Trucking,* 82 Wash. App. 646, 920 P.2d 192 (1996), *aff'd,* 134 Wash. 2d 413, 951 P.2d 250 (1998) (relying, in part, upon *Keene I* and *Gruol*, 11 Wash. App. 632, 524 P.2d 427 (1974)).

[562.1] *Plastics Engineering*, 315 Wis. 2d at 582-87, 759 N.W.2d at 625-28.

[563] *See, e.g.,* Hatco Corp. v. W.R. Grace & Co., 801 F. Supp. 1334, 1346 (D.N.J. 1992), *modified on reconsideration*, No. Civ. A-89-1031, 1994 WL 172302 (D.N.J. Apr. 29, 1994) (*Independent v. Grace*); Dayton Indep. Sch. Dist. v. National Gypsum Co., 682 F. Supp. 1403, 1410-11 (E.D. Tex. 1988), *rev'd on other grounds sub nom.* W.R. Grace & Co. v. Continental Cas. Co., 986 F.2d 865 (5th Cir. 1990) (*Dayton*); *Lac D'Amiante*, 613 F. Supp. at 1563; *Armstrong,* 45 Cal. App. 4th 145 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996); California Union Ins. Co. v. Landmark Ins. Co., 145 Cal. App. 3d 462, 193 Cal. Rptr. 461, 469-71 (1983) (*California Union v. Landmark*); Norfolk S. Corp. v. CIGNA Specialty Ins. Co., No. 410, 025 (La. Dist. Ct. Feb. 12, 2001), *reprinted in* 14 Mealey's Litig. Rep.—Ins., No. 15, at G1 (Feb. 20, 2001); Bristol-Myers Squibb Co. v. AIU Ins. Co., No. A-145, 672 (Tex. Dist. Ct. May 3, 1996), *reprinted in* 10 Mealey's Litig. Rep.—Ins., No. 26, at B1 (May 14, 1996); *Gruol, 11 Wash. App. 632, 524 P.2d 427*, 431 (1974). *Accord City of Va. Beach v. Aetna Cas. & Sur. Co., 426 F. Supp. 821*, 827 (E.D. Va. 1976); *In re* W.R. Grace & Co. Asbestos Property Damage Claims, Liquidator Nos. 1895-1916

court recognized the "probable fiction" inherent in that method of spreading liability, but was not asked to decide the total period over which damages should be spread. Instead, the court noted that trial courts have flexibility to apply an apportionment scheme that differs from time on the risk if the facts of the case permit a fairer apportionment. The court specifically noted that the fairest apportionment would be a "fact-based allocation" of damages but emphasized that it is often impossible in environmental damage cases to make this determination given the many years that have passed since the "triggering event."[654.2]

[1] Drafting History Rejecting Proration or "Non-Cumulation"

In drafting the CGL policy, the insurance industry drafters sought to avoid a key problem that would occur when CGL insurance policies responded to progressive injury or damage: How to draft a policy form that would be triggered by injury that took place over time, but whose limits would not "cumulate," or "pyramid," to use the words of the day,[654.3] to allow policyholders to recover under more than one year's policy limit.

During the policy revision project that culminated in the introduction of the 1966 CGL form, the drafters struggled to write a policy that would secure for their companies the marketing benefit of expanding the trigger without exposing them to cumulation of limits. They considered, as discussed above more generally in connection with trigger of coverage, a manifestation trigger, a "last exposure" trigger, "non-cumulation," and proration (by means of an explicit pro rata clause). As summarized in a 1961 drafting document, they rejected all of those options:

> The objections were:
> 1. When the Claim is Brought
>
> > a) Injury may be in one policy period and claim in another policy period (This is foreign to the insurance concept.)
> > b) Possibility of collusion.

[654.2] *Boston Gas*, 454 Mass. at 367, 910 N.E.2d at 312.

[654.3] *See, e.g.*, Gilbert Bean, "Products Liability Insurance," at 5-6 (Oct. 1952) (on file with authors); Richard Schmalz, "Taking the Suddenness Out of Accident—Some Drafting Problems and Possible Solutions" at 2 (Apr. 1961) (on file with authors).

[d] Proration Clause

The CGL drafters also conceived of prorating an insurer's liability among the triggered policies as a way to reduce the total amount that a policyholder could collect for a course of progressive injury. The CGL drafting committees engaged in a dialogue about this approach.[654.13] In March 1959, the Joint Scope of Coverage Subcommittee proposed a proration provision as a means to accomplish this restriction:

> In opening the discussion, a member suggested a fourth approach that the accident be pro rated over the period of the exposure i.e. the length of the exposure would apply rather than a specific date. Various companies covering within the exposure period would pro rate the total claims.
>
> * * *
>
> Pro Rate
>
> a) Generally objectionable, even with language of the following type to prevent pyramding [sic] of claims and limits: "but in no event shall the coverage be in excess of the highest limits under any policy individual [sic] covering the accident."[654.14]

The CGL drafters rejected that approach and did not consider it again until 1964. At that time, one of the three principal CGL drafters, George Katz of Aetna, distinguished between the two kinds of proration—proration to reduce coverage for the policyholder,[654.15] and proration among insurers after one of them has paid the policyholder.[654.16] In doing so, he made clear that proration to the policyholder was not practical:

1961) (on file with authors). See discussion of "non-cumulation" and "other insurance" clauses in *Plastics Engineering*, 315 Wis. 2d at 578-81; 759 N.W.2d at 624-25.

[654.13] Questionnaire entitled "Caused by Accident," attached to agenda for Dec. 3-4, 1958 meeting of General Liability Rating Committee, at 4 (on file with authors); Minutes of General Liability Rating Committee of NBCU, at 5 (Jan.7-8, 1959) (on file with authors).

[654.14] Minutes of Joint Scope of Coverage Subcommittee, at 1-2 (Mar. 3-4, 1959) (on file with authors).

[654.15] In this use of the term proration, the policyholder cannot collect the entire liability from one of a series of triggered policies but receives only a share from each.

[654.16] In this use of the term proration, the policyholder can collect the entire liability from one policy or insurer (within the policy's limits) and, thereafter, the paying insurer can spread the loss over the triggered years, either on its own books (if it wrote the other

> Mr. Katz . . . went on to explain that prorating cannot be effectuated between the insurer and the claimant. Between two insurers, of course, they would prorate. We cannot ask our Claims Departments to adjust parts of claims; also, we cannot defend our pro rata share of claims, but must defend the entire claim.[654.17]

When the 1966 Form was prepared for release, Mr. Schmalz gave a speech confirming that the revised policy contained "no proration formula":

> The policy applies under the new program to bodily injury or property damage which occurs during the policy period. Inasmuch as the new policies afford blanket occurrence coverage it is possible that where the injury actually occurs over two or more policy periods, the Claims Department will have to make some sort of reasonable allocation to each. There is no pro-ration formula in the policy, as it seemed impossible to develope [sic] a formula which would handle every possible situation with complete equity.[654.18]

Although the CGL policy drafters rejected proration, the concept was (and today is) used in other kinds of standard insurance policies. Thus, when assessing the significance of the drafters' decision not to put proration language into the CGL policy, it is important to recognize that insurance policies of various kinds (e.g., fire insurance, D&O insurance) have contained explicit proration provisions for a very long time—and the decision not to include such a provision in the standard CGL policy was deliberate.

[*Next page is 4-159.*]

triggered years) or by equitable contribution from the other insurance companies involved. The term "proration," in this latter sense, is also sometimes called "proration among insurers" or "proration among indemnitors."

[654.17] Minutes of meeting of the Joint Forms Committee, at 11 (Sept. 21-23, 1964) (on file with authors).

[654.18] Richard Schmalz, "New Comprehensive General Liability and Automobile Program," Mutual Insurance Technical Conference, at 6 (Nov. 15-18, 1965) (on file with authors).

EXHIBIT 2 TO 11-18-2014 ALI LETTER

CONFIDENTIAL

1958

MINUTES OF THE JOINT MEETING ON MUTUAL BUREAU AND NATIONAL BUREAU SCOPE OF COVERAGE SUBCOMMITTEE HELD IN THE OFFICES OF THE MUTUAL INSURANCE RATING BUREAU ON TUESDAY AND WEDNESDAY, MARCH 3-4, 1959

MEMBERS PRESENT	REPRESENTED BY
American Mutual Liability Insurance Company	R. C. Kean
Lumbermens Mutual Casualty Company	E. W. Day
Michigan Mutual Liability Insurance Company	W. O. Miller*
MUTUAL BUREAU STAFF	D. E. Kuizenga
	T. O. Morris, Jr.
Aetna Casualty and Surety Company	M. Lydiard
Hartford Accident & Indemnity Company	H. Mildrum
Travelers Insurance Company	D. Griffin
Royal Globe Insurance Group	E. Bomse
NATIONAL BUREAU STAFF	N. Nachman

*Present first day of meeting only.

The meeting convened at 10:00 A.M. on March 3, 1959.

1. Caused By Accident - Occurrence - Products Liability

The Subcommittees resumed discussion of the intent of "caused by accident" vs. "occurrence" as respects Products Liability. At the February 3-4, 1959 meeting the subcommittees considered and agreed to discuss with their claims people the following approaches to when an "accident" should be considered as having taken place in order to avoid duplication of coverage for a single accident under more than one policy:

(1) The date the injured party institutes the claim,

(2) The date the injury manifests itself, and

(3) The last day of the last exposure to the condition causing the injury.

In opening the discussion, a member suggested a fourth approach that the accident be pro rated over the period of the exposure i.e. the length of the exposure would apply rather than a specific date. Various companies covering within the exposure period would pro rate the total claims.

After a lengthy discussion on the various approaches the meeting agreed to consider each approach by listing the objections.

The objections were:

I. When the Claim is Brought

a) Injury may be in one policy period and claim in another policy

CONFIDENTIAL

period (This is foreign to the insurance concept.)

b) Possibility of collusion.

2. Date Injury Manifestes Itself

a) Inconsistent with what we mean by "caused by accident" This approach may not be adaptable to the "sudden" accident e.g. a stairway accident resulting in a back injury which does not manifest itself for six months.

3. Last Day of Last Exposure

a) Principal exposures would often be in other policy period.

b) Not possible to determine when the policy coverage terminates.

c) Possibility of collusion.

4. Pro Rate

a) Generally objectionable, even with language of the following type to prevent pyramding of claims and limits: "but in no event shall the coverage be in excess of the highest limits under any policy individual covering the accident."

The meeting concluded that none of the four proposals would accomplish the desired result.

A member of the Committee then suggested the following language to express the underwriting intent:

> "all injury or damage which results from continuous or repeated exposures to the same cause is an accident. Such accident shall be deemed to have occurred when the exposure culminates in knowledge of injury or (Demonstrable injury).

In tentatively adopting this principle, it was agreed that there would be no change in the "Boom" concept, further that approach #2 "Injury Manifested" is best expressed by this language.

2. Resume of Committee Actions

It was recommended that the Mutual Bureau and National Bureau staffs prepare a statement of tentative agreements reached in all meetings to date in order that the two subcommittees may review their expression of intent prior to making a report to their respective Rating Committees.

The report should cover the following items which have been discussed:

a) Relationship Liability

b) Cost of replacement of Defective Products

c) Guarantee of Performance on Suitability

d) Tangible vs. Intangible

e) Consequential Loss

3. "Caused By Accident" - Other General Liability

The meeting received for discussion and consideration a questionnaire on "Caused By Accident" which was recently considered by the General Liability Rating Committee of the National Bureau and referred by the Mutual Bureau's Liability Rating Committee to its Scope of Coverage Subcommittee.

With reference to the "Caused By Accident" questionnaire, the following questions were discussed:

2(c) - Infant murdered by a person (aunt) who was the beneficiary of a life insurance policy but had no insurable interest in the infant's life - negligence alleged on the part of the Life Company selling the policy - Liability policy with Life company as named insured covered.

It was the consesus that it is not the intent to cover such "Business" malpractice, although, a feeling exists presently that coverage is afforded. It was suggested that the intent as respects coverage for "business malpractice" under General Liability sublines other than products may be inconsistent with the tentative agreement reached previously as respects "business risks" i.e. defects in goods or products resulting from "management errors" (no coverage) and those resulting from employee - production line errors (coverage). However, it was believed that such inconsistency may be the basic difference between Products Coverage and that afforded under other General Liability sublines.

2(d) - Exposures over a long period of time (B.I.) Toxic particles causing death; (P.D.) Lint clogging drain and causing property damage.

It was recognized that "suddeness" is no longer a necessary part of the "caused by accident" coverage for B.I. coverage; but it was the intent that some elemen of "suddeness" be present for P.D. coverage to apply.

2(f) - Is it the intent to determine coverage on the basis of when the actual injury complained of occurs and not when the cause of the injury occurs?

It was contended that whether coverage is on an accident

or an occurrence basis, coverage is determined on the basis of when the actual injury complained of occurs and not when the cause of the injury occurs.

4. Adjournment

It was agreed that the next joint meeting of the subcommittee would be held in the office of the National Bureau on Friday, April 17, 1959 and again on Tuesday and Wednesday, April 28-29, 1959.

EXHIBIT 3 TO 11-18-2014 ALI LETTER

MINUTES
JOINT FORMS COMMITTEE MEETING
SEPTEMBER 21, 22 and 23, 1964

The Joint Forms Committee met on September 21, 22 and 23, 1964 at the offices of the National Bureau of Casualty Underwriters.

The following attended the meeting:

For the Mutual Insurance Rating Bureau

American Mutual Liability Insurance Company	R. M. Molloy
Employers Mutual Liability Insurance Company	R. J. Wendorff
Hardware Mutual Casualty Company	R. P. Hamm
Liberty Mutual Insurance Company	R. A. Schmalz
	S. J. MacLellan (1)
Lumbermens Mutual Casualty Company	F. O. Terbell
Utica Mutual Insurance Company	H. C. Foster (2)
Staff	J. Marrone
	E. W. Bowen

For the National Bureau of Casualty Underwriters

Aetna Casualty & Surety Company	G. Katz
	D. R. Edwards
Fidelty & Casualty Company	F. W. DeCamp (3)
Glens Falls Insurance Company	A. P. Gown
Hartford Accident & Indemnity Company	H. P. Schoen
New Amsterdam Casualty Company	J. O. Honeywell
United States Fidelity & Guaranty Company	S. H. McCoy
Staff	E. F. Earle
	M. Machman
	E. B. Brown

(1) Present only first day
(2) Not present third day
(3) Not present first day

The meeting convened at 10:00 A.M., Mr. Earle presiding. The Committee agreed to Mr. Earle's suggestion that they work from (1) "Explanatory Memorandum - July 15, 1964 Drafts of General Liability Policy Revisions", and (2) a memorandum dated September 21, 1964 which contained J. D. C. suggested changes in the July 15, 1964 drafts.

5. Definitions of "Automobile", "Collapse Hazard" and "Completed Operations Hazard" - Page GA-6

The Committee considered the changes in these definitions indicated on the first page of the September 21 memorandum next to "Page GA-6".

(1) "automobile"

Mr. Foster stated that the word "or" in the phrase "or the ways immediately adjoining" was disjunctive. Mr. Schmalz added that this involved a fringe coverage and there was no intention to cover automobiles used only on the premises adjoining which "or" suggests.

Mr. Nachman asked if it was intended to cover automobiles on a trip to a repair shop. Mr. schmalz replied in the affirmative, provided the repair shop was in the vicinity. He qualified his remarks by adding that it is difficult to determine precisely what the intention is, but probably there was no intention to insure a trip to a repair shop any appreciable distance away.

The Committee approved the substitution of "including" for "or" in the last line of the definition of "automobile" so that the last phrase will read, "including the ways immediately adjoining;" and also deleted the comma which follows "named insured".

(2) "collapse hazard"

After Mr. Brown pointed out that the change indicated in the September 21 memorandum made the definition consistent with the definition of "underground property damage hazard", the Committee approved the change so that "at any time" was inserted before "resulting therefrom" in the first sentence of the definition.

(3) "completed operations hazard"

The Committee considered and approved the amendment of the first three lines of this definitions set forth in the September 21 memorandum which reads as follows:

> "'completed operations hazard' includes bodily injury and property damage arising out of operations or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily...."

Mr. Schmalz explained that the Joint Drafting Committee removed the phrase "performed by or on behalf of the named insured" because they believed that there are operations which are not "performed by or on behalf of the named insured", but which are in the scope of the completed operations hazard. He related the following actual case: A New York named insured was charged with liability for the negligent loading of a freight car in Canada. The named insured's merchandise was loaded on the car in Canada by an independent corporation which did not have a contractual relation to the named insured. Bodily injury was sustained in New York when the car was opened and the merchandise fell out. The claim made against the New York named insured was that it had "procured" the loading and was responsible for the completed operation. The named insured had not purchased completed operations

coverage, but the insurer felt it could not deny coverage because it could not claim that the car was loaded "by or on behalf of the insured". Mr. Katz synopsized the case by saying that the insured had merely ordered the goods and it could not be said that the loading was "by or on behalf of the named insured".

Mr.Schmalz referred to the Reed Roller Bit case (Reed Roller Bit Co. vs. Pacific Employers Ins. Co.; 198 F.2d 1), and stated that since the word "performed" was in the past tense an argument could be made that the definition did not apply to a representation during an operation, which is related to an accident after the operation is completed. The Joint Drafting Committee believes the change strengthens the definition against this sort of situation and that a further reinforcing is achieved by the insertion of the words "at any time" in the phrase "made at any time with respect thereto".

6. Definition of "Insured" - Page GA-8

The Committee examined the change in the September 21 memorandum which provides for a substitution in the first line of the definition of "qualifying as an insured" for "described". Mr. Earle expressed the opinion that this was a more apt expression. Mr. Schmalz explained that in the "Persons Insured" sections there are limitations on the scope of coverage and this amendment emphasizes that a person has to qualify as insured in the face of limitations and not merely be described.

Mr. Hamm questioned the phrase "to which the word relates" at the end of the first sentence of the definition, feeling that it was ambiguous. Mr. Earle suggested that "provision" be substituted for "word". Mr. Schoen feared the introduction of too many new words. Mr. Honeywell asserted that "word" was ambiguous. Mr. Schmalz was of the opinion that the essential matter was to identify which "Persons Insured" provision was meant. Mr. Schoen suggested that the last portion of the first sentence read, "of the applicable coverage provision to which the word relates". It was thought this language would encounter difficulty if you have more than one coverage part.

The Committee agreed on the phrase "of the applicable insurance coverage" and approved the following text for the first sentence of the definition:

> " 'insured' means any person or organization qualifying as an insured in the 'Persons Insured' provision of the applicable insurance coverage."

7. "Products Hazard" - Page GA-9

The Committee considered the amendment of the first two and a half lines of this definition set forth in the September 21 memorandum which reads as follows:

> " 'products hazard' includes bodily injury and property damage arising out of the named insured's products or reliance upon a representation or warranty made at any time with respect thereto,...".

Mr. Hamm suggested that the Committee consider substituting "to such products" for "thereto". Mr. Schmalz thought this might limit application of the definition to products only, rather than to "goods or products".

The Committee approved the change in the first two and a half lines set forth above.

8. Territorial Limitation - GA-10

The Committee considered the change suggested in the September 21 memorandum that the last three lines beginning with the words, "but the company shall have no obligation etc" be deleted.

Mr. Schmalz said that the reason for removing the above language is because it was considered to be redundant. He suggested that the word "if" be added near the end of the remaining language which would then read, "...and if the original claim or suit for damages is brought therein."

Mr. Earle asked what reason there was for requiring that the claim be originally brought in the United States. Mr. Schoen was of the opinion that the companies would not preclude coverage if a claim is originally made in Europe and the suit is originally brought later in the United States.

The Committee approved the deletion of the lines and the addition of the word "if" as noted above.

9. "Damages" Definition - Page GA-7

The Committee then considered the change in this definition contained in the July 15, 1964 draft and explained in the July 15 memorandum. The memorandum explains that the phrase "and damages for loss of use of property resulting therefrom" replaced "and damages for loss of use of property physically injured or destroyed". The memorandum further explains that the amendment "ties in with the change in the 'property damage' definition and emphasizes the intent that all loss of use of covered property is included, not just that of the property physically injured." The Committee approved the change already contained in the July 15, 1964 draft which reads as follows:

> " 'damages' means those damages which are payable because of bodily injury or property damage to which this policy applies, including, respectively, damages for death and for care and loss of services, and damages for loss of use of property resulting therefrom;"

The Committee agreed that the further consideration requested by Mr. Terbell, regarding the removal of the word "death" from the definition of "bodily injury" and placing it in the definition of "damages", was to be postponed until after the problem of defining "occurrence" is resolved. Nevertheless, discussion was had on this matter at this time.

Mr. Katz described the background for having placed the word "death" in the definition of "damages." Essentially, he said that if the definition of occurence is such that it is triggered at the time of bodily injury or property damage, then to include death in bodily injury would make it possible for a policy to cover

bodily injury sustained before the policy period, if death occurred during the policy period. Mr. Katz read a quote from Sawyer that "...death is clearly included in damages for bodily injury...". Hence, the Joint Drafting Committee placed "death" in the definition of"damages". Mr. Tarbell felt that this was a very blunt change in the policy. Mr. Katz stated the problem is interrelated with the definition of "occurrence", and possibly, if the Committee found another approach for "occurrence" it may solve the problem of "death". Mr. Tarbell maintained that if our exclusions do not apply to "death" the courts would make a shambles of the policy because of the ambiguity.

Mr. Schoen expressed sympathy with Mr. Tarbell's view, but explained that the problem of triggering coverage and defining "occurrence" are important considerations which may force the Committee to do some things it did not like. Mr. Molloy urged the Committee to defer further discussion on this topic. The Committee agreed that Mr. Tarbell shall have the right to raise this question again after a definition of "occurrence" is agreed to.

10. "Named Insured" Definition - Page GA-8

The Committee considered this definition which is new in the July 15, 1964 draft. Mr. Katz explained that it would be awkward to italicize "insured" and not "named". Mr. McCoy asked if the use of italics and bold face for defined words was to be optional. Mr. Katz replied in the affirmative, and added that this new definition makes it clear to whom cancellation is to be mailed.

Mr. Schmalz said that the definition of "named insured" might be too narrow, so that possibly:

(1) The company could not cancel by notice to the legal representative of the named insured, and

(2) The named insured's legal representative could not cancel.

Mr. Tarbell asked why the "provided" clause in the Assignment condition of current policies had not been used. The Joint Drafting Committee could not recall the reason, though Mr. Katz thought that the clause was probably believed to be surplusage.

Mr. Gowan said that if the company knows of the new address of the named insured you must mail to the new address. He did not believe that the courts will require the companies to mail to a representative they do not know about, or whose address is unknown. Mr. Earle added that the companies want to be able to mail to the deceased named insured.

Mr. Schoen suggested that we could add the proviso clause to the Assignment condition, although this clause has been removed from the Garage and Comprehensive Personal Liability Policies. Mr. Earle brought the attention of the Committee to the minutes of the May 2-4, 1961 J.F.C. Meeting, where the Committee had approved the present draft of the Assignment condition.

Mr. Tarbell made a motion to reinstate the proviso clause at the end of the Assignment condition. The motion was defeated. Four members of the Committee voted in favor of this motion and five were opposed.

Mr. Brown noted that Mr. William Aldridge, Secretary of the National Council should be informed of the Committee's action to no longer use the proviso language. Mr. Marrone is to notify Mr. Aldridge.

11. October Meeting

The dates for the next meeting were changed from October 13, 14 and 15, 1964 to October 20, 21 and 22, 1964. The meeting will be held at the Mutual Bureau offices.

12. "Occurrence" Definition - Page GA-9

Mr. Tarbell asked Messrs. Katz and Schmalz to explain, for the benefit of the Committee, the nature of the problems encountered in defining this term.

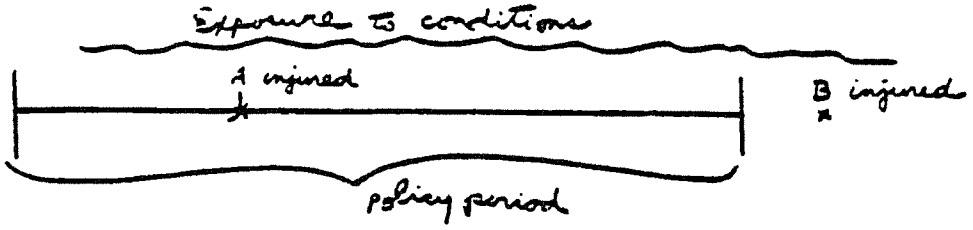
Mr. Schmalz replied that the policy requires that bodily injury or property damage be caused by something, which means we must then define the causative element to trigger off the coverage. The word "accident" is not satisfactory because it can mean something other than the immediate contact with the means of injury. He cited the following examples:

(1) Mrs. Murphy swallows poison which is an accident, but another accident was also involved in that the wrong pills had been placed in the bottle, or perhaps, the bottle had been incorrectly labeled.

(2) Assume a policy period which is the entire year of 1964. A number of persons were injured by exposure to conditions during 1964 and several others are injured by the same conditions, but at a later time, in 1965, after the policy period. This latter group could claim to have been injured by the same occurrence which caused injury in 1964, and conceivably the policy will apply because the policy covers exposure to conditions which cause bodily injury during the policy period, and those sustaining injury in 1965 have been injured by precisely the required kind of exposure (i.e., one which caused bodily injury during the policy period).

(3) Another problem is encountered in circumstances where there is intentional harm to some and not to others, but all injuries arise from one occurrence. Since the policy covers an occurrence which causes unintentional harm, the policy will cover the occurrence, but the intentional harm from this same occurrence would also be covered.

Mr. Schmalz suggested that the alternatives would appear to be (1) go to pure cause during the policy period, or (2) cover all bodily injury or property damage during the policy period. Mr. Katz drew the following diagram on the board to explain example #2:



(B's exposure is to the same "occurrence" (exposure to conditions) which caused A's injury during the policy period and so may be insured under the policy.)

Mr. Schmalz explained that the Mutual Bureau wanted "neither expected nor intended" to be more general, and did not want the quoted phrase to apply to "the bodily injury or property damage". The Mutual Bureau desired to be assured of the right to deny coverage for all bodily injury or property damage if any bodily injury or property damage is intended.

Mr. Schoen asserted that coverage should be triggered on the impact or the initial injury. In response to this, Mr. Gowm gave an example of a switch on a refrigerator being turned off by error during the policy period, but the food does not begin to spoil until after the policy period. Mr. Schoen's response was that he intends to cover all damage to the food, even if spoiled after the policy period. His reason for this position is that minutely examined, the damages commenced immediately when the switch was turned off.

Mr. Schmalz directed the following example particularly to Mr. Schoen: Assume a plant dumps acid into a sewer over three years in which three separate policies and insurers are involved. After the third year the city discovers the holes and sues the plant, alleging the dumping of acid over the three-year period. Are the three companies to prorate, or was there no injury until the third year when the holes were made?

Mr. Schoen asserted that the companies should prorate because the injury took place over the three years; in addition, if there was no insurer on the risk in the second and third year the company on the risk the first year should still only prorate. He alleged that the underwriters won't distinguish between: (1) boom injury which causes slowly growing injuries, and (2) the continuing impact case. The first case, he asserted, is really an accident, and only in the second type of injury should the damages be prorated. Mr. Katz stated that the "exposure to conditions" wording causes problems in the first type of case. ("occurrence" also discussed in items 15, 20 and 22.)

13. Assignment Condition - Page GA-14

The question was asked as to what was intended by the phrase "subject otherwise to the 'Persons Insured' paragraph" in subparagraph (2) of this condition. It was also remarked that granting coverage to "any person having proper temporary

custody of any owned or hired vehicle, as an insured" went too far, because the intention was to insure this person only with respect to the particular vehicle he has custody of, and the language makes him an insured for anything covered by the policy. Mr. Katz pointed out that the reason for subparagraph (2) is to show continuation of coverage for the financial responsibility law in the case of death of the owner. The subparagraph was further criticized for being ambiguous as to whose "owned or hired vehicle" the reference applied to. Mr. Schmalz said that the phrase "subject otherwise to the 'Persons Insured' paragraph" appears to be wrong because this condition creates a new class of insureds separate from the "Persons Insured" provision.

Mr. Bowen brought the Committee's attention to the fact that if the named insured did not purchase auto insurance, this condition nevertheless would grant auto insurance on his death. The Committee thereupon deleted the phrase, "this policy shall cover" which follows "the named insured shall die," and replaced it with "such insurance as is afforded by this policy shall apply".

Mr. Katz suggested that it be considered that subparagraph (2) be broadened to include all property in the proper temporary custody of a person after the death of the named insured. A partial reason for this suggestion was that the Mutual Bureau Rating Committee had suggested that subparagraph (2) include saddle animals and watercraft.

After further discussion the Committee considered the following draft of subparagraph (2) which was suggested by Mr. Katz:

> "(2) with respect to the maintenance or use of automobiles or registered mobile equipment owned or hired by the named insured, to the person having proper temporary custody thereof, as insured, subject otherwise to the 'Persons Insured' paragraph, but only until the appointment and qualification of the legal representative."

Mr. Katz thought that companies may want to cover a person who steps in after the named insured's death with regard to other property, but the policy will express the intention only as to registered automobiles, which is an area all companies presumably intend to cover.

Mr. Schmalz noted that by the terms of paragraph (a) of the "Persons Insured" provision of the Comprehensive General Liability Coverage Part (Page CGL-6), the exceptions to coverage in the subparagraphs to (a) would not apply to the new insureds added under this condition. He stated that the alternatives were (1) add these additional interests to the "Persons Insured" provision, or (2) add the exceptions to (a) of the "Persons Insured" provision to the end of the language now being considered for subparagraph (2).

Mr. Katz made a motion which was carried, to delete "subject otherwise to the 'Persons Insured' paragraph,". The language finally approved for the Assignment condition is the following:

"9. ASSIGNMENT. Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon; if, however, the named insured shall die, such insurance as is afforded by this policy shall apply (1) to the named insured's legal representative as the named insured but only while acting within the scope of his duties as such, and (2) with respect to the maintenance or use of automobiles or registered mobile equipment owned or hired by the named insured, to the person having proper temporary custody thereof, as insured, but only until the appointment and qualification of the legal representative."

14. "Property Damage" Definition - Page GA-9

The Committee considered the change in this definition contained in the 7/15/64 draft and which is explained in the July 15 memorandum. The memorandum explains that "the word 'physical' before 'injury' has been deleted at the request of the rating committees." Thus, the intent is clarified that the injury or destruction must be to "tangible" property but such property need not be physically damaged, e. g. the damages sustained by reason of the closing down of a building would be within the definition.

Messrs. Katz and Schmalz were in favor of the word "tangible", though Mr. Katz felt more strongly in favor of the use of this word. They explained that the language of the definition is not rigid and will allow for interpretation.

Mr. Bowen offered the example of a generating plant failing to deliver electric power because of an accident which causes:

(1) a manufacturing plant to shut down,

(2) food spoilage, and

(3) injury to a patient on an operating table.

Mr. Katz said that the language was broad enough for companies to administer their claims. The Committee approved the change in the definition.

15. "Occurrence" Definition - Page GA-9

Mr. Katz said he believed that tying coverage to "resulting bodily injury or property damage during the policy period" is more effective because the courts have determined "accident" to mean the cause of the bodily injury or property damage and the cause is not necessarily the event at time of impact.

Mr. Schmalz said he would agree to use of "injurious exposure to conditions". He added that people still feel that injury occurs when manifest and not at the time of the exposure, and the underwriters want to cover the immediate cause and not the manifestation. He placed the following definition on the board which is the last language agreed to at an informal meeting the previous evening:

" 'occurrence' means an accident or injurious exposure to conditions, provided bodily injury or property damage is neither expected nor intended from the standpoint of the insured."

In conjunction with this definition, the insuring agreement would include restrictions with regard to policy period and the policy territory. Mr. Schmalz stated that in a sense "injurious" is redundant (the exposure has to be injurious to cause bodily injury or property damage), but when you consider the word "occurrence" by itself, it is helpful. Mr. Schoen said the word suggests that we are talking about the impact, the injury itself.

Mr. Schmalz thought that "injurious exposure" was better than "injurious conditions", because the latter suggests something collective, whereas, the former suggests injury to individuals. He added that the insuring agreement would contain the phrase, "...during the policy period and within the policy territory, and the company shall have the right...".

Mr. Wendorff said that the draft would not eliminate the case where negligence took place during the policy period, but the bodily injury was sustained after the policy period. Mr. Katz said that the courts could go back to the negligence in manufacturing and allow them to say this negligence was the occurrence and so, the policy would cover the injury after the policy period.

Mr. Schoen said that as a fundamental principle we want to cover everything that flows from an impact in the policy period, and also everything flowing from an injurious exposure during the policy period. Mr. Schmalz said his understanding was the same, though it was not the approach he would choose. He thought Mr. Katz believed that as to a protracted exposure, the policy in effect at the time the injury became manifest should pay and there should not be proration. Mr. Katz said he did not completely agree with Mr. Schmalz's remarks, and went on to explain that prorating cannot be effectuated between the insurer and the claimant. Between two insurers, of course, they would prorate. We cannot ask our Claims Departments to adjust parts of claims; also, we cannot defend our pro rata share of claims, but must defend the entire claim. As to the word "accident", Mr. Katz said it will cause the same problems as before, but the companies will live with it as they have done.

Mr. Schoen said his underwriters don't want to accept full liability because they are on a risk the last week of exposure. Also, once off a risk they don't want to be concerned about future claims. The main aim is to give the underwriters a starting point and a stopping point. He cited two types of cases:

(1) dust falls continuously on surrounding property, and

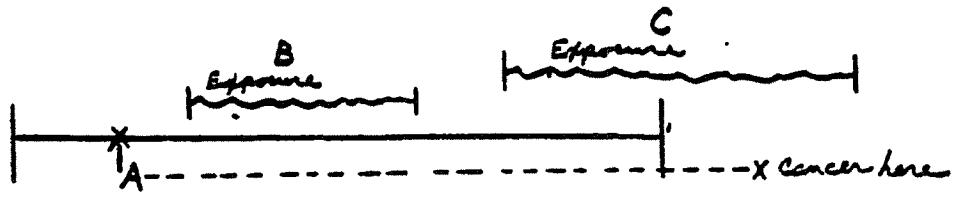
(2) one day's inhalation of cement during the policy period and six years later the person suffers from silicosis.

Mr. Schoen said that (2) is not an exposure case and his company intends to pay

for the silicosis six years later. Mr. Katz said that the difficulty in (2) is that it can be argued that injury actually took place six years later. In response to a question by Mr. Molloy, Mr. Schmalz added that the Committee had rejected the approach of covering when the injury becomes manifest.

Mr. Katz asked for a showing of hands on how many of the members approved of the common practice of writing occurrence coverage on the double condition that both the exposure and the injury must be during the policy period. Six of the members of the Committee were in favor, and three (Messrs. Schoen, Schmalz and Katz) thought the approach wrong primarily because of the coverage gaps that could develop.

Mr. Schoen drew the following diagram on the board:



Mr. Schoen said he intends to cover A who suffers an accident during the policy period which develops into cancer after the policy period. As to B, he intends to cover everything which follows from an exposure wholly in the policy period. Mr. Schmalz stated that as to C, where there has been exposure over two policy periods, Mr. Schoen intends to prorate the loss.

Mr. Nachman offered the case of a toxic substance being dumped into a stream during the policy period, but cows ingest it after the policy period. Mr. Schoen agreed that there was no intention to cover the cows which ingested the toxic substance after the policy period. He said this is what the companies do now with products insurance. In the case of ingestion over two policy periods, each company should pay for part of the injury. Mr. Schoen cited his company's soya bean case as being one which involved repeated impacts.

Mr. Honeywell asked the Committee what they believed the result in the soya bean case would have been had there not been a second insurer. The consensus was that probably Mr. Schoen's company would have had to pay all of the damages.

Mr. Schmalz directed the following example to Mr. Schoen: Assume the ingestion of poison over two policy periods. Five days in the first and fifteen days in the second. If the person had stopped ingesting after five days he may not have even gone to a doctor, yet Mr. Schoen says the liability should be prorated because injury was over the entire spectrum of the exposure. Others would say the first

five days of ingestion were inconsequential and injury was done in the last fifteen days, so the second insurer should pay all. Still others would say the company insuring at the time of the first ingestion should pay all because this was when the injury started.

Mr. Katz stated that proration would encourage insureds to recall and admit other instances in the past where they were guilty of the act complained of in order to bring in other companies or policies. This will only encourage confusion and litigation between companies.

Mr. Schoen referred to a Louisiana case in which a negligently wielded pick ax caused a leak in a gas pipe during the policy period, which then caused an explosion after the policy period. He said the explosion should be covered in the second policy only. (Even though there may have been an accumulation of gas during the first policy period, which would not be unlike the accumulation of poison in the soya bean case.)

Mr. Katz modified the definition on the board to read:

> " 'occurrence' means the accident or (the) injurious exposure to conditions which is the immediate cause of the bodily injury or property damage, provided bodily injury or property damage is neither expected nor intended from the standpoint of the insured."

Mr. Katz's objection to the prior draft was that the word "occurrence" could go back to the remote cause of the injury and the above language would require the court to find the immediate cause. Another advantage of this language is that if a company was on the risk during a period of innocent exposure it could argue that this was not the exposure that was the immediate cause of the injury.

The Committee considered indenting the words,"the accident" and "injurious exposure to conditions" to be assured that the "which" provision will apply to both. Mr. Katz suggested removing the word "the" before "injurious" saying the courts will then have to refer the "which" phrase to both "accident" and "injurious exposure to conditions". The Committee agreed to remove the word "the" before "injurious."

Several members of the Committee expressed concern that "immediate cause" may be interpreted to mean "proximate cause".

Mr. Schmals referred to the Louisiana case and said he did not believe that "immediate cause" would stop a court from going back to the pick ax in gas pipe. ("occurrence" also discussed in Items 12, 20 and 23).

16. Premium Condition - Page GA-10

The Committee considered the following revised language of this condition which was set forth in the September 21 memorandum:

> "1. Premium. All premiums for this policy shall be computed in accordance with the company's rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.

Premium designated in this policy as 'advance premium' is a deposit premium only which shall be credited to the amount of the earned premium due at the end of the policy period. At the close of each period (or part thereof terminating with the end of the policy period) designated in the declarations as the audit period the earned premium shall be computed for such period and, upon notice thereof to the named insured, shall become due and payable. If the total earned premium for the policy period is less than the premium previously paid, the company shall return to the named insured the unearned portion paid by the named insured.

The named insured shall maintain records of such information as is necessary for premium computation, and shall send copies of such records to the company at the end of the policy period and at such times during the policy period as the company may direct."

Mr. McCoy was apprehensive of the reference to "the company's rules, rates, rating plans, ...etc." which are contained in the company's manuals. Other members of the Committee were concerned with not informing the named insured specifically of the kind of records he must keep for premium computation. Mr. Katz suggested that the terms which are used for premium computation be defined on the schedule (perhaps the reverse side), or simply placed on a separate sheet which is given to the named insured. Mr. Brown expressed the opinion that the new language would satisfy most cases.

A motion was made and passed to adopt the revised language set forth above.

17. Legal Liability Arising Out of Casualty Insurance Engineering

Mr. Schoen distributed copies of a memorandum he had prepared which was captioned as is this item. He thought that the companies should, somehow, disavow that a partial inspection is a complete inspection and so, at least not be liable for acts of omission. Mr. Brown said there was no difference between omission and commission. In reply, Mr. Schoen said that if the company examines only one of fifteen buildings the company might be able to disavow responsibility for the buildings not inspected. Mr. Schmals said he did not believe that a flat disclaimer of liability would be effective and also, it would damage relations with the public. Mr. Schoen explained that his company wants to accept responsibility only for what it does and not for those parts or buildings not inspected. Mr. Brown said the answer was for the companies to buy their own insurance.

The consensus of opinion was that it will be difficult to limit the companies' liability arising from inspections, but that an effort should be made to find policy language to attempt to remedy, or at least mitigate the situation. Mr. Schoen's memorandum is to be reviewed and the subject will be discussed at the next meeting of the Committee.

18. Inspection and Audit Condition - Page GA-11

It was noted that the words "the premium basis or" which appear in this condition are no longer in the revised Premium Condition. A motion was made and passed to delete the words "the premium basis or" from this condition.

19. General Instructions, Assembly of Parts - Page GA-1

Mr. Molloy was concerned about the assembly of parts because his company wanted to be able to print several separate policies. Mr. Brown said that to accomodate all the differences to provide for separate policies would play havoc with the Standard Provisions Program. Mr. Katz said he will make changes in the present Standard Provisions Part to adapt it for use as an automobile policy. Mr. Schmalz supported Mr. Molloy's position, saying that if Mr. Molloy's company wanted to print separate policies he should not have to include non-applicable portions of the Standard Provisions Part. (For example, the financial responsibility language.)

Mr. Katz made a motion which was passed, to delete the words "these provisions" from number 2 of the General Instructions, and substituting therefor, "such of these Standard Provisions as pertain thereto," Also, a comma was added after the word "assembled". The purpose of this change is to give greater flexibility in combining parts.

Placing of Exclusions

Some of the members thought that the companies should have the option to place the exclusions elsewhere than immediately after the insuring agreement. Messrs. Katz and Schmalz felt that it was extremely important to place the exclusions immediately after the insuring agreement. They felt this was a substantive matter and not merely one of form, especially on the M & C and O. L. & T. parts. Mr. Katz maintained that the exclusions are a part of the insuring agreements. Mr. Tarbell felt that the placing of the exclusions should be the prerogative of the companies. Mr. Schoen supported his view.

Mr. Tarbell made a motion to amend the last clause in General Instruction #2 beginning with "except", to read "except that it is recommended the exclusions appear at the end of the coverage agreement of which they form a part." The motion was defeated. Five members of the Committee voted in favor of the change and six against it.

20. "Occurrence" Definition - Page GA-9

Mr. Schmalz distributed copies of three possible definitions of occurrence, which were as follows:

1. "occurrence" means the accident or injurious exposure to conditions, which is the immediate cause of the injury for which claim is made or suit is brought, provided injury is neither expected nor intended from the standpoint of the insured.

2. "occurrence" means (1) the accident or (2) the injurious exposure to conditions, which is the immediate cause of the bodily injury or property damage with respect to which the claim is made or the suit is brought.

3. "occurrence" means the contact (including a related series of contacts or continuous exposure) with harmful conditions, substances or forces which results without further cause in the injury for which claim is made or suit is brought, provided injury is neither expected nor intended from the standpoint of the insured.

The Committee considered definition #1. Mr. Earle suggested that "bodily injury or property damage" be substituted for the word "injury" where it first appears in the phrase "cause of the injury", because "injury" may relate only to bodily injury. Mr. Schmals thought to retain the word "injury" where it first appears because it has the connotation of a wrong. He cited the example of an insured cutting down a tree because he thought he had the right to do so. The Rating Committee wanted to cover this incident if the cutting down was innocent, that is, if there was no intention of "injury". Mr. Molloy was concerned by the possibility that the insured who does something which he knows will cause injury to someone in general, might successfully find coverage by claiming he did not expect injury to "Mrs. Smith in particular." Messrs. Schmals and Katz thought the courts would not stretch the language this far. Mr. Molloy added that the second "injury" may not be interpreted to have the different connotation from the first "injury", which is intended. Mr. Honeywell gave an example of a truck which deliberately crosses a field, the driver being aware that he is tearing up the field. Mr. Schmals thought the language would successfully deny coverage for the incident. Mr. Schmals read the definition of "injury" from Webster's Abridged Dictionary. Mr. Schmals said he believed the second use of "injury" in definition #1 was superior to the use of "bodily injury and property damage" because use of the latter phrase in this place would probably deny coverage for a man who "innocently" cuts down the tree.

The Committee then amended definition #1 to replace the first "injury" with "bodily injury and property damage". Mr. Earle noted that this change emphasizes the possibility that the second "injury" may not refer to property damage. The Committee agreed to add "or damage" after the second "injury" to make certain that the "provided" clause would also apply to property damage. Also, it was agreed that "with respect to which" should replace "for which", because the phrase "for which" may have narrowed coverage to actions for bodily injury and property damage, and not include suits for loss of use and loss of services, etc. The Committee removed the comma after the word "conditions" because the word "the" before "accident or injurious exposure to conditions" would tie both types of events to the clause beginning with "which". Messrs. Molloy and Brown voiced objections to the phrase, "which is the immediate cause of", because they believed intention was not clear and there may be confusion with proximate cause. Mr. Schmals replied to their contention saying that the phrase made it relatively certain that where two accidents have lead to the injury, as in the case where poison was accidentally included with canned food and later a consumer is accidentally injured when he eats the food, the courts will say in all cases that the last accident is what the policy intends to cover.

Mr. Gowan recited an example case where a named insured builds a dam knowing there is a flood every spring. In the spring there is a flood and the back-up of

water from the dam causes damage to a neighbor's land. Was the immediate cause of the damage the "flood" or the "dam"?

A motion was made and passed to approve the first definition of "occurrence" as amended. Eight members of the Committee voted in favor and three were opposed.

The text of the approved definition is as follows:

> "'occurrence' means the accident or injurious exposure to conditions which is the immediate cause of the bodily injury or property damage with respect to which claim is made or suit is brought, provided injury or damage is neither expected nor intended from the standpoint of the insured."

Messrs. Hamm and Wenderff thought the definition would gain by the deletion of the word "immediate". Mr. Schmals thought the best alternative would be the draft considered at the informal meeting the evening before, although recognising its weakness with regard to "accident". There is an ALR section which favors the interpretation of accident which the Committee desires to trigger coverage. ("occurrence" also discussed in items 12, 15 and 23).

21. Insuring Agreement, CGL Part - Page CGL-2

Because of the definition of "occurrence" which was approved, the Committee agreed to change the insuring agreement of this part so that "caused by an occurrence" is replaced by "resulting from an occurrence which takes place during the policy period and within the policy territory;".

22. Territorial Limitation Page GA-10

Mr. Katz thought it would be better if this provision made a positive statement of where the policy does cover. At Mr. Schmals's suggestion, the Committee agreed that discussion be postponed until the next meeting, at which time he and Mr. Katz will present new text for this provision.

23. "Occurrence" Definition - Page GA-9

Mr. Schmals stated that the new definition of "occurrence" is so personal to the person who is hurt that the courts will consider each person's injury to be a separate occurrence, though the facts be what would ordinarily constitute one occurrence. He urged the Committee to delete "with respect to which claim is made or suit is brought" from the definition agreed to. Mr. Katz thought no change was necessary. He and Mr. Schmals agreed that the cases have sustained "one accident" when injuries to several persons are reasonably close in space and time.

Mr. Katz explained Mr. Schmals's concern as being that if you identify the "immediate cause" as the accident, the courts will say that if there is a split second difference in time you will have separate accidents.

Mr. Honeywell cited the example of the Coconut Grove fire where there was one major occurrence, however, separate causes particularly caused the injuries and the deaths of various persons. Some persons were trampled, some suffocated or were injured

when a balcony collapsed, etc. Mr. Schmalz said the words "immediate cause" will allow the courts to find individual accidents and apply separate limits.

Mr. Katz suggested that the Committee go back to using bodily injury or property damage for the time trigger in "occurrence", pointing out that this is the means used for completed operations. Mr. Schoen said that using bodily injury or property damage in completed operations fails safe.

Mr. Schmalz said he thought the Committee had agreed to follow the "causation" approach. He suggested that we "clean up" the definition of "occurrence" agreed to, stating that it had the advantage of allowing the companies to rely upon the precedents for "accident". Mr. Katz suggested the Committee use the July 15 draft of "occurrence".

Mr. Schmalz thought that the word "the" at the beginning of the definition should be replaced with "an", so the phrase would read, "means an accident". He placed the following on the board:

> "'occurrence' means the [an] accident or injurious exposure to conditions[2][which is the immediate cause of [4][the][3] bodily injury or property damage][5] [6][for which claim is brought][6], provided ....etc."

Mr. Schmalz said the questions were whether to delete everything between brackets 1 to 6, or only 5 and 6, and also to substitute "an" for "the". He believed it was essential at least to remove the words between brackets 5 and 6.

Mr. Katz suggested substituting, "which results during the policy period, in the inception" for "which is the immediate cause".

On Mr. Schmalz's motion, the Committee voted to delete the words between brackets 1 to 6. Mr. Schmalz explained the insuring agreement would then be amended to read "...caused by an occurrence...". Six members of the Committee voted in favor and four against the motion.

Mr. Schoen explained that he voted against the motion because he feels "the immediate cause" is important. Mr. Hamm was opposed to the use of the phrase because it would upset the word "accident" which the companies fairly well know how the courts will react to.

Mr. Wendorff said we should use a double anchor. Tie the policy down to (1) occurrences during the policy period, and (2) bodily injury and property damage during the policy period. Mr. Schmalz said the choice should not be made to use causation and result. One or the other, but not both. Mr. Katz thought we could use both, and proposed that the insuring agreement read, "...caused by an occurrence which takes place during the policy period and within the policy territory...", and that "occurrence" be defined as follows:

" 'occurrence' means an accident or injurious exposure to conditions which results in bodily injury or property damage during the policy period, provided bodily injury or property damage is neither expected nor intended from the standpoint of the insured."

Mr. Gowan said that the above approach would follow what has been done with completed operations.

Mr. Schmalz pointed out that this double test allows for gaps in coverage where you have an accident in one policy period and emergence of injury in the second policy period. He cited the Louisiana case where the pick ax struck the gas pipe causing leak during the policy period and the explosion was after the policy period. Mr. Katz thought this double test was best because it is what the companies have been doing and they have had no trouble with it.

At Mr. Schmalz's suggestion, it was agreed that he and Mr. Katz will prepare an analysis of all the pros and cons for the various approaches to defining occurrence. This analysis is to be distributed before the next meeting. ("occurrence" also discussed in items 12, 15 and 20).

24. General Instructions, Assembly of Parts - Page GA-1

Mr. Terbell desires maximum flexibility in placing parts together. Mr. Katz explained that restrictions have been placed only in one area (exclusions) for substantive reasons, and the policies are more flexible than they have ever been. Any flexibility not preserved is inadvertent and he would be glad to accept any better language. Mr. Terbell agreed that he would submit revisions of the general instructions at the next meeting to afford greater flexibility. Mr. Katz said he would prepare and distribute a supplement to the explanatory memorandum sent out last year on the optional methods of placing the parts together.

25. Insuring Agreement, Defense Language - CGL-2

Mr. Wendorff said his company was disturbed by the thought of leaving out the bracketed language (subparagraph (2)) at the end of the insuring agreement. He believes it is highly desirable for the companies to be able to point to language which says they do not have to defend after the limits are exhausted. Mr. Katz thought subparagraph (2) might induce a primary carrier to pay its limits and say it has no further responsibility, which is something not intended.

It was agreed that further discussion be postponed until the next meeting and that Michigan Mutual, which has expressed an opinion on this matter, be invited to attend. Mr. Schmalz said he would prepare a memorandum on this subject.

26. Insured's Duties in the Event of Occurrence, Claim or Suit, Page GA-12

The Committee was referred to page 2 of the July 15 memorandum which states that the words "other occurrences" have been substituted for "other accidents or other bodily injury or property damage" in the second sentence of (a) because they are more appropriate. Mr. Schmalz explained that the Mutual Bureau Rating Committee

was in favor of the words removed. The Committee examined the language, but could not find good reason for keeping the words replaced. Mr. Katz thought the words replaced might cause confusion. The Committee approved the draft adding only that the word "occurrences" in the last line be underlined.

27. Action Against Company - Page GA-12

The Committee approved the change indicated on page 2 of the September 21 memorandum so that in the second line "there shall have been full complaince" is substituted for "the insured shall have fully complied".

28. Other Insurance - Page GA-13

The Committee approved the changes indicated in the July 15 memorandum. These changes are that "valid and collectible" appears in the first line to conform to the same reference later in the condition, and the "but" clause (last six lines) has been added. The Committee then removed "s" from the word "limits" where it appears in the phrase "has paid its limits" near the middle of the condition, and added "for prorating losses", after "a different provision" in the last sentence. The reason for adding "for prorating losses", was to make it clear that the policy continues to apply even though other insurance contains an excess clause.

29. Changes Condition - Page GA-14

The Committee was referred to the July 15 memorandum which states that the bracketed material has been shortened. The Committee rejected this suggested change and agreed to amend the condition so that the bracketed portion will read as in present policies. Some companies exercise the present option to initial changes in the declarations.

30. Approval of Standard Provisions for General - Automobile Liability Policies

A motion was made and carried which approved the jacket in its present form with the exception of the following items which are to be considered at the next meeting:

1. automobile
2. mobile equipment
3. occurrence
4. possible substitution of a definition "Policy Territory" for the present "Territorial Limitation."

31. Exclusion (b) - Automobile and Aircraft - Page CGL-2

The Committee considered the change in this exclusion which is explained in the July 15 memorandum as being that "aircraft" has been transferred to this exclusion (d), and subdivision (1) speaks of automobiles "loaned to" rather than "operated by" the named insured. Also, an exception had been inserted for parking lot operations at the request of the rating committees.

The Committee agreed to add the words "or operated" after "owned" in subparagraph (1), and to delete subparagraph (ii) of subparagraph (2). Subparagraph (ii) was deleted because it was believed that the persons to whom it was directed would be included in subparagraph (1).

The Committee considered if provision should be made to give coverage to the named insured if he should move the trucks of others on his own premises. Mr. Schmalz thought the companies should attempt to give coverage to the insured who cannot be expected to have his own automobile insurance, i. e., one who does not own or hire automobiles. The alternative would be to ask such an insured to purchase a small piece of automobile insurance.

Mr. Molloy asked why the exclusion did not contain exceptions with regard to products and incidental contracts. Mr. Schmalz replied that the language only excluded particular automobiles, so that the exclusion will not really restrict products -- completed operations insurance. With regard to incidental contracts, Mr. Schmalz cited the example of the insured who agrees to hold someone harmless with regard to his owned automobiles or aircraft. The insured should have an automobile or aircraft liability policy and these policies are almost always written with an omnibus clause, which means the insured's indemnitee would be an additional insured under the omnibus provisions, and so would be protected despite the contractural liability exclusion in the automobile or aircraft policy.

Mr. Katz suggested an amendment of subparagraph (2) and the "but" clause immediately following, which was as follows:

> "(2) any other automobile or aircraft operated by any person in the course of his employment by the named insured;
> but this exclusion does not apply to the parking of any private passenger automobile not owned by, or rented or loaned to the named insured on premises owned by, rented to or controlled by the named insured or the ways immediately adjoining;"

The Committee approved the language quoted above.

32. Exclusion (c) - Transportation of Mobile Equipment - Page CGL-3

The Committee considered the changes which are explained in the July 15 memorandum as being that the exclusion now requires that the injury arises out of as well as "in the course of" the transportation, and that the automobile doing the transporting be "owned by or rented or loaned to the named insured".

The Committee examined the word "transportation" to determine if it accomplished the desired result. It was felt that the word contained the concept of moving equipment from one job site to another and so it expressed the intention. Some members had misgivings, but no superior word could be found. The Committee added the words "or operated" after "automobile owned", and approved the exclusion.

33. Exclusion (d) Watercraft - Page CGL-3

The Committee was referred to the July 15 memorandum which stated that aircraft had been removed to exclusion (b) at the request of the rating committees. Messrs. Katz and Schmalz explained that watercraft were not included in exclusion (b) because they believed that the intention is to give on premises watercraft coverage. (Exclusion (b) excludes on premises exposure for automobiles and aircraft.) The Committee approved the exclusion as it appears in the July 15 draft.

34. Elevator Coverage

The Committee considered the granting of automatic coverage for elevators on the O. L. & T. and M & C parts. Mr. Schmalz thought the elevator exclusion on these parts might be eliminated and it would be a matter of only picking up the premium. Mr. Bowen stated that the Mutual Bureau Rating Committee opposes such action. Messrs. Schmalz and Katz pointed out that the automatic coverage for elevators would only apply to described premises and newly acquired premises and the present drafts require the insured to report both the new premises and the elevators they contain.

Mr. Bowen added that the Mutual Bureau Rating Committee desires that the definition of elevator exclude hoists used to transport people. There was some sentiment that this would be awkward, however, Mr. Schmalz pointed out that this was not unlike including dumbwaiters used exclusively for materials.

Respectfully submitted,

Joseph Marrone

Joseph Marrone

JM:nm

EXHIBIT 4 TO 11-18-2014 ALI LETTER

MUTUAL INSURANCE TECHNICAL CONFERENCE
NOVEMBER 15-18, 1965

New Comprehensive General Liability and Automobile Program

R. A. Schmalz, Ass't. Counsel, Liberty Mutual Insurance Company

I. Introduction

The general subject of today's program has been considered at previous sessions of this Conference. Four years ago I had the pleasure of speaking to the Conference in a general way about the growing need for rather extensive revisions of general liability policies. Two years ago, when things had become pretty well crystalized, I recall a panel discussion during which actual policy changes were reviewed in considerable detail.

As the revised program had not then been filed, however, there was no real sense of urgency about coming to grips with the practical impact of the new programs on the various stages of company operations.

As you know, the Mutual and National Bureaus have filed a completely revised program for general liability insurance which is scheduled to become effective on May 1, 1966. Revisions of a number of business lines automobile policies will be made simultaneously in order to take advantage of the packaging possibilities inherent in the new approach. The General Liability Program has already been approved in a number of States and we are rather confident that the May 1, 1966 effective date is solid.

Rather than repeat much of the material which has been covered in the past, our panel this afternoon will concentrate on the practical impact of the new programs on company operations with heavy emphasis on the underwriting aspects in the contracting, mercantile and manufacturing areas. Before turning the program over to our three anchor men, however, I should like to mention a few of the changes which, although not involving underwriting considerations primarily, will affect a number of the other phases of company operations. 0767

II. Policy Preparation

The revised programs introduce a new approach to standard provisions forms. Instead of separate standard provisions policies, there is a single booklet which contains those provisions common to the whole field of liability insurance. These provisions are to be printed or assembled with one or more Standard Coverage Parts to form a complete policy.

Other features of the new approach are an extensive use of definitions and the placement of the exclusions immediately following the coverage grant.

The changes in format were made for two reasons. First, from the standpoint of contract interpretation, it seemed necessary to give greater precision to the expression of the more refined underwriting concepts underlying the new program. The old schedule liability policies were subject to criticism because they contained a number of optional coverages activated by a premium entry in the declarations. Thus the policy on its face often promised a great deal more coverage than the premium charge contemplated. The new Standard Coverage Parts are tailored to give the exact scope of coverage actually bought. We hope this will help to eliminate misunderstandings with policyholders and enable companies to achieve a better enforcement of underwriting intent if it should become necessary to litigate coverage questions.

Secondly, the new format is designed to permit a greater degree of packaging than is permissible under the present standard provision rules. A rather free combination of general liability and automobile liability coverages will be possible, along with Premises Medical Payments Coverage and Automobile Physical Damage Coverages.

The changes in format will have a considerable impact on those companies which print their own policy forms, as they will have to decide which combinations are the most practical for their operations.

Material has already been sent to the companies explaining the various options available. A completely revised portfolio of Standard Provisions Endorsements will shortly be filed. The endorsement portfolio has been given a great deal of attention in order to reduce the number of forms and the need for preparing a particular endorsement in several slightly different ways to handle manual variations. The portfolio has been broken down into sections according to the primary function of the endorsement, such as, for example, to add additional insureds or to introduce addtional exclusions. Each section will have a separate index with cross references. It is also planned when new manual pages are re-printed to insert a reference to the appropriate endorsement which has been prepared to handle the footnotes to the manual classes.

While a certain amount of nostalgia for the old forms is only natural, we think that the policy preparation people will be able to adjust to the changes without difficulty and will appreciate the improved indexing system.

III. Claims and Claims Legal Departments

In general the new program should ease the burden on the Claims and Claims Legal Departments, as a number of the revisions are specifically designed to clarify areas of coverage which have grown somewhat hazy over the years owing to a number of conflicting and unfavorable court decisions.

For many years there has been some doubt as to whether the Claims Department should defend suits after the policy limits had been exhausted by payment of prior settlements or judgments. The intent has always been that no such defense was required on what seems to me to be the very salutary ground that a company should not be put in the awkward position of having to defind a suit if it has no financial stake in the outcome. Contrary to the intent, however, such a general feeling seemed to be growing to the effect that the obligation to defend is completely separate from the obligation to pay that the claims people were having a great deal of difficulty in upholding the intent. The new policy spells out clearly that a company is not obligated to defend after its limit of liabil-

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The completed operations hazard has become a growing source of problems for the Claims Department. In the first place, there has been no clear line of demarcation between those operations which are regarded as within the scope of standard premises operations coverage and those which require completed operations coverage. The new program specifically establishes a line of demarcation at the earlier of three times:

(1) when the contract work is completed, or

(2) if the contract involves work at more than one site when the operations at the particular site involved have been completed, or

(3) when the portion of the work out of which the injury or damage arises has been put to its intended use by the owner or some other person not connected with the construction of the project.

There has also been a very marked tendency of the courts to view the completed operations hazard as but a rather minor subdivision of the products hazard. As a result many courts have held that the completed operations hazard has no application to a risk in the contracting business. Temporary endorsements have been developed to overcome these holdings. The new program provides for a complete separation between the products hazard and the complete operations hazard in order to achieve even greater clarity in this area.

The concept of consequential damages has often raised difficult coverage questions for claims men and claims attorneys, particularly in the property damage area. All sorts of intangible property damage losses have been urged as candidates for coverage under standard liability policies, including such specialized forms as Director's Liability Coverage and Employer Benefit Plans Coverage.

This is partly because the grant of coverage is currently expressed in terms of "injury to or destruction of property, including the loss of use thereof." Not only is the word "property" unqualified, thus embracing intangible as well as tangible property, but there appears to be a separate grant of coverage with respect to the loss of use of property.

Under the new policy, loss of use is treated purely as a consequential damage and no consequential damages are payable unless the policy applies to the injury or destruction of the underlying tangible property. Thus, for example, if a machine essential to the production line is damaged while in the care, custody or control of the insured, there is clearly no coverage under the new policy for the loss of production. Other speakers will have a great deal more to say about the coverage in this area.

The Claims Department will also be aided by some tightening up of the old exclusions with respect to damage to the insured's products or work out of which the accident arises. In the past the tendency has been to urge that the accident arose out of some relatively insignificant part of the total product or the total work, whereas the intent is that the exclusion applies to the insured's whole unit or the insured's whole project if the accident arises out of any part of it. A special broad form property damage coverage is available at additional premium charge. The new policy provisions should greatly aid the Claims Department in enforcing the underwriting intent when broad form property damage coverage is not given.

On the other hand, there are some provisions in the new program which may cause the claims people some difficulty. In products failure cases they will have to do a more extensive investigation than has been necessary in the past because of the new distinction between design errors and production errors. This is an important underwriting concept which I will not discuss, as it will be covered by one of our subsequent speakers.

I merely point out that a more detailed technical investigation to determine the precise cause of a products failure will be essential in many cases.

The policy applies under the new program to bodily injury or property damage which occurs during the policy period. Inasmuch as the new policies afford blanket occurrence coverage it is possible that where the injury actually occurs over two or more policy periods, the Claims Department will have to make some sort of reasonable allocation to each. There is no pro-ration formula in the policy, as it seemed impossible to develope a formula which would handle every possible situation with complete equity.

IV. Loss Prevention

Loss Prevention Departments have had to do some serious thinking about the best method of making their services available following the recent cases holding their engineers liable for accidents occurring at projects with respect to which inspections or recommendations have been made. The new policy contains a provision in the inspection and audit condition to the effect that neither the company's right to make inspections nor the making of any inspections or any reports thereon shall constitute an undertaking, on behalf of or for the benefit of the named insured or others, to determine or warrant that such property or operations are safe. This language is designed to put the services of the Loss Prevention Department in their true perspective.

V. Sales and Merchandising

The Sales and Merchandising aspects of company operations have also been given attention in the new program. I've already mentioned the format changes which permit packaging, a concept which many regard as one of the most powerful merchandising tools available today. The introduction of occurrence coverage on a blanket basis is also a strong merchandising point.

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The policy territory has been expanded to include the air space and the high seas for local and coastwise trade although not for international travel except between the United States and Canada. Products accidents are also covered anywhere in the world if the original suit for damages is brought within the United States or Canada and the product was sold for use or consumption in those two countries.

VI. Underwriting

But unquestionably the impact of the new program on the Underwriting Department will be the greatest of all. Now I would like to turn the balance of the discussion over to our three underwriting experts. I shall ask each of them to outline for you in turn the underwriting impact of the new program on his particular field with the request that you hold your questions until the last speaker has concluded his formal remarks. We will then have a general question period on the ground covered by all of the speakers.

Thank you very much for you attention to my remarks. I now call on Mr. Rose to tell you about the changes of especial interest to contracting risks.

EXHIBIT 5 TO 11-18-2014 ALI LETTER

GENERAL LIABILITY RULES AND FORMS COMMITTEE
MINUTES OF MEETING OF MARCH 28, 1978
INSURANCE SERVICES OFFICE CONFERENCE ROOM
125 MAIDEN LANE, NEW YORK, NEW YORK

Present:

Aetna Insurance Company	- R. F. Figulski
Allstate Insurance Company	- M. J. Klett
Hartford Fire Insurance Company	- J. B. Rafferty
Insurance Company of North America	- R. C. Briggman
Maryland Casualty Company	- J. M. Krafft
Sentry Insurance Company	- D. K. Holliday
Travelers Insurance Company	- S. G. Fullwood
U. S. Fidelity and Guaranty Company	- W. S. Seipp
U. S. Fire Insurance Company	- E. F. Schade

Others Present:

Allstate Insurance Company	- J. S. Bacula
Continental Casualty Company	- M. Donaldson
Employers Insurance of Wausau	- R. Rice
Liberty Mutual Insurance Company	- J. C. Morrow
Travelers Insurance Company	- E. Rinehimer
U. S. Fidelity and Guaranty Company	- W. J. Flint

Staff:

G. Boyd, M. Jendraszek, W. Navarra and W. Wang

The meeting was called to order at 10:00 A.M. by Mr. Rafferty.

A statement from ISO's General Counsel relative to insurance laws in Colorado, Illinois, New York and Virginia was read, and a copy of this statement is attached.

The meeting was adjourned at 3:00 P.M.

Respectfully submitted,

Graham V. Boyd Jr.

Graham V. Boyd, Jr.
Manager
General Liability Division

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STATEMENT ON COMMITTEE DISCUSSION OF PRICING

1. Article VIIA of the New York Insurance Law effective January 1, 1970, Article 4, Title 10 of the Colorado Insurance Code effective January 1, 1972 and Title 38. 1 of the Code of Virginia effective October 1, 1976, prohibit so-called "anti-competitive" behavior. Pursuant to the provisions of these laws, anything relating to the rating of insurance in these states, including territories and classifications, shall not be discussed by the committee.

2. The Illinois Rating Law (Article XXX-1/2 of the Insurance Law) terminated on August 1, 1971. In the absence of a rating law, all matters relating to the pricing of insurance in Illinois, may not be discussed by the committee.

MINUTES GLRF-78-1
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-1 PROCEDURAL RULES

BACKGROUND

The attached*Procedural Rules for the General Liability Rules and Forms Committee as recommended by the Commercial Lines Committee were adopted at the committee meeting of March 3, 1977.

STAFF RECOMMENDATION

That these rules be approved for 1978.

COMMITTEE ACTION

Following a brief discussion, a motion was duly made, seconded and carried,

THAT the staff's recommendation be adopted.

*Not attached to minutes.

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MINUTES GLRF-78-2
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-2 GOALS AND OBJECTIVES - 1978

BACKGROUND

By mail vote dated September 23, 1977, the committee approved the following goals and objectives for 1978 for recommendations to the Commercial Lines Committee (CLC):

1. Continue to develop the new Commercial General Liability (CGL) policy form including policy simplification for implementation in 1980 or 1981 whichever is practical.

2. Eliminate to the maximum extent possible state exceptions to manual rules.

The CLC reviewed the committee's recommended goals and objectives at its October 18-19, 1977 meeting and amended the first goal to read as follows:

1. Continue to develop the new Commercial General Liability (CGL) policy form concepts in accordance with the established timetable approved by the CLC.

As a result of the CLC's amendment, this matter was presented to the General Liability Rules and Forms Committee again through a mail vote for adoption.

Two members voted against the adoption of the amended goal because they felt that the previously approved timetable is no longer practical and appealed to the CLC for reconsideration.

The CLC at its November 17, 1977 meeting agreed to change this goal to read as follows:

1. Continue to develop the new Commercial General Liability (CGL) policy form concepts in accordance with the timetable to be established by the General Liability Rules and Forms Committee

STAFF RECOMMENDATION

That the committee confirm the Goals and Objectives for 1978 as approved by the CLC.

COMMITTEE ACTION

At the outset, staff pointed out that goal #1 as agreed by the CLC at its November 17 meeting should have been worded as follows:

1. Continue to develop the new Commercial General Liability (CGL) policy form concepts in accordance with the timetable to be approved by the CLC.

GLRC-78-2 GOALS AND OBJECTIVES - 1978

COMMITTEE ACTION (CONT'D.)

Staff also pointed out that according to the Ad Hoc Committee's plan, the finalized policy (non-simplified version) will be available for this committee to review at its August and September meetings which are scheduled on August 16-17 and September 13-14, 1978 respectively.

The committee observed that a new timetable regarding the implementation of the proposed policy revision is required as soon as possible so that it can be presented to the CLC for approval. A motion was duly made, seconded and carried,

> THAT staff work with the Ad Hoc Committee to develop a timetable for review at the next G.L. Rules and Forms Committee meeting.

Following the adoption of the above motion, another motion was made, seconded and carried,

> THAT the staff's recommendation be adopted.

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MINUTES GLRF-78-3
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-3 MEETING SCHEDULE - 1978

BACKGROUND

The procedural rules for the General Liability Rules and Forms Committee indicate that the committee shall meet as often as required but at least bi-monthly and a meeting schedule shall be established for the year. In addition, the rules require that meetings will be coordinated with the meetings of the General Liability Rating Committee and the Commercial Lines Committee.

COMMENTS

Accordingly, staff has set up the following meeting schedule with any additional meetings to be scheduled as necessary:

March 28, 1978
May 24, 1978
August 16-17, 1978
September 13-14, 1978
October 26, 1978
December 7, 1978

STAFF RECOMMENDATION

That the committee adopt the meeting schedule for 1978.

COMMITTEE ACTION

Following discussion, a motion was made, seconded and carried,

THAT the staff's recommendation be adopted.

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MINUTES GLRF-78-4
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-4 GENERAL LIABILITY AMENDATORY ENDORSEMENT

BACKGROUND

The General Liability Rules and Forms Committee, at its October 13, 1977 meeting reached a basic agreement on the contents of the amendatory endorsement for the CGL policy. However, it was felt at that time that the committee was not in a position to take an action in approval of the language of this endorsement before the members had an opportunity to review it in its entirety as amended at that meeting.

It was, therefore, decided that final approval will be given by means of a mail vote and staff was instructed to develop the language of this amendatory endorsement as the committee agreed upon and to send the endorsement with an explanatory memorandum to the committee for mail vote.

A mail vote, dated November 22, 1977 was forwarded to the members of the committee accordingly. A copy of this mail vote is attached.* However, two members voted against adoption of the amendatory endorsement for reasons stated in their letters as attached.

COMMENT

Although the majority of the committee voted for adoption, staff believes that it is appropriate to place this matter on the agenda for further consideration so that the members will have a chance to discuss the dissenters' opinions.

STAFF RECOMMENDATION

Staff recommends that the committee reconsider the appropriateness of the language used in the amendatory endorsement based upon the dissident opinions.

COMMITTEE ACTION

In light of the current circumstances pertaining to general liability insurance, the committee felt this was not the appropriate time to introduce these changes. A motion was duly made, seconded and carried,

THAT the concepts of this amendatory endorsement be referred to the Ad Hoc Committee on Comprehensive Forms and Rules for incorporating into the revised G.L. policy.

*Not attached to minutes.

MINUTES GLRF-78-4
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-4 GENERAL LIABILITY AMENDATORY ENDORSEMENT

COMMITTEE ACTION (CONT'D.)

In connection with the above action, staff pointed out that the amendment of the contamination or pollution exclusion to provide coverage for radioactive isotopes was incorporated into this amendatory endorsement for the purpose of expediency. Since the action regarding this part of the endorsement was taken by the committee separately and because this clarification is needed now, staff suggested that it be filed as a separate amendatory endorsement.

The committee agreed, however, several members felt that the language previously adopted by the committee for this purpose was not clear and should be further amended. Following a brief discussion, a motion was duly made, seconded and carried,

> THAT the language for this endorsement be redrafted and the new language be sent to the committee for approval by mail vote.

MINUTES GLRF-78-6
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-6 PESTICIDE OR HERBICIDE APPLICATOR COVERAGE ENDORSEMENT - Pennsylvania

BACKGROUND

In accordance with the committee action taken at the September 14, 1977 meeting, the attached endorsement G540 which was developed to comply with the Pennsylvania Pesticide Control Act of 1973 was filed in Pennsylvania. This endorsement was subsequently approved. The detailed information regarding the committee's deliberations on this subject can be found in Item GLRF 77-13 of the minutes of the committee September 14, 1977 meeting.

The attached* inter-office correspondence of January 4, 1978 which is self-explanatory, raises a problem concerning on-premise coverage for certain insureds subject to certification under the 1973 Act.

COMMENTS

Staff believes that the issue involved therein was not previously considered by the committee. This was because the emphasis of this endorsement was intended to provide coverage for persons or organizations in pesticide or herbicide business only.

STAFF RECOMMENDATION

Inasmuch as the purpose of developing a special endorsement for Pennsylvania is to comply with the Pennsylvania law, the endorsement should be further amended by extenting on-premise coverage to insured as well.

Staff recognized that a similar problem may also exists in other states. However, an amendment on the countrywide endorsement should not be made at this time. Should the problem arises in any other state at a later date, the Pennsylvania endorsement can be filed in that state at that time.

COMMITTEE ACTION

Following discussion, a motion was duly made, seconded and carried,

THAT staff be authorized to revise the Pennsylvania Pesticide endorsement to provide on-premises coverage.

*Not attached to minutes.

MINUTES GLRF-78-7
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-7 UNDERGROUND RESOURCES AND EQUIPMENT EXCLUSION ENDORSEMENT - (G325)

BACKGROUND

Staff has received inquiries from attornies representing ISO affiliated companies concerning the application of endorsement G325, Exclusion (Underground Resources and Equipment) in light of new technologies dealing with oil and gas. Copy of this endorsement is attached* for your ready reference.

Natural gas producers have devised a method whereby natural gas is pumped out of a well, odorized, and then pumped back into a gas storage field or a salt dome for storage until it is to be pumped out for use at a later time.

It also becomes common today that imported crude oil is being poured into dried up oil wells using the gravity system. (This consists of pouring the crude oil into a dry well and allowing it to seep back into the oil bearing rock strata.) When needed, this oil is pumped back using the conventional method for pumping oil.

The inquiries are prompted by a review of this endorsement as a result of expanding technologies in the field of natural resources. Citing the first example of the storage of natural gas, the gas, prior to being pumped back into the ground, has been reduced to physical possession above the surface of the earth. If this stored gas was lost as a result of an explosion caused by the operations of another party, the wording of the present endorsement could be considered ambiguous. The issue, then, concerns the interpretation of the definition "underground resources" used in the exclusionary endorsement G325.

The problem here is that the exclusion applies to "oil, gas... which have not been reduced to physical possession above the surface of the earth...". There is no ambiguity in this exclusion when it is applied to a gas production field, as such gas have never been reduced to physical possession above the surface of the earth." However, it appears that a latent ambiguity may arise when this exclusion is applied to a gas storage field, as the gas in such a field at one time has been reduced to physical possession above the surface of the earth.

STAFF COMMENTS

Staff believes that the situation involved in the cited example should be excluded from a liability policy, although it is doubtful as to whether the present language is legally sufficient for this purpose since the endorsement was not designed to meet this situation.

*Not attached to minutes.

GLRF-78-7 — UNDERGROUND RESOURCES AND EQUIPMENT EXCLUSION ENDORSEMENT (G325)

STAFF COMMENTS (CONT'D.)

This endorsement was developed more than twenty years ago and at that time the new technologies used by oil or gas industry today were not known to the drafters.

STAFF RECOMMENDATION

Staff recommends that endorsement G325 be amended in order to clarify that the oil or gas stored underground be also excluded.

COMMITTEE ACTION

Following discussion, a motion was duly made, seconded and carried,

THAT the staff's recommendation be adopted.

Staff was instructed to draft the revised endorsement language and present it to the committee for approval.

MINUTES 6 4 0 0 GLRF-78-8 14
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

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GLRF-78-8 OCCURRENCE CONCEPT VS. MANIFESTATION CONCEPT

BACKGROUND

In connection with the development of a new Commercial General Liability (CGL) policy, the Ad Hoc Committee on Special Comprehensive Forms and Rules is considering alternative methods for providing coverage under the revised policy. The idea was prompted by observations of the Ad Hoc Committee members that the "occurrence" concept used in the current CGL policy may not be in the best interest of the insurance industry due to the dynamic social and economic changes of the past decade.

Presently, the standard general liability policies provide coverage for injury which occurs during the policy period, regardless of when the exposure to harmful condition takes place, or when injury become known or manifest. Under this concept, if an injury results from the cumulative exposures over a period of time, it will be covered by all policies providing coverage during the period of exposure. As a result, the losses will be paid by the carriers providing coverage during the exposure period on a pro-rata basis.

A number of affiliated companies feel that this method is not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods. The situation becomes more critical today than when the "occurrence" concept was adopted because of advancements in science and technologies. Disease and other maladies which had been considered part of the human condition are now being identified as being caused by specific products or processes. Furthermore, products manufactured today are much more complicated and sophisicated than those made years ago, particularly in the area of foods, drugs and chemicals.

These developments result in a situation where liability is retrospectively determined over many years which could not possibly have been predicted by the insured or the insurer. This situation together with the current court climate and the public awareness of consumerism make it undesirable for the insurance industry to continue to provide liability coverage on an "occurrence" basis, as there is every reason to believe that

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BACKGROUND (cont'd.)

what we are seeing now is only a warning at what we will face in the future.

Although there are problems associated with the "occurrence" concept, in affording liability coverage under certain circumstances, there are other members who feel that this concept has proved to be workable for most cases. In most court cases involving the application of the term "occurrence", the court has basically followed the industry's intent of this concept. "Occurrence" and "occurs", as used in the current policies, have not been found to be ambiguous.

A number of experienced underwriters believe that the problems associated with the "occurrence" can be eliminated if the industry changes the method of affording liability coverage. They believe in a method, known as the "manifestation" concept, will help the industry to accomplish this purpose.

Under the "manifestation" concept, when injury is caused by continuous or repeated exposures to conditions over a period of time involving several policy periods, the losses would only be covered by the policy in effect at the time the injury becomes manifest. This will be accomplished by setting up a deemer clause in the policy which arbitrarily makes the policy respond to all losses caused by injury which becomes manifest during the covered policy period regardless of when the injury may have actually been incurred.

The problems under this concept appear to be that the manifestation of injury is itself an ambiguous concept. For examples, it would be very difficult to determine when injury becomes manifest. It is when a reasonable person should have preceived that something is wrong; or when visible signs of physical change occur; or when there is loss of motion; or when there is disability; or when there is a diagnosis of injury by a physician; or when there is a diagnosis of injury by a surgeon after exploratory surgery? Does the injury have to be related to the cause of injury to become manifest?

This situation is compounded when this concept is applied to property damage coverage. ISO

In addition to dramatic effects on the coverage of the policy and loss distribution, by forcing losses which have been incurred over a period of time to a specific, artifically determined point in time, it will increase the exposure of the

BACKGROUND (Cont'd.)

policy in effect at the point in time. This may create a need for higher limits of liability to protect insureds from the "compressed" liability. This in turn will force insurers to seek more reinsurance on risks.

Despite these problems, some underwriters believe this concept is not an unreachable goal. They also believe that while "manifestation" may not be the best way to accomplish the desired purposes, changes in affording coverage must be made and the limitation of all loss arising out of one occurrence to one policy period must be accomplished.

Based upon the above analysis, the major pros and cons of these two concepts can be outlined as follows:

"Occurrence" concept

Pros:

1. This concept was first introduced in 1966 and is now well established and accepted in the insurance community.

2. This concept has proved to be workable in the majority cases and the companies' claims personnel are familiar with claims handling under this method.

3. There are very few court cases which have misconstrued the intent of the policy.

4. Insureds enjoy cumulative protection under this concept where continuous or repeated exposure to conditions continue over several policy period.

Cons:

1. It is difficult and often impossible to determine when injury occurs and if it is determined, it is impossible to determine how much injury occurred in which policy period.

2. It pyramids the limits available to insureds for one "occurrence" where it is, according to some, the intent to offer one limit for one "occurrence".

3. It is nearly impossible to determine the adequate premium for a risk where there is potential exposure for unexpected future loss.

BACKGROUND (cont'd.)

4. Losses thrown back in time by injury "occurring", but unrecognized cannot be reflected in ratemaking as they are beyond the experience period.

"Manifestation Concept"

Pros:

1. This concept establishes the single policy responsible for the "occurrence" and eliminates controversy as to who pays how much.

2. The carriers liability is limited to a single policy period and thus prevents the pyramiding of limits.

3. Losses will be brought forward in time and thus, in most cases, enter the ratemaking experience.

Cons:

1. The idea of "injury first manifest" is ambiguous and possibly cause controversy.

2. The industry will have to give up the established case law based on the "occurrence" concept.

3. The artificial bundry which funnels all losses into a single policy period is considered arbitrary and may generate increased future litigation and adverse court decision.

4. It may have a great impact on reinsurance arrangement.

5. Manifestation does not really help when there are multiple claimants involved due to long period of exposure as each claimants for manifestation of injury may fall in a different policy period.

ALTERNATIVES

Because of some of the problems inherent in "manifestation", the Ad Hoc Committee has raised several alternative methods of arriving at the same goal, i.e., prevention of the pyramiding of limits. Some of these alternatives are as follows:

1. Expand the language of the current limits of liability provision which declares that "all injuries arising out of exposure to same or essentially same general conditions shall be deemed as arising out of one occurrence" to make it clear that that provision applies

ISO

ALTERNATIVES (cont'd.)

regardless of the policy periods in which the exposure takes place.

There are basically two ways of doing this. One way is to say that the limits of this policy shall be reduced by any payment made under any other policy for injury arising out of an occurrence which is within or without the policy period. This approach is legally questionable as it would modify the terms of one contract by action taken under another contract.

Another approach is to exclude any injury arising out of an occurrence prior to the effective date of the policy. This also presents problems as coverage only applies to injury which occurs during the policy period and any losses during the policy period and any losses occurring after the policy period which result from an occurrence during the policy period would not find coverage anywhere.

2. The second alternative being explored is that of adding a provision which indicates that where several policies apply to a loss, the insured has no more protection from the combined policies than he would have if the policy with the highest limit would provide as if it were the only policy applicable. All policies would then pay their pro-rata share based on the highest limit. Again this poses legal questions yet to be resolved.

COMMENTS

The Ad Hoc Committee will continue to pursue its tasks based on the various methods discussed above. But, it is felt that a decision of this nature should not be made at the Ad Hoc Committee level. It should be made at a higher level committees and involved broad industry participation, due to the tremendous impact on the industry.

The Ad Hoc Committee is seeking guidance from the General Liability Rules and Forms Committee on this matter. If the decision of the superior committee is in conflict with the direction that the Ad Hoc Committee is currently pursuing, i.e., trying to prevent the stacking of limits, the Ad Hoc Committee will adjust its course of action to comply with the superiod committee's decision.

STAFF RECOMMENDATION

That the General Liability Rules and Forms Committee review the pros and cons of this issue and provide the guidance to the Ad Hoc Committee.

GLRF-78-8 OCCURRENCE CONCEPT VS. MANIFESTATION CONCEPT (CONT'D.)

COMMITTEE ACTION

The committee basically agreed that problems as pointed out by the Ad Hoc Committee exist. The Committee also shared the Ad Hoc Committee's concern.

Recognizing the difficulties and complexities of the problems involved, the committee agreed to endorse the principle of anti-stacking of limits as a viable solution to this problem. The committee also agreed that the "manifestation" concept was not the direction to pursue for the purpose of anti-stacking of limits.

Following discussion, a motion was duly made, seconded and carried,

> THAT the G.L. Rules and Forms Committee authorizes the Ad Hoc Committee to proceed with this direction.

MINUTES
GLRF-78-9
GENERAL LIABILITY RULES AND FORMS COMMITTEE
MEETING OF MARCH 28, 1978

GLRF-78-9	MAIL VOTE - MINUTES OF OCTOBER 13, 1977 MEETING
BACKGROUND	By mail vote, dated December 21, 1977, the General Liability Rules and Forms Committee approved the minutes of the October 13, 1977 meeting which were distributed on November 28, 1977.
STAFF RECOMMENDATION	The above is for the committee's information. No action is necessary by the committee.
COMMITTEE ACTION	The committee noted the approval of this mail vote.

CONFIDENTIAL

EXHIBIT 6 TO 11-18-2014 ALI LETTER

ATTENDEES AT MEETING OF DES/ASBESTOSIS
April 21, 1977 - 10:00 A.M.

NAME	COMPANY
W.J. Kearney	Admiral Insurance Co.
R. Matalewski	Aetna Life & Casualty
C. A. Piano	Aetna Life & Casualty
W. N. Edwards	American ReInsurance
J. F. Fisher	American ReInsurance
D. J. Ellsworth	American Mutual
J. H. Pollard	American Mutual
E. McIlwaine	Chubb & Son
D. O. Ellis	Commercial Union Cos.
E. Harris	Continental Insurance Co.
P. N. Steinlage	Employers Insurance of Wausau
R. Buell	Fireman's Fund
R. Gidney	Hartford Group
D. Connell	Hartford Group
J. McMahon	Insurance Company of North America
R. Pellatiro	Insurance Company of North America
E. Keena	Kemper Insurance
R. Hempton	Liberty Mutual
C. Caldon	[illegible] Insurance Co.
J. Robinson	Reliance Insurance Co.
M. V. Albert	Security Insurance Co. of Hartford
D. Slitt	Security-Textron of Hartford
A. W. Wiechniak	Travelers Insurance Company
F. H. McAleer	Zurich Insurance Company
R. F. Ingegneri	American Insurance Association
C. F. Berryman	American Mutual Insurance Alliance

MEMORANDUM OF MEETING OF DISCUSSION GROUP

ASBESTOSIS - APRIL 21, 1977

Executive Conference Room
12th Floor
85 John Street
New York, New York 10038

The meeting of the discussion group on asbestosis opened with a consideration of the question "who owes a defense?". The problem arises in asbestosis claims because of the long duration of the condition. As a result, several insurers could be on the risk and periods of non-insurance may also exist. Consequently, the crucial question, is when did the injury occur for coverage purposes? Two views emerged, which might be characterized as the majority and minority view. (2) The minority view was that the event which triggered coverage was the discovery or diagnosis of asbestosis. (3) While there is no authority directly in point to sustain this view, the advocates of this position relied on U. S. F. & G. v American Insurance Company, 345 N.E. 2d 267. The minority also argued that their view should be tested through litigation and that, if successful, the result would be that asbestosis, as an industry problem, could be contained. (4) The majority view was that coverage existed for each carrier thoughout the period of time the asbestosis condition developed i.e. from the first exposure through the discovery and diagnosis. The majority also contended that each carrier on risk during any part of that period could be fully responsible for the cost of defense and loss. The majority relied on Borel v Fibreboard Paper Products Corporation, 493 F. 2d 1076, U. S. Court of Appeals, Fifth Circuit (applying Texas law).

The majority was cognizant of the fact that Borel was not a coverage case. Despite this, however, the majority believed that the essential holding of Borel, i.e. that the injury was cumulative and that with each exposure the plaintiff suffered an injury, would lead to the courts holding that each carrier covered the loss and would be liable for the full defense and possibly the full loss as well. Amongst those carriers favoring the majority view, it was reported that some were working out agreements to pro-rate the loss and defense costs with one carrier acting as a lead carrier. The question was raised as to whether these agreements included insureds where periods of noncoverage existed. It was reported that the insureds were also agreeing to participate on a pro-rata basis for both the defense costs and the losses. One of the carriers advised it would supply a copy of such an agreement which could be distributed to the entire group. This has not as yet been received and therefore cannot be distributed at this time.

CONFIDENTIAL MATERIAL
Subject to Protective Order
IAA, et al

The next question discussed was settlement possibilities which might occur before trial. (5) All agreed that the interest of the insured should be given priority consideration so that no possible cause of action for bad faith could arise.

The group was then asked whether they would be willing to identify their insureds so that a list could be prepared which would be distributed. It

was agreed that this was desirable. With such a list, as soon as a new suit is received, reference could be made to the list and contact between the carriers involved facilitated. To date, only one company has supplied its list of insureds and therefore distribution cannot be made with this memorandum. The possibility of reducing defense costs by the sharing of technical knowledge and possibly using single counsel for multiple defendants was next considered. It was suggested that carriers interested contact Mr. Ingegneri if they wished to use single counsel and Mr. Ingegneri would advise them of other carriers who indicated a similar interest. It was recognized that problems with insureds would have to be resolved before single representation was resorted to.

With respect to the pro-rata sharing of the loss and other costs, the majority were of the opinion that this was an equitable manner to proceed. They also expressed concern that if litigation were resorted to, the result might be conflicting decisions in the various states. The method of dividing the loss and defense expenses could be subsequently resolved by negotiations and/or arbitration. It was suggested that the arbitration procedures utilized in the cumulative injury workmen's compensation cases in California might be utilized. Attached are copies of the Workers' Compensation Inter-Insurer Arbitration Agreement, its Rules and Regulations and the Arbitration Request Notice.

One other view was expressed, i.e. that a test case be brought and attempt to have this decided directly by the United States Supreme Court. The consensus that there was little likelihood of this approach being successful. Finally, the group discussed the possible use of governmental immunity as a defense. In this connection, the case of Sanner v Ford Motor Company, 364 A. 2d 43, Superior Court of New Jersey, Law Division, was cited which held that a manufacturer of a vehicle produced in strict compliance with U. S. Army plans could not be held liable for an alleged design defect.

Attention was also called to a recent case McNeece v United States, which is pending in the United States District Court for the Eastern District of Texas. In this case, employees are seeking to recover from the United States Government alleging that under the Walsh-Healy and OSHA Acts, the United States Government has a duty to warn employees of the danger of working with asbestosis.

The meeting closed with a unanimous rejection of a suggestion that liability in asbestosis cases be admitted and the carriers agree between themselves as to their repsective losses and expenses.

For the convenience of the group, attached is a separate memorandum summarizing the cases discussed.

Respectfully submitted,

Chas. F. Barryman
Assistant Vice President
American Mutual Insurance Alliance

Richard F. Ingegneri
Claims Counsel
American Insurance Association

RFI:rc

The "A-C-Ps" of Liability Insurance: Allocation, Contribution, and Proration in the *Restatement of the Law of Liability Insurance*

By Lorelie S. Masters[1]

In 2010, the American Law Institute ("ALI") embarked on a project of utmost importance to the insurance industry, to policyholders and consumers, and to insurance coverage practitioners representing policyholders and insurance companies alike. Initially called the *Principles of the Law of Liability Insurance*, the Council of the ALI in late 2014 voted to make this project a full *Restatement*. In this work, now entitled the *Restatement of the Law of Liability Insurance*,[2] the ALI, as with all of its *Restatements*, seeks to produce a "work of highly competent group scholarship, thus reflecting the searching review and criticism of learned and experienced members of the bench and bar."[3] *Restatements* are written by Reporters who revise their drafts based on input from experts and other parties interested in the subject matter, seeking to capture the consensus of views from various constituencies who represent different perspectives on the subject matter. The *Restatement of the Law of Liability Insurance* thus

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[1] Lorelie S. Masters is a partner at Perkins Coie LLP in Washington, DC, and, since 2010, has served as an Advisor to the *Restatement of the Law of Liability Insurance*. She advises policyholders and represents them in litigation and arbitrations over insurance coverage. Ms. Masters is co-author of two widely recognized legal treatises: *Insurance Coverage Litigation*, updated annually; and *Liability Insurance in International Arbitrations: The Bermuda Form* (2d ed.), which won the British Insurance Law Association's 2012 Book Prize. Ms. Masters served as the policyholder Co-Chair of the Insurance Coverage Litigation Committee of the American Bar Association's Litigation Section from 2000-2003 and as an editor of the group's award-winning journal, *Coverage*. She has written extensively on insurance coverage issues and has served as an arbitrator and expert witness. The views expressed in this article are the author's own and should not be attributed to her clients, the ALI, or others. The author thanks Amy Bach and Ann V. Kramer for their thoughtful comments on this article.

[2] As a result of the deliberative process discussed in the text of this article, the ALI traditionally has issued *Restatements* on important areas of the law, including the *Restatements of Contracts*, *Torts*, and *Conflict of Laws*. According to the ALI's handbook published in 2005, *Restatements* are "'clear formulations of common law and its statutory elements or variations,' reflecting the law as it presently stands or as it might plausibly be stated by a court." American Law Institute, *Capturing the Voice of the American Law Institute, A Handbook for ALI Reporters and Those Who Review Their Work*, at 312 (2005) (available at www.ali.org/doc/stylemanual.pdf; *see also* http://www.ali.org/index.cfm?fuseaction=projects.main). In contrast, a *Principles* project seeks to declare what the ALI thinks the law ought to be.

[3] Quoted from http://www.ali.org/index.cfm?fuseaction=about.instituteworks (accessed Jan. 14, 2015). The ALI website also states: "Many Institute publications have been accorded an authority greater than that imparted to any legal treatise, an authority more nearly comparable to that accorded to judicial decisions." *Id.*

reflects the views on the comprehensive drafts written by this *Restatement's* Reporters[4] from judges and lawyers on both sides of the issues, academics, policyholders, insurers, and other interested groups.

Even though the *Restatement* may affect businesses broadly, discussions at the Advisors' and Members' meetings, the ALI Council meetings, and ALI General Membership meetings often have focused on the effect that these provisions will have on ordinary consumers. In addition, a key objective of the project, as stated by the Reporters, is to try to reduce the amount of litigation between policyholders and insurers.

This article focuses on a key issue currently under discussion by the Advisors and Members' groups: the **allocation** of liability between policyholders and insurers, and among insurers. The need to apply an allocation rule arises when a continuing course of injury or damage triggers multiple years of occurrence-based insurance coverage. In those situations, insurers often argue that a portion of the policyholder's liability should be assigned, or "allocated," to the policyholder. Allocation between insurers and policyholders is related – but should not be confused with – allocation among insurers and the **contribution** claims among insurers that arise when one insurer has overpaid its share of liability. Courts choose between two general allocation rules: (1) the "all sums," joint and several, or pick and choose rule; or (2) **proration**. Because insurance presents issues of state law, there is no one law on insurance issues. Thus, allocation has been a hard-fought issue in countless insurance coverage disputes in

[4] The Reporters of the *Restatement* are Tom Baker of the University of Pennsylvania Law School; and Kyle D. Logue of the University of Michigan Law School.

courtrooms, state and federal, across the United States.[5] It was a topic of keen interest in the discussions held in 2014 about the then-pending drafts of the ALI *Restatement* provisions.

As discussed in this article, the insurance industry for decades has struggled to draft standard liability insurance policy language that will be widely marketable and as profitable as possible, both satisfying policyholders' desire for broad protection while limiting insurers' liability. During the second half of the 20th century, drafting committees set up by the insurance industry, on numerous occasions, declined to include a proration provision in their forms. Such a provision would have served to limit an insurer's responsibility to a portion of the policyholder's liability. This has been true both for comprehensive or commercial general liability ("CGL") insurance sold to businesses and other commercial entities, and for personal lines liability insurance sold to individual consumers. Because primary CGL and personal lines[6] insurance policy forms must be approved by state insurance commissions before they can be sold to the public, the understanding of the insurance industry in drafting standard-form policy provisions is relevant and should be considered in drafting and approving the *Restatement* provisions governing allocation.

ALI discussions have focused on which allocation rule should be adopted:

- Joint and several or pick and choose allocation – a rule that requires the companies that sold insurance to the policyholder in each year of coverage triggered by an ongoing course of injury or damage to pay in full for the

[5] Federal courts in the United States resolve insurance coverage disputes under diversity of citizenship jurisdiction.

[6] Some states require hearings on proposed standardized policy language before approval is granted. Other states employ a "file and use" system which allows the insurers to use provisions upon filing assuming no objection is made or hearing required. Carrie Cope, *New Appleman on Insurance Law*, "Regulation of Policy Forms," ch. 10 (Library ed.) (available at http://www.lexisnexis.com/legalnewsroom/insurance/b/applemaninsurance/archive/2010/04/19/regulation-of-policy-forms.aspx). *See also, e.g.*, http://thismatter.com/money/insurance/insurance-regulation.htm.

policyholder's liability. The classic joint and several or "all sums" rule of allocation allows for the policyholder to pick from among the triggered years of one policy period to respond to the policyholder's liability; or

- Proration – a rule that allows insurers to assign to the policyholder a portion of the policyholder's liability for a course of injury or damage continuing over a period of years.

Proration permits insurance companies to minimize their liability for a continuing course of injury or damage – and directly contradicts the intent of the standard language drafted by the insurance industry and approved for use by state insurance departments and commissions. It is the thesis of this article, and the strong position of certain policyholder lawyers involved in the ALI drafting process, that the insurance industry should not be allowed to obtain through the ALI *Restatement* process, a result that it has been unable to achieve on its own either through its insurance-industry drafting process or the approval process required by state insurance commissions. Further, adopting a proration rule would, in effect, allow the insurance industry to market liability insurance as broadly protective of liability for injury or damage that takes place over a long period of time; but, when a claim comes in, then allow insurance companies to limit their liability in a way inconsistent with their advertising and marketing to consumers at the time the insurance was purchased.

This article begins with an overview of the ALI process, followed by a discussion of the scope of the *Restatement of the Law of Liability Insurance*. Thereafter, it gives background on the allocation issue and addresses the insurance industry's efforts – ultimately futile – to try to draft a proration clause to be included in primary CGL insurance policy forms that harmonizes both marketing of such standard-form policy language and reduction of risk to insurers. An

analysis of relevant insurance industry drafting documents shows that, in drafting standard-form CGL policy language, the insurance industry specifically rejected proration under occurrence-based and other insurance policies that are activated by injury or damage that takes place during the policy period. The insurance industry has drafted proration clauses and included them in certain types of liability insurance policies, but has rejected suggestions made by insurer representatives during policy drafting processes that such a clause be incorporated into the CGL Form. The article also surveys the law on "other insurance clauses" which generally has concluded that such clauses do not apply to require proration to the policyholder.

The insurance industry should be held to its word about the intended meaning of its policy language and should not be allowed, through the *Restatement* process, to obtain a result that it could not achieve either through its own policy drafting processes or the state insurance regulatory processes.

The ALI Process

The ALI creates its *Restatement* and *Principles* projects through a dialectic, involving input from a wide variety of sources. Reporters, usually law school professors, are appointed to write the drafts and oversee the dialectical process of reviewing and revising the text, which is comprised of black-letter statements of law, followed by Comments and Reporters' Notes. The groups commenting on the Reporters' drafts typically include:

- Advisors, appointed by the ALI's Council. The Advisors include practicing lawyers from outside law firms and policyholder businesses and insurance companies, judges, academics, insurance brokers, and others with an interest in the subject area;

- A Members Consultative Group ("MCG" or "Members"), which consists of ALI Members who volunteer their time to the project. Like the Advisors, the MCG includes practicing lawyers from outside law firms and companies, judges, academics, insurance brokers, and others with an interest in liability insurance.
- The ALI's Council; and
- The ALI's General Membership.

Altogether, all interested constituencies are included in this dialectical process. For this *Restatement*, those constituencies include judges, professors, academics, law firm lawyers representing both policyholders and insurance companies, in-house counsel from policyholder companies and insurance companies, lawyers from interested groups, and insurance brokers.

The Reporters' drafts have been discussed at meetings of the Advisors, the MCG, and the ALI Council. They have also been presented to the ALI General Membership at annual meetings of the ALI which are held once a year. After each of these meetings, the Reporters have taken the comments into account, and revised the drafts based on the input received.[7] The Reporters may make additional revisions depending on the discussion at the full membership meeting, or the membership may vote to approve the text presented. Once approved by the full ALI, the text may be cited and quoted.[8]

[7] The ALI drafting and revision process is discussed at http://www.ali.org/index.cfm?fuseaction=about.instituteworks. After the ALI Council approves a draft, it is presented for debate and discussion as a Tentative Draft to the full ALI Membership.

[8] ALI website at http://www.ali.org/index.cfm?fuseaction=projects.main ("Once it is approved by the membership at an Annual Meeting, a Tentative Draft or a Proposed Final Draft represents the most current statement of the American Law Institute's position on the subject and may be cited in opinions or briefs (e.g., as Restatement Third, Trusts, Tentative Draft No. 6, 2011) until the official text is published.").

In directing the process, the Reporters of the *Restatement of the Law of Liability Insurance* have sought to encourage efficiency and fairness to both insurers and policyholders, as well as to serve the interest of the public, including individual consumers and small businesses.

The ALI drafting and revision process is discussed at http://www.ali.org/index.cfm?fuseaction=about.instituteworks. The Membership may approve a Tentative Draft, subject to revisions agreed to at the ALI's annual Membership meeting; or may refer the Draft to the Reporters for further revision. After all sections are approved by the full membership, a Proposed Final Draft may be submitted to the Council and membership. Once approved by both the Council and the Membership, the ALI publishes the *Restatement* in final.

The Scope of the Restatement

The *Restatement of the Law of Liability Insurance* will ultimately contain four chapters. Chapters 1 and 2 have been written and approved but may require revision given the change in 2014 from a *Principles* project to a *Restatement*. Chapter 1 addresses basic principles of insurance contract interpretation, the doctrines of waiver and estoppel, and the effect of misrepresentations made by policyholders during the application process. Chapter 2 focuses on the obligation of a liability insurer to defend (and pay defense costs), as well as the duty to settle and cooperation issues. Chapter 3, partially written, addresses the scope of insured risks and topics such as trigger, allocation, and important policy exclusions and conditions. Chapter 4 has not yet been written; it will focus on advanced insurance contract issues like choice of law, remedies, bad faith, and enforceability. The public may find the text of the Sections approved to date at http://www.ali.org/index.cfm?fuseaction=publications.ppage&node_id=135.

Chapter 1 was presented as a "Discussion Draft" at the ALI's May 2012 Annual Meeting. Following further drafts and input from the Advisors, MCG, Council, and ALI General

Membership, the ALI considered "Tentative Draft No. 1" at its Annual Meeting in May 2013. The ALI General Membership then voted to approve Sections 1 through 15 of Tentative Draft No. 1, which included all sections in Chapter 1, "Basic Liability Insurance Contracts Principles"; and the first four sections of Chapter 2, entitled "Management of Potentially Insured Liability Claims." The Sections approved in May 2013 include:

- Interpretation (Chapter 1, Topic 1);
- Waiver and Estoppel (Chapter 1, Topic 2); and
- Misrepresentation (Chapter 1, Topic 3).

In May 2014, the ALI membership voted to approve Sections 16 through 34 of Tentative Draft No. 2. Those topics included the remaining sections of Chapter 2, Sections 12 through 34, which include:

- Defense (Topic 1);
- Settlement (all sections of Topic 2); and
- Cooperation (Topic 3).

The Reporters have now proposed certain changes to the sections already approved are appropriate or required given that the project now is a *Restatement*.[9]

Section 1 of the *Restatement* includes definitions of terms relevant to the *Restatement*. For example, Section 1 includes a relevant definition, defining "standard form term" as:

> A term is a standard form term if it appears in, or is taken from, an insurance policy form (including an endorsement) that an insurer makes available for a non predetermined number of transactions.[10]

[9] Those changes will be the subject of a future Lexis Nexis article addressing the *Restatement.*

[10] Approved when included in the *Principles of the Law of Liability Insurance*, Tentative Draft No. 1 § 1(11), approved by ALI membership in May 2013 (available at

(Cont'd . . .)

One of the Comments to this definition explains further what constitutes a "standard form term" in an insurance policy:

> Unless the circumstances clearly indicate to the contrary, any term that is not specifically negotiated by the parties to the insurance policy is a standard form term. A term contained in an insurance policy form approved for use by an insurance regulatory authority for any insurer is a standard form term, unless the circumstances clearly indicate the contrary. Similarly, a term that is a standard form term in one insurance policy is a standard form term in another policy. An insurance policy term created by an insurance broker or other entity may become a standard form term through such sufficiently regular use in the market that the term is treated by market participants as one of the standard options available for use in the market. A term does not have to be contained in the forms of multiple insurers for it to be a standard form term.[11]

This Comment gives the term wide applicability. The objective was to give the term a meaning drawn from real-life experience about how standardized insurance policy terms are used in different types of liability insurance and in today's marketplace where the insurance industry seeks to provide insurance products of wide acceptability and applicability.

Background of the "Allocation" Issue

The two competing approaches to allocation are based on different rationales or analyses:

- The "joint and several" or "all sums" approach typically considers the contract language as a whole; liability insurance's "dominant purpose of indemnity"[12]; and insurance industry documents and custom and practice – or even "lore" – showing that the insurance industry recognized the applicability of a continuous trigger and rejected proration of any part of that contractual responsibility from the insurer(s)

(. . . cont'd)
http://www.ali.org/00021333/Liab%20Ins%20TD%201_revised%20as%20of%20Jan%202014%20-%20online.pdf) (accessed Feb. 2, 2015).

[11] Approved as part of the *Principles of the Law of Liability Insurance* § 1, Comment e (*supra* n.10).

[12] *See Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1041 (D.C. Cir. 1981) ("*Keene v. INA*").

to the policyholder. In its purest form, this rule allows the policyholder to pick the year or years triggered by continuing injury or damage that should respond to the policyholder's liability. Other approaches require all triggered insurance policies to share the liability between and among themselves.

- Proration, alternatively, allows the insurance company(ies) to assign a portion of the policyholder's liability to the policyholder. Proration decisions typically ignore or do not consider insurance industry history, custom and practice, and often reject an analysis of the policy language as a whole, applying instead conceptions of "equity" or "fairness" to insurers. Such decisions typically do not focus on the public policy favoring enforcement of contract or the important public policy role served by insurance.[13]

The joint and several/pick and choose rule accords with the intent of the insurance industry in drafting and obtaining regulatory approval for standard-form CGL policy forms[14] and should form the basis of *Restatement* pronouncements addressing "allocation" in insurance policy forms that do not include fully negotiated proration provisions. This intent is evidenced in the historical documentation of the CGL Form, often referred to as the "drafting history." This drafting history has developed over the decades since the 1950s when insurance industry groups

[13] In part as a result, the Delaware Supreme Court recognized that "[i]nsurance is different" from other forms of contract. *E.I. duPont de Nemours & Co. v. Pressman*, 679 A.2d 436, 447 (Del. 1996).

[14] The insurance industry in 1986 changed the name of these forms from Comprehensive General Liability to Commercial General Liability forms (collectively referred to here as "CGL" policies). This name change did not change the intent of this coverage to cover all risks except those clearly and explicitly excluded. See discussion of drafting documents in the text accompanying footnotes 10-15, 43-48, 76-87, and 90 cited in Lorelie S. Masters & Jordan S. Stanzler, *Insurance Coverage Litigation* § 1.01 (Wolters Kluwer Law & Business, 2000 & Supp. 2015) (hereafter "Masters & Stanzler"). As one drafting document put it in emphasizing the advantages of combining a variety of formerly separate coverages into the CGL Form: "[T]he objective is to cover all hazards not specifically excluded." Albert, *The Comprehensive Liability Policies*, Ins. Couns. J. at 11 (July 1944) (quoted in Masters & Stanzler at 1-35).

periodically revised the industry's standard policy forms, sought regulatory approval for the revised forms and publicized them to insurance buyers. During these revisions, insurance industry representatives collectively discussed how their policies should respond to asbestos and other "long-tail" claims, an issue that grew in importance to the insurance industry during this period. Under the law in the 50 states, the District of Columbia, and the U.S. Territories, insurance companies must file CGL policy provisions with state regulators and obtain regulatory approval before including the provisions in insurance policies.[15]

This drafting history should be taken into account in the ALI's deliberations on allocation. While the insurance industry created the documents discussed below in the process of drafting standard policy provisions and obtaining regulatory approval for standard-form CGL policy provisions, the industry uses substantially the same language in most personal lines liability insurance policies, as well as in excess general liability policies and other liability insurance policies. Thus, adopting a proration theory as the preferred or default rule in the *Restatement* would negatively affect consumers who rely on homeowners' and other liability insurance for protection from liability for harm taking place over multiple years, and would equally contradict the insurance industry drafting and regulatory history described below.

As evidenced by insurance company filings with regulators throughout the United States, the standard "occurrence-based" CGL policy agrees to protect the policyholder from liability[16]

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[15] See citations, n.6 *supra*.

[16] Liability insurance protects a policyholder not just from actual liability, as encompassed in a judgment against the policyholder, but also from alleged liability and the often considerable costs incurred in defending litigation. Liability insurance policies thus protect the policyholders both from settlements and judgments, and from defense costs even if the allegations against the policyholder are "groundless, false or fraudulent." See quotation of duty to defend language in, for example, *Trizec Properties, Inc. v. Biltmore Construction Co., Inc.*, 767 F.2d 810, 812 (11th Cir. 1985); and *Horace Mann Insurance Co. v. Barbara B.*, 4 Cal. 4th 1076, 1086 (1993). The duty to defend applies if there is at least a potential for coverage. See discussion of duty to defend standard and cases in Masters & Stanzler ch. 3.

for injury or damage that takes place during the policy period.[17] In insurance parlance, an insurance policy is "triggered" by such injury or damage if the injury or damage continues over a period of policy years, each insurance policy on the risk while the injury or damage continues is triggered, and each policy is obligated to and intended to provide full coverage up to its limits of liability. Both the policy language and the documents created by insurance industry drafting committees at the times the policy language was drafted confirm this intent, as discussed below.

Support of the Joint and Several Rule in the Standard CGL Policy Form

The insuring agreement of the standard CGL policy provides that the insurance company "will pay on behalf of the Insured "*all sums*" or "*those sums*" that the Insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies cause by an occurrence."[18] The definitions section of standard general liability insurance policies[19] contains the following definition of *occurrence*: "an accident, including continuous or repeated exposure to conditions, which results in . . . property damage . . . neither expected nor intended from the standpoint of the Insured."[20] *Property damage* is defined as

[17] *See* 7 Steven Platt *et al*., *Couch on Insurance 3d* § 102.23 (online database updated Nov. 2014) (discussing general rules on trigger of coverage). *See also Montrose Chem. Corp. v. Admiral Ins. Co.*, 897 P.2d 1, *republished at* 913 P.2d 878 (Cal. 1995) ("*Montrose*") (this general trigger-rule "is followed in every jurisdiction that has considered the issue except Louisiana."). See also cases cited in Masters & Stanzler § 4.01 nn.2-4.

[18] The insuring agreement from standard-form CGL policies is quoted in various decisions discussed in Masters & Stanzler ch. 4. *See, e.g., Keene v. INA*, 667 F.2d at 1039 (pre 1986 CGL Form ("all sums")). In most cases, the analysis of the CGL policy as a whole did not change after the 1986 Form was approved for use. It is always important, of course, to check the governing policy language. However, whether insurance policies use "all sums" or "those sums," the word "sums" remains undefined and "includes no restrictions of the concept of the 'sums' which the insurer must pay." III W. Jeffrey Woodward, Richard J. Scislowski, Maureen C. McLendon, & Jack P. Gibson, *Commercial General Liability Insurance* at XI.C.4 (Int'l Risk Mgt. Institute, 2013).

[19] *See* Masters & Stanzler, ch. 1, which discusses various parts of the insurance policy.

[20] The 1986 and later ISO Forms took the "expected or intended" language out of the occurrence definition and put it into an exclusion. For example, the 1986 Form defines "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." For a discussion of the "expected or intended" see Masters & Stanzler, ch. 7.

"physical injury to or destruction of tangible property which occurs during the policy period.[21] The CGL policy contains no proration clause.

As shown by these provisions, the "all sums"/"those sums" language is not limited or qualified in any way. The phrase, "during the policy period," used by insurance companies and by some courts to support proration does not appear in the insuring agreement that defines the grant of coverage. Instead, it appears in the definition of "property damage"; thus, that phrase, critical to insurer arguments, appears in a completely different section of policy form, the "Definitions" section, where it does not modify, and structurally cannot modify, the "all sums" or "those sums" language in the insuring agreement. Unless the insurance policy contains an explicit clause requiring proration to the policyholder, allocation of liability to the policyholder in reliance on the "during the policy period" phrase is an improper reading of both the policy language and the structure or organization of the policy.

Courts have held that, in purchasing CGL insurance policies, policyholders reasonably could have expected them to apply to cover liability from a cause of harm continuing over the years.[22] Moreover, as one court explained, where the public purchases standard-form insurance, the policy language should not be subject to "hidden pitfalls":

> Where members of the public purchase policies of insurance, they are entitled to the broad measure of protection necessary to fulfill their reasonable expectations. They are not to be subjected to technical encumbrances or to hidden pitfalls, and their policies are to be construed liberally to the end that coverage is afforded to the full extent that any fair interpretation will allow. [23]

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[21] For discussion of relevant policy provisions, see Masters & Stanzler §§ 4.01-4.05.

[22] *E.g., Joy Techs., Inc. v. Liberty Mut. Ins. Co.*, 421 S.E.2d 493 (W. Va. 1992) ("*Joy Technologies*").

[23] *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 482 (1961).

At a minimum, when read as a whole, the insurance policy language has been found to be ambiguous on the issue of allocation. The ALI process should not endorse a rule that construes this ambiguity not in favor of coverage, but against it – and against the insurance industry's own intent in drafting the standard-form language.

The Insurance Industry Drafting Process

Primary CGL insurance policies, like certain other coverages, are, and historically have been, drafted by committees of insurance industry executives working under the auspices of insurance industry groups. These insurance industry committees since 1971 have been organized in a single entity, the Insurance Services Office, Inc. ("ISO"), an insurance rating bureau that creates insurance rates[24] and drafts standard policy forms; in addition, on behalf of member insurance companies, ISO presents those standard forms to state insurance regulators in the 50 states, the District of Columbia, and U.S. Territories for required regulatory approval.[25] Standardized policy forms permit insurers to analyze and price the insurance they sell more accurately. Without standardization of insurance policy provisions, insurance companies could not market and sell insurance policies on a mass basis, and insurance would not be as widely

[24] ISO also formulates and provides to its member and subscriber insurance companies insurance "rates," derived from analysis of claims data collected by ISO. Liability (and other) insurance companies buy these ratings and policy drafting and filing services from ISO. Insurance companies use the rates provided by ISO to calculate insurance premiums for the various lines, or types, of insurance sold in the United States. See discussion about ISO at www.verisk.com/iso.html ("Since 1971, ISO has been a leading source of information about property/casualty insurance risk.") (accessed Jan. 3, 2015).

[25] Before 1971, these insurance industry groups were committees of various insurance "rating bureaus," including the Insurance Rating Board ("IRB"), the Mutual Insurance Rating Bureau ("MIRB"), and the National Bureau of Casualty Underwriters ("NBCU"). These and other rating bureaus merged to create the Insurance Services Office, Inc. ("ISO"), the insurance industry organization that, since 1971, has drafted standard CGL policy forms. *See*, for example, the discussion of the development of the insurance policy drafting process in Masters & Stanzler §§ 1.02-1.04, 4.02 and in the citations therein.

available to provide the protection against loss that helps facilitate commerce and protect commercial and personal assets on a widespread basis in our modern economy.[26]

Since its inception, the insurance industry has revised the standard CGL Form periodically to respond to court decisions interpreting certain policy terms, and to make CGL insurance a more attractive, and thus a more marketable, product.[27] These forms have been revised, and approved for use by state insurance departments and commissions at various intervals.[28] For the purposes of the allocation issue, the 1955, 1966, and 1986 versions of the CGL Form are particularly relevant and discussed here.

These efforts are recorded in many documents produced by insurance industry drafting committees. A sampling of those documents is discussed below.[29] Policyholders were not represented on any of the insurance industry drafting committees. In addition, most policyholders, even large commercial policyholders, have little leverage to negotiate different terms, in part because of the importance that the insurance industry attaches to maintaining the uniformity of its policy language and the regulatory process applicable to those policy provisions.

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[26] See discussion and citations in Masters & Stanzler, § 1.02, 1.04. *See also, e.g.*, the discussion of the insurance industry drafting process in the following court decisions: *In re Insurance Antitrust Litig.*, 938 F.2d 919 (9th Cir. 1991), *aff'd in part, rev'd in part, modified*, 5 F.3d 1556 (9th Cir. 1993), *cert. denied sub nom. Reinsurance Corp. of America v. Calif.*, 509 U.S. 921 (1993) (*Insurance Antitrust*); *American Home Products Corp. v. Liberty Mutual Insurance Co.*, 565 F. Supp. 1485, 1500-03 (S.D.N.Y. 1983) ("*American Home Products I*"), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984);*Aerojet-General Corp. v. Transport Indemnity Co.*, 948 P.2d 909, 932 (Cal. 1997); *Morton International, Inc. v. General Accident Insurance Co. of America*, 266 N.J. Super. 300 (App. Div. 1991), *aff'd*, 629 A.2d 831 (N.J. 1993).

[27] See discussion and citations in Masters & Stanzler §§ 1.02-1.04.

[28] See discussion and citations in Masters & Stanzler § 1.02.

[29] This discussion is taken from a longer discussion of the drafting history of the CGL policy form relevant to the issues of allocation and proration included in Masters & Stanzler §§ 4.07[A][2] (on trigger of coverage) & [D][1] (on allocation). The drafting history documents quoted in this article have been entered into evidence in public trials, and otherwise over the years have entered the public domain.

The Insurance Industry's Rejection of Proration, Non-Cumulation, and Other Approaches in the 1950s and 1960s

***Rejection of Proration in the 1955 CGL Policy Form*:** Before 1966, the standard CGL policy was written on an "accident" basis, typically without even defining the term "accident."[30] Insurance industry drafters in the late 1950s and early 1960s sought to revise the CGL policy form to provide "occurrence"-based coverage, in order to respond to court decisions that had interpreted the term "accident" to provide coverage for injury or damage that took place over more than one policy period. Many insurance companies during this period were adding "occurrence" wording to their policies by endorsement in any event, given court decisions rejecting their preferred interpretation of "accident" as a "boom event," limited to one point in time. In addition, policyholders wanted insurance products that would protect them from their increasing exposure to liabilities for injuries and damage that continues over a period of years.[31]

In working to revise the 1955 CGL Form, the insurance industry drafters struggled to secure the marketing benefit of an "occurrence" form for such continuing damage, while at the same time mitigating insurers' exposure to liability spanning multiple policy years. As part of this effort, the drafting committee members repeatedly considered a variety of different triggers, including a manifestation trigger and a "last exposure" trigger, other concepts like "non-cumulation"[32] and "deemer" clauses[33] in addition to allocation clauses.

As summarized in a 1959 drafting document, the insurance industry drafters rejected all of those options:

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[30] *See, e.g.*, 1955 CGL Form, available at www.lexisnexis.com.

[31] See discussion of the evolution, and expansion, of tort concepts of liability from *MacPherson v. Buick Motor Co.*, 111 N.E. 1050 (N.Y. 1916) (Kellogg, J.), forward through the 20th century. Masters & Stanzler § 14.03.

[32] See discussion of non-cumulation clauses in text accompanying nn.54-56, 83, 88-90 *infra*.

[33] See discussion of deemer clauses in text accompanying nn.82, 84-87 *infra*.

The objections were:

1. When the Claim is Brought

    a) Injury may be in one policy period and claim in another policy period (This is foreign to the insurance concept.)

    b) Possibility of collusion.

2. Date Injury Manifestes [sic] Itself

    a) Inconsistent with what we mean by "caused by accident[.]" This approach may not be adaptable to the "sudden" accident e.g. a stairway accident resulting in a back injury which does not manifest itself for six months.

3. Last Day of Last Exposure

    a) Principal exposures would often be in other policy period.

    b) Not possible to determine when the policy coverage terminates.

    c) Possibility of collusion.

4. Pro Rate

    a) Generally objectionable, even with language of the following type to prevent pyramiding [sic] of claims and limits: "but in no event shall the coverage be in excess of the highest limits under any policy individual [sic] covering the accident."

The meeting concluded that none of the four proposals would accomplish the desired result.[34]

[34] Minutes of the Joint Meeting on Mutual Bureau and National Bureau Scope of Coverage Subcommittee, at 1-2 (Mar. 3-4, 1959) (quoted in Masters & Stanzler, § 4.07, at 4-153–4-154).

The CGL drafters thus rejected proration in 1959 and did not consider it again until 1964. At that time, one of the three principal drafters of what became the 1966 CGL Form, George Katz of Aetna, distinguished between the two kinds of proration – proration to reduce coverage for the policyholder,[35] and proration among insurers after one of them has paid the policyholder.[36] In doing so, he made clear that proration to the policyholder, or "claimant," was not practical:

> Mr. Katz . . . went on to explain that prorating cannot be effectuated between the insurer and the claimant. Between two insurers, of course, they would prorate. We cannot ask our Claims Departments to adjust parts of claims; also, we cannot defend our pro rata share of claims, but must defend the entire claim.[37]

***Rejection of Proration in the 1966 CGL Policy Form*:** After completing the 1966 edition of the CGL Form, the insurance industry drafters[38] and other commentators on the new form publicly acknowledged that their revision of the 1955 Form did not provide for proration of policy limits for injuries that spanned multiple policy years.

For example, in 1966, E.R. Woodworth of the Insurance Company of North America confirmed that, with introduction of the "occurrence" based wording, the 1966 CGL Form was designed to protect policyholders against liability for injuries or damage that extends over

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[35] In this use of the term "proration," the policyholder cannot collect the entire liability from one triggered insurance policy but receives only a pro rata share from each of a series of policies during the "trigger" period of injury or damage, with no recovery for portions of that period when the policyholder was uninsured or self-insured.

[36] That is, the policyholder may collect the entire liability from one policy or insurer (within the policy's limits) and, thereafter, the paying insurer may spread the loss over the triggered years, either on its own books (if it sold insurance to the policyholder for the other triggered years) or by seeking equitable contribution from the other insurance companies on the risk during the period of continuous injury or damage. The term "proration," in this sense, is also sometimes called "proration among insurers" or "proration among indemnitors." In litigation, it typically arises through **contribution claims** by insurers who claim they paid the policyholder more than their share of the liability, and sue other insurers on the risk for contribution or indemnity.

[37] Joseph Marrone, Minutes, Joint Forms Committee Meeting, at 11 (Sept. 21-23, 1964) (quoted in Masters & Stanzler, § 4.07, at 4-158.2).

[38] See Ch. 2 of Masters & Stanzler for a discussion and citations regarding the drafting process for standard-form CGL insurance policies.

multiple policy periods. The drafters referred to that situation as one that would result in "pyramiding" of limits, meaning that each policy year triggered by a course of continuing injury or damage would be required to respond in full, without proration or apportionment.

> The new policy will apply only to bodily injury or property damage which occurs during the policy period and within the policy territory. Coverage will no longer attach [as it did in the 1955 CGL Form] when the accident occurs, but rather when the injury or damage takes place, and will apply, regardless of when the accident took place. This is particularly true, for example, if the injury or damage is from waste disposal, or similar operations, [and] should continue after the waste disposal ceased or operations [are] completed, as can happen. *It could produce losses on each side of a renewal date and, in fact, over a period of years with a separate policy period applying in each year*. Policy limits are renewed every year, and the underwriter may find a rather substantial pyramiding of his liability limits under the new contract for delayed action injuries.[39]

Richard Schmalz, another primary drafter of the 1966 Form, confirmed that more than one policy period would be triggered to pay when the injury actually takes place over two or more policy periods.[40] As Mr. Schmalz recognized, the CGL policy contains no clause requiring pro rata allocation because the insurance industry drafters were unable to draft provisions that could apply fairly to all situations, as is necessary in a standard-form policy like the CGL. When the 1966 Form was prepared for release, Mr. Schmalz gave a speech confirming that the revised policy contained "no proration formula":

> The policy applies under the new program to bodily injury or property damage which occurs during the policy period. Inasmuch as the new policies afford blanket occurrence coverage it is possible that where the injury actually occurs over two or more

[39] E.R. Woodworth, New Comprehensive General Liability Policy: The Effect on Contracting Risks 9 (Apr. 14, 1966) (comments at Cleveland seminar) (quoted in Masters & Stanzler, § 4.07, at 4-128 (emphasis added in quotation in Masters & Stanzler)).

[40] Richard A. Schmalz, New Comprehensive General Liability and Automobile Program, Mutual Insurance Technical Conference (Nov. 15-18, 1965) (quoted in Masters & Stanzler at § 4.07, at 4-128–4.129).

> policy periods, the Claims Department will have to make some sort of reasonable allocation to each. *There is no pro-ration formula in the policy, as it seemed impossible to develope* [*sic*] *a formula which would handle every possible situation with complete equity*.[41]

The policy provisions governing trigger and allocation remained the same when the insurance industry revised the 1966 Form to create the 1973 Form. In the late 1970s, however, the insurance industry again turned to the question of allocation – and, as discussed below, again rejected proration.

***Rejection of Proration in the 1970s and 1980s*:** In the late 1970s, the insurance industry drafting committees revived the effort to draft a proration formula for the standard CGL policy form when a number of insurance companies renewed concerns that the policy language in the 1973 CGL Form was "not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods."[42] These renewed concerns arose in light of the insurance industry's recognition of its exposure to potential asbestos liabilities. The insurance industry in 1977[43] created a "discussion group," called the Enterprise Liability Study Group, to discuss the industry's response to the *Borel* decision,[44] which adopted the theory of "enterprise liability" in the context of asbestos personal injury.

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[41] *Id.* (quoted in Masters & Stanzler § 4.07, at 4-158.2 (emphasis added in quotation from Masters & Stanzler)).

[42] Graham V. Boyd, Jr., "Memorandum to Members of the General Liability Rules and Forms Committee," at production #610004324 (Apr. 18, 1978) (enclosing minutes of the committee's Mar. 28, 1978 meeting) (quoted in Masters & Stanzler § 4.07, at 4-130–4-131).

[43] *See* Masters & Stanzler § 4.01[B].

[44] *Borel v. Fibreboard Paper Prods. Corp*., 493 F.2d 1076 (5th Cir. 1973).

As shown in meeting minutes, on April 21, 1977, the Enterprise Liability Study Group concluded that each insurance policy triggered by continuing injury or damage was liable in full to pay for the policyholder's liability, with no proration to the policyholder:

> The majority view was that coverage existed for each carrier throughout the period of time the asbestosis condition developed – i.e., from the first exposure through the discovery and diagnosis. The majority also contended that *each carrier on* [*the*] *risk during any part of that period could be fully responsible for the cost of defense and loss*.[45]

Thus, the insurance industry's Enterprise Liability Study Group recognized that, in the context of long-tail, continuing injury from asbestos, each CGL insurer's policy on the risk during any part of the extended period of asbestos-related injury "could be fully responsible for the cost of defense and loss" for that claim.[46] In March 1978, the members of the insurance industry's General Liability Rules and Forms Committee again recognized that the standard CGL policy language was "not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods."[47] As the minutes of this ISO drafting committee reflect, however, the committee again declined to add proration language to the standard CGL policy form or otherwise to prevent the "pyramiding" of limits problem in the context of asbestos and other claims for "long-tail" or continuing injury.[48]

The insurance industry rejected proration in its standard "occurrence" language in the 1970s and 1980s. Instead, as part of the revisions creating the 1986 CGL Form, the industry

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[45] Charles Berryman & Richard Ingegneri, Memorandum of Meeting of Discussion Group – Asbestosis 1 (Apr. 21, 1977) (quoted in Masters & Stanzler at § 4.07, at 4-130 (emphasis added in quotation from Masters & Stanzler)).

[46] *Id.*

[47] *See* "Memorandum to Members of the General Liability Rules and Forms Committee," at production #610004324 (Apr. 18, 1978) (enclosing minutes of Mar. 28, 1978 meeting) (quoted in Masters & Stanzler § 4.07, at 4-130–4-131).

[48] *See id.* at production #610004324-29 (at Masters & Stanzler § 4.07, at 4-130–4-131).

adopted a new approach: it introduced a claims-made form, as an option to be used with large commercial risks. Under the claims-made form, coverage is triggered by a claim made against the policyholder during the policy period. Under that trigger, only a single policy year is normally triggered, a result the industry sought to limit its exposure to multi-year injuries triggering multiple policy years under traditional CGL form policies. After massive objections from policyholders and regulators, the insurance industry retrenched, offering two CGL forms, one with the traditional occurrence concept, triggered by injury or damage during the policy period; and one with a claims-made trigger.[49] However, the insurance industry drafters again did not introduce any proration formula into the "occurrence" form.

That remains true today – the standard CGL "occurrence" form has no proration provision and remains on the market for businesses and to ordinary consumers in their automobile and homeowners insurance policies.

Proration Clauses Used by Insurance Industry in Other Types of Insurance

As shown by this history, the insurance industry's decisions not to include a proration requirement in the standard CGL "occurrence" policy forms was not inadvertent. It was a considered decision, discussed across the industry; disclosed to the public through the regulatory process, and watched (and in public hearings rejected) by state insurance regulators across the country.

This is not to say that it would have been impossible to craft such a provision. Insurance industry drafters have proven repeatedly that they are capable of writing proration or

[49] Masters & Stanzler §§ 1.11, 4.03. Indeed, the proposal to change the CGL trigger to a claims-made trigger for all policyholders met stiff resistance from state insurance commissions, policyholders, and businesses; and, for those reasons, it did not advance. See discussion in *Insurance Antitrust*, 938 F.2d at 928-30; see also Masters & Stanzler § 4.01[B][5].

apportionment clauses when consistent with the coverage and trigger, and when they thus choose to prevent the policyholder from recovering from more than one policy period or insurer. For example, a 1928 Manufacturers' Public Liability Policy contained the following apportionment clause:

> Concurrent Insurance. If the Assured carries a policy of another insurer, against any loss and/or expense covered by this Policy, the Assured shall not recover from the Company a larger proportion of the entire loss and/or expense than the amount hereby insured bears to the total amount of valid and collectible insurance applicable thereto.[50]

The first version of the New York Standard Fire Insurance Policy, admittedly a first-party coverage, also contained a proration provision. The insurance industry first promulgated that policy form and mandated its use for all fire risks more than 100 years ago, in 1886. It included the following proration clause explicitly assigning part of the policyholder's loss to the insured:

> The company shall not be liable under this policy for a greater proportion of any loss on the described property . . . than the amount hereby insured shall bear to the whole insurance . . . covering such property . . . .[51]

Similarly, today, some directors and officers ("D&O") policy forms include proration or apportionment provisions. While not an industry-wide standardized coverage like fire or general liability insurance, and not sold to individuals, D&O insurance is a common coverage, and use of

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[50] Clyde Crobaugh & Amos Redding, *Casualty Insurance*, at 439 (1928) (quoted in Masters & Stanzler at § 4.07[D][1][d], at 4-159). This general language was carried forward into the accident-based standard CGL forms of the 1940s and 1950s as the "other insurance clause." While helpful as long as the trigger was an "accident" and that term connoted a "boom" or other event fixed at a discrete moment in time, this clause did not help with "cumulation," or pyramiding of policy limits outside the policy period once the policy was triggered by injury that took place over a period of years, as was true for occurrence-based policy forms. It is important also to note that, unlike "other insurance clauses" included today in CGL insurance policies, this clause explicitly assigned liability to the "assured." Thus, unlike today's other insurance clauses, this clause intended to be assigned to the policyholder. See discussions *infra* of "other insurance clauses."

[51] Guilford Deitch & Joseph Wood, "The Old New York Standard," chapter 2 of The New York Standard Fire Policy, at 10, lines 96-98 (The Rough Notes Co., 1905 and 1930) (quoted in Masters & Stanzler at § 4.07[D][1][d], at 4-159).

such provisions in D&O policies shows that the insurance industry knows how to draft, and use, such proration provisions when it believes that such provisions can be included in the coverage without appreciably diminishing its marketability.[52] For D&O and like coverages, the insurance industry drafters have thought it important to include a proration clause in their policy forms, and have developed proration clauses that limit the insurance company's exposure. Conversely, in the general liability insurance context, the insurance industry has not reached consensus on adding such proration provisions to the standard CGL Form other coverage relied on by individual consumers for protection. Courts correctly have refused to read such a clause into liability insurance policies that do not include them.[53] The ALI should follow their lead.

Rejection of "Non-Cumulation": The insurance industry also considered in the 1950s and early 1960s "non cumulation," an approach intended to let progressive injury trigger a series of consecutive annual policy years and, at the same time, limit financial exposure, by "rolling up" all of the triggered limits into one year. In this approach, insurers proposed using a version of a "non-cumulation clause" providing that, if injury continued over several policy periods, the amounts paid or payable under the earlier triggered policies would reduce the limits of the later policies.

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[52] For a discussion of D&O allocation, see, e.g., Dan A. Bailey, "Allocation," available at www.baileycavalieri.com/38-D&O_Allocation.pdf. Mr. Bailey's law firm typically represents insurers only. *See also* Darren S. Teshima, "Can D&O Insurers Contract Around Duty to Advance Costs?," available at http://www.law360.com/articles/587028/can-d-o-insurers-contract-around-duty-to-advance-costs (accessed Jan. 30, 2015). D&O insurance also typically uses a claims-made trigger.

[53] *E.g., Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (applying Missouri law); *Plastics Eng'g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613 (Wis. 2009).

The drafters specifically rejected this concept in March 1959 in the minutes of the Joint Scope of Coverage Subcommittee,[54] discussed above. In the spring of 1961, the CGL drafters returned to this concept, proposing the following non-cumulation clause:

> Our proposal then is as follows:
>
> * * *
>
> introduce a new provision, along the lines suggested by the final paragraph of Insuring Agreement IV in Dick Schmalz's memo, to avoid accumulation of limits in the exposure type of case that results when exposure continues over successive policy years.[55]

That proposal died a quick death. In May 1961, the drafters rejected that approach, concluding that it could not be enforced, particularly when, as is common, different insurers issued policies over a period of time. They also believed that it might create marketing difficulties by encouraging policyholders to change insurers:

> Considerable doubt was expressed by members of the Joint Forms Committee during discussion of this problem that such a provision would be enforceable as a practical matter, particularly if the successive policies were issued by different companies. On the other hand, if the application of the provision were limited to successive policies issued by the same company, it would highlight the advantage of switching coverage from one company to another.[56]

Drafting History Showing That Multiple Policies May Respond to a Continuing Loss

Insurance companies argue that allowing a policyholder to pick the triggered policy year to respond to continuing injury or damage is "unfair." That position flies in the face of the conclusion reached by a key policy drafter Gilbert Bean. Mr. Bean specifically affirmed that a

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[54] Minutes of Joint Scope of Coverage Subcommittee at 1-2 (Mar. 3-4, 1959) (quoted *supra* in text accompanying n.34).

[55] Report of Joint Drafting Committee to Joint Forms Committee, at 4-5, attached to April 17, 1961 letter from George Katz to Edward Earle of NBCU (quoted in Masters & Stanzler § 4.07[D] at 4-156).

[56] Explanatory Memorandum from the Joint Forms Committee to the Rating Committees of the National and Mutual Bureau Regarding May 4, 1961 Draft, at 8 (June 7, 1961) (quoted in Masters & Stanzler § 4.07[D] at 4-157).

"separate policy" could "appl[y] each year" when damage – for example, in a long-tail waste disposal case – continued over a period of years:

> [T]he policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place. So *if the injury or damage from waste disposal should continue after the waste disposal ceased, as it usually does, it could produce losses on each side of a renewal date*, and in fact over a period of years, *with a separate policy applying each year*.[57]

In a 1968 publication, another key drafter from the 1960s, Richard H. Elliott, then secretary of the National Bureau Casualty Underwriters, a key insurance rating organization involved in the drafting process, observed that "the definition of occurrence serves to identify the time of loss for the purpose of applying coverage – the injury must take place during the policy period," and that, in cases involving progressive injury, "more than one policy period afford[s] coverage."[58]

After an extensive review of the drafting history and with a focus on insurance's "dominant purpose of indemnity,"[59] the court in *Keene v. INA* concluded that the policyholder should "be able to collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due," subject to the insurers' rights of contribution among themselves under "other insurance clauses."[60]

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[57] Gilbert L. Bean, "New Comprehensive General and Automobile Program: The Effect on Manufacturing Risks," address delivered at the Mutual Insurance Technical Conference 6 (Nov. 15-16, 1965) (emphasis added) (quoted in Masters & Stanzler § 4.09 at 4-199).

[58] Richard H. Elliott, "The New Comprehensive General Liability Policy," in *Liability Insurance Disputes* 12-5 (S. Schreiber ed., 1968) (quoted in *American Home Products I*, 565 F. Supp. at 1502).

[59] 667 F.2d at 1041.

[60] 667 F.2d at 1050. See discussion of "other insurance clauses" infra at text accompanying nn.72-81.

Decisions on Allocation by State Appellate Courts

Well-reasoned decisions by state supreme and appellate courts in at least 12 states have adopted the joint and several rule on allocation, and rejected proration, in complex long-tail claims, like environmental claims, triggering coverage in multiple policy years. These courts appropriately recognize the overall economic advantages of this approach. They also focus on its superiority to the proration approach advocated by insurers. The joint and several rule ensures the timely availability of insurance funds to facilitate environmental cleanups, and discourages the unnecessary litigation between policyholders and insurers necessitated under proration schemes. It also enforces the bargains made between policyholders and insurers and effectuates the insurance industry intent shown in industry drafting history and lore. Some state supreme courts have also applied the joint and several rule to the related "dollars and cents" issue of whether deductibles, self-insured retentions, or fronting policies in the primary layer should be prorated.[61]

The joint and several liability/pick and choose rule accomplishes loss recovery more effectively than the alternative **allocation** and **contribution (proration)** theories that insurers consistently advocate.[62] Moreover, it more accurately reflects the quality of protection that the insurance industry markets to customers and presents to regulators. The joint and several/pick and choose rule avoids time-wasting finger-pointing and is administratively simpler to apply.

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[61] In such cases, insurers have argued that deductibles, SIRs, or fronting policies should be considered "insurance," requiring the policyholder to pay a pro-rata share. *E.g.*, *Aerojet*, 948 P.2d 909; *Am. Nat'l Fire Ins. Co. v. B&L Trucking & Constr. Co.*, 951 P.2d 250 (Wash. 1998); *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115 (Wash. 2000). For a full discussion of this issue, see Masters & Stanzler § 4.08[B] & [C].

[62] Contribution applies only among insurance companies and arises only if only insurer has overpaid, a process that Keene called a "reallocat[ion]." *Id*. at 1051; *see also id*. at 1050 n.37. Contribution is an equitable doctrine requiring "clean hands"; arguably, contribution/proration should not apply when the insurance industry has in its industry processes rejected proration as between policyholders and their insurers.

Unlike proration, it does not raise complicated issues of proof or analysis. Indeed, that was part of the rationale for joint and several allocation.[63]

As the U.S. Court of Appeals for the District of Columbia Circuit concluded in its landmark decision in *Keene Corp. v. Insurance Co. of North America*,[64]

> The only logical resolution of this [allocation] issue is for Keene to be able to collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due, subject only to the provisions in the policies that govern the allocation of liability when more than one policy covers an injury. That is the only way that Keene can be assured the security that it purchased with each policy.[65]

State Supreme Courts That Have Adopted the "All Sums" or Joint and Several Liability Rule on Allocation:

California Law:
State of Calif. v. Continental Ins. Co., 281 P.3d 1000 (Cal. 2012);
Aerojet-General Corp. v. Transport Indem. Co., 948 P.2d 909 (Cal. 1997).

Delaware Law:
Hercules, Inc. v. AIU Ins. Co., 784 A.2d 481 (Del. 2001). *See also Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co*., 652 A.2d 30 (Del. 1994) (applying Missouri law).

Illinois Law:
Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150 (Ill. 1987). *See also John Crane, Inc. v. Admiral Ins. Co.,* 2013 IL App (1st) 109340-B (June 4, 2013) (following *Raymark* and refusing to follow *Outboard Marine Corp. v. Liberty Mut. Ins. Co.,* 670 N.E.2d 740 (Ill. Ct. App. 1996); *Missouri Pac. R.R. v. Int'l Ins. Co.,* 679 N.E.2d 801 (Ill. Ct. App. 1997); *see also Benoy Motor Sales, Inc. v. Universal Underwriters Ins. Co*., 679 N.E.2d 414 (Ill. Ct. App. 1997).

Indiana Law:
Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049 (Ind. 2001).

Missouri Law:

[63] 667 F.2d at 1051 n.38.

[64] 667 F.2d at 1050-51.

[65] 667 F.2d at 1050.

Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co., 652 A.2d 30 (Del. 1994) (applying Missouri law). *See also Doe Run Resources Corp. v. Certain Underwriters at Lloyd's London*, 400 S.W.3d 463 (Mo. Ct. App. 2013).

New York Law:
Continental Cas. Co. v. Rapid-Am. Corp., 609 N.E.2d 506 (N.Y. 1993) (rejecting proration of defense costs under a CGL policy) ("*Rapid-American*"); *but see Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002) (adopting proration under non-standard CGL policy language, concluding "this is not the last word on allocation" in New York) ("*ConEd*").

Ohio Law:
Pa. Gen. Ins. Co. v. Park-Ohio Indus., 930 N.E.2d 800 (Ohio 2010); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co*., 769 N.E.2d 835 (Ohio 2002).

Pennsylvania Law:
J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502 (Pa. 1993).

Rhode Island Law:
Emhart Indus., Inc. v. Century Indem. Co., 559 F.3d 57 (1st Cir. 2009) (following *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d 403 (R.I. 2001) (imposing most costs on one insurer despite the existence of other insurance).

Texas Law:
Lennar Corp. v. Markel Am. Ins. Co., 413 S.W.3d 750 (Tex. 2013); *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994).

Washington Law:
Am. Nat'l Fire Ins. Co. v. B&L Trucking & Constr. Co., Inc., 951 P.2d 250 (Wash. 1998); *Weyerhaeuser Co. v. Commercial Union Ins. Co*., 15 P.3d 115 (Wash. 2000).

Wisconsin Law:
Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613 (Wis. 2009).

State Intermediate Appellate Courts That Have Adopted the "All Sums" or "Joint and Several Liability" Rule on Allocation:

Missouri Law:
Doe Run Res. Corp. v. Certain Underwriters at Lloyd's London, 400 S.W.3d 463 (Mo. Ct. App. 2013).

Oregon Law:
Cascade Corp. v. Am. Home Assur. Co., 135 P.3d 450 (Or. Ct. App. 2006) (interpreting Or. Rev. Stat. § 465.480 (3)-(5) Env. Ins.).

See also:

Connecticut Law:
O'Brien v. United States Fidelity & Guar. Co., 669 A.2d 1221 (Conn. 1996) (court refused to apply "other insurance" clause to require automobile policyholder to obtain a portion of his recovery from another insurance company). *See Reichhold Chems., Inc. v. Hartford Accident & Indem. Co.*, 750 A.2d 1051 (Conn. 2000) (applying "all sums" allocation under Washington law); *but see Reichhold Chems. v. Hartford Accident & Indem. Co.*, 750 A.2d 1051 (Conn. 2000) (applying proration under New York law). See decisions in insurer vs. insurer disputes: *Metropolitan Life Ins. Co. v. Aetna Casualty & Surety Co.*, 765 A.2d 891 (Conn. 2001); *Security Ins. Co. v. Lumbermen's Mut. Cas. Co.*, 826 A.2d 107 (Conn. 2003) (holding that a policyholder, who is self-insured or has no proof of insurance, is responsible for its defense costs for those times in which it was self-insured or had no applicable coverage).

District of Columbia Law:
Keene Corp. v. Ins. Co. of No. Am., 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982) (no decision made on choice of law), the landmark decision on continuous trigger and the joint and several or pick and choose rule on allocation.

Hawaii Law:
Sentinel Ins. Ltd. v. First Ins. Co. of Haw., Ltd., 875 P.2d 894 (Haw. 1994) (squarely adopting proration *between insurers*, but indicating it might not apply between a policyholder and its insurers).

Minnesota Law. Applying joint and several liability rule in certain circumstances:
In re Silicone Implant Ins. Coverage Litig., 667 N.W.2d 405 (Minn. 2003);
SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305 (Minn. 1995) (*overruled on other grounds, Bahr v. Boise Cascade Corp.*, 766 N.W.2d 910 (Minn. 2009). .

Court decisions adopting proration typically ignore the regulatory and drafting history of the CGL Form, ignore the contractual language, or both.[66] Some decisions adopting proration

[66] For examples, see:

Colorado: *Public Serv. Co. of Colo. v. Wallis & Cos.*, 986 P.2d 924, 935 (Colo. 1999).

Connecticut: *Sec. Ins. Co. v. Lumbermen's Mut. Cas. Co.*, 826 A.2d 107 (Conn. 2003) (requiring proration of defense costs for those periods where policyholder had no insurance or had self-insured retentions); *Metro. Life Ins. Co. v. Aetna Cas. & Sur. Co.*, 765 A.2d 891 (Conn. 2001).

Kansas: *Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003).

Kentucky: *Aetna Cas. & Sur. Co. v. Commonwealth*, 179 S.W.3d 830 (Ky. 2005); *Ohio Cas. Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 511 S.W.2d 671 (Ky. Ct. App. 1974).

Louisiana: *Arceneaux v. Amstar Corp.*, 66 So. 3d 438 (La. 2011) (allowing proration on indemnity only) ("*Arceneaux III*"); *Arceneaux v. Amstar Corp.*, No. 2014-CA-0271, 2015 WL 798980, at *7 (La. Ct. App., 4th Cir.,

(Cont'd . . .)

have construed non-standard policy language that the court found required proration but left open the possibility that other cases, involving other policy language, could lead to adoption of a different allocation rule.[67] Courts adopting proration also typically refer to "equity" and "fairness" (to insurers) in reaching their result. Those courts ignore the inequity and the unfairness of disregarding insurance industry drafted standard form language, thus nullifying the bargain (to the extent standardized policy language can be said to be negotiated) that the parties struck.[68] Two states with proration decisions on the books limit proration to indemnity and have not extended proration to the duty to defend.[69]

At best, states are more or less evenly divided on this issue, with several recent cases giving the "joint and several" approach an edge. In addition, as courts have concluded, disagreement among courts about the meaning of form policy terms evidences ambiguity.[70]

(. . . cont'd)
Feb. 25, 2015) ("Continental's duty to defend American Suger going forward in this litigation is not subject to proration") (*Arceneaux IV*").

Maryland: *Riley v. United Servs. Auto. Ass'n*, 871 A.2d 599 (Md. Ct. Spec. App. 2005) (allocation by time on the risk), *aff'd*, 899 A.2d 819 (Md. 2006); *Baltimore v. Utica Mutual Ins. Co.*, 802 A.2d 1070, 1101 (Md. Spec. App. 2002), *cert. granted*, 810 A.2d 961 (Md. 2002), *cert. dismissed*, 821 A.2d 369 (Md. 2003).

New Hampshire: *EnergyNorth Natural Gas, Inc., v. Certain Underwriters at Lloyd's*, 934 A.2d 517, 526-27 (N.H. 2007).

New Jersey: *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116 (N.J. 1998) ("*Carter-Wallace*"); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 993-94 (N.J. 1994).

[67] *See, e.g.*, *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, 312 (Mass. 2009); *Consolidated Edison Co. v. Allstate Ins. Co.*, 746 N.Y.S.2d 622 (N.Y. 2002); *see also Crossmann Communities of N.C., Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589 (S.C. 2011); *Ohio Cas. Ins. Co. v. Unigard Ins. Co.*, 268 P.3d 180 (Utah 2012); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 141 (Utah 1997).

[68] For a discussion of allocation, additional insurance industry drafting and regulatory history relevant to this issue, and relevant case law, see Masters & Stanzler §§ 4.02 and 4.07 and state-law survey charts in Tables 4-1 (trigger of coverage) and 4-2 (allocation).

[69] Louisiana: *Compare Arceneaux III*, 66 So. 3d at 438 (La.; proration of duty to indemnify only), *with Arceneaux IV*, 2015 WL 798980 at *5-7 (La. Ct. App.; no proration of defense costs).

New York: *Compare Rapid-American*, 609 N.E.2d at 514 (refusing allocation of duty to defend/defense costs to policyholder); *with Con Ed*, 774 N.E.2d at 693-95.

[70] *E.g.*, *Hartford Acc. & Indem. Co. v. Dana Corp.*, 690 N.E.2d 285, 295, 297 (Ind. Ct. App. 1997) ("We conclude that the division of authority on this issue is instructive and is evidence that more than one reasonable interpretation

(Cont'd . . .)

Such ambiguity on standard-form policy provisions like those should be interpreted in favor of coverage.[71]

Inapplicability of "Other Insurance Clauses"

The *Keene* court emphasized that the insurance company or companies that have paid the policyholder under the joint and several/pick and choose rule have the right to seek contribution from other insurance companies on the risk during the period of continuing injury. In discussing this right of contribution by an insurer chosen by the policyholder to respond, the D.C. Circuit explained that this right of contribution is implemented and confirmed in standard CGL policies by the "other insurance clause." The court also rejected the insurers' arguments that "other insurance clauses" required a different result. The court found that, in fact, "other insurance clauses" do not apply at all in a dispute between a policyholder and its liability insurers.

It is a well-established principle of both insurance law and insurance industry custom and practice that "other insurance" clauses apply only in battles between insurance companies. They do not apply to disadvantage policyholders or require allocation to the policyholder.[72] Payment of the policyholder's claim always takes priority over claims by insurers which seek contribution or indemnity from other insurers. "Other insurance clauses" apply only to determine "reallocat[ion]" of the loss between, or among, concurrent insurers.[73] "[O]ther insurance" clauses thus apply to apportion coverage only if there is other "concurrent" insurance coverage.[74]

(. . . cont'd)
of the term . . . is possible"); *accord Travelers Indem. Co. v. Summit Corp. of Am.*, 715 N.E.2d 926, 938 (Ind. Ct. App. 1999).

[71] *E.g.*, *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 470 (Ind. 1985).

[72] *See, e.g.*, 667 F.2d at 1050.

[73] Douglas R. Richmond, *Bad Faith Litigation* – "*Other Insurance*" *Provisions: Cutting Through the Virtually Impenetrable Thicket "of" Other Insurance*, New Appleman on Insurance: Current Issues in Insurance Law 69 (Dec. 2007) ("Richmond II"); Douglas R. Richmond, *Issues and Problems in "Other Insurance," Multiple*

(Cont'd . . .)

Concurrent insurance coverage is insurance that is concurrent as to both (1) time insured and (2) the risk insured.[75] For example, in *St. Paul Fire & Marine Insurance Co. v. Vigilant Insurance Co*., insurance company versus insurance company case, the court refused to apply an "other insurance clause," even in a case between insurance companies, because the insurance policies there applied to different time periods. Thus, they were not concurrent in time, and, under the rules applicable to "other insurance" clauses, the clauses did not apply.[76]

Courts have drawn clear distinctions between the rights of contribution among insurance companies and an insurer's obligation to indemnify its policyholder.[77] As a California court explained:

> As a general rule, "courts will give heed to 'primary' and 'excess' insurance provisions of insurance policies. This rule is particularly applicable where the dispute is between two or more insurance carriers and . . . the rights of policyholders or their accident victims will be unaffected by its application."[78]

Because "other insurance clauses" provide a scheme by which an insurance company's liability is to be apportioned with other insurers, the clauses should not be used to impose liability on the policyholder:

(. . . cont'd)
Insurance and Self-Insurance, 22 Pepp. L. Rev. 1373, 1380-81 (1995) ("Richmond I"); *see, e.g*., *Reliance Ins. Co. v. St. Paul Surplus Lines Ins. Co*., 753 F.2d 1288 (4th Cir. 1985) (applying D.C. law); *Zurich Ins. Co. v. Northbrook Excess & Surplus Ins. Co*., 494 N.E.2d 634, 650 (Ill. App. Ct. 1986), *aff'd sub nom. Zurich Ins. Co. v. Raymark Indus., Inc*., 514 N.E.2d 150 (Ill. 1987) ("*Raymark*"); *Plastics Engineering*, 759 N.W.2d at 624..

[74] *St. Paul Fire & Marine Ins. Co. v. Vigilant Ins. Co*., 919 F.2d 235, 241 (4th Cir. 1990) (applying North Carolina law); *see also Carter-Wallace*, 712 A.2d at 1123-24.

[75] *Twin City Fire Ins. Co. v. Home lndem. Co*., 650 F. Supp. 785, 791 (E.D. Pa. 1986).

[76] 919 F.2d at 241.

[77] *Raymark*, 494 N.E.2d at 650 ("'other insurance' clause does not affect the individual insurance company's obligations to the insured.").

[78] *Interinsurance Exch. of Auto. Clubs v. Spectrum Inv. Corp*., 258 Cal. Rptr. 43, 50 (Ct. App. 1989) (*citing National Am. Ins. Co. v. Insurance Co. of N. Am*., 74 Cal. App. 3d 565, 574 (1977)). *Accord Mission Ins. Co. v. Hartford Ins. Co*., 155 Cal. App. 3d 1199, 1208 (1984).

> "Other insurance" clauses only affect insurers' rights among themselves; they do not affect the insured's right to recovery under each concurrent policy. Inter-insurer loss allocation by way of "other insurance" clauses never permits allocation of a loss to the insured. Payment of the insured's claim always takes priority over the allocation of the loss between concurrent insurers.[79]

Thus, to the extent an insurer attempts to use an "other insurance clause" to diminish recovery by the policyholder, the insurance company has the burden to show that the clause applies.[80] Under generally accepted principles of policy interpretation adopted by the *Restatement*, insurers cannot meet that burden unless the plain meaning of the clauses show that they apply to policyholders. The clauses, called an "impenetrable thicket" by courts and commentators,[81] have no such plain meaning. Using "other insurance clauses" to support proration of the policyholder both improperly places the burden of proof on the policyholder to defeat an argument that functions as an exclusion of coverage, and improperly allows insurers to use the clause to disadvantage the policyholder.

Inapplicability of "Deemer" and Non-Cumulation Clauses

Some insurance policies, particularly those sold in certain periods by Liberty Mutual Insurance Company, contained a "deemer" clause that provides:

> With respect to injury to or destruction of property, including the loss of use thereof, caused by exposure to injurious conditions over a period of time involving two or more liability policies issued by [Liberty Mutual] and affording insurance for such injury to or

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[79] *Richmond I*, 22 Pepp. L. Rev. at 1380-81. *See, e.g., Emp'rs Empires Reinsurance Corp. v. Phoenix Ins. Co*., 230 Cal. Rptr. 792, 798 (Ct. App. 1986); *Raymark*, 494 N.E.2d at 650; *Bazinet v. Concord Gen. Mut. Ins. Co*., 513 A.2d 279, 281 (Me. 1986).

[80] The original reason for "other insurance" clauses was to prevent overinsurance and double recovery by the policyholder under property and fire insurance policies. In the context of third-party liability insurance, the fear of overinsurance is greatly diminished because recovery would not inure to the benefit of the policyholder. *E.g., Jones v. Medox, Inc.*, 413 A.2d 1288, 1290 (D.C. 1980); *see also* Susan Randall, *Coordinating Liability Insurance*, 1995 Wis. L. Rev. 1339, 1353 n. 48 (1995). Thus, the rationales and need for the clause are less salient in the context of liability insurance, where insurers can (and do) resort to arguments for equitable contribution.

[81] *See generally, e.g.*, Richmond II, *supra* n.73.

> destruction of property . . . caused by the same general injurious conditions shall be deemed to occur only on the last day of the last exposure and the applicable limit of liability contained in the policy in effect on the last day of such exposure shall be the applicable limit of liability.[82]

Some also contain a "Non-Cumulation of Liability – Same Occurrence" clause as follows:

> If the same *occurrence* gives rise to *personal injury or property damage* which occurs partly before and partly within any annual period of this policy, each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by the company with respect to such *occurrence*, either under a previous policy or policies of which this policy is a replacement, or under this policy with respect to previous annual periods thereof.[83]

These "anti-stacking" provisions have not convinced courts to reject the language in the insuring agreement triggering multiple policy periods.[84] In *Joy Technologies,* for example, the West Virginia Supreme Court recognized "that, where a definite meaning has been ascribed to language used in an insurance policy, that meaning should be given to the language by the courts."[85] Insurance companies have confirmed that, under the "all sums" or "those sums" language, general liability insurance is "triggered" when bodily injury or property damage takes place during the policy period.

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[82] *See, e.g., Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*, 928 F. Supp. 176 (N.D.N.Y. 1996).

[83] A.S. Klein, Annotation, *Insurer's Liability or Punitive Damages or Refusal to Make Under-Contracts for Consequential for Wrongful Delay Payments Due*, 47 A.L.R.3d 314 (1998) (emphasis in original); *see also Liberty Mut. Ins. Co. v. Treesdale, Inc.*, 418 F.3d 330 (3d Cir. 2005) (finding that non-cumulation clause precludes stacking of coverage under Pennsylvania law) (quoted in Masters & Stanzler § 4.09 at 4-198–4-199).

[84] *Joy Technologies*, 421 S.E.2d at 494; *Viking Pump, Inc. v. Century Indem. Co.*, 2009 Del. Ch. LEXIS 180, *aff'd, withdrawn from publication*, 2010 Del. LEXIS 678 (Del. 2010) (Table) (unpublished decision); *see also Spaulding Composites Co. v. Aetna Cas. & Sur. Co.*, 176 N.J. 25 (2003) (finding that non-cumulation clauses are unenforceable under New Jersey law); *Ernie Haire Ford, Inc. v. Universal Underwriters Ins. Co.*, 331 Fed. App'x 640(11th Cir. 2009) (applying Florida law).

[85] *Joy Technologies*, 421 S.E.2d at 499 (citing *Christopher v. United States Life Ins. Co.*, 116 S.E.2d 864 (W. Va. 1960)).

Relying on the insurance company's own internal documents, the West Virginia Supreme Court in *Joy Technologies* affirmed the insurance company's conclusion that general liability insurance covers environmental damage taking place over a period of years:

> The record shows at the time Liberty Mutual adopted this standard form for the commercial general liability policy, a memorandum entitled "Summary of Broadened Coverage Under New GL Policies With Necessary Limitations to Make This Broadening Possible," was circulated internally with the company. *That memorandum indicated that the policies covered liabilities including*:
>
> > *Coverage for gradual BI [bodily injury] or gradual PD [property damage] resulting over a period of time from exposure to the insured's waste disposal*. Examples would be gradual adverse effect of smoke, fumes, air or stream pollution, contamination of water supply or vegetation. We are all aware of cases such as contamination of oyster beds, lint in the water intake of down stream industrial sites, the Donora Pa. atmospheric contamination, and the like.[86]

The *Joy Technologies* court concluded that "[t]he 1966 commercial general liability insurance policies, as originally issued, covered gradual bodily injury and property damage resulting over a period of time from exposure to the insured's waste disposal, as was suggested by Mr. Bean in the memorandum issued in conjunction with the drafting of the policies.[87]

Although not widely addressed, courts also have refused insurers' reliance on non-cumulation clauses to escape liability.[88] The language in non-cumulation clauses can vary substantially, and it is important, for that reason, to compare the language in a policyholder's

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[86] 421 S.E.2d at 497 (emphasis added) (quoted in Masters & Stanzler § 4.09 at 4-200),

[87] 421 S.E.2d at 497. The Bean memorandum to which the court refers is that quoted in the text accompanying n.54 *supra*.

[88] *See, e.g., Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, No. 86-7501, 1989 U.S. Dist. LEXIS 7435, at *3 n.2 (E.D. Pa. June 30, 1989), *aff'd in part, vacated in part on other grounds*, 25 F.3d 177 (3d Cir. 1994) (rejecting application of a general non-cumulation clause) ("*Air Products*"); *Viking Pump*, 2014 Del. Super. LEXIS 707 (withdrawn). *Contra Air Products*, 1984 U.S. Dist. LEXIS 7435, at *7-8 (rejecting non-cumulation clause that sought to eliminate all liability by the insurer). See also the discussion of non-cumulation clauses in Masters & Stanzler § 19.03[B].

insurance policy to the language at issue in a particular decision. These clauses can be grouped roughly into the following categories. "General non-cumulation clauses" refer to "loss covered." Other non-cumulation clauses refer to "payments" by the insurance company and have been called "specific" non-cumulation clauses. Courts refuse to implement the clauses finding them ambiguous and, in effect, acting as invalid escape clauses.[89] The New Jersey Superior Court equated the non-cumulation clause to an (or another) other insurance clause, refusing to use either the non-cumulation clause or other insurance clause to disadvantage the policyholder.[90]

CONCLUSION

The ALI's *Restatement of the Law of Liability Insurance* should not adopt a rule on allocation that ignores the drafting and regulatory history and the insurance industry's own intent in rejecting proration for standard CGL insurance policies. Such a rule contradicts policyholders' contractual expectations and reasonable expectations of protection under not only commercial liability insurance policies, but also under the personal lines insurance policies bought every year by millions of ordinary consumers. A provision specifying proration of liability to the policyholder should be adopted (if at all) only by the regulatory process that the insurance industry must follow in seeking significant changes to standardized coverages like the CGL coverage, or as a result of a true meeting of the minds in contract. With regard to standardized liability coverages, if the insurance industry has obtained the requisite regulatory approval, and, after public review and comment, includes a proration clause, it is appropriate to give it effect if its terms are clear and unambiguous. For coverages or insurance policies not

[89] *Air Products*, 1989 U.S. Dist. LEXIS at *3, n.2.

[90] *Carter-Wallace,* 712 A.2d at 1123-25.

requiring regulatory approval, the same approach is appropriate if parties with equal bargaining power freely agree to include such a provision.

Outside of those situations, the ALI should reject the inequity and anti-consumer (and anti-regulatory) intent of proration and instead should follow the contractual and marketing intent of the insurance industry, as confirmed, clearly, by its own drafting history and marketing documents. The ALI should not be a party to a process that ignores the insurance drafting documents and the insurance regulatory process which was adopted in this country to protect both consumers and the public. Doing so would not advance the ALI's mission and intent of promoting "the clarification and simplification of the law and its better adaptation to social needs, secur[ing] the better administration of justice, and encourag[ing] and carry[ing] on scholarly and scientific legal work."[91] Consistent with the ALI's mission:

- It is *simpler* to follow the rule confirmed by the insurance industry's drafting history.
- It *better serves social needs* to avoid conclusions that have not been adopted through the regulatory process used by state insurance commissions across the country to protect the consumers and the public.
- It *secures the administration of justice* to defer on this issue to state regulatory processes designed to protect consumers; and to follow the court decisions which follow – and enforce – the contract language (and thus promote the public policy of enforcing contract).

[91] ALI Charter, as quoted on ALI available on ALI website, Governance (Certification of Incorporation) tab, ALI Overview (Creation) tab (http://www.ali.org/index.cfm?fuseaction=about.chartercite accessed Jan. 16, 2015).

- Finally, it *encourages the scholarly work* in the field of insurance law to rely on the insurance industry's own pronouncements on allocation.

The *Restatement* should make clear that, where – as here – it is possible to ascertain industry intent on standard-form policy language, that intent should govern, unless and until a policy form includes a proration clause that has received regulatory approval or the parties to the insurance policy at issue have "specifically negotiated" the terms of the insurance policy. This is consistent with the definition of "standard form" policy terms adopted by the full ALI membership[92]; advances the public policies promoting freedom, and enforcement, of contract; and accords with equity[93] and good process.

[92] *See supra* text accompanying nn.7, 8.

[93] As noted above (text accompanying notes 66-68 *supra*), courts adopting proration often point to principles of "equity" and "fairness" as support for proration. What is equitable and fair about ignoring boilerplate contract language that the insurance industry itself has repeatedly recognized is not intended to support proration?

The Empire Strikes Back! What is the Insurance Industry's Perspective On the Restatement?

Speakers:

Michael Aylward (Morrison Mahoney — Boston, MA)

Laura Foggan (Wiley Rein — Washington, DC)

THE EMPIRE STRIKES BACK

A Critique of the Restatement of the Law of Liability Insurance

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--Umbrella Issues Subcommittee Co-Chair (2009-present).
--CLE Co-Chair (2004-2006).

American College of Coverage and Extra-Contractual Lawyers
--Founding member, Board of Regents (2012-present)

Defense Research Institute
--Board of Directors (2000-2003)
--Insurance Law Committee Chair (2004-2006)
--Law Institute (2004-2015)

Federation of Defense and Corporate Counsel
--Reinsurance Excess Surplus Lines Committee Chair (2007-2008)
--Amicus Committee Member (2010 to present)

International Association of Defense Counsel
--Reinsurance, Excess and Surplus Lines Committee (2005-2007)
--Board of Editors, *Defense Counsel Journal*.

In 2002, he was honored by the Defense Research Institute as its Outstanding Committee Chair for his leadership of DRI's Insurance Law Committee. In 2006, he received DRI's G. Duffield Smith Award for Outstanding Publications for his article analyzing post-*Campbell* trends in punitive damages jurisprudence.

Mr. Aylward has lectured and written frequently on insurance issues and has contributed chapters to the *New Appleman* insurance treatise (2007 and 2010); the Law and Practice of Insurance Litigation (West 2005) and Emerging Issues in the CGL (National Underwriter 2008); the ABA's *Environmental Liability and Insurance* treatise (2012) and Thompson Reuters' 2015 *Reinsurance Desk Handbook.*

In 2014, he was elected to the American Law Institute. In 2015, he was appointed to serve as an Advisor on the ALI's *Restatement of the Law of Liability Insurance.*

THE EMPIRE STRIKES BACK
A Critique of The American Law Institute's Restatement of the Law of Liability Insurance

By
Michael F. Aylward

I. INTRODUCTION

Nearly six years after work on it began, the American Law Institute's *Restatement of the Law of Liability Insurance* is more than half way to completion. Surprisingly, despite its significance for the future of insurance jurisprudence, the *Restatement* has only recently received attention from representatives of the insurance industry and their advocates. Although insurers are now fully engaged in analyzing and responding to proposed provisions, much remains to be done with respect to the Chapters due to be voted on next year, as well as the still to be drafted Chapters 3 and 4. In this article, we will trace the history and evolution of this project and what its future may hold for insurance and practitioners of insurance coverage law.

The *Restatement of the Law of Liability Insurance* represents the first significant national effort to codify insurance law. Indeed, one might wonder why the ALI took on this project, given the state-specific nature of insurance law. While much of this *Restatement* sets forth familiar legal principles, some sections challenge conventional wisdom and propose new rules that are surprising and, in some cases, disturbing.

--The American Law Institute

The American Law Institute is a Philadelphia-based organization of lawyers, legal scholars and judges who are devoted to maintaining and advancing the law. Founded in 1923 by eminent judges and scholars such as Benjamin Cardozo and Learned Hand, the ALI takes as its mission the goal of promoting "the clarification a simplification of the law and its better adaptation to social needs, to secure the better administrative of justice and to encourage and carrying out scholarly insights of legal work." Over the past century, the ALI has had a profound impact on American law through model statutes such as the Uniform Commercial and Penal Codes as well as its various Restatements of the Law in areas as diverse as torts, conflicts of law and the law of lawyering.

--A Short History of the Restatement of Liability Insurance

In 2010, the American Law Institute embarked on an analysis of legal issues presented by liability insurance disputes. The idea for this project appears to have begun with a suggestion by Professor Kenneth Abraham of the University of Virginia, one of the foremost academic specialists on insurance law in America. The ALI named Professors Thomas Baker of the University of Pennsylvania Law School and Kyle Logue of the University of Michigan Law School to serve as the project's Reporters. A team of 44 judges, industry executives and outside counsel with specific expertise in this area of the law were appointed by the ALI to serve as Advisers to the Reporters. There is also a large Members Consultative Group, consisting of ALI

members who are interested in insurance and who have volunteered to review drafts and provide input to the Reporters.

ALI Restatements proceed though a slow iterative process. First, Reporters circulate Memoranda and Preliminary Drafts. These initial drafts are reviewed by the Advisors and the Members Consultative Group, who provide feedback to the Reporters. With this input, the Reporters produce so-called Tentative Drafts. When these drafts are approved, a so-called Council Draft is submitted to the ALI Council, a small group of senior members that vet all proposed text before they go to the full membership for final approval at the ALI's annual May meetings in Washington, D.C.

This project was originally envisioned as a "Principles of the Law." Unlike the ALI's more familiar "Restatements," Principles projects are geared more towards regulators and legislatures and set forth "best practices" that the Reporters feel should be adopted, whether they currently reflect the way that most courts address such issues or not. In short, *Principles* set forth the law as it should be, whereas *Restatements*, for the most part, codify the law as it is.

Four years into the project, however, the new executive director of the ALI decided that it should be a Restatement. As a result, and despite the fact that Chapters One and Two had already by then been voted on and approved by the full ALI membership, the Reporters were obliged to pull back Chapters One and Two at the end of 20145 and reassess their provisions to eliminate aspirational provisions that were not rooted in the common law or that were otherwise inappropriate for inclusion in a Restatement.

Around the same time, the ALI released a revised Style Manual in January 2015. The new Style Manual provides insight with respect to the circumstances in which Reporters may vary from the majority rule in writing a Restatement. The ALI is clear that Restatements are meant to be much more than a codification of existing law. In particular, if the "majority" approach is outmoded, impractical and the "minority" view reflects the emerging trend and better rule, the Reporters have discretion to abandon the majority rule, so long as they clearly state what they are doing. As the Style Manual states:

> The Restatement process contains four principal elements. The first is to ascertain the nature of the majority rule. If most courts faced with an issue have resolved it in a particular way, that is obviously important to the inquiry. The second step is to ascertain trends in the law. If 30 jurisdictions have gone one way, but the 20 jurisdictions to look at the issue most recently went the other way, or refined their prior adherence to the majority rule, that is obviously important as well. Perhaps the majority rule is now widely regarded as outmoded or undesirable. If Restatements were not to pay attention to trends, the ALI would be a roadblock to change, rather than a "law reform" organization. A third step is to determine what specific rule fits best with the broader body of law and therefore leads to more coherence in the law. And the fourth step is to ascertain the relative desirability of competing rules. Here social-science evidence and empirical analysis can be helpful.

In the Spring of 2015, the Reporters released a new Discussion Draft of Chapters One and Two that eliminated many of the provisions that insurers had vehemently objected to, notably sections dealing with misrepresentation, waiver and estoppel and the duty to defend. While the revised Discussion Draft of Chapters One and Two was initially fast-tracked for approval at the May 2015 ALI Annual Meeting, the Reporters ultimately agreed to only present it for discussion.

In late September, the Reporters submitted a Council Draft No. 1 of Chapters One and Two for consideration by the ALI Council. The Reporters took the unusual step of submitted Chapters 1 and 2 to the Council while holding back two sections that they reserved for further discussion with the project Advisors at their October 28, 2015 meeting. Sections 13(3) and 19 of Chapter Two were the subject of intense discussion at the Reporters' meetings with the Restatement Advisors and MCG at the close of October, along with the newly-released text of Chapter 3. On December 28, 2015, the Reporters published Council Draft No. 2, which incorporated their final decisions with respect to Sections 13(3) and 19 as well as a refined presentation of Chapter 3 based on the input that they had received at their October meetings.

This latest draft will be reviewed by the ALI Council at its next meeting in January 2016. If all proceeds accordingly to schedule, Chapters 1, 2 and 3 will be submitted for a vote by the ALI at its Annual Meeting in Washington, D.C. in May 2016, with Chapter 4 to follow in 2017.

II. THE RESTATEMENT IN BRIEF

When it is finally completed, the Restatement of the Law of Liability Insurance will contain four chapters. Chapter One addresses basic principles of insurance contract interpretation, the doctrines of waiver and estoppel and the effect of misrepresentations made by policyholders during the application process. Chapter Two focuses on the obligation of a liability insurer to defend (or pay defense costs), as well as the duty to settle and cooperation issues. Chapter Three will address the scope of insured risks and topics such as trigger, allocation, and issues related to high profile exclusions and conditions, while Chapter Four will focus on advanced insurance contract issues like choice of law, remedies, bad faith, and enforceability.

A. Chapter One (Basic Liability Insurance Contract Principles)

Following an opening definitional section, Chapter One consists of three topics: (1) Interpretation (in Sections 2-4); (2) Waiver and Estoppel (in Sections 5-6) and (3) Misrepresentations (in Section 7-11).

Topic 1: Interpretation (Sections 2-4)

§ 2: Insurance Policy Interpretation

Section 2 sets forth familiar and established principles of contract construction (*e.g.*, insurance policies shall be interpreted in the same manner as other contracts).

§ 3: The Presumption In Favor of Plain Meaning

Section 3 is far more controversial. Instead of adopting "plain meaning" as a fixed rule, it proposes a *presumption* of plain meaning that can be refuted by extrinsic evidence of contractual intent. Furthermore, even if a policy term is unambiguous on its face, that plain meaning can be overcome if a judge "determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence."

Comment c. indicates that "plain meaning" is assumed to be the understanding that "an ordinary reasonable person would have, if that person took the time to read all of the relevant parts of the policy in the context of the claims at issue…" The Reporters are at pains not to adopt an exception for "sophisticated insureds" although their modified objective standard clearly reflects the circumstances in which a particular insured or business lies. This "tailored objective" standard "takes into account the level of sophistication and insurance-purchasing experience expected of the party buying the policy, but not that party's subjective understanding." Comment e.

§ 4: Ambiguous Policy Terms

In most states, when standard-form policy language is involved, a finding of ambiguity automatically results in coverage ("tie goes to the insured"). The rules in many states provide that, on boilerplate or standard-form policy language, an insurer's preferred interpretation must be the only reasonable interpretation. Thus, even if an insurer's proposed interpretation is demonstrably reasonable, ambiguity (and coverage) will be found so long as the insured's proposed interpretation is also reasonable. As set forth in Comment j., however, Section 4 does not adopt the standard "tie breaker" rule followed in many jurisdictions but instead declares that coverage should be found only if a court is otherwise unable to determine the meaning of an insurance policy term "using all other permissible sources of meaning, including extrinsic evidence."

In comment (b) to Section 4, the Reporters explore the relationship between *contra proferentem* and the doctrine of "reasonable expectations." They comment that the reasonable expectation doctrine is not actually a rule of interpretation but rather "is a rule regarding the enforceability of terms that are inconsistent with the reasonable expectations of the insured." Their position is that while policies should be interpreted in accordance with the reasonable expectations of coverage, coverage may not be found based on this doctrine where to do so would confound the actual language of the policy.

Topic 2: Waiver and Estoppel (Sections 5-6)

Sections 5 and 6 set forth the general rules governing the application of the doctrines of waiver and estoppel to insurance coverage disputes. For the most part, the principles enunciated follow the common law in most jurisdictions both as regards the distinction between waiver and estoppel and the general principle that an insurer cannot "waive into coverage." Section 6 does state, however, that an insurer's post-loss conduct can estop it to dispute coverage if the insured reasonably relies on it to their detriment.

Topic Three—Misrepresentation (Sections 7-8)

The analysis of misrepresentation issues in Topic Three was one of the most contentious issues during the *Principles* phase of this project In particular, insurers objected to Section 7's use of a "fraud' standard of proof as well as the requirements in Section 11 that insurers accept coverage, albeit at the cost of additional premium to the insured, in cases of "innocent misrepresentation." Both of these provisions have been eliminated in the 2105 Council Draft, along with any distinction between negligent and intentional misrepresentations. As revised, Sections 7 and 8 generally track the rules in most states with respect to intent, materiality and reliance.

§ 7: Misrepresentation

Section 7 states that an insurer may decline to pay a claim or, after returning all premiums owed, may elect to rescind an insurance policy if its insured made a false or misleading representation in an application for coverage or for the renewal of the policy that the insurer reasonably relied on. Earlier language that further required insurers to prove that the insured had acted intentionally or recklessly was removed in the April 30, 2015 Discussion Draft and is not contained in the 2015 Council Draft.

§ 8: Materiality Requirement

The subject of a misrepresentation is "material" if it either would have caused the insurer either not to have issued the policy at all or to have issued it under substantially different terms.

B. Chapter Two: Management of Potentially Insured Liability Claims (Sections 10-30)

Chapter Two is divided into three topics: (1) defense; (2) settlement, and (3) cooperation. According to the Reporters, these three Topics have "engendered much confusion in the case law" and there is a "real opportunity to clarify and improve the law. . . . ." The Reporters go on to assert that Chapter Two is an attempt to "clarify and unify existing law" and that it largely sets forth rules that already apply in most jurisdictions. Indeed, Chapter Two is generally less controversial than Chapter One and thus was changed less in the Council Drafts issued in 2015.

Topic 1 – Defense

Sections 10-23 analyze the right and duty of insurers to defend. Section 13 proposes a "four corners plus" approach to the duty to defend that would require insurers to consider not only the facts alleged but also facts that become known through the insurer's investigation. However, extrinsic facts will only defeat a duty to defend that otherwise exists where the issue concerns whether the claimant is an insured or whether a vehicle is covered under an auto policy.

Text in Section 12 that would have declared insurers vicariously liable for the conduct of defense counsel was shed in the metamorphosis of this project from a *Principles* to a *Restatement*. However, insurers may still be liable for the acts of their employees, an issue that

may arguably create liability for the conduct of staff counsel. Insurers may also be liable for negligence in the selection or supervision of defense counsel.

Section 16 addresses the circumstances in which an insured may insist on its own defense counsel and, for the most part, adopts the California *Cumis* standard. Section 17 states that an insurer's determination of the hourly rate for independent counsel may not be determined solely based on what the insurer pays to its panel counsel. An earlier provision requiring the insurer to front the full amount charged subject to a right to sue defense counsel at the conclusion of the litigation to recoup excessive fees has been eliminated.

Section 18 provides that an insurer may terminate its defense duty by entering into a settlement with the underlying claimant to dismiss the covered claims, but only with the insured's express consent.

Section 20 states that if multiple insurers have a duty to defend, the insured may target a single insurer to handle its defense. Unlike the Illinois "targeted tender" approach, however, that insurer is entitled to contribution from other insurers that shared a similar obligation.

Section 21 states that insurers may not retroactively recoup their costs of defense, absent explicit policy wordings allowing such recovery. The Reporters are at pains to reconcile this finding with Section 35 of the *Restatement (Third) of Restitution and Unjust Enrichment*, which does allow for equitable restitution under analogous circumstances.

§ 10: Scope of the Right to Defend

Comment b. states where an insurance policy gives the insurer the right to defend, that right extends all aspects of the policyholder's defense, including the right to select counsel and the right to receive reports from defense counsel pertaining to the defense or settlement of the suit. Assigning this right to insurers is consistent with the policy language, as well as with the practical reality that, in most cases, insurers are better equipped to handle a legal defense than all but the most sophisticated policyholders.

While an insurer' right to defend is deemed "unlimited" in so-called "full coverage" cases, Comment a. takes note of situations where some portions of a claim may not be covered, either as falling outside the scope of coverage, being subject to policy exclusions or as involving damages exceeding the available policy limits. Whether such circumstances curtail or preclude the insurer from exercising its right to defend is discussed in Section 18.

§ 11: Confidentiality

Section 11 provides that information communicated by a policyholder to its insurer does not waive the confidentiality of such communications. It further provides in Subsection 2 that:

> An insurer does not have the right to receive any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of

> professional conduct, if that information could be used to benefit the insurer at the expense of the insured.

Comment c. makes clear that the insurer is free to obtain publicly available information, such as deposition transcripts, that may bear on coverage concerns but is not entitled to private information, such as statements made by the policyholder client to defense counsel.

§ 12 Liability of Insurer for Conduct of Defense

Section 12 was originally entitled "Vicarious Liability" and stated that, where an insurer engages counsel to defend its policyholder, it is vicariously liable for any breach of professional obligation by defense counsel and related service providers.

Following intensive debate, the Reporters announced at the March 2015 Advisers meeting that they were withdrawing the original text of Section 14. As restated in Section 12, insurers are now only liable if defense counsel was an employee of the insurer acting within the scope of their employment or if the insurer "negligently selected or supervised defense counsel," including by failing to ensure that the firm has adequate malpractice coverage.

§ 13: Conditions Under Which Insurers Must Defend

Section 13 sets forth general principles that define the duty to defend. Subsection (1) declares that an insurer's duty to defend arises if there is a claim against its insured "that is based in whole or in part on any set of alleged facts and an associated legal theory that, if proven, would be covered by the policy, without regard to the merits of those allegations or that theory." Comment c. states in explanation:

> This widely accepted rule reflects a public policy of construing defense coverage broadly. The complaint-allegation rule and the one-way use of information beyond the complaint are two of the most important ways in which the duty to defend is broader than the duty to indemnify.

Likewise, Comment a, confirms that an insurer's defense obligations continue through final resolution of the underlying claim:

> An allegation in a complaint that would subject the insured to a covered liability conclusively establishes that the insurer has a duty to defend. In such case, the insurer must defend the claim until the duty to defend terminates in one of the ways enumerated in § 20. This widely accepted "complaint allegation" rule generally means that the insurer must defend the claim all the way through final adjudication of the claim, unless the claim is settled or the insurer prevails in a declaratory-judgment action establishing that the claim is not covered by the liability insurance policy.

Section 13 appears to adopt a "four corners plus" approach whereby the duty to defend may be activated either by an allegation or legal theory "complained in the complaint or comparable document stating the claim or that is identified in the course of the investigation or

defense of the claim or inferable from the complaint or comparable document, that a reasonable insurer would regard as an actual or potential basis for all or part of the claim." Briefly stated, Section 13 sets forth the following rules:

1. If there is an allegation that clearly gives rise to a potential for coverage, the insurer must defend until the litigation concludes or the case settles.

2. If the complaint is vague or silent with respect to pertinent facts, an insurer has a duty to defend only if the insurer "knows or reasonably should know of other information that would lead a reasonable insurer to conclude that a claim is based on an allegation that, if included in the complaint, would require the insurer to defend." Except with regard to the two situations identified in Section 13(3), this rule works in one direction only: facts or circumstances not alleged in the complaint or comparable discount may not be used to justify a refund or failure to defend."

Section 13 has also been amended to substitute "legal action" for "claim" to avoid becoming entangled in the issue of whether and when a claim that is not actually in suit may trigger a duty to defend, an issue which the Restatement does not purport to resolve.

Much of the recent discussion concerning Section 13 focused on the circumstances in which a liability insurer could look to extrinsic facts to defeat a duty to defend. Earlier drafts limited this ability to specific issues, such as whether the claimant was an insured or a vehicle was covered under the policy. During the October 28, 2015 Advisors Meeting, however, there was a spirited debate as to whether Section 13(3) should attempt to identify all specific instances in which extrinsic facts could preclude a duty to defend or whether a more generalized statement of the rule would be more effective. Ultimately, the Reporters adopted the latter approach. In contract to Council Draft No. 1, Council Draft No. 2 now provides that:

> (3) An insurer is not required to defend a legal action brought against an insured if undisputed facts that are not at issue in the legal action for which defense is sought establish as a matter of law that the legal action is not covered. Unless such undisputed facts establish as a matter of law that the legal action is not covered, the insurer must defend until its duty to defend is terminated under § 18.

In short, Section 13 has adopted the California Montrose approach, wherein extrinsic facts may be relied on to eliminate a duty to defend so long as the facts are not in dispute and do not contradict factual allegations in the underlying action.

Section 13 distinguishes between "factual uncertainty" and "legal uncertainty." "Legal uncertainty" refers to the situation where the courts in that jurisdiction have not clearly ruled on the scope or meaning of certain coverage terms. In that regard, Comment e. suggests that an insurer may either deny the claim and face estoppel with respect to indemnity as set forth in

Section 19 or may be relieved of any duty to defend if it is later held not to have owed coverage. Alternatively, the insurer may defend under a reservation of rights.

§ 14: Duty to Defend: Basic Obligations

Section 14 provides that, where an insurer has a duty to defend it must do so in a professional manner protecting the insured from all risks including risks not covered by the liability insurance policy. Subsection 2 states that an insurer may carry out its obligation to defend by using staff counsel except where independent counsel is required as per Section 16. It further states that, unless the policy provides otherwise, the costs of defense are assumed to exist independent of policy limits.

§ 15: Reserving the Right to Contest Coverage

Section 15 states that an insurer may contest coverage only if it gives notice to its policyholder before agreeing to defend of the grounds on which it intends to contest coverage. The reservation must identify all bases for disputing coverage of which the insurer is or should be aware. To preserve its right to contest coverage, the insurer already defending a claim must update its reservation as soon as it learns of a ground for denial.

The reservation shall consist of a written explanation of the grounds that makes reference to the specific policy terms and facts upon which the defense is based in language that is understandable by reasonable persons in the position of the insured. If an insurer cannot reasonably complete its investigation of a claim before it has to undertake the policyholder's defense, the insurer may preserve its right to contest coverage by providing an initial general notice of reservation of rights so long as it sends a more detailed notice letter as soon as practicable. If an investigation is ongoing, an insurer may preserve its rights by issuing "an initial, general reservation of rights," as long as it provides a detailed reservation as soon as practicable.

The Reporters have since eliminated language in Section 15 that would have required insurer to give the policyholder the opportunity to discuss the insurer's coverage defenses with appointed defense counsel "for the limited purpose of understanding the impact of the reservation of rights on the defense of the claim and evaluating whether to retain other counsel at the insured's own expense."

§ 16: The Obligation to Provide an Independent Defense

Where an insurer has a duty to defend and "there are common facts at issue in the claim and the coverage defense such that the claim could be defended in a manner that would advantage the insurer at the expense of the insured," the insurer must agree to provide independent counsel. Independent counsel is not required merely because the underlying suit seeks damages in excess of the applicable limits. This is more or less the *Cumis* approach that most courts already follow. It is less problematic for insurers than the "reject the defense" approach followed in some states that allows independent counsel in cases where an insurer reserves rights. It is also better for policyholders than the rule followed in some other states that

does not require independent counsel or requires that the insurer consent to the insured's selection.

Comment c. does not take a clear position with respect to whether a claim for punitive damages (assuming punitive damages are uninsurable in that jurisdiction) necessarily gives rise to a right to independent counsel, indicating that, "while troubling," any such conflict must be evaluated on a case-by-case basis to see whether it would result in the defense being conducted in a manner that advantages the insurer at the expense of the insured. The Comment notes that efforts of defense counsel to reduce the policyholder's exposure with respect to compensatory damages will typically also reduce the policyholder's exposure to the uncovered punitive damage counts. Nevertheless, the Comment notes the possibility that a claim for punitive damages could give rise to a serious conflict in the defense if, for example, the compensatory damage claim is small in relation to the potential punitive damages. In such cases, the defense may be handled in a "hard edged manner" that disproportionately risks exacerbating the punitive damages exposure or the manner of presentation at trial could affect the jury's allocation between pain and suffering damages, on the one hand, and punitive damages, on the other.

§ 17: The Conduct of an Independent Defense

If independent counsel is justified pursuant to Section 16, the insurer is obliged to pay the reasonable costs of defense in a "timely manner." The determination of what is a "reasonable" fee is fact-based and, while the fees that an insurer may pay to panel counsel to defend similar types of cases may be relevant, it is not dispositive as it is presumed that panel counsel discount their fees in return for a guaranteed volume of work from insurers.

Comment b. had originally stated that in the event of a dispute over fees, the insurer was obliged to front the full cost of defense subject to a right to bring a claim for recoupment against defense counsel (not the insured) after the litigation was concluded. This proposal proved extremely controversial and was dropped when Council Draft No. 1 was put forward in 2015.

§ 18: Terminating the Duty to Defend a Claim

Section 18 enumerates the situations in which an insurer may withdraw from the defense of a case that it was originally obligated to defend:

(1) An explicit waiver by the insured of its right to a defense of the action;

(2) Final adjudication of the action;

(3) Final adjudication or dismissal of part of the action that eliminates any basis for coverage of any remaining components of the action;

(4) Settlement of the claim that fully and finally resolves the entire action;

(5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining components of the action;

(6) If so stated in the insurance policy, exhaustion of the applicable policy limit;

(7) A correct determination by the insurer based on undisputed facts not at issue in the legal action for which the defense is sought, as permitted under § 13(3); or

(8) Final adjudication that the insurer does not have a duty to defend the action.

Comment d. states that a partial adjudication may end the duty if the covered causes of action are resolved and rights of appeal are extinguished. Further, if so stated in the policy, exhaustion of the applicable policy limit will eliminate any continuing duty to defend.

§ 19: Consequences of Ordinary Breach of the Duty to Defend

Section 19 provides that "an insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action." Further, it originally provided that an insurer that failed to defend lost the right "to contest coverage for the claim."

This aspect of Section 19 met with vehement opposition by insurers, who variously pointed out that the proposed estoppel rule was very much a minority rule inappropriate for a Restatement; that the proposal was at odds with how the Restatement of Contracts addressed the damages consequent to a breach and that, in fact, many states had adopted contract-based remedies for an insurer's failure to defend that seemed to have addressed the problem without the draconian solution that the Reporters envisioned.

Shortly before the Advisors' meeting in October 2015, the Reporters withdrew the original text of Section 19(1) and instead proposed that insurers should only lose the right to raise defenses to indemnity if their failure to defend lacked a reasonable basis. This proposal was the subject of intense discussion prior to and during the Advisors Meeting and was eventually adopted in Council Draft No. 2 that was promulgated on December 28, 2015.

§ 20: When Multiple Insurers Have a Duty to Defend a Claim

Where more than one insurer has a duty to defend, that duty is joint and several notwithstanding any term in any insurance policy that purports to establish a priority of responsibility for the defense among the insurers except as provided in the exceptions detailed in Section 23.

Where multiple insurers have a duty to defend, the policyholder may choose one except as provided in the following section. If that insurer refuses to defend, it is subject to the estoppel consequences provided in Section 19 and the policyholder may select another to defend. In such circumstances, "only the selected insurer has the right to defend the claim" although it may seek contribution from any non-selected insurer for the costs of defense and any judgment rendered. Nevertheless, other insurers whose obligations to defend would otherwise have arisen will have the right to associate in the defense.

Section 20 purports to present a practical approach to 'other insurance" disputes. It states an insured may select any of its insurers to defend, without regard to "other insurance" wordings. It is then up to the designated insurer to sort out whether there is another insurer that properly should provide the defense and, if so, to make sure that the proper insurer in fact provides the defense. Section 20 does provide limited deference to "other insurance" clauses if

> [T]he policies establish an order of priority of defense obligations among them, or if there is a regular practice in the relevant insurance market that establishes such a priority, that priority will be given effect…

Although Section 20 allows insurers to "tender" their defense to a designated insurer, there is an important distinction between this approach and Illinois' "targeted tender" rule. As noted in Comment d., Section 20 allows the targeted insurer to obtain contribution from other insurers whereas the Illinois approach requires the targeted insurer to bear full responsibility for the claim and precludes claims for contribution from other carriers.

§ 21: Insurer Recoupment of the Costs of Defense

Section 21 provides that, unless an insurance policy expressly states otherwise, insurers have no right to seek reimbursement for defense costs "even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs." This is the default rule. Comment a. also states the history of this rule, observing that, "[f]or many years it was assumed that existing insurance policies did not grant insurers a right of reimbursement. This assumption was challenged in litigation starting in the latter part of the 20th century." The Comment discusses the traditional "contractual approach" and the more recent "equitable rule" which some courts have adopted, allowing insurers to seek reimbursement for claims found to fall outside of coverage. Comment c. summarizes the underpinning of this Section based on the "more recent trend":

> The early understanding and the more recent trend, however, treat reimbursement as a contractual right that must be explicitly stated in the policy. No courts or commentators adopting or advocating the equitable approach contend that an insurer is prohibited from disclaiming the right to reimbursement. Thus, under both the equitable and contractual approaches, the baseline legal rule is merely a default rule.

Comment c. acknowledges that barring a right to reimbursement may discourage insurers from voluntarily undertaking the defense of claims that are probably not covered. However, it also notes that parties may contract around this default rule by entering into separate agreements to allow reimbursement in return for the insurer's promise to defend. .

If an insurance policy sets forth such a right, the insurer may seek reimbursement only under the following conditions set forth in Section 21(2):

(i) the insurer has reserved its right to seek reimbursement in accordance with Section 15;

(ii) the underlying claim has been resolved; and

(iii) a determination of no coverage has been made.

The Reporters acknowledge (but not agree) that this "no recoupment" default rule is at odds with Section 35 of the Restatement (Third) of Restitution and Unjust Enrichment, which does allow for equitable restitution under analogous circumstances.

§ 22: Defense Cost Indemnification Policies

This Section provides that defense cost indemnification policies that oblige the insurer to pay defense costs on an ongoing basis should be treated in the same manner as policies containing standard duty to defend language.

§ 23: The Right to Associate in the Defense of a Claim

It is not uncommon for certain types of liability insurance policies, particularly excess policies, to give an insurer the right to "associate" in the policyholder's defense even when the insurer has no contractual duty to defend. Section 23 provides that, in such cases, the insurer is entitled to receive information from defense counsel that is necessary to assess the policyholder's liability so long as the information in question does not include confidential information concerning coverage issues. The insurer should also be afforded "a reasonable opportunity to be consulted regarding major decisions in the defense of the claim that is consistent with the insurer's level of engagement with the defense of the claim."

Topic 2 – Settlement

§ 24: The Liability Insurer's Duty to Make Reasonable Settlement Decisions

Section 24 addresses settlement when either a liability insurer has the authority to settle a claim against the policyholder or the policy grants the insurer a right to consent to a settlement negotiated by the policyholder. It provides that the insurer has a duty to the policyholder to make reasonable decisions but stipulates that this duty pertains only to claims that potentially exceed policy limits. The Section defines a "reasonable settlement decision" as "one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending a claim." Subsection (3) provides that this duty extends to accepting reasonable settlement demands made by plaintiffs with a proviso that the insurer's liability is "never greater than policy limits." The duty also includes the "duty to contribute its policy limits . . . if that settlement exceeds those policy limits."

Comment a. describes the rationale for these rules as follows:

> The objective is to encourage liability insurers to make efficient and equitable settlement decisions. In addition, because insureds are generally more risk adverse than insurers, this rule maximizes the joint well-being of the parties by shifting the risk of excess judgments from insureds to insurers.

> The purpose of the duty to make reasonable settlement decisions is to align the interest of insurer and insured in cases that expose the insured to damages in excess of the policy limits. Therefore, the duty is owed only with respect to cases that expose the insured to such damages.

Comment b. refers to this principle as a "long-standing rule of insurance law." The Comment observes that the Reporters use the term "duty to make reasonable settlement decisions" instead of the more common term "duty to settle," to emphasize their view that insurers do not have a duty to settle every claim but, rather, "to make reasonable settlement decisions." It emphasizes that insurers "may reject unreasonable settlement demands," as defined in Section 24(2) of the black-letter. The reasonableness standard is "flexible," permitting the finder of fact "to take into account the whole range of reasonable settlement values." This range includes consideration of whether an insurer made reasonable offers and counteroffers.

Comment f. specifically distinguishes between an insurer's rejection of a reasonable settlement demand and its failure to make a reasonable offer at all:

> A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer's decision not to make a reasonable offer, or counter-offer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

Comment f. makes plain that this difference rises from differences in proof of causation. When an insurer rejects a reasonable settlement demand leading to an excess judgment against the policyholder, causation is plain. It is less clear when an insurer fails to make any offer or counter-offer. This rule applies to both duty to defend and defense costs indemnification policies.

Comment g. acknowledges the argument that these rules may "hamper negotiation strategies by liability insurers in settlement discussions, to the detriment of policyholders as a whole." The Comment uses several examples. For instance, Comment g. points to a possible refusal by a reasonable insurer to make any settlement offers until the claimant has submitted one "because doing so produces a lower all settlement figure (provided the case ultimately settles) or because doing so forces the claimant to reveal through its settlement demand information about the case that might be of use to the insurer in the defense." The Comment acknowledges that insurers may be reluctant to pursue such strategies because of the risk of an excess judgment. As a result, the Comment notes that "[s]uch bargaining practices may tend to produce lower settlements on average, a fact that can lead to lower overall liability insurance premiums." These are facts that "would merely be evidence of a lack of reasonableness on the part of the insurer to be considered by the trier of fact along with other evidence . . . ."

Section 24 rejects this perspective for several reasons. The Comment states, as a first reason, that "minimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions. Rather, the primary objective is to protect

insureds from the conflict of interest inherent in the standard less-than-full-coverage case where the insurer has the sole settlement discretion." The rule also does not prevent liability insurers from rejecting settlement demands or refusing to make settlement offers. "Rather, the rule simply imposes on insurers (and, thus, the insurance pool) the risk of being wrong in making that determination in individual cases." Section 24 specifically includes both the amount of the potential judgment and the costs of defending a claim in its definition of "reasonable settlement decision."

Comment h. notes various reasons why defense costs should be considered in the definition of a reasonable settlement decision but ultimately concludes that they should not be and that doing so would impose a duty on insurers to pay "nuisance value" in most cases.

Comment m. observes that the issue of whether an insurer has failed to make a reasonable settlement decision is not the same as whether an insurer has acted in bad faith or breached the implied duty of good faith and fair dealing as liability for failing to make a reasonable settlement decision does not require proof of bad intent. The Reporters observe, therefore, that the issue is one of "reasonableness" and not a question of "good faith" or "bad faith."

Comment n. states that the insurer's duty is owed only to its policyholder and that while an excess insurer may have a right of action to "subrogation," an insurer's duty here is to the policyholder, not the excess insurer. Nor, as Comment o. states, is the duty owed to tort claimants; they typically have no right to bring direct actions against the insurers based upon a failure to negotiate settlement. This is not, of course, the rule in all jurisdictions. *See, e.g., Rhodes v. AIG Domestic Claims, Inc.*, 461 Mass. 486 (2012) (awarding doubled damages to accident victim based on insurer's failure to effectuate a settlement in case where insured's liability was clear. This Section "follows the majority rule."

§ 25: The Effect of a Reservation of Rights on Settlement Rights and Duties

Apart from cases that insurers do not settle given their evaluation of the insured's potential liability, insurers are reluctant to pay to settle cases that are not covered in whole or in part. Faced with the conflict between an insurer not having any duty to pay to settle cases that are not covered and the need to protect the insured from potentially catastrophic exposures, some courts have granted insurers the right to recoup that portion of the settlement that is later found not to be covered. However, Section 25 precludes recoupment in such circumstances "unless specifically provided for in the policy or the insured has otherwise agreed."

Further, Section 25 confirms the insured's right to settle without waiving its rights to later get coverage for its payment. Section 25(3) states that a policyholder may settle without the insurer's consent so long as:

(i) the insurer is made aware of the proposed settlement;

(ii) the insurer withdraws its reservation of rights;

(iii) a reasonable person would have accepted the settlement; and

(iv) if the settlement includes uncovered damages, that portion of the settlement is reasonable.

Comment a. states that an insurer has no duty to settle uncovered claims, but an insurer's reservation of rights does not eliminate its duty to make reasonable settlement decisions. Again, as with Section 17, the insurer bears the risk of liability for an excess judgment when, at trial, its decision is found to be unreasonable or it rejects an offer to settle within limits.

As with the discussion of an insurer's right to recoup defense costs, Comment c. discusses a perceived inconsistency between insurer arguments that policyholders are otherwise unjustly enriched by receiving settlement payments to which they are not contractually entitled and the discussion of unjust enrichment in Section 35 of the *Restatement (Third) of Restitution*.

§ 26: The Effect of Multiple Claimants on the Duty to Make Reasonable Settlement Decisions

A situation in which there are more claimants than policy limits can raise difficult questions of timing and entitlement to its proceeds, particularly when an insurer has not paid defense costs as they are incurred. Courts have struggled to identify appropriate rules to govern such situations. Does the insurer in such cases act in bad faith if it pays its full limit to settle some of the cases but not all? Alternatively, if the insurer is unable to settle all of the claims, does the insurer nonetheless have a duty to settle such claims as it can?

The answer, according to Section 26, is interpleader. Thus, the Reporters state that an insurer has a duty to make "a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure." The insurer may satisfy this duty by "joining all affected claimants in the underlying action and tendering its policy limits to the court" with a motion to allocate the limits "among the claimants on the basis of the relative value of their claims."

If a claimant in such a situation rejects a portion of the policy limits offered in full satisfaction of its claim, the insurer's duty to defend remains in effect until the claim is settled, the claim is finally adjudicated, or a court finds that the insurer does not have a duty to defend.

§ 27: Damages for Breach of the Duty to Make Reasonable Settlement Decisions

Section 27 provides that an insurer that fails to make a reasonable settlement decision is liable for the entire amount of the judgment, not just the amount within its policy limits. Furthermore, the insurer may be liable for "any other reasonably foreseeable harms." If there is an excess judgment, this liability encompasses possible liability for emotional distress. This rule applies only if there is an excess judgment.

Comment d. discusses the minority rule which limits damages in duty to settle cases "when the insured has insufficient assets to cover the excess judgment." Under this rule, it is assumed that the insured has not been financially harmed because the excess judgment will simply be unpaid. This Section instead adopts a majority rule which measures the policyholder's damages by "the difference between the policy limit and the judgment against the insured." The

Comment cites several reasons for this decision. For instance, although the insured may be judgment-proof, the policyholder will continue to face that debt unless the insured files for bankruptcy or the tort plaintiff waives the debt. The Reporters also note that "the minority rule discourages settlement compared with the majority rule."

Comment e. states that an insurer that fails to effectuate a reasonable settlement is liable for all damages flowing from that failure even if the resulting excess judgment may include elements, such as punitive damages, that would not otherwise have been covered. This is contrary to the view of cases such as *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999), and *Lira v. Shelter Insurance Co.*, 913 P.2d 514 (Colo. 1996), cited in the Reporters' Notes. In those cases, state courts in some of the states that do not allow for coverage of punitive damages have ruled that an insurer may not be held liable for award of punitive damages that resulted from alleged failure to settle within policy limits because such damages are not insurable.

The Comments acknowledge the tension between state-law principles barring coverage for punitive damages and the approach set forth in this Section. However, Section 27 expresses "a strong public policy in favor of encouraging reasonable settlement decisions by liability insurers." Including punitive damages as an element of damages for breach of this duty to make reasonable settlement decisions compensates insureds for "the full harm caused by an insurer's unreasonable decision" and, thus, "is integral to the regulatory function of the duty."

§ 28: Excess Insurers' Right of Subrogation

Section 28 recognizes that an excess insurer may pursue a right of equitable subrogation against a primary insurer for failing to effectuate a reasonable settlement. This appears to reflect the emerging majority view on this issue, although it is not one that is universally accepted.

Topic 3 – Cooperation

§ 29: The Insured's Duty to Cooperate

Section 29 provides that policyholders have a duty to cooperate with their insurers in:

(i) "the investigation and settlement of a claim for which the insured seeks coverage;

(ii) the insurer's defense of a claim, "when applicable"; and

(iii) situations in which the insurer associates in the defense.

As the Comments note, the duty to cooperate "serves to align the incentives of insurer and insured," helping to ensure that the insured has the incentive to aid the insurer in its defense and management of the claim. The duty requires the insured to render "reasonable assistance," with reasonableness assessed depending on the complexity of the claim, the insurer's ability to obtain information from other sources, the extent to which the insurer needs the policyholder's cooperation, etc. Comment c. explicitly states that the duty to cooperate is not intended to

"become a trap for the insured," and states that an insurer "may not unilaterally withdraw from the defense of a claim based on non-cooperation." Instead, an insurer must follow the procedure set forth for reserving rights and pursuing a declaratory judgment action in such situations. Similarly, Comment d. states that the duty to cooperate does not obligate the insured to comply with unreasonable requests.

§ 30: Consequences of the Breach of the Duty to Cooperate

Section 30 states that, where an insured has failed to cooperate with its insurer, the insurer may avoid coverage only if the insured's action has substantially prejudiced the outcome of the case. Further, if the insurer can show that its policyholder colluded with the claimant, the insurer is excused from coverage unless the insured proves that the collusion "if undetected, would not have caused substantial prejudice to the insurer in the outcome of the claim."

The Comments note that most jurisdictions require an insurer to prove substantial prejudice before a breach of the duty to cooperate will relieve the insurer of its policy obligations. However, a few jurisdictions continue to follow a "strict condition precedent rule under which an insurer may avoid its policy obligations if the insured has materially breached its duty to cooperate." Comment b. discusses the differing standards that courts may apply to the substantial prejudice test. Some jurisdictions require the insurer to show "a substantial likelihood that the insured's cooperation would have allowed the insurer to defeat the plaintiffs' claim." Other jurisdictions apply a presumption that the insured's breach of the duty did prejudice the insurer, giving the insured the opportunity to rebut that presumption. This Section follows the "substantial likelihood test" which "sets a high standard for meeting the substantial prejudice requirement," focusing "on the impact of the failure to cooperate on the outcome of a claim. It is not enough that the insured's failure to cooperate increase the cost or difficulty of the defense." The Comments state that the rule in this Section applies the "disproportionate forfeiture principle" in which "a small and minimally blameworthy breach of a condition by an insured does not excuse the insurer from performance, because the harm to the insurer from the breach is so much less than the value of the coverage to the insured." According to the Comments, this result is both fair and efficient because it protects insureds or policyholders from the exposures for which they "purchase liability insurance: their own negligence." It is fair, according to the Comments, "because it is consistent with widely accepted proportionality norms, as well as the public policy in favor of compensation of the underlying claimants."

C. Chapter Three: General Principles Regarding the Risks Insured (Sections 31-45)

Chapter Three represents a comprehensive effort to analyze and apply the building blocks of all liability insurance policies, including (1) the scope of coverage; (2) conditions to coverage; (3) terms affecting the amount that an insurer must pay.

Topic 1 – Coverage

§ 31: Insuring Clauses

Section 31 sets forth the general rules with respect to insuring agreements and states that terms granting coverage are intended to be interpreted broadly and do not depend on their location in the policy for their status.

§ 32: Exclusions

Unlike terms conferring coverage, exclusions are to be read narrowly. A provision in earlier drafts stating that exclusions should generally be read separately from the standpoint of each insured has been deleted. Exceptions to exclusions may not be read to confer coverage not otherwise granted in the insuring clause.

Exclusions requiring proof of intent will generally be interpreted as requiring proof of subjective intent, although Comment d. confirms that insurers may draft around this requirement, as homeowners form exclusions commonly do. Comment d. also points out that subjective intent must be proved by objective evidence and may sometimes be inferred as a matter of law, as in cases of sexual assault.

§ 33: Timing of Events That Trigger Coverage

Section 33 describes the role that "trigger" clauses play in liability insurance, whether in the context of "occurrence"-based policies or "claims made" policies. Comment f. adopts the "injury in fact" approach as the default solution, for long-tail claims, while acknowledging that "injury in fact" may implicate multiple years of coverage depending on the causal circumstances of loss. Comment g. assigns the burden of proof in such cases to insureds, although the burden appears to be light and an insured may be able to compel coverage based on mere evidence of exposure, subject to each insurer's ability to show that no harm actually occurred in its policy period.

§ 34: Insurance of Liabilities Involving Aggravated Fault

Section 34 declares that it is not against public policy for insurers to pay to defend cases involving aggravated fault, as where an insured acted with intent to cause injury, nor are insurers precluded from paying judgments or settlements in such cases. Insofar as the law forbids insurers from indemnifying cases of aggravated fault, Section 34(2) proposes that insurers pay such losses in the first instance but be allowed to obtain reimbursement from their policyholders.

Section 34 observes that there is little empirical support for the proposition that the availability of insurance may encourage anti-social behavior or that its unavailability is likely to act as a deterrent in such cases. Further, Comment f. rejects the proposition that punitive damages are uninsurable as a matter of public policy, even in cases based on the insured's own intentional acts.

Topic 2 – Conditions

§ 35: Conditions in Liability Insurance Policies

Section 35 defines a "condition" as an event that "unless excused, must occur, or must not occur, before performance under the policy becomes due." Whether a term is a "condition" or not does not depend on where it is placed in a policy. Subsection (3) states that a failure to satisfy a condition will generally only defeat coverage if it results in prejudice to the insurer. Earlier language requiring "substantial prejudice" was removed, although Comment e. confirms the Reporters' view that the prejudice must be "material."

Comment d. states that the insured's breach must have impacted the insurer's ability to protect its interests in a "significant" way; "an increase in the cost or burden of defense or investigation is not sufficient." Examples of prejudice are "loss of a defense in the underlying claim, a significant increase in the amount of damages or the settlement value of the claim, the destruction of evidence needed for the insurer to prove that the claim is not covered, and the extinction of the insurer's subrogation rights in a context in which the insurer would have had a meaningful possibility of recovery pursuant to those rights."

Prejudice is also required to sustain a breach of the cooperation clause, although Council Draft No. 2 is more equivocal on this point than prior drafts, stating that courts have "sometimes" so ruled. Comment g. states, moreover, that prejudice may often be found as a matter of law in cases where the insured has settled before giving notice or is late in tendering its defense. In such cases, the Reporters observe that denying reimbursement for the settlement or "pre-tender' costs would be "proportional" to the insured's breach.

§ 36: Consent or Approval of Insurer as a Condition

Section 36 addresses instances where coverage is contingent on the insurer giving advance consent, as is the case with indemnity payments and, in some types of policies, defense costs. It provides that the insurer need not give its assent, so long as consent is sought within the time required and a reasonable insurer would have consented.

§ 37 The Exception for Claims-Reporting Conditions in Claims-Made and Reported Policies

Having articulated a general requirement of prejudice for notice conditions in Section 35, the Reporters proceed to carve out an exception for "claims made" policies in Section 37 in light of the different role that such terms play in "claims made" coverage. Section 37 does insist, however, that policyholders be given a "reasonable" amount of time within which to report claims that are received towards the end of the policy period.

§ 38: Circumstances Under Which Anti-Assignment Conditions Are Enforceable

Section 38 distinguishes between the assignment of a specific claim and rights under a policy generally. As to the former, Section 38 states that insureds are free to assign individual

claims. As to the latter, an insured may only enter into such an assignment as part of a merger or other corporate transaction that also transfer financial responsibility, the policy has already expired and the transfer does not materially increase the risk insured by the carrier.

Comment c. also confirms that these rights only extent to liabilities that were already insured under the policy; successor entities may not obtain coverage for pre-merger liabilities.

Topic 3 – Application of Limits, Retentions and Deductibles

§ 39 Policy Limits

Section 39 explain the role of policy limits and the difference between "per occurrence" and aggregate limits.

§ 40 Retentions and Deductibles

Section 40 explains the role of deductibles and self-insured retentions and the principal difference between the two, namely that an insurer's policy obligations generally do not arise until a retention is satisfied by the insured, whereas an insurer's duty to defend and other obligations are not contingent upon the insured reimbursing a stated deductible.

§ 41 Number of Accidents or Occurrences

Analyzing the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate "occurrence" limits, the Reporters have adopted the majority "cause" approach and have made the further important determination that "cause" is based on the source of the insured's liability and not the process or processes that are the physical cause of the underlying injuries.

§ 42 Excess Insurance: Exhaustion and Drop Down

Section 42 addresses two issues of consequence to excess insurers: (1) what event triggers an excess insurer's duties and (2) whether insurers must "drop down" following the insolvency of a primary insurer.

Section 42(1) provides that an excess insurer's duties are not triggered until the underlying limits are exhausted, although Section 42(2) adopts the so-called *Zeig* rule that allows those limits to be exhausted through a combination of sums paid by the underlying insurers and the policyholder. Comment d. states that this is only a default rule and that an excess insurer can draft around the *Zeig* rule by adopting language stating that "liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits," or (2) "coverage under this policy shall attach only after the full amount of the underlying limits have been paid by the underlying insurers."

Section 43(3) provides that an excess insurer's duties may not be accelerated by the insolvency of a primary insurer but that the primary insurer's insolvency does not relieve the excess insurer of its duty to pay the limit that it contracted to pay.

§ 43 Indemnification from Multiple Policies: The Default Rule

Section 43 states that, in most cases, "when more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy." Insurers may, however, internally allocate their obligations through the use of "other insurance" clauses or similar terms so long as they do not conflict with each other and do not operate to eliminate coverage altogether. Thus Section 43(2) states that "when an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy and provided that there is no more allocation to the insured than there would have been under the applicable policy that is most favorable to the insured with regard to allocation."

§ 44 Long-Tail Harms and Successive Policies

Despite the preceding section's adoption of "joint and several" liability as the default rule where two policies insure the same risk, Section 44 carves out an exception for "continuing or repeated harm" that causes injury in successive policies. For these "long-tail" cases, insurer's coverage obligations are pro-rated on a "time on the risk" basis by dividing their years of coverage by the overall duration of the underlying injury or damage. While recognizing the division of authority on the issue, the Reporters have concluded that "pro rata by years" is the most consistent, simplest, and fairest solution to this problem."

§ 45 Contribution

Section 45 permits an insurer that has paid more than its share of a judgment or settlement to recover from another insurer that has not paid its fair share so long as the other insurer has not, in the interim, entered into a settlement and obtained a release from the insured. Note that this right of contribution only applies to indemnity claims and does not apply in the not uncommon situation where a carrier settles out early for a small amount.

III. A CRITIQUE OF THE RESTATEMENT

Although the *Restatement of the Law of Liability Insurance* nears its mid-point, there is still considerable uncertainty with respect to key provisions and, perhaps more importantly, what impact it will have in shaping the future course of the common law.

With the promulgation of counsel draft No. 2, the Restatement of the Law of Liability Insurance is nearing completion. From advantage point of lawyers and claims people who handle coverage disputes on behalf of insurance companies, it must be acknowledged that Counsel Draft No. 2 and those portions of Chapters 1 and 2 that have now been approved by the ALI Council are a vast improvement over the original *Principles* text as well as early Tentative Drafts of Chapters 1, 2 and 3. In particular, the *Restatement* no longer contains earlier proposals that would have:

- Permitted coverage by estoppel and waiver.

- Limited an insurer's right to rescind to cases of intentional fraud.

- Imposed vicarious liability for the misconduct of defense counsel.

- Allowed an insured to consult with defense counsel to determine whether a reservation of rights presented a conflict of interest requiring independent counsel.

- Required insurers to front the full cost of disputed rates subject to a remedy solely against the law firm.

Yet despite these improvements there are still several provisions in the *Restatement* that cause grave concern to insurers. In particular, insurers have focused on the following Sections of the *Restatement*.

A. Provisions for Contract Interpretation (Section 3 and 4)

ALI Restatements are generally meant to embrace majority rules unless they are outmoded or impractical to apply. As a result, it is surprising that the project's Reporters have chosen to abandon the "plain meaning" rule of contract interpretation, which is the acknowledged standard for interpreting insurance policies in nearly every state, for a novel "presumption of plain meaning."

The Reporters claim to be threading an intermediate approach between strict application of the "plain meaning" rule and the broader "contextual approach" that allows consideration of all sorts of extrinsic evidence to show ambiguity. The Reporters state that "the presumption in favor of plain meaning set forth in this Section rejects the plain-meaning rule's absolute preclusion of extrinsic evidence regarding the meaning of policy terms that on their face have a single meaning would apply to the claim in question, but accord the language of those terms a significance that the contextual approach may deny them." The Reporters assert, however, that extrinsic evidence should be considered, not to determine whether there is *another* reasonable meaning but rather whether that other meaning is in fact, more reasonable and therefore more reflective of the actual meaning of the policy term than the one evident from the terms of the policy itself. The Reporters suggest that permitting consideration of extrinsic evidence is, in fact, in line with the approach that most courts follow in assessing summary judgment filings and may, in fact, be more efficient if it eliminates the need for a second round of summary judgment practice in the event that ambiguity is considered or determined.

The Reporters also reject the oft-stated proposition that policy terms should be interpreted so as to avoid internal inconsistencies or surplusage. Rather, the Reporters observe that "it must be recognized, however, that insurance policies may consist of components that evolve over time along different paths, are amended or retained because of understandings that develop in the market and in judicial interpretations, or make explicit rights or obligations that the law would imply in any event. As a result, insurance policies frequently contain what might be considered redundancies or surplusage."

Sections 3 and 4 are also troubling in their one-sided aspect. Although the black letter rules seem to promote an approach that permits an evenhanded search for the true meaning of the

parties, the Comments and Reporters Notes, in fact, make clear that this remedy is heavily weighted towards policyholders. Policyholders are free to present a wide-range of extrinsic evidence in support of their proposed interpretation, including evidence of a policy's drafting history; regulatory filings with state insurance departments; other versions of the policy available on the market and expert testimony regarding custom and practice in the insurance industry, the history, purpose, and functions of policy terms and forms of insurance coverage . By contrast, insurers may only present extrinsic evidence that the insured would or should have had knowledge of act the time of contracting! While this might presumably encompass the direct discussions between the insurer and policyholder in the negotiations for coverage, even such course of dealing evidence may be inadmissible: As Comment f. to Section 3 states:

> Because the objective of using the extrinsic evidence is to understand the meaning that a reasonable person in this policyholder's position would ascribe to the term, such evidence may only be used against an insured when the policyholder could reasonably have been expected to have been aware of it.

In short, insurers are giving up the certainty and protection of the "plain meaning" rule for an uncertain new regime of contract interpretation that seems more likely to generate ambiguity and delay than facilitate the resolution of coverage disputes.

B. Liability for Conduct of the Insured's Defense (Section 12)

Although Section 12 no longer automatically makes an insurer vicariously liable for the misconduct of defense counsel, it nonetheless opens the door to claims beyond those that are permitted under the rule in most states. Thus, insurers may now be liable for negligence in the selection and supervision of counsel or for failure to ensure that defense counsel have appropriate malpractice insurance limits. Furthermore, as Section 12 states that insurers are likely for the actions of their employees, it leaves open the possibility that insurers may be vicariously liable for the conduct of staff counsel.

C. Liability for Punitive Damages (Section 27)

Section 27 provides that an insurer's failure to effectuate a reasonable settlement within limits makes it liable for all damages flowing from that failure, including punitive damages even if such damages would not ordinarily been insurable. As yet, there is not a single court in the United States that has so found. Nevertheless, the Reporters purport to rely on significant dissents in rulings from the California and Colorado Supreme Courts in which the majority had refused to impose liability on this basis.

D. Trigger of Coverage (Section 33)

Notably, Section 33 does not contain any discussion of what circumstances may serve as an end-point to a continuous trigger. In the absence of such an end-point, an insured might argue that it can obtain coverage for continuing losses even after the losses ceased to be fortuitous, as where the insured has already been sued or put on notice of its claimed liability.

While a claim of this sort would mainly be of concern to insurers, policyholders also have need of some sort of ending point. Long-tail liabilities that may be excluded in more recent policies may give rise to significant blocks of years for which the insured must be responsibility per the allocation discussion in Section 44 if the triggered coverage block is not cut off at some point.

E. Coverage for Cases of Aggravated Fault (Section 34)

Chapter 3 adopts a rule of subjective intent as a default principle in Section 32 despite the fact that courts around the United States are closely divided with respect to whether to use a subjective or objective standard (or a hybrid standard in many states that distinguish between the meaning of "expected" and "intended"). Further, the Restatement fails to address the significant body of case law in which intent has been presumed as a matter of law in cases of inherently injurious conduct such as sexual assaults.

F. Coverage for Punitive Damages (Section 34)

Although the Restatement reflects the majority rule that coverage should not be barred as a matter of public policy where the insured is merely vicariously liable for the intentional misconduct of its agents or representatives, it goes well beyond the rule in most states in precluding public policy entirely. While the Reporters are to be commended for declaring that such issue should be resolved on the terms of the policy and not principles of public policy, it appears that their treatment of this issue in Section 34 is contrary to the emphasis on public policy in their discussion of whether coverage should be required for instances of intentional harm or other types of aggravated conduct in Section 32.

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ALI Council Members and Emeriti
The American Law Institute
4025 Chestnut Street
Philadelphia, PA 19104

Re: Restatement of the Law, Liability Insurance

Dear ALI Council Members and Emeriti:

I write in my capacity as the American Insurance Association Liaison to the American Law Institute (ALI) Restatement of the Law, Liability Insurance project to urge that, consistent with the ALI process for developing a Restatement, the Council should allow for additional dialogue and consideration of Chapters 1 and 2 of the Liability Insurance project, and defer any final vote approving them until a future Council meeting.

As a Restatement, the project is just one year old. It is addressing a completely new subject for ALI. In its October 2014 meeting, the Council voted to change the project from Principles of the Law of Liability Insurance to the Restatement of the Law of Liability Insurance. This is also new territory. I believe it is the only time in ALI's history that a Principles project has been changed to a Restatement. Members of the Council know that these are very different work products. Principles projects may be based on the Reporters' subjective views of what the law should be. Restatements, in comparison, must be grounded on existing law. In February 2015, just eight months ago, ALI Reporters Professor Tom Baker and Professor Kyle Logue released the first Tentative Draft No. 1 of the Restatement project. The drafts of Chapters 1 and 2 of the Restatement have generated substantial controversy and debate, often focused on whether the positions taken by the Reporters depart too often and too dramatically from the common law and are inconsistent with the mission of an ALI Restatement. Important comments and critiques of some of the Sections of Council Draft No. 1 have been submitted as recently as the past few weeks. Moreover, given the unique nature and circumstances of this project, a special burden falls on the Ali to ensure a careful, deliberative process that sets the right precedent moving forward.

Members of the Liability Insurance project ALI Advisory Committee and the MCG, as well as other commentators, have pointed out that a number of Sections in Chapters 1 and 2 that depart from the common law, sometimes without acknowledging the major changes they would introduce into existing insurance law. Controversial Sections include, but are not limited to, Sections 3 and 4 (policy

interpretation), Section 12 (insurer liability for conduct of defense), Sections 13, 18 and 19 (duty to defend), Section 21 (recoupment), Sections 24 and 27 (settlement), and Section 30 (duty to cooperate). To demonstrate the serious character of these comments, Attachment 1 to this letter articulates concerns raised about the approach taken in the illustrative listed provisions. These Sections, with the exception of Section 19, have seen little revision, despite the significant scholarship and discussion they have generated. These Sections represent more than a third of the provisions in Chapters 1 and 2, and there are many instances where the Restatement position deviates from the prevailing law and does not set forth a clear and convincing basis for doing so. The draft Restatement also does not discuss extensive contrary law and policy considerations set out in recent submissions made by commentators on the draft. Because the March 2015 meetings of the ALI Advisors and Members Consultative Group took place very soon after the Restatement draft was first released, many -- if not most --of the highly substantive comments on Chapters 1 and 2 were submitted after those meetings. In light of those comments and materials, I respectfully submit that Chapters 1 and 2 merit additional discussion and review with the ALI Advisors and MCG.

The general public policy path taken to date in the Restatement draft also has been strongly criticized by Yale Law School Professor George L. Priest, who is a nationally recognized expert on the operation of private and public insurance, and the role of the legal system in promoting economic growth and sound public policy. Professor Priest has authored an article analyzing the current approach of Chapters 1 and 2 of the project. The article concludes that, while provisions may seek to put policyholders in a "better position" than they are today, the rules would ultimately make all policyholders worse off by unfairly increasing insurance costs and reducing the availability of insurance. Professor Priest urges that the policy objective of the RLI project should be to develop provisions which maximize the availability of insurance, which would in turn reduce risk levels and benefit society as a whole. Professor Priest's article, titled "A Principled Approach to Insurance Law: The Economics of Insurance and the Current Restatement Project," is available at www.ssrn.com. In an effort to assist those interested in Professor Priest's critique of the RLI project, ALI Member Victor Schwartz of the Shook Hardy & Bacon firm prepared a summary of Professor Priest's article, which is Attachment 2 to this letter.

Consistent with the ALI's publicly-stated process for development of Restatements, the Restatement's aim of providing a clear statement of the common

law, and the ALI's stated commitment to transparency with respect to the positions adopted in a Restatement, I respectfully submit that Chapters 1 and 2 should be the subject of ongoing discussion and review to incorporate more of the recently submitted comments and scholarship. Allowing for continued dialogue in the Advisors and MCG meetings to be held later this month, in light of the new materials submitted, is most consistent with the ALI mission in creating a Restatement through a process of "engag[ing] the best minds in the profession over an extended period of time, with access to extensive research, testing rules against disparate fact patterns in many jurisdictions." ALI Style Manual, p. 6. Ensuring that there is a full opportunity for debate on the content of the project is consistent with the spirit of the ALI process and can help improve the final Restatement produced as a result of those efforts. Moreover, there remains time for a refined draft to be advanced through the ALI process, fully consistent with the timetable aspired to for this project.

As the American Insurance Association's liaison to the project, I look forward to continuing to work with the ALI in this effort as the Restatement of the Law of Liability Insurance project progresses.

Very truly yours,

Laura A. Foggan

ALI Restatement of the Law, Liability Insurance
Examples of Draft Sections Generating Concern

In the Restatement of the Law, Liability Insurance, Council Draft No. 1, examples of sections that depart from the common law, sometimes without even acknowledging that they would dramatically alter existing insurance law, include at least the following:

Section 2: Insurance Policy Interpretation and
Section 3: Presumption in Favor of Plain Meaning

There is serious concern that these sections depart from black letter law that an insurance policy term is given its plain meaning. They proscribe rules where the plain meaning of a policy term can be overcome by extrinsic evidence, essentially eliminating certainty and guidance for everyone and inviting unnecessary and expensive collateral litigation. Section 2 is the introductory section proscribing the rules for interpreting insurance contracts. It starts down a slippery slope with respect to ordinary rules of contract interpretation by stating that they apply to the interpretation of liability insurance policies "[e]xcept as this Restatement or applicable law otherwise provides." In other words, Section 2 foreshadows and allows for departures from ordinary rules of contract interpretation throughout the Restatement. Section 3(2) states that "An insurance policy term is interpreted according to its plain meaning, if any, unless the court determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence. That different meaning must be one to which the language of the term is reasonably susceptible after consideration of the extrinsic evidence." Section 3(2) has been heavily criticized for deviating from the plain meaning rule and it has been the focus of concerns about undermining the development of uniform, predictable meanings for insurance terms.

Section 12: Insurer Liability for the Conduct of the Defense

Section 12 addresses the insurer's liability for the conduct of defense counsel when the insurer defends an insured. Section 12(2) would impose liability on insurers for defense counsel's breach of a professional obligation when the insurer negligently selects or supervises defense counsel. However, courts generally treat defense counsel as independent contractors with respect to insurers, even if insurers are paying the defense. Further, a majority of the jurisdictions that have addressed this issue have held that insurers are not vicariously liable for the acts of defense counsel that are independent contractors. The current draft adopts a minority position that is at odds with recent rulings, as well as the prevailing view.

Section 13: Conditions Under Which the Insurer Must Defend

Black letter law throughout the country allows an insurer to rely on extrinsic facts on ancillary matters such as insurance contract formation, conditions precedent and the like, in denying a duty to defend. Any suggestion that an insurer could not deny a defense based on grounds such as late notice, misrepresentation or failure to cooperate because those defenses require reference to extrinsic facts would be wildly inconsistent with the black letter law. Section 13 must make clear that it adheres to this settled principle, and that its discussion of the limits of extrinsic evidence and the consideration of all facts and circumstances does not alter this well-established law. To do so, it would be necessary for Section 13(3) to state that it limits

only the insurer's ability to deny coverage based on extrinsic evidence contradicting the complaint, and does nothing to interfere with the basic proposition that an insurer may deny coverage based on extrinsic facts on ancillary matters not addressed in the complaint at all, such as policy compliance and conditions precedent to coverage. Any other approach would wildly swing away from settled law on insurers' ability to rely on contract terms in denying a duty to defend, such as those requiring prompt notice and cooperation.

Section 18: Terminating the Duty to Defend

In contrast to the existing common law rule, Section 18 provides that a duty to defend terminates only when one of eight subsections are met. Unless one of the circumstances in Section 18(1)-(7) is present, Section 18(8) encourages, if not requires, insurers to seek an explicit judicial determination "that the insurer does not have a duty to defend the claim." This rule fundamentally alters the terms of insurance contracts and contradicts black letter law. It would amount to a windfall for insureds—who would continue to receive a defense potentially far beyond what they bargained and paid for while insurers await a court determination on the duty to defend. Going forward, it would result in more expensive premiums, as the rule would encompass a duty to defend that exceeds the terms of the contract. More than 60 years ago Learned Hand wrote, "[i]t follows that, if the plaintiff's complaint against the insured alleged facts which would have supported a recovery covered by the policy, it was the duty of the [insurer] to undertake the defence [sic], until it could confine the claim to a recovery that the policy did not cover. Lee v. Aetna Cas. & Sur. Co., 178 F.2d 750, 753 (2d Cir. 1949) (emphasis added). At some point, in every defense, the duty to defend must cease. It has long been recognized that, once an insurer has "confine[d] the claim to a recovery the policy did not cover," the duty has ceased. Lee, 178 F.2d at 753. Section 18 seeks to prolong the duty, until a court determines that it has ceased; this contradicts existing law and goes beyond the obligation the insurer assumed and beyond the protection for which an insured bargained.

Section 19: Consequences of Breach of Duty to Defend

For Section 19, the Restatement black letter rule should be that the breach of a duty to defend results in contract damages, consistent with the weight of authority. A deviation from the contract damages rule is not supported by a trend in the law, a modern view, or any empirical evidence demonstrating a need for change in the law. Moreover, as written, Section 19 would impose punitive liability on an insurer without regard to the actual contract damages incurred by the policyholder. It creates a problem of disproportionate outcomes, by lacking any nexus between the "remedy" of losing the right to contest coverage and the actual harm demonstrated, if any. And, it would create incentives for a policyholder to "set up" an insurer in the hopes of producing some type of breach and thereby obtaining indemnity for an uninsured loss. Section 19 does not tie its application to an insurer that materially breaches the duty to defend, and the Restatement makes clear that a variety of actions may constitute a breach of the duty to defend, creating serious concerns about an immaterial breach – easily cured or curable -- leading to draconian results. Insurers have significant incentives to undertake the defense of a potentially covered claim, in defense costs savings, the reduction in settlement or judgment amounts attributable to an insurer-controlled defense, and the avoidance of the costs of an action for breach of the duty to defend. But Section 19 seems to be based on the erroneous premise that an insurer may intentionally seek to escape its defense obligations rather than fulfill them. That

premise of a bad actor is without foundation, and cannot justify a forfeiture rule. Any incidence of purposefully wrongful conduct will be covered in later sections of the Restatement.

Section 21: Insurer Recoupment of Defense Costs

In adopting the minority view in a sweeping rule that would prohibit recoupment in all circumstances where there is no explicit contractual agreement permitting it, Section 21 of the draft turns too far away from articulating black letter law as it stands. To the extent this section is seeking to "ascertain the relative desirability of competing rules" (ALI Revised Style Manual, January 2015), a Restatement provision reversing the majority common law approach to recoupment is unsound because it is not a subtle change in the law, but a major one -- and this change is not supported by reliable empirical analysis or a clear trend in direction of the law. Further, adherence to the majority view allowing recoupment is justified based on coherence with other precedents – such as the ALI's own Restatement Third, Restitution and Unjust Enrichment (R3RUE) -- and the law as a whole. The Restatement should adopt the majority view, providing a default rule allowing recoupment of the costs of defense when a court later determines that an insurer advanced costs under a reservation of rights for an uncovered claim. As it stands, the Restatement does not even give courts the flexibility to apply equitable considerations and reach just results with respect to recoupment claims taking into account the individual circumstances of each claim.

Further, it is unsound to suggest that a right to recoupment should only be recognized if explicitly provided for in an insurance policy. By definition, recoupment claims arise in a situation in which the insurer never had a duty to defend under the terms of its insurance policy. Because the insurance policy imposed no defense obligations, and the costs of defense were not incurred pursuant to the insurance policy's dictates, that policy's terms are irrelevant for determining the insurer's right to recoupment. In Section 21, a right to recoupment should be recognized consistent with the prevailing view in the existing case law. Unfortunately, the approach in the draft Restatement is not to recognize a right to recoupment in all cases, thus rejecting the majority view. It turns the majority view on its head and rejects recoupment across the board.

Section 24: The Insurer's Duty to Make Reasonable Settlement Decisions, and Section 27: Damages for Breach of the Duty to Make Reasonable Settlement Decisions

Sections 24 and 27 of the Restatement of the Law of Liability Insurance, taken together, would rewrite existing law and transform the negotiation of settlements, to the major advantage of claimants. Section 24 appears to impose automatic liability on an insurer who rejects a settlement demand later found to be anywhere within a range of "reasonable" values if there is an excess judgment. In addition to the insurer's decision whether or not to accept a given settlement offer that is the focus of Section 24, courts considering the reasonableness of settlement demands and offers generally consider a number of factors including but not limited to the potential damages award, the plaintiff's likelihood of success in proving liability, whether the insurer conducted a good faith investigation, whether the insurer considered advice of counsel and whether the insurer informed the policyholder of the settlement offers. For excess liability to attach, courts also generally require proof that the insurer's conduct caused the resulting excess judgment, both proximately and in fact.

Under these sections, moreover, the policyholder may recover the full amount of damages assessed against it in the underlying suit, without regard to policy limits. Further, the insured may also recover for "any other foreseeable loss, " which under the Restatement draft would include loss of business reputation, emotional distress and punitive damages awarded against the insured. There are many aspects of these sections that are at odds with prevailing law. For instance, an insurer weighing a settlement offer is not obliged by the policy to consider possible harm to the insured's business reputation from an adverse judgment. Parking Concepts, Inc. v. Tenney, 83 P.3d 19, 26 (Ariz. 2004). It would be inconsistent to include this loss as an element of damages because the insurer's decision not to accept a settlement offer is not the cause of any harm to business reputation. Rather, that loss resulted from the conduct of the policyholder that gave rise to the lawsuit as well as to the adverse judgment. Section 27 also is at odds with the common law and the public interest in providing that payment for the insured's punitive damages may be passed on to the insurer. Allowing the recovery of punitive damages would permit the insured to "shift to its insurance company, and ultimately to the public, the payment of punitive damages awarded in the third party lawsuit against the insured as a result of the insured's intentional, morally blameworthy behavior against the third party." PPG Indus., Inc., 975 P.2d at 658. As the California Supreme Court explained in the PPG Industries case, "No allow such recovery would (1) violate the public policy against permitting liability for intentional wrongdoing to be offset or reduced by the negligence of another; (2) defeat the purposes of punitive damages, which are to punish and deter the wrongdoer; and (3) violate the public policy against indemnification for punitive damages."

Section 30: Consequences of the Breach of the Duty to Cooperate

Under Section 30, a policyholder's breach of the duty to cooperate relieves the insurer of its obligations under the policy "only if the insurer demonstrates that the failure caused substantial prejudice to the insurer in the outcome of the claim." This rule formulation is not supported by existing case law and represents unsound public policy. Section 30 eviscerates the contractual obligation of the insured to cooperate with insurer because, even if the insured breaches that duty, under the draft Restatement the insurer has no recourse unless the insurer can show "substantial prejudice to the insurer in the outcome of the claim." Most courts allow an insurer to be relieved of its policy obligations if the insurer is able to show "actual prejudice" from the insured's failure to cooperate. See Darcy v. Hartford Ins. Co., 554 N.E.2d 28, 33 (Mass. 1990) (surveying cases). Further, courts have long appreciated that purposeful misconduct by a policyholder at any point in the handling of a claim can cause substantial harm to an insurer that is deserving of relief. They have not limited the consequences of a policyholder's breach of the duty to cooperate only to impacts on the claim's "outcome." In addition, the requirement that an insurer await the "outcome" of the claim before being able to allege a breach of a policyholder's duty to cooperate would be impractical. Once the final "outcome" is known, a subsequent claim for breach of the policyholder's duty to cooperate would needlessly extend litigation that could have been resolved much earlier and in a manner that minimized instead of exacerbated the harm caused to the insurer.

Dated: 10/12/15

Summary of Professor George L. Priest's Forthcoming Law Review Article on the *Restatement of the Law of Liability Insurance*

By Victor E. Schwartz*

I. Introduction

For decades, Yale Law School Professor George L. Priest has researched and written about important issues in insurance law and policy. This scholarship has made him an internationally recognized expert on the operation of private and public insurance, and the role of the legal system in promoting economic growth and sound public policy. He has also instructed some of the nation's brightest legal scholars on the subject of insurance law and policy. Thus, when Professor Priest "takes on" a topic of insurance law, the legal and academic community pays attention.

Recently, Professor Priest has focused his attention on the American Law Institute (ALI) Restatement of the Law of Liability Insurance (RLI) project. This first-of-its-kind ALI project was commissioned to "restate" the most sound legal rules from existing case law on a wide range of insurance law topics. Professor Priest has monitored the development of this project and found that a number of the project's proposed legal rules would adversely impact insurance operations, causing harm to insurers, policyholders, and society as a whole.

Professor Priest has prepared a law review article analyzing the first two chapters of the four chapter RLI project and its public policy implications on the cost and availability of insurance. The forthcoming article – a draft of which is available at www.ssrn.com – is titled, "A Principled Approach to Insurance Law: The Economics of Insurance and the Current Restatement Project." The article incorporates highly complex economic analyses, assumptions, and terminology. In an effort to assist those interested in Professor Priest's critique of the RLI project, I have prepared the following summary.

II. The Importance of Maximizing the Availability of Insurance

Professor Priest's fundamental criticism of the current RLI project is its failure to recognize just how vital, from an economic and public policy perspective, it is to develop insurance law rules with an eye towards promoting greater availability of insurance. According to Professor Priest, "the most important objective of the law governing liability insurance is to maximize the availability of insurance." He states that this objective "helps all of society," and, in particular, low-income individuals whose entry into the insurance market allows more people to obtain the benefits of coverage and reduces costs for existing policyholders.

As Professor Priest explains, the RLI project gives short shrift to this objective, and, instead, puts forth unsound rules that would reduce a person's ability to acquire insurance. He states that the RLI project's two authors (called "Reporters") have developed what they believe to be "pro-policyholder" rules; rules that, by and large, would require insurers to pay more claims and pay greater amounts per claim.

Professor Priest explains that the fallacy in the Reporters' basic approach to the RLI project is that these unwarranted "pro-policyholder" rules would benefit only a small number of policyholders in the short-term. In the long-term, all policyholders would be disadvantaged because such rules would effectively require insurers to increase their premiums to cover the costs of paying more claims. These needless cost increases would price some policyholders (e.g. low-income policyholders) out of the insurance market; a result that would further increase insurance costs on the remaining smaller pool of policyholders.

In Professor Priest's view, the failure of the RLI project Reporters to develop rules that account for these economic realities stems, in part, from an incorrect view of insurance as purely a means to redistribute risks from one party (a policyholder) to another (an insurer). Professor Priest shows that the operation of insurance really achieves much more than so-called "risk-spreading"; it can be risk-reducing.

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Professor Priest identifies three specific ways in which maximizing the availability of liability insurance – the goal he believes should be the guiding principle of the RLI project's development – effectively reduces risk levels and benefits society. They include:

1. Aggregation of Risks – An increase in the number of policyholders enables insurers to better predict the likelihood that a loss will occur. As this predictive ability improves, it can reduce the level of risk associated with an injury (and allow for more accurate pricing of insurance policies).
2. Segregation of Risks – An increase in the number of policyholders allows insurers to better distinguish high-risk from low-risk policyholders. By grouping together individuals of similar risks, insurers can reduce the overall level of risk (and better tailor policies).
3. Controlling Moral Hazard – A moral hazard occurs where a policyholder takes more risk knowing he or she has insurance coverage. An increase in the number of policyholders enables insurers to better identify and curb moral hazard through deductibles, coinsurance, or coverage exclusions. Insurers can reduce risk levels by reducing policyholder incentives to engage in risky behavior.

Professor Priest's main critique of the current RLI project, therefore, is that it overlooks these important functions of insurance to reduce risk levels, and instead favors rules that would reduce insurance availability without any demonstrated need to do so. Such a path, he asserts, is unsound public policy.

III. Specific Problem Areas in the New Restatement

Rather than examine every provision in the RLI project, Professor Priest highlights a few to illustrate his concerns. While the Reporters designed these provisions to put policyholders in a "better position" than they are today, the rules would ultimately make all policyholders worse off by unfairly increasing insurance costs and reducing the availability of insurance.

1. Misrepresentation – Professor Priest discusses the RLI project's early treatment of misrepresentation doctrine as a cautionary tale. The RLI project had proposed to change the traditional common law rule allowing an insurer to rescind a policy based on a policyholder's misrepresentation. Although this rule is supported by "good economic reasons," the Reporters wanted to add a requirement that a policyholder must intentionally or recklessly misrepresent facts.

   The proposed rule would have significantly impaired insurers' ability to rescind a policy, increasing insurance costs which would be passed on to all policyholders. Fortunately, controversy generated by this topic – most notably that the proposed approach was not supported by existing case law – prompted the Reporters to adopt the traditional common law rule.
2. Duty to Defend – Professor Priest criticizes the RLI project's "extremely punitive" rules governing an insurer's breach of the duty to defend a claim. These proposed rules would have an insurer forfeit all of its coverage defenses (as provided in the policy), and lose the right to assert any control over the defense or settlement of a claim. Professor Priest explains that this "radical" minority approach would, absent any clear public policy need, require insurers to pay claims not covered under a policy, which would increase costs and reduce the availability of insurance.
3. Duty to Settle – Professor Priest believes the RLI project adopts an improper, overly "formalistic" approach to whether an insurer has acted "reasonably" in attempting to settle a claim. He cautions that this rigid rule could trap insurers and subject them to liability for a broad array of unfair penalties, including punitive damages that have been awarded against a policyholder in an underlying action. He explains that this unwarranted, enhanced liability exposure would increase insurance costs and reduce the availability of insurance.

IV. Conclusion

The core "takeaway" of Professor Priest's forthcoming law review article is that the current RLI project has its priorities misplaced. The Reporters' chief priority is to craft rules benefitting policyholders, but they set out to achieve this goal by unfairly making insurers pay more money, more often. Professor Priest demonstrates that this approach may benefit some policyholders in the short-term, but would hurt all policyholders in the long-term. Professor Priest further states that to correct this problem, the primary objective of the RLI project should be to develop provisions which maximize the availability of insurance. This approach will truly benefit all policyholders.

Selected Privilege and Ethical Issues Arising in the Insurance Context

Speakers:

Martin Pentz (Foley Hoag – Boston, MA)

Tony Zelle (Zelle McDonough – Boston, MA)

Ned Currie (Currie Johnson – Jackson, MS)

FOLEY HOAG LLP

Common Interest Doctrine And The Tripartite Relationship: Insurer Use Of Privileged/Protected Defense Material To Attack The Policyholder In The Coverage Case

By Martin C. Pentz and Michael Hoven[1]

I. Introduction

The relationship between an insurer, the policyholder, and the policyholder's defense counsel (appointed or independent) creates unique problems in applying the law of attorney-client privilege and the work product doctrine. An issue policyholders frequently face in coverage litigation concerns the status of opinion work product, and related privileged communications, authored by their defense attorney in the underlying litigation. That attorney, of course, commonly will have prepared evaluations of the strength of the case, or of the strength of particular claims or claims against particular parties. The insurer may have requested this material, or its equivalent, perhaps as a condition of paying for the defense of the case, citing its legitimate interest in evaluating the case for possible settlement or trial. When the case is resolved, there may be uncertainty regarding how much of the settlement or award should be allocated to claims that are covered and how much should be allocated to claims that fall outside the coverage.

In the event of a dispute on this issue and resulting coverage litigation, the policyholder, represented by new counsel, may wish to take a position about the relative strength of the claims that differs from that reflected in defense counsel's work product. The insurer may wish to use that work product as an admission of the policyholder and to argue to judge or jury that even the policyholder's own attorney agreed with the insurer's evaluation of the case. The mental impressions of underlying defense counsel are surely highly protected opinion work product, and may have been expressed in attorney-client communications; can the insurer nonetheless use them in litigation against the policyholder?

Insurers make two arguments to support such use. First, they argue that policyholders, by contesting the coverage decision, have put "at issue" their attorney's mental impressions. But policyholders need not, and often do not, rely on defense counsel's opinions in the coverage case, such that "at issue" precedents will be inapposite. Insofar as the coverage case involves a dispute over the reasonableness of defense counsel's fees, the issue is whether the attorney's work, and the fees charged therefor, were reasonable, not the content of the lawyer's advice or mental impressions. For that purpose, the policyholder can produce the bills from the underlying litigation (perhaps slightly redacted), and the insurer will be positioned to mount a defense.

Second, insurers argue that they had a common interest with the policyholder in containing the exposure posed by the underlying litigation, and so have a right to the otherwise privileged or protected materials generated during that litigation. Insurers are on more solid ground here; there is a zone of common interest, even when there is concurrently adversity (or potential adversity) concerning coverage. But even here, why is it necessary to allow the insurer to use evaluative work product of defense counsel in the underlying case to attack the policyholder in coverage litigation?

This paper focuses on the application of the common interest doctrine in coverage litigation. First, it presents the conflicting and not entirely satisfactory range of approaches that courts have taken to the issue. A recent opinion of the First Circuit, *Vicor Corporation v. Vigilant Insurance Company*, 674 F.3d 1 (1st Cir. 2012), is given special treatment because it illustrates the fundamental problem

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and the difficulty courts have had in resolving it. Second, the authors present a proposed modification of the existing doctrine to prevent the use, in coverage litigation, of materials disclosed pursuant to a common interest in the underlying litigation. The proposal derives from a recognition of the special character of privilege and work product in the tripartite relationship, and borrows from established principles of privilege law that, in some contexts, permit a partial or "selective" waiver of privilege or work product protection while maintaining privilege/protection for the same documents in other contexts or for other privileged/protected documents on the same subject.

II. The Current State of the Law

The common interest doctrine protects parties from waiving privilege or work product protection when they share privileged communications or work product materials with other parties who have a shared interest. *See generally* Edna Selan Epstein, *The Attorney-Client Privilege and the Work-Product Doctrine* 274-97 (5th ed. 2007). The shared interest must be a legal interest to avoid waiver of privilege, whereas a shared business interest is generally sufficient to protect work product materials. *Id.* at 1038. In the context of coverage litigation, insurers have argued that the common interest doctrine gives them the right to see the policyholder's privileged or work product material from the underlying litigation. While such material would generally be protected from disclosure to other parties, insurers argue that there was a common interest in the underlying litigation such that they were entitled to the material, without any waiver of privilege.

The statements of defense counsel in the underlying case, including those concerning the relative legal exposure among parties or claims, may constitute party admissions. *See, e.g.*, *Lightning Lube v. Witco Corp.*, 4 F.3d 1153, 1198 (3d Cir. 1993) (out-of-court statements by attorney are party admissions if "directly related to the management of the litigation" or authorized by the client). If the policyholder cannot assert privilege or work product protection against the insurer, it may argue that the legal opinions of its attorney should be excluded as impermissible opinion testimony or as unacceptably confusing to a jury, but this would not exclude all statements by its attorney and, of course, would not allow the policyholder to withhold the materials from discovery. *See Bensen v. Am. Ultramar*, 92 Civ. 4420, 1996 U.S. Dist. LEXIS 10647, at *41-43 (S.D.N.Y. July 26, 1996) (excluding admissions by attorneys under Rules of Evidence 701 and 403).

Cases in which an insurer has wholly accepted a defense or wholly denied coverage provide for clear applications of the common interest doctrine. If the assumption of coverage is unequivocal, there clearly is a common interest; if coverage is denied, there is no common interest. *But see Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 194 (1991) (finding common interest where coverage was denied). A more nuanced situation arises when the insurer has reserved rights as to indemnity.

Courts confronting this situation must determine whether a policyholder and an insurer have a common interest sufficient to warrant compelling the policyholder to turn over privileged or work product material. Courts have developed several approaches for determining the presence or scope of a common interest, which can be grouped into three categories depending on the primary focus of the court: (1) decisions that focus on the insurer's position concerning coverage; (2) decisions that focus on the nature of the representation in the underlying litigation; and (3) decisions that focus on the parties' respective interests (typically as reflected by their conduct). In addition, some courts apply the doctrine differently with respect to the work product doctrine.

A. The Insurer's Position as Dispositive

In keeping with the conventional focus on the coverage determination made by the insurer, some courts have found that the reservation of rights itself resolves the issue. A court may conclude that the reservation of rights precludes the identity of interests required. *First Pac. Networks v. Atl. Mut. Ins. Co.*, 163 F.R.D. 574, 579 (N.D. Cal. 1995) (reservation of rights creates conflict of interest); *Chi. of Alaska v. Emplrs. Reinsurance Corp.*, 844 P.2d 1113, 1116 (Alaska 1993) (defending under reservation of rights creates conflicts of interest).

This creates a clear, bright-line rule, but is the minority view. It also creates perhaps unnecessary obstacles to insurer use of defense counsel work product for purposes of making prudent settle-or-try defense decisions or in valuing the underlying case.

B. The Nature of the Representation

Instead of looking to the insurer, courts may focus on the lawyer: how is he or she chosen and paid, and who does he or she represent? This may be related to the insurer's decision to defend or reserve rights, since a reservation of rights gives the policyholder the right to have independent counsel in many jurisdictions. Nonetheless, the nature of the lawyer's representation can have significance independent of the insurer's decision, and may take into account decisions made by the policyholder.

Courts may treat the policyholder's decision to retain independent counsel as determinative. For example, a Virginia trial court held that while the insurer's decision to defend under a reservation of rights "alerted [the policyholder] to the *possibility* that their interests were adverse," it was the policyholder's election to have independent counsel that defeated application of the common interest doctrine. *RML Corp. v. Assurance Co. of Am.*, 60 Va. Cir. 269, 276 (Cir. Ct. 2002) (emphasis added); *see also In re Texas E. Transmission Corp. PCB Contamination Ins. Coverage Litig.*, MDL Docket No. 764, 1990 U.S. Dist. LEXIS 7912, *14 (E.D. Pa. June 27, 1990) (rejecting application of common interest doctrine because retention of independent counsel signaled that the scope of shared interest was uncertain).

Alternatively, courts may focus on who paid defense counsel in the underlying litigation rather than who chose defense counsel. In *Vicor Corporation v. Vigilant Insurance Company* (of which more later), the First Circuit held that because the insurers paid for counsel and part of the settlement, defense counsel was deemed to represent both the policyholder and the insurers, even though the insurers had defended under a reservation of rights and the policyholder chose its own counsel. 674 F.3d 1, 18-19 (1st Cir. 2012).[2] Because the attorney represented both the policyholder and insurer, the parties had a common interest that made at least some privileged and work product materials discoverable. *Id.* at 19. In contrast, a California appellate court rejected the argument that the insurer's payment of independent defense counsel sufficed to create a common interest between the insurer and the policyholder, even where the insurer also selected defense counsel. *Rockwell International Corp. v. Superior Court*, 26 Cal. App. 4th 1255, 1267 (1994). The court held that counsel was retained *for* the policyholder and represented the policyholder alone. *Id.*

C. Identity of Interests

Courts may try to assess whether there is an identity of interests between the policyholder and insurer without regard to formalities of representation. Courts following this approach can be further subdivided into two camps. In the first camp are courts that focus strictly on the interests within the underlying litigation. In the second camp are courts that consider the policyholder's and the insurer's interests more broadly, namely, by taking into account the potentially adverse positions on coverage even when the parties' interests are aligned within the formal bounds of the underlying litigation.

The Illinois Supreme Court in *Waste Management* – in a decision that appears to be unique on this issue – determined that the policyholder and the insurer had a common interest in avoiding liability in the underlying litigation that compelled the disclosure of privileged materials in the coverage litigation even though the policyholder's attorney did not represent and was not retained by the insurer. *Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 194 (1991). Various courts have disagreed with *Waste Management* on precisely this issue and held that where the insurer did not participate in the defense of the underlying litigation there is categorically no common interest. *See, e.g.*, *Bituminous Cas. Corp. v. Tonka Corp.*, 140 F.R.D. 381, 386-87 (D. Minn. 1992) (no common interest because policyholder's attorney never represented the insurer); *Remington Arms Co. v. Liberty Mut. Ins. Co.*, 142 F.R.D. 408, 418 (D. Del. 1992) (same).

More commonly, courts recognize that even the shared goal of avoiding or minimizing liability does not eliminate all potential adversity when an insurer defends under a reservation of rights. In those cases, courts look to the conduct of the parties to answer

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[2] The First Circuit applied Massachusetts law, but whether it correctly discerned that law is debatable. The Court cited two cases for the proposition that "Massachusetts law . . . considers an attorney retained by an insurer to represent the insured as the attorney for both": *Imperiali v. Pica*, 338 Mass. 494 (1959), and *Rhodes v. AIG Domestic Claims, Inc.*, No. 01-1360-BLS2, 2006 Mass. Super. LEXIS 19 (Mass. Super. Jan 27, 2006). *Rhodes*, in turn, cites *Imperiali* and *McCourt Co., Inc. v. FPC Properties, Inc.*, 386 Mass. 145 (1982). None of the cases addresses a situation in which a policyholder chose its own independent counsel following an insurer's reservation of rights. Indeed, *McCourt* concerned whether a law firm repeatedly retained by an insurer had that repeat customer as its *only* client, or whether the policyholders that it represented were also clients; the SJC held that both the insurer and the policyholder were clients. 386 Mass. at 146-47. *Imperiali*, in assessing whether an insured had complied with a policy's cooperation clause, noted that "an attorney undertaking the defence of the case covered by the policy is an attorney for both the insurer and the insured." 338 Mass. at 499. There too, however, the attorney's relation with the insurer was treated as a given. *See id*. at 495.

a background question of privilege law: was there a reasonable expectation that the documents sought would remain private? *See, e.g.*, *ALIT Ltd. v. Brooks Ins. Agency*, No. 10-2403, 2012 U.S. Dist. LEXIS 38144, *29 (D.N.J. Mar. 20, 2012); *Lectrolarm Custom Sys. v. Pelco Sales, Inc.*, 212 F.R.D. 567, 570 (E.D. Cal. 2002); *Northwood Nursing & Convalescent Home v. Cont'l Ins. Co.*, 161 F.R.D. 293, 297 (E.D. Pa. 1995).

ALIT and *Lectrolarm* involved third parties who sought discovery of communications between policyholders and insurers in underlying litigation, and argued that there was *not* a common interest. Without a common interest, any privilege would be waived by the disclosure between the policyholder and insurer. In both cases, the court held that the substance of the materials exchanged between the parties indicated that they expected those materials to remain confidential. The policyholder and insurer in each case communicated freely and frequently about the underlying litigation, including evaluations of potential liability and potential damages. Both courts concluded that this indicated that the parties had expected the communications to remain private, so they were protected by the common interest doctrine.

In *Northwood Nursing*, an insurer agreed to defend one underlying action, denied coverage on other actions, and had, at the time of the court's decision, not made decisions on yet other cases. 161 F.R.D. at 297. The court held that there was a common interest where the insurer agreed to defend and was not a common interest where coverage was denied. *Id.* Where the insurer had not determined whether coverage applied, the court held that the policyholder had a reasonable expectation that its communications with its attorney would be protected from disclosure to the insurer. *Id.*

D. Work Product Doctrine

Most courts discussing common interest do not address any distinction between privilege and work product, or expressly state that the common interest doctrine "applies with equal force to claims of work product" as to claims of privilege. *E.g.*, *Metro Wastewater Reclamation Dist. v. Cont'l Cas. Co.*, 142 F.R.D. 471, 478 (D. Colo. 1992). There is, however, one way in which courts have distinguished work product material from attorney-client communications in this context. Material prepared in anticipation of the underlying litigation may be distinguished from material prepared in anticipation of the coverage litigation and left unprotected.

Making this distinction narrows the potential scope of work product protection by allowing an insurer access to work product in the underlying litigation, while shielding work product that was created during the coverage litigation. This approach was taken in *Waste Management*, which held that work product prepared for a lawsuit in which the parties shared a common interest was not protected in subsequent litigation in which the same parties were adverse. 144 Ill. 2d at 198.

The District of Minnesota adopted a contrary position on the protection of work product materials prepared in underlying litigation. *Bituminous Cas. Corp. v. Tonka Corp.*, 140 F.R.D. 381, 386-87 (D. Minn. 1992). In *Bituminous*, the court recognized that the documents the insurers sought were not prepared for the instant declaratory judgment action, but said that "[t]he inquiry this court must answer is whether the documents were in fact prepared in anticipation of some litigation." *Id.* at 387. The court concluded that the documents were prepared in anticipation of prior litigation and were protected from disclosure. *Id.* at 390.

III. The *Vicor* Example

The First Circuit's decision in *Vicor* illustrates the fundamental problem. In the underlying litigation, Vigilant provided a defense to Vicor subject to a reservation of rights. *Vicor Corp. v. Vigilant Ins. Co.*, 674 F.3d 1, 16 (1st Cir. 2012). Vicor chose its own counsel, who provided periodic reports to Vigilant in order to comply with Vigilant's billing "guidelines." *Id.* The case ultimately settled for $50 million. *Id.* The settlement did not allocate a dollar amount per claim, or allocate the settlement amount between covered and uncovered claims. *Id.* Vigilant determined that approximately $13 million of the settlement amount was for covered claims, leaving Vicor responsible for the remaining $37 million. *Id.*

Vicor then brought the coverage suit, arguing that all of the $50 million settlement was for covered claims. *Id.* at 17. Vigilant moved to compel the production of all documents related to the underlying litigation that had been withheld as privileged or work product. *Id.* In particular, Vigilant was concerned with a report by defense counsel in the underlying case that categorized the claimed damages. *Id.* The district court denied the motion. *Id.*

On appeal, the First Circuit vacated the denial, relying on its view that Massachusetts holds that defense counsel represents both insurer and insured, and holding that the common interest between Vicor and Vigilant in the underlying litigation made at least some of the withheld materials discoverable. *Id*. at 19-20. The Court also found it noteworthy that underlying defense counsel for Vicor had shared evaluative work product with Vigilant on numerous occasions. *Id.* at 19. For the First Circuit, this meant that Vicor was trying to "have it both ways," and should not be permitted to benefit from the common interest doctrine by avoiding waiver in the underlying litigation and then assert the privilege in the coverage litigation. *Id.* The court further concluded that, even where work product was protected, Vigilant might have a substantial need for the documents that would overcome the protection. *Id.* at 20.

While the First Circuit thus vacated the district court's denial of Vigilant's motion to compel, its instructions on remand gave scant guidance as to which documents must be produced and which remained protected. Vicor would not be permitted "to shield *all* communications between it and underlying defense counsel," and "[d]ocuments produced while the insurers were providing a defense are *unlikely* to be protected." *Id.* at 19-20 (emphasis added). Yet neither were "all communications [between insurer and insured] . . . excepted from the applicable privileges," and the insurers were not "necessarily entitled to the entire defense file, as they claim." *Id.* at 20. The First Circuit therefore rejected the parties' arguments that all privileged or work product materials should be produced (the insurers' position) or that no privileged or work product materials should be produced (Vicor's opinion), without stating where the line dividing protection from production should be drawn.[3]

IV. A Modest Remedial Proposal

The application of the common interest doctrine in coverage litigation is, as we have seen, unpredictable and inconsistent. Even the First Circuit Court of Appeals, in a recent case applying what it took to be established state law, could say no more than that the common interest doctrine dictated that some (but not all) privileged and work product materials should be produced in the coverage litigation. The current state of the law puts defense counsel in an untenable position: to help their clients reach a favorable settlement requires providing the insurer with the most accurate assessment of the case possible – which may simultaneously provide the insurer with a potent weapon in the not unlikely event of coverage litigation.

Any solution to this problem must serve two goals. First, it must preserve the value of the common interest doctrine in the relationship between the insurer and the policyholder. The insurer should have access to the best information available in order to make settlement decisions, and the material shared between the insurer and the policyholder should not thereby become discoverable to the plaintiff in the underlying litigation. Second, it must alleviate the conflict faced by defense counsel, when helping their client now might mean hurting their client down the road.

Certain insurers have developed one possible solution by "splitting the file": assigning one claim handler to manage the policyholder's defense, and another to determine whether coverage applies. *See* Jay M. Levin, Lauren Angelucci, *Erecting an Ethical Wall Between Coverage and Defense by Splitting Claim Files* at 4-5, ABA Insurance Coverage Litigation Committee CLE Seminar (March 2015); Brent W. Huber and Angela P. Krahulick, *Bad Faith Coverage Litigation: The Insurer's Covenant of Good Faith and Fair Dealing*, 42 Tort Trial & Ins. Prac. L. J. 29, 47 (Fall 2006). This would permit defense counsel to share information with the insurer to advance the insured's defense without the risk that the same information would be used to deny or limit coverage. *Erecting an Ethical Wall* at 5-6.

Two problems prevent splitting the file from being a fully effective solution. First, it is not mandatory. At most, an insurer's decision not to split the file *may* be a factor that a factfinder could consider in evaluating whether an insurer handled a claim in good faith. *See Twin City Fire Ins. Co. v. City of Madison*, 309 F.3d 901, 909 (5th Cir. 2002); *but see Am. Capital Homes, Inc. v. Greenwich Ins. Co.*, No. C09-622-JCC, 2010 U.S. Dist. LEXIS 89403, at *14-15 (W.D. Wash. Aug. 30, 2010) ("no support" for the argument that assigning a single adjuster to defense and coverage issues constitutes bad faith). Second, the screen established by splitting the file may not effectively prevent information from crossing over between the insurance company personnel assigned to defense and coverage. The screen would have to encompass more than merely the front-line adjusters, and would have to ensure that the adjusters

[3] The issue appears not to have been pressed on remand, so we do not have the benefit of the district court's application of the common interest rulings of *Vicor*.

handling the defense were not aware of the potential coverage issues. *See Armstrong Cleaners, Inc. v. Erie Ins. Exch.*, 364 F. Supp. 2d 797, 817 (S.D. Ind. 2005).

The authors propose a different solution: a doctrinal fix that would bring clarity to this murky area of law, and relieve defense counsel of the dilemma of whether helping their client by providing the insurer with an assessment necessary to evaluate settlement would simultaneously injure their client by providing the insurer with a weapon in potential coverage litigation. The law as it currently stands already provides that:

1. The policyholder and an insurer defending under a reservation of rights share a common legal interest that permits the policyholder to share privileged and work product material with the insurer without waiving the privilege or work product protection as to third parties.

Recognizing the unique nature of the tripartite relationship, and borrowing from Federal Rule of Evidence 502 and the doctrine of selective waiver, the authors propose the additional rule that:

2. Privileged or work product material regarding an underlying proceeding that is shared by a policyholder with an insurer pursuant to a common defense interest should not, in any coverage case concerning that proceeding, either (i) be offered in evidence or otherwise used by the insurer, or (ii) furnish a basis for discovery of privileged or work product information not previously disclosed.

This proposal recognizes the reality that, in the reservation of rights context, the policyholder and insurer are not parties who once shared a common interest and then had a falling out. Instead, the relationship always consisted of zones of common interest alongside zones of adverse interest. Any attempt to define the scope of common interest chronologically ignores this aspect of the tripartite relationship.

The proposal also fosters "full and frank communication" in coordinating the defense in the underlying litigation, thereby serving one of the fundamental purposes for the attorney-client privilege in the first place. *See Upjohn Co. v. United States*, 449 U.S. 383, 389-90 (1981). It also serves the particular goal of the common interest doctrine: to allow parties to share information without risking its disclosure to an adversary. The position taken by insurers in coverage litigation achieves the contrary goal: compelling policyholders to hand over information to their adversary. Indeed, the common interest doctrine itself arguably already calls for at least part of the remedy proposed here: if the disclosure to the insurer did not waive the privilege in the first place, then why should the insurer be permitted to deploy the material at issue in the coverage case, where doing so necessarily would involve a *further* disclosure to judge and/or jury? The policyholder's objection or motion to strike grounded in privilege should be sustained.

Existing doctrine regarding partial waiver of privilege (now embodied in Federal Rule of Evidence 502) and so-called "selective waiver" principles (where applicable) already embrace a pragmatic approach to limiting the impacts of disclosure of privileged or work product protected material. Rule 502 permits a party to disclose information in a federal proceeding, or to a federal agency, without necessarily waiving the privilege or protection applicable to other materials on the same subject. Similarly, the doctrine of selective waiver recognizes that disclosure of material to a government agency should not necessarily permit use of the same material against the disclosing party in subsequent litigation.

The touchstone of the analysis under Rule 502 or selective waiver is fairness. FRE 502(a)(3); *In re Grand Jury Proceedings John Doe Co. v. United States*, 350 F.3d 299, 302 (2d Cir. 2003). In the context of coverage litigation, fairness favors protecting the privileged and work product material created in the underlying litigation. Insurers would not be prevented from mounting an effective defense. They could still discover the underlying facts, and present testimony from retained experts. A leading commentator on privilege law has said that, where "underlying facts were provided" and "the adversary was free to do its own work and reach its own conclusions," it would be "punitive" not to allow selective waiver. Edna Selan Epstein, *The Attorney-Client Privilege and the Work-Product Doctrine* 1093 (5th ed. 2007). All that the present proposal would prevent insurers from doing is saying, in support of its arguments regarding allocation or reasonableness of defense costs, "Even your attorney who defended the case said so!"

THE LEGAL OBLIGATIONS OF AN INSURER THAT HAS OBTAINED INFORMATION FROM APPOINTED DEFENSE COUNSEL THAT SUPPORTS A DENIAL OF COVERAGE

Tony Zelle: Zelle McDonough & Cohen

There are many ethical issues that challenge attorneys in the tripartite relationship with an insurer and the insured the attorney has been assigned to defend. One that has no easy answer, for the attorney or the insurer, stems from the attorney's possession of information that could be relied upon by the insurer to disclaim coverage. What should defense counsel do? Can he tell the insurer the information if he knows it could hurt the policyholder? Can he withhold the information from the insurer, knowing that the insurer has a contractual right to deny coverage? Addressing the challenge begins with the predicate that there is an attorney-client relationship with both the insurer and the policyholder and the primary client is the policyholder.

The ABA Model Rules of Professional Conduct provides guidance to defense counsel facing this scenario. Model Rule 1.6, Confidentiality of Information, requires that a "lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation" or one of the narrow exceptions in paragraph (b) permits the disclosure. On the other hand, Model Rule 1.4 requires a lawyer to "keep the client reasonably informed about the status of the matter" and to "explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." In a formal opinion, the ABA Committee on Ethics and Professional Responsibility directly addressed this issue, noting that a lawyer may not reveal information gained from an insured "or use it to the benefit of the insurance company, when the revelation might result in denial of insurance protection" for the insured. Formal Opinion 08-450 at 5. Further, the Committee stated,

> [T]he insured is required, as a condition of the insurance protection, to cooperate and assist in the defense, and, implicitly, to reveal to the lawyer all pertinent information known to the insured. None of that, however, undermines the insured's right to expect that the lawyer will abide by Rule 1.6 and withhold from the carrier information relating to the representation that is damaging to the insured's interests under the policy.

Formal Opinion 08-450 at 7.

The ethical loophole in this Opinion lies in the fact that the policyholder's contractual obligation to cooperate and assist in the defense does not obligate the policyholder to share information that may not be integral to the defense. Put another way, while a policyholder may have an ethical obligation not to seek coverage if he knows, after the defense counsel has explained the matter "to the extent reasonably necessary to permit the client to make informed decisions regarding the representation," if the policyholder does not make the ethical decision, he is likely to get coverage he does not deserve.

The policyholder's ethical dilemma is not the subject of this article, nor is it about the defense attorney's ethical obligations as they are spelled out quite clearly by the rules and Opinions like Formal Opinion 08-450 cited above. Rather, this article explores the legal obligations of an insurer that has obtained information that supports a denial of coverage from defense counsel who did not know that sharing the information with the insurer would preclude coverage.

It is incumbent on insurers to engage defense counsel who have a basic understanding of common coverage issues. Insurers must put themselves in a position to protect themselves and their defense counsel against problems prescribed by the rules of ethics and professional responsibility that may arise from the disclosure of information in the course of the investigation and defense of a claim. Defense counsel who are aware of these ethical issues will refrain from revealing information to the insurer that could affect its coverage determination and will know how to communicate with the insurer in a manner that will not impair the policyholder's rights or the insurer's rights to disclaim coverage when warranted by the fact. In contrast, a problem for an insurer will arise when defense counsel does not understand how information he shares with the insurer may affect coverage. When information that adversely affects an insured's coverage is disclosed because the defense counsel does not know it will have that effect, the lawyer's ignorance may prevent a finding that the ethical rules were violated; but it may not protect the insurer's contractual rights. The limited legal authority addressing the issue suggests that an insurer can be estopped from disclaiming coverage based on information it obtains from defense counsel, even if defense counsel was not providing advice concerning coverage and was unaware that the information it provided affected coverage.

This dilemma is illustrated by *Parsons v. Continental National American Group*, 550 P.2d 94 (Ariz. 1976), in which the Arizona Supreme Court held that CNA was estopped from disclaiming coverage based on information provided by defense counsel, despite the fact that the decision does not identify evidence that would support the inference that the attorney knew that the information provided would affect coverage. In addition, there is no indication the attorney was found to run afoul of the ethical rules prohibiting such a disclosure.

In *Parsons*, the claimants alleged they were assaulted by their neighbor's fourteen year old child. CNA hired defense counsel to investigate the claim and to defend its insureds. Defense counsel told CNA that he obtained:

> a rather complete and confidential file on the minor insured who is now in the Paso Robles School for Boys, a maximum-security institution with facilities for psychiatric treatment, and he will be kept there indefinitely and certainly for at least six months . . . The above referred-to confidential file shows that the boy is fully aware of his acts and that he knew what he was doing wrong. It follows, therefore, that the assault he committed on claimants can only be a deliberate act on his part.

After receiving this information, CNA sent a reservation of rights letter to the insureds stating that it would investigate and defend the claim under a full reservation of rights. The letter explained that it was possible that the act involved might be found to be an intentional act and

that the policy specifically excluded liability for bodily injury caused by an intentional act. In the underlying case, the trial court granted the claimants' motion for a directed verdict after the defense presented no evidence and there was no opposition to the motion. Judgment was entered in the amount of $50,000. The claimants then garnished and CNA successfully defended the garnishment action by claiming that the intentional act exclusion applied. Defense counsel that had previously represented the insureds in the underlying action represented CNA in the garnishment action.

The Arizona Supreme Court held that CNA was estopped from denying coverage and waived the intentional act exclusion because CNA "took advantage of the fiduciary relationship between its agent," the defense attorney, and the insureds. 550 P.2d at 97. Then, with a scant evidentiary basis, the court attributed an improper intent to defense counsel and wrote: "[w]hen an attorney who is an insurance company's agent uses the confidential relationship between an attorney and a client to gather information so as to deny the insured coverage under the policy in the garnishment proceeding we hold that such conduct constitutes a waiver of any policy defense, and is so contrary to public policy that the insurance company is estopped as a matter of law from disclaiming liability under an exclusionary clause in the policy." 550 P.2d at 99. The intent appears to be inferred from the defense counsel's report that concluded: "the assault he committed on claimants can only be a deliberate act on his part," though the court failed to make a finding that defense counsel knew that intentional acts are excluded.

The holding in *Parsons* stands in stark contrast to *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973), where the defense counsel's intent to benefit the insurer to the detriment of the policyholder was not inferred. Defense counsel sent evidence, information, and briefs to the insurer, at its request, that supported the insurer's late notice investigation. The insurer then hired defense counsel to defend the insured in a lawsuit based on its alleged negligence. Defense counsel led the insured to make his employees available for statements, one of which had as a purpose the development of late notice evidence against the insured. This statement was taken by defense counsel at the request of the insurer. Over the course of a year and half, defense counsel wrote several letters to and had several telephone calls with the insurer regarding developing its coverage defense, additional investigation, and advising on the legal possibilities of establishing a coverage defense. Defense counsel never advised the insured that there was a conflict of interest, that he was providing information to the insurer regarding the late notice issue, or that the statements taken were going to affect the insurer's coverage determination. The court held that prejudice against the insured was shown as a matter of law and that the insurer was estopped from denying coverage. The court also held that a general non-waiver agreement that the insured signed did not relieve the insurer of its duty to inform the insured of the specific conflict or relieve the insurer of the consequences of its failure to inform the insured.

In *Medical Mutual Liability Insurance Society v. Miller*, 451 A.2d 930 (Md. App. 1982), Medical Mutual assigned its own general counsel to represent the insured. The court determined that an apparent conflict of interest arose when the insured disclosed to defense counsel that he had not explained the potential risks of the surgical procedure to the patient. According to the court, Medical Mutual's interest in pursuing the option of disclaiming liability was in direct conflict with the insured's interest in maintaining his malpractice insurance coverage. The court held

that defense counsel's continued representation of the insured prejudiced the insured to such an extent that Medical Mutual was estopped from disclaiming liability.

Medical Mutual distinguished *Fidelity & Casualty Co. v. McConnaughy*, 179 A.2d 117 (Md. Ct. App. 1962), in which the court held that the insurer was not estopped from disclaiming coverage because the insurer could have obtained the same information from sources other than defense counsel. In *McConnaughy*, defense counsel informed the insurer that the insured admitted he requested a third party witness to falsely testify that he had observed the car accident at issue and that the insured was not at fault. The insured argued that the insurer was estopped from disclaiming coverage because the disclaimer was based on information defense counsel provided to the insurer in violation of defense counsel's duty of confidentiality to the insured. The court agreed that defense counsel breached his duty to the insured, but determined that the insurer was not estopped from disclaiming coverage because the insurer could have obtained the same information from other sources. The court explained that "[t]he insurer, through its own claim investigator, or through counsel who did not represent [the insured], could have ascertained what [the insured] disclosed to his lawyers, if it did not already know it well enough from [the third party witness's] deposition, and then could have disclaimed. We are not persuaded that because the company verified its belief that there had been a breach of the policy provisions by [the insured], through lawyers who continued to represent it and the insured at a time when their interests were not parallel, it lost whatever rights it otherwise would have had." 179 A.2d at 122.

The *McConnaughy* case supports the premise that if defense counsel unknowingly provides information that could adversely affect the policyholder's coverage and the insurer independently develops that evidence or other facts supporting a coverage disclaimer, it can rely on the independently developed information to disclaim coverage, even though it also obtained information from defense counsel. If the only evidence the insurer has to disclaim coverage is the information obtained improperly from defense counsel, the insurer would likely not have had a basis to disclaim that would have been approved by the *McConnaughy* court.

When presented with information from defense counsel that could support a denial of coverage, the prudent insurer will split the file and maintain a defense file, in which the information provided by counsel is recorded, and a coverage file, where the information is not known to the claim professional. This will ensure that the coverage determination is made independently of the information obtained by defense counsel. Taking this step will place the insurer in a sound basis to defeat any bad faith claim.

Mr. Zelle has developed a national reputation representing insurance companies in coverage and bad faith claims. He was elected to the Defense Research Institute's board of directors in 2014. Previously, he served as Chair of DRI's Insurance Committee. As chair of the Bad Faith and Extra-Contractual Claims Subcommittee, he compiled and edited the first edition of the Compendium of Bad Faith Law in 2002. Mr. Zelle has tried and handled the appeals of the leading bad faith cases in Massachusetts and Rhode Island and has handled bad faith litigation across the country.

PROTECTING THE ATTORNEY-CLIENT PRIVILEGE: ETHICAL CONSIDERATIONS FOR INSURANCE COVERAGE COUNSEL WHEN TREATED AS AN ADJUSTER

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INTRODUCTION

The attorney-client privilege is a frequent discovery issue in insurance bad faith and coverage litigation whenever the policyholder seeks production of the insurer's claim file. But the privilege also is an ethical principle. *See* Rule 1.6, ABA Model Rules of Professional Conduct. Because the privilege belongs to the insurer client, coverage counsel must be vigilant to maintain the confidentiality of his or her communications with the insurer when handling assigned coverage questions. Courts recently have been chipping away at the privilege claimed by insurers for communications with coverage counsel. At least one state's Supreme Court has gone so far as to declare that in first party bad faith actions based upon "the handling and processing of claims", "there is a presumption of no attorney-client privilege". *Cedell v. Farmers Ins. Co. of Washington*, 295 P.3d 239, 247 (Wash. 2013). The burden is shifted to the insurer who must convince the state trial court that the privilege attaches to such communications, but only after producing the "privileged" communications to the court *in camera*. *Id.* Given the universal rules establishing an attorney-client relationship, when this presumption is applied in a discovery dispute there arises a troubling unanswered question: if it is presumed that the attorney-client privilege does not apply to communications between coverage counsel and the insurer client, does this presumption logically mean that the attorney-client relationship vanishes under those circumstances

notwithstanding coverage counsel's assignment?[1] And with respect to coverage counsel's ethical obligations to the insurer, what can coverage counsel do to maintain the privilege at all stages of the assignment, thereby protecting communications from future discovery when the clam is later litigated in a bad faith lawsuit?[2] Unfortunately, case law has not developed to provide answers to these questions. In fact, the questions do not appear to have arisen in any reported decision.

For centuries and beyond, the attorney client privilege has been the foundation that permits every lawyer to render frank, open and honest legal counsel to their clients regarding the latter's legal rights, duties and obligations under the law. The privilege is at the heart of coverage counsel's relationship with the insurer client. Coverage counsel's ability to communicate with the insurer, openly discuss the strengths and weaknesses of a claim, and finally render an opinion or make a recommendation free from concern of discoverability often can be vital to the insurer's decision to deny, pay, defend or indemnify the particular claim.

However, in recent years courts in some states dramatically have eroded the attorney-client privilege between insurance coverage counsel and their insurer clients.[3] In such states the insurer may be required to re-think the scope of the assignment of coverage questions to its counsel, and how to best utilize counsel in such a manner as to preserve the attorney-client privilege. Insurers handling claims for policyholders in states with no controlling precedent may want to pay heed to this same consideration. On the other hand, at the outset of a coverage assignment coverage counsel arguably might be required to expend considerable effort to ethically protect privileged

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[1] The privilege attaching to such communications springs forth from the attorney-client relationship. *See Upjohn Co. v. United States*, 449 U.S. 383, 396, 101 S. Ct. 677, 686, 66 L. Ed. 2d 584 (1981).

[2] Consider the applicability of Rule 1.6(c), ABA Model Rules of Professional Conduct to coverage counsel where it states that counsel "shall make reasonable efforts to prevent the inadvertent...disclosure of...information relating to the representation of a client."

[3] Too aggressively, from the Authors' viewpoint.

communications from future discovery should a claim denial or controversy erupt in a bad faith action filed by the policyholder. Additionally, should coverage counsel know (or ought to know) when retained that the nature of the assignment likely will trigger the "No Privilege Presumption" rule, are there additional ethical obligations counsel should consider?

A. Erosion of the Attorney-Client Privilege Applicable To Insurer and Coverage Counsel Communications[4]

The general rule is that coverage counsel's communications with the insurer are privileged so long as the lawyer truly serves his or her position as a legal advisor. *See Aetna Cas. & Sur. Co. v. Superior Court*, 153 Cal. App. 3d 467, 476, 200 Cal. Rptr. 471, 476 (Ct. App. 1984).[5] In bad faith litigation, the exceptions to this general rule are well known and fairly uniform. They include the "advice of counsel" defense to bad faith[6] and the "crime fraud exception."[7] However, states such as Washington, New York, Idaho, Louisiana and Ohio have altered traditional notions of the applicability and even existence of the privilege in the insurance bad faith and coverage litigation context.

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[4] The authors acknowledge as a resource a paper written by ACCEC Fellow Diane L. Polscer, Gordon & Polscer, LLC, "Recent Assaults on the Most Sacred Privilege of All: Are Insurers Protected by the Attorney-Client Privilege?" Ms. Polscer's article was presented October 7-9, 2015 at the Litigation Counsel of America Conference in Charleston, South Carolina.

[5] In *Aetna Cas.*, the Court generally discussed the inapplicability of the attorney-client privilege in circumstances where the attorney acts in a capacity other than as a legal advisor, and held that it was error to allow the policyholder access to confidential communications where the attorney was acting as a legal advisor.

[6] *See* Restatement (Third) of the Law Governing Lawyers § 80 (2000); *The Bobrick Corp. v. Dwyer, Schraff, Meyer, Grant & Green*, 2008 WL 4173619, *1 (D. Haw. 2008); *Computer Associates Int'l, Inc. v. Simple.com, Inc.*, 2006 WL 3050883, *2 (E.D.N.Y. 2006); *Ropak Corp. v. Plastican, Inc.*, 2006 WL 1005406, *6 (N.D. Ill. 2006); *Henry v. Quicken Loans, Inc.*, 263 F.R.D. 458, 468 (E.D. Mich. 2008).

[7] *Shorter v. State*, 33 So. 3d 512, 518 (Miss. Ct. App. 2009); *Murphy & Demory, Ltd. v. Murphy*, 1994 WL 1031072 (Va. Cir. Ct. 1994); *People v. Superior Court (Bauman & Rose)*, 37 Cal. App. 4th 1757, 44 Cal. Rptr. 2d 734 (2d Dist. 1995).

1. Washington, Idaho and Louisiana

In *Cedell*, the Washington Supreme Court created a *de facto* presumption that the attorney client-privilege does not apply in "first party insurance claims by insureds claiming bad faith in the handling and processing of claims, other than [under insured motorist] claims." *Cedell*, 295 P.3d at 247. *Cedell* involved a first-party bad faith action against an insurer arising out of a fire that destroyed the insured's residence. Despite the fact that the Fire Department and the insurer's own arson investigation determined that the fire was accidental, the insurer delayed its coverage determination based on alleged inconsistent statements given by the insured's girlfriend who was not insured under the policy. The insurer estimated its exposure under the policy and retained coverage counsel to assist in making a coverage determination. The Court specifically determined that the insurer "hired [coverage counsel] to do more than give legal opinions." The Court noted that the record suggested that coverage counsel "assisted in the **investigation**" of the claim by conducting an examination under oath of the insured and his girlfriend, and corresponding with the insured. Additionally, coverage counsel "assisted in the **adjustment** of the claim" by negotiating with the insured. and *Id.* at 247 (Emphasis added).. Coverage counsel also "assisted in adjusting the claim" by sending the insured a letter making a "'one-time offer'" in an amount considerably less than the insurer's acknowledge exposure[8] and threatening denial of the claim if the offer was not accepted within 10 days. *Id.* at 247. At the time this offer was made, the insured had been out of his house for seven months.

[8] The offer was for "only a quarter of what the [trial] court eventually found the claims to be worth." Id. at 241.

The insured retained counsel, who sued the insurer for bad faith in handling the claim. When plaintiff's counsel requested the insurer to produce its entire claim file, the insurer responded by producing "a heavily redacted claims file, asserting that the redacted information was not relevant or was privileged" under the attorney-client privilege. *Id.* at 242.. The trial court required an *in camera* inspection and then ordered the insurer to produce the disputed documents. The discovery dispute landed at the Washington Supreme Court and was resolved with draconian results. The Court created an analytical framework where trial courts in first-party bad faith actions start with the presumption that the attorney-client privilege does not apply to insurer claim files. The Court stated:

> [I]n first party insurance claims by insured's [sic] claiming bad faith in the handling and processing of claims . . . there is a presumption of no attorney-client privilege. However, the insurer may assert an attorney-client privilege upon a showing *in camera* that the attorney was providing counsel to the insurer and not engaged in a quasi-fiduciary function.[9] Upon such a showing, the insured may be entitled to pierce the attorney-client privilege. If the civil fraud exception is asserted, the court must engage in a two-step process. First, upon a showing that a reasonable person would have a reasonable belief that an act of bad faith has occurred, the trial court will perform an in camera review of the claimed privileged materials. Second, after in camera review and upon a finding there is a foundation to permit a claim of bad faith to proceed, the attorney-client privilege shall be deemed to be waived.

Id. at 246-247.

In short, the *Cedell* Court found that there is a presumption that the attorney client privilege does not exist in a first-party bad faith case when the claim is based upon claims "handling and processing". *Id.* at 246. In order to rebut the presumption and show that the communications are privileged, the insurer first must produce the disputed (*i.e.*, "privileged") documents *in camera*,

[9] The *Cedell* Court explained that quasi-fiduciary tasks are those associated with "investigating and evaluating or processing the claim." In other words, the type of tasks typically reserved for adjusters or other claims professionals. *Cedell* at 246.

prove that coverage counsel provided legal counsel or advice only, and was not performing any quasi-fiduciary function similar in nature to those performed by an insurance adjuster in adjusting the first party claim.[10] Even then, however, should the trial court rule that the communications are privileged, the policyholder has a second bite at the apple by arguing waiver under the civil fraud exception. The Court structured a two-step process requiring only that the insured show that the insurer acted in bad faith and that there is a foundation to permit a bad faith claim to proceed. *See Id.*[11]

The holding in *Cedell* is particularly troublesome for any number of reasons. First party claims handling, claims practices and claims processing are at issue in the vast majority of first party bad faith cases. Therefore, whenever insurance coverage counsel is engaged by the insurer, the "Presumption" rule created by the Court automatically assumes that coverage counsel has performed "quasi-fiduciary" tasks, the same as those performed by the claims adjuster. This is so even though the scope of coverage counsel's assignment goes far beyond that of the adjuster's.

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[10] Federal courts in the state of Washington have been reluctant to conduct such *in camera* reviews. *See Ingenco Holdings, LLC v. Ace Am. Ins. Co.*, 2014 WL 6908512, at *3 (W.D. Wash. 2014), where the court observed that "every federal court to consider the issue has held that the *in camera* review mandate of *Cedell* does not apply in federal court." *See also., MKB Constructors v. Am. Zurich Ins. Co.,* No. C13–611JLR, 2014 U.S. Dist. LEXIS 78883, at *18–23, 2014 WL 2526901 (W.D. Wash. 2014); *Indus. Sys. & Fabrication, Inc. v. W. Nat'l Assur. Co.,* No. 2:14–cv–46–RMP, 2014 U.S. Dist. LEXIS 154021, at *4, 2014 WL 5500381 (E.D.Wash. 2014). In *Ingenco Holdings*, the court held that, "[i]nstead, a federal court exercises discretion in deciding whether in camera review is appropriate . . . [and that] [i]t is difficult to conceive of a circumstance in which the court would exercise its discretion to conduct an *in camera* review of more than 800 pages of documents." *Ingenco Holdings*, 2014 WL 6908512, at *3 (citing *MKB Constructors,* 2014 U.S. Dist. LEXIS 78883 at *19–20, 2014 WL 2526901; *Indus. Sys.,* 2014 U.S. Dist. LEXIS 154021, at *4, 2014 WL 5500381).

[11] Within weeks of being handed down, *Cedell* was adopted by an Idaho federal court in *Stewart Title Guar. Co. v. Credit Suisse, Cayman Islands Branch*, 2013 WL 1385264, at *4-5 (D. Idaho Apr. 3, 2013). In *Stewart Title*, the court stated that, "the Washington Supreme Court issued a well-reasoned decision concerning the extent of the attorney/client privilege in bad faith cases . . . [and] "if the Idaho Supreme Court were faced with the facts of this case, they would apply the holding in *Cedell*." Similarly, in *Shaw Grp., Inc. v. Zurich Am. Ins. Co.*, WL 199626, at *2 (M.D. La. Jan. 15, 2014), the United States District Court for the Middle District of Louisiana also adopted the *Cedell* framework.

Equally troubling is the Court's holding that in undertaking the *in camera* review, the trial court's finding of sufficient facts supporting a bad faith claim is the equivalent of the crime-fraud exception to the attorney-client privilege. Now potentially discoverable, are coverage counsel's opinion letters or portions thereof, notes and work product. Communications between coverage counsel and the insurer arising out of what the *Cedell* Court would deem to be truly and solely legal work nonetheless are not privileged unless and until the insurer produces them *in camera* and succeeds in convincing the trial court that the privilege applies.[12]

Another troubling aspect of *Cedell*, from coverage counsel's standpoint, is the mere assumption that coverage counsel's work preparatory to rendering legal advice to the insurer *de facto* is the equivalent of claims handling. Before insurer coverage counsel, or policyholder counsel for that matter, can render a coverage opinion regarding the claim (and meeting the standard of care imposed on coverage counsel), counsel often is required to perform legal due diligence by: 1) investigating and marshalling the relevant and material facts; 2) in first party claims, take the insured's statement under oath; 3) where the insured is not represented, communicate with the insured; and 4) negotiate with the insured. This does not in and of itself, as reasoned by the *Cedell* Court, render coverage counsel to that of an adjuster, for these functions often are merely a part of the whole of legal services provided by counsel to the insurer. Because of their knowledge of the law with respect to the specific claim or legal issue, referral to coverage counsel is often necessary in order for the insurer to act on the claim. Such might require coverage

[12] It begs the question where there may be voluminous amounts of attorney-client communications that require an inordinate amount of time for the trial judge to review and analyze each and every communication separately. This could prove to be a Sisyphean task for any trial judge with a busy docket.

counsel to undertake tasks similar in nature to "claims handling" if these are a necessary predicate for counsel to render advice to the insurer. Simply, this is called the practice of law.

Another troubling aspect of *Cedell* is that it offers the mischance, or perhaps the unforeseen consequence, that the trial court determines the existence of a triable issue of bad faith when making the *in camera* inspection during the early phase of document production motion practice. Such things should be left for substantive motion practice such as summary judgment. But under the scheme engineered by the Washington Supreme Court, the trial court could make substantive rulings on the sufficiency of evidence supporting the bad faith claim long before discovery is finished.

Cedell may – and ought to – be of limited application in other jurisdictions. The Court's holding is based upon its finding that in first party insurance claims, the insurer acts as the policyholder's quasi-fiduciary. *See Cedell*, 176 Wash.2d at 696. The duties a quasi-fiduciary owes to the principal are of a higher nature, and a quasi-fiduciary has a higher standard of care. *Id.* (citing *Van Noy v. State Farm Mut. Auto. Ins. Co.*, 142 Wash. 2d 784, 791 (Wash. 2001)). However, the overwhelming majority rule in this country is that an insurer does not owe quasi-fiduciary duties to the first party insured.[13] As such, *Cedell* arguably should have potential appeal or applicability in only those states recognizing such a quasi-fiduciary relationship in first party claims. Nonetheless, it is noteworthy that Washington courts have extended *Cedell* to third-party

[13] *See Metro Renovation, Inc. v. Allied Grp., Inc.*, 389 F. Supp. 2d 1131, 1135 (D. Neb. 2005) (holding that "Nebraska would adopt the general rule and not allow a fiduciary-duty claim in this first-party insurance dispute."); *Crabb v. State Farm Fire & Cas. Co.*, No. 2:04-CV-00454 PGC, 2006 WL 1214998, at *10 (D. Utah May 4, 2006)("in a first-party relationship between an insurer and its insured, the duties and obligations of the parties are contractual rather than fiduciary"); Gorman v. Se. Fid. Ins. Co., 621 F. Supp. 33, 38 (S.D. Miss.) aff'd, 775 F.2d 655 (5th Cir. 1985)("[u]nder Mississippi law, there is no fiduciary relationship or duty between an insurance company and its insured in a first party insurance contract.")

bad faith litigation. *See Carolina Cas. Ins. Co. v. Omeros Corp.*, No. C12-287, 2013 U.S. Dist. LEXIS 53225, at *6-7 (W.D. Wash. Apr. 12, 2013).

2. New York

New York courts have also developed similar restrictions on the attorney-client privilege where the insured alleges bad faith against the insurer. In *Nat'l Union Fire Ins. Co. of Pittsburgh v. TransCanada Energy USA, Inc.*, 119 A.D.3d 492, 990 N.Y.S.2d 510, 511-12 (2014), the Supreme Court of New York determined that the attorney-client privilege offered no protection to insurer documents that were created prior to the denial of an insured's claim where the insured alleged bad faith against the insurer. Specifically, the court stated:

> The motion court properly found that the majority of the documents sought to be withheld are not protected by the attorney-client privilege or the work product doctrine or as materials prepared in anticipation of litigation. Following an *in camera* review, the court determined that certain documents were privileged because they contained legal advice. As for the remaining documents, the court found that the insurance companies had not met their burden of demonstrating privilege. The record shows that the insurance companies retained counsel to provide a coverage opinion, i.e. an opinion as to whether the insurance companies should pay or deny the claims. Further, the record shows that counsel were primarily engaged in claims handling—an ordinary business activity for an insurance company. Documents prepared in the ordinary course of an insurer's investigation of whether to pay or deny a claim are not privileged, and do not become so "'merely because [the] investigation was conducted by an attorney'" (*see Brooklyn Union Gas Co. v American Home Assur. Co.*, 23 AD3d 190, 191 [1st Dept 2005]).

Id. at 511-12.

Like *Cedell*, the Court in *TransCanada* held that certain documents and communications might fall under the attorney-client privilege where they contain legal advice. And like *Cedell*, the *TransCanada* Court held that the attorney-client privilege did not exist where coverage counsel's work was deemed to be "primarily claims handling." However, the Court in *TransCanada* did not specify whether a coverage opinion falls under the protection of the attorney-client privilege. *Id.*

at 511. As such, there is an argument that a coverage opinion is privileged if it contains only legal opinions and advice to the insurer regarding the interpretation of certain policy provisions. But the precise issue of whether a coverage opinion constitutes a privileged communication under the attorney-client privilege was not addressed in *TransCanada*. Insurers and insurance coverage attorneys are faced with the potential that a coverage opinion does not constitute a protected attorney-client communication if it was authored prior to the denial of coverage and created in the "ordinary course of an insurer's investigation of whether to pay or deny a claim." *Id.*

3. Ohio Case Law

In *Boone v. Vanliner Insurance Company*, 91 Ohio St.3d 209 (Ohio 2001), the Ohio Supreme Court held that, "in an action alleging bad faith denial of insurance coverage, the insured is entitled to discover claim file materials containing attorney-client communications related to the issue of coverage that were created prior to the denial of coverage." *Id.* At 213-214. Arguably, the holding in *Boone* stands for the proposition that insurance coverage opinions containing legal advice about policy provisions issued prior to a denial of coverage are discoverable, and that the attorney-client privilege will not apply. Under the *Boone* framework, this arguably would be true regardless of whether insurance coverage counsel performed the same function of or otherwise acted in the capacity of a claims adjuster. The *Boone* Court reasoned that "[a]t that stage of the claims handling, the claims file materials will not contain work product, *i.e.*, things prepared in anticipation of litigation, because at that point it has not yet been determined whether coverage exists."

Boone was modified by the Ohio legislature in 2007 when the statute regarding privileged communications was amended as follows:

The following persons shall not testify in certain respects:

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> An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima-facie showing of bad faith, fraud, or criminal misconduct by the client.

Ohio Rev. Code Ann. § 2317.02(A). Under the modified statute, there is now a presumption that the attorney-client privilege applies—even if the insured alleges bad faith. In order to compel production of the privileged communication, the amended statute now requires the insured to make a prima-facie showing of bad faith and provides for an *in camera* inspection by the court with respect to the communications between insurer and attorney.

Some Ohio courts have either refused or paid no heed to the applicability of the legislative amendment to § 2317.02(A). These courts have reasoned that the legislative amendment does not apply to written communications or claim documents.[14] Other courts have simply continued to apply *Boone* without any recognition of the legislative amendment.[15] Thus, there remains uncertainty as to whether attorney-client communications predating the denial of a claim are discoverable upon a prima facie showing of bad faith after an *in camera* review, or whether such communications are discoverable by simply alleging that the insurer committed bad faith.

While taking different routes, Washington, New York, Idaho, Louisiana and, to a limited extent, Ohio courts refuse to recognize the attorney-client privilege for communications between

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[14] *See Little Italy Dev., LLC v. Chicago Title Ins. Co.*, 1:11 CV 112, 2011 WL 4944259, at *2 (N.D. Ohio Oct. 17, 2011)

[15] *See DeMarco v. Allstate Ins. Co.*, 2014-Hoio-933, ¶¶ 15-19, 2014 WL 1327846 (Ohio App. 2014); *Park-Ohio Holdings Corp. v. Liberty Mut. Fire Ins. Co.*, No. 1:15-CV-943, 2015 WL 5055947, at *2 (N.D. Ohio Aug. 25, 2015).

insurer and its coverage counsel made prior to the denial. The decisions in these states are a warning shot to insurer coverage counsel nationwide that courts are showing an increased willingness to erode the time honored protection of the attorney-client privilege in the insurance coverage context. Given this increased willingness to minimize application of the attorney-client privilege in the insurance coverage context, insurance coverage counsel are being called upon to advise their insurer clients how to preserve the privilege and protect communications from future discovery. But going further, with respect to protecting from discovery communications to and from the insurer client, do coverage counsel have additional considerations arising out of ethical rules?

B. Maintaining and Preserving the Attorney-Client Privilege

The *Cedell* prospect of opening to discovery the insurer's and coverage counsel's communications might prompt a temptation to severely limit written communications, and most certainly the content. Reducing open discourse to oral communications between coverage counsel and insurer has drawbacks, for many states, to one degree or another, require the insurer to maintain a claim file sufficiently documenting all activities. *See Creating Defensible Files and Avoiding Bad Faith Claims*, 16 Andrews Ins. Indus. Litig. Rep. 25 (2000)("[U]nfair insurance or claims practices regulations and statutes . . . require that [an] insurer maintain claim files in sufficient detail that pertinent events and dates of the events can be reconstructed").[16]

The attorney-client relationship in a coverage dispute begins when coverage counsel is consulted and/or retained by the insurer. Coverage counsel will at that point want to consider how to maintain and protect privileged communications from future discovery. In light of existing

[16] *See also* Wash. Admin. Code 284-30-340; N.Y. Comp. Codes R. & Regs. Tit. 11, §216.11.

regulatory and statutory requirements requiring insurers to maintain complete claim files, a suggested approach is for coverage counsel to have a thorough initial discussion with the insurer regarding responsibilities and tasks, and limit the scope of the engagement letter or agreement accordingly. For example, if coverage counsel is retained solely to provide a coverage opinion, the engagement letter or agreement can be limited to make it clear that coverage counsel is retained only to provide a coverage opinion, that such opinions are being prepared in anticipation of litigation, that such opinions are being provided pursuant to the attorney-client relationship and that the attorney is not retained to perform any tasks associated with the adjustment of the claim. By memorializing the expectations of the insurer and coverage counsel, when the policyholder seeks discovery of communications between insurer and coverage counsel, the insurer can show that the coverage counsel was acting as a legal advisor only and not performing adjuster functions. This approach is consistent with the Model Rules of Professional Conduct. For example, Rule 1.2 states:

> Rule 1.2 Scope of Representation and Allocation of Authority between Client and Lawyer
>
> (a) Subject to paragraphs (c) and (d), a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer may take such action on behalf of the client as is impliedly authorized to carry out the representation.
>
> ***
>
> (c) A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent.

In regard to limiting the scope of an agreement between insurer and attorney, comment 6. to Rule 1.2 states:

> **Agreements Limiting Scope of Representation**

> [6] The scope of services to be provided by a lawyer may be limited by agreement with the client or by the terms under which the lawyer's services are made available to the client. When a lawyer has been retained by an insurer to represent an insured, for example, the representation may be limited to matters related to the insurance coverage. A limited representation may be appropriate because the client has limited objectives for the representation. In addition, the terms upon which representation is undertaken may exclude specific means that might otherwise be used to accomplish the client's objectives. Such limitations may exclude actions that the client thinks are too costly or that the lawyer regards as repugnant or imprudent.

In addition to limiting the scope of the engagement letter or agreement, coverage counsel can label reports and coverage opinions as "attorney-client protected" documents, and use the subject line in e-mails to state that coverage counsel is providing legal advice. Thereafter, coverage counsel should remain aware of his or her specific responsibilities, stay within the confines of those responsibilities and promptly advise the insurer whether certain requested tasks potentially fall outside the scope of representation. Otherwise, the insurer runs the risk of losing the benefit of the attorney-client privilege.

Unfortunately, despite the insurer's and coverage counsel's best efforts, the modern reality of today's legal climate is that the attorney-client privilege may not apply. As noted in the Washington, New York, Idaho, Louisiana and Ohio decisions, at the outset of a bad faith suit there may be a presumption that the attorney client privilege does not exist for pre-denial communications and the insurer must overcome the presumption. In some instances, coverage counsel tasked with rendering a coverage analysis and advising the insurer may find it next to impossible to avoid undertaking activities some courts deem to be ordinary claims handling, thereby potentially affecting the attorney-client privilege.

Because there are no bright-line guidelines, what can insurance coverage counsel consider to fulfill his or her ethical obligations to the insurer in maintaining and preserving the attorney-

client privilege in the event a court determines that he or she was performing "adjuster activities" rather than serving solely as legal advisor?

C. Implications For Coverage Counsel When Deemed to be Acting as Claims Adjusters?[17]

In the *Cedell* context, there are implications when insurance coverage counsel is held by a trial court to have performed claims handling functions resulting in a ruling that the attorney-client privilege does not exist prior to the insurer's denial of a claim. These implications include the question as to what standard of care and what ethical obligations apply to counsel. For example, with respect to the policyholder, is counsel to be considered as an adjuster only, or both adjuster and lawyer? This is a distinction with a difference, for the lawyer typically must adhere to a professional standard of care while the adjuster generally has an ordinary standard of care.[18] With respect to counsel's relationship with the insurer, if a court holds that there is no attorney-client privilege applicable to pre-denial communications, the existence of the attorney-client relationship is implicated. In this context, what standard of care applies to coverage counsel undertaking claims functions—professional or ordinary?

Coverage counsel should become familiar with the ethical obligations, if any, the client's adjusters are expected to follow, and consider how such obligations may impact dealings with both the insurer and the policyholder. It is beyond the scope of this paper to discuss every potential ethical duty imposed upon claims adjusters. However, a cursory review of some of the more

[17]The authors acknowledge and credit as a resource a paper co-authored by ACCEC Founding Regent, Lewis F. Collins, Butler Wehmuller Katz Craig LLP, "Bad Faith: When Attorneys Act in a Claims Role," presented at the 2015 CLM Annual Conference.

[18] *See* 3 Modern Tort Law: Liability and Litigation § 26:22 (2d ed.)(discussing the fact that attorneys are to adhere to a professional standard of care maintained by practicing attorneys in that particular area); *See also Injury at Sea v. Pac. Claims, Inc.*, 122 Wash. App. 1020 (2004)(noting that insurance claims adjusters are held to a lower standard of care unless acting in the capacity of an attorney).

significant adjuster ethical considerations may shed light on ethical obligations a court potentially could apply to coverage counsel if deemed to be performing the same role as a claim adjuster.

The specifics of adjuster ethics vary from state to state. The following ethical duties and responsibilities are a compilation gleaned from the Code of Professional Conduct ("the Code") issued by the American Institute for Chartered Property Casualty Underwriters, which is an industry leader in property-casualty insurance education, research and ethics.[19] The Code emphasizes that the adjuster deal fairly and truthfully with the insured.[20] Central to this ethical responsibility is that the adjuster's investigation should include an evaluation of all facts available, and render a fair result based on applicable policy provisions and the facts available. In addition, if added facts become available, the adjuster should consider such facts and reconsider the coverage decision if applicable. In addition, Cannon Four requires that adjusters diligently and competently discharge their duties.[21] Arguably tied to this ethical responsibility, is the adjuster's duty to evaluate and process the claim in a timely manner and ensure that the claim decision is communicated to the policyholder in a timely manner. As an additional consideration, Cannons 1 and 6 of the code require that the adjuster should always avoid the appearance of impropriety,[22] and strive to maintain dignified and honorable relationships.[23] Cannons 1 and 6 go to the heart of

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[19] *See The Canons, Rules, and Guidelines of the CPCU Code of Professional Conduct*, The Institutes, 1st Edition, 3rd Printing, July 2013, http://www.theinstitutes.org/doc/canons.pdf. The CPCU's Code, which was introduced in 1976, prescribes a minimum standard by which all member adjusters are expected to comply, and provides Canons and Rules regarding ethical conduct, as well as disciplinary rules, procedures and penalties.

[20] *See* Cannon 3 of the Code requiring that the adjuster obey all applicable laws and regulations, and avoid any conduct that would cause unjust harm.

[21] *See* Cannon 4 of the code.

[22] *See* Cannon 1, R.1.1 (indicting that an adjuster should avoid even the appearance of impropriety when performing his or her professional duties and should act in a manner that ultimately will best serve his or her own professional interests).

[23] *See* Cannon 6.

avoiding conflict of interest issues that often times arise between policyholder, adjuster and insurer.

Again, the aim of this paper is not to discuss every potential ethical duty imposed upon claims adjusters, but to recognize that adjuster ethics can most certainly influence and shape the efficacy of a defense if the claim goes into litigation. By way of example, an adjuster's failure to adhere to applicable ethical considerations can lead to the policyholder filing a bad faith suit. Under Cannon four, an adjuster's ethical failure to competently discharge their duties by evaluating a claim and communicating a coverage decision in a timely manner might result in a waiver of applicable policy defenses in certain states.[24]

At this time, there appear to be no reported decisions imposing ethical standards of an adjuster on insurance coverage counsel deemed to be acting as a claims adjuster. Notwithstanding this, a policyholder's bad faith expert might attempt to proffer such an opinion. Until case law is developed, insurance coverage counsel in consideration of the insurer client's best interests should adhere to those obligations when the particular tasks and responsibilities requested by the insurer client could potentially result in a ruling that counsel performed adjuster functions leading to abrogation of the attorney-client privilege.

CONCLUSION

Insurance coverage counsel cannot assume that every pre-denial attorney-client communication will be protected under the cloak of privilege—even where those communications

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[24] *See Yowell v. Seneca Specialty Ins. Co.*, 2015 WL 4575450, at *4 (E.D. Tex. 2015)(generally holding that failure of the insurer to provide a timely coverage determination can lead to the application of waiver); *Peavey Co. v. M/V ANPA*, 971 F.2d 1168, 1176 (5th Cir. 1992)(holding that Zurich waived non-coverage defense based on untimely investigation);

are contained in opinion letters. With this in mind, insurance coverage counsel is tasked with determining how ethically to protect communications with the insurer client. By limiting the scope of their engagement letters or agreements, coverage counsel can minimize the risk that courts will deem them to be acting as adjusters rather than as legal advisors and counsellors.

However, and despite counsel's best efforts to frame the engagement letter or agreement so as to only assume tasks and responsibilities of a legal advisor or counsellor, should more courts adopt the *Cedell* rule in discovery, there remains the possibility that a court will remove the attorney-client privilege and deem the insurance coverage attorney to be acting as a claim adjuster. Facing that possibility, there is also the risk that a court will impose the same standard of care involved with the adjustment of claims on the insurance coverage attorney.