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President's Message for the First Edition of the Journal of the American College of Coverage Counsel

Dear Fellows,

I am delighted to welcome you to the first volume of the Journal of the American College of Coverage Counsel. The idea of this Journal, published as a special issue of *The Insurance Law Review*, was conceived with the thought that since the College is comprised of the pre-eminent coverage counsel in the nation, and since our members are prolific authors, there ought to be a way to publish their works and memorialize them. Moreover, creating the Journal allows the College to partner with the Insurance Law Center at the University of Connecticut School of Law, whose brilliant young law students have worked with our member-authors to produce this work before you.

The articles in this journal have not only been written by "the best of the best"; their topics reflect the most cutting-edge issues in the field of coverage law. The College, through its meetings and symposia has always presented content designed not only for academics, but also for practitioners. The Journal has been designed to reflect this. There is much in the Journal to be enjoyed by a law professor or student; there is also material to be used by an active lawyer. As always, with the College, both carrier-side and policyholder-side perspectives are represented. In sum, this Journal illustrates of all the good things the College does.

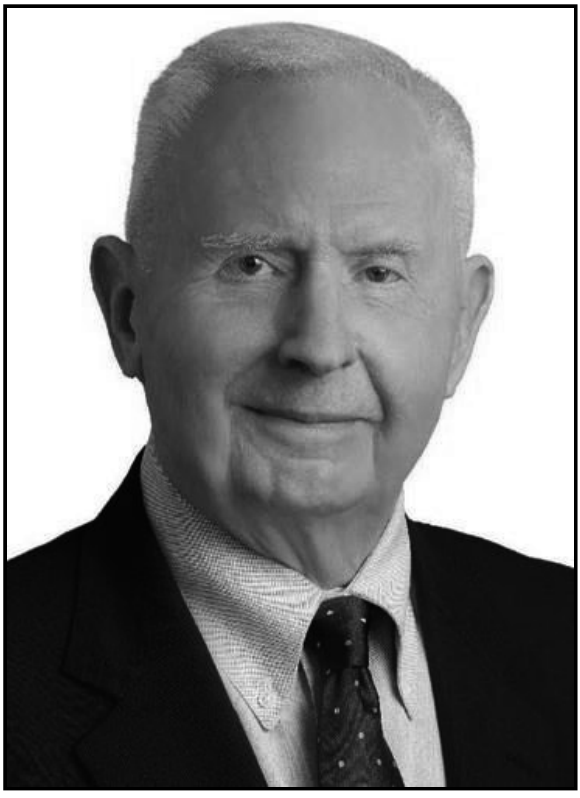
A great deal of thanks is owed to Travis Pantin, Director of the Insurance Center, for his support and assistance in creating the Journal. Thanks also to the hard-working student editors who sometimes gave up weekends to correct text, edit footnotes and do all the myriad things that go into the creation of a publication. The current Editor-in-Chief, Caitlyn Myers, deserves special recognition for her hard work. These student editors have not worked alone. They have been joined by Fellow's Editors Michael Aylward and Doug Skelley whose yeoman efforts here reflect their love of the College, and of scholarship.

Finally, this first edition of the Journal is dedicated to the memory our former *member* Doug Houser, who died in 2017. Doug was a founding fellow of the College. He was a past Chair of the Tort and Insurance Section of the American Bar Association, a past President of the Federation of Defense and Corporate Counsel, a member of the American College of Trial Lawyers and the American Law Institute—and these were only a few of his accomplishments. More importantly, Doug was a genuine friend and mentor to many of us in the College. A towering presence in the field, he could often

be seen at conferences spending time with the youngest attorneys there—he was always approachable. I believe he would truly enjoy the Journal.

Once again, welcome to this first edition. May there be many more.

Stephen Pate
President of the American College of Coverage Counsel



Dedicated to Doug Houser
Founding Fellow of the American College of Coverage Counsel

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Volume I

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ARTICLES

ARTIFICIAL INTELLIGENCE IN THE INSURANCE INDUSTRY AND BAD FAITH RISK

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Contents

I. INTRODUCTION

As with nearly every other sector of the American economy, interest in AI has exploded within the insurance industry in recent years. Today, 80% of all insurers have implemented or plan to add AI components to their claims infrastructure within a year.[1] Similarly, a new study reports that 77% of companies are integrating AI into their operations.[2]

The shift towards AI is not just about automation; it is also about harnessing the power of advanced algorithms to analyze complex data sets, identify patterns, and predict outcomes with a level of precision that surpasses human capabilities. In particular, insurers hope that AI will help them to streamline the claims process and make it more efficient by reducing the time and resources required to handle claims while at the same time enhancing the accuracy of assessments.

Moreover, AI's ability to process vast amounts of data quickly and efficiently enables insurers to offer more personalized services to their customers. For instance, AI can help identify individual customer needs and preferences, allowing insurers to tailor their products and services accordingly. This personalization can lead to increased customer satisfaction and loyalty, as policyholders feel that their specific needs are being addressed more accurately.

The integration of AI in the insurance industry also presents opportunities for innovation. Insurers can develop new products and services that leverage AI's capabilities, such as real-time risk assessments and dynamic pricing models. These innovations can enhance the overall customer experience and provide insurers with a competitive edge in a rapidly evolving market.

In this article, we will first review the history of artificial intelligence. Next, we will consider the specific applications of AI in insurance underwriting and claims handling. Having set the stage, we will proceed to examine the types of conduct that will likely generate AI/bad faith claims. Finally, we will address how the very nature of artificial intelligence may compel changes in the way insurers may be obliged to defend bad faith claims in the future.

1. Press Release, Ethical AI in Insurance Consortium, 2024 Survey Reveals Crucial Ethical AI Adoption Challenges in Insurance Industry (Mar. 12, 2024) (on file with author).

2. *Id.*

II. A BRIEF HISTORY OF ARTIFICIAL INTELLIGENCE

Artificial intelligence ("AI") is the simulation of human intelligence in machines, allowing them to perform tasks that typically require human cognition.[3] These tasks include learning, reasoning, problem-solving, perception, and language understanding. Algorithms are step-by-step procedures that the AI technology uses to achieve its goal. Algorithms work by taking large sets of data and identifying correlations among different data points; they then use those correlations to make conclusions about the data, predict outcomes, or advise on the best course of action. In essence, AI is powered by algorithms that enable it to process information, adapt, and make intelligent decisions.

Although human analysts can certainly do these things, a well-designed algorithm can do them more efficiently and more effectively than any human. For this reason, AI can be a valuable tool any time a decision requires or is improved by an analysis of the relationship between multiple data points in a large, complex data set.

When AI technology was first introduced, algorithms were developed and refined with the help of a human teacher. A human would assemble a training data set and then analyze, label, or classify the data. The algorithm would learn by example based on the human's analysis or classifications, and then attempt to recreate the human's work when presented with new data. The advent of "machine learning" advanced AI technology to a new level of complexity, allowing algorithms to learn without the guidance of a human teacher.

Algorithms that are taught through machine learning do not require a human teacher or training data; instead, they can go out and find their own data sets, or take a given data set and discover correlations among the data points on their own, without the guidance of a human teacher. These types of algorithms may initially be less accurate than those taught by humans, but many can improve when they receive feedback on their predictions. The advent of machine learning was a huge development in both the power and risk of AI because algorithms could now find correlations among data that a human teacher may have "never defined or even anticipated."[4]

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3. U.S. National Institute of Standards and Technology defines AI as "a machine-based system that can, for a given set of objectives, generate outputs such as predictions, recommendations, or decisions influencing real or virtual environments." NIST, *Artificial Intelligence Risk Management Framework (AI RMF 1.0)*, NIST AI 100-1 1 (2023), https://doi.org/10.6028/NIST.AI.100-1.

4. Alfred R. Cowger, Jr., *Corporate Fiduciary Duty in the Age of Algorithms*, 14 CASE W. RESERVE J.L. TECH. & INTERNET 138, 147 (2023).

III. THE OPPORTUNITIES AND RISKS THAT AI POSES TO THE INSURANCE INDUSTRY

AI has the potential to revolutionize the way the insurance industry "prices, creates, and delivers insurance policies; interacts with customers; and the way it analyzes and evaluates policyholder claims."[5] AI could, for example, evaluate insurance customer calls and questions, identify gaps in coverage or appetite for new coverages based on those questions, draft new policies to fill the gaps, price the coverage, and prepare marketing materials. When designed correctly, AI may also help avoid human bias and potential discrimination in underwriting by limiting the introduction of individual biases into the process.

AI can quickly perform data entry tasks and verify data, allowing for faster processing of a claim. AI also can estimate the cost of a loss to a policyholder, quickly summarize documents and communications, categorize claims by urgency and complexity, automatically resolve and pay simple claims, and recommend settlement decisions and amounts to human claims handlers.[6] Automating these tasks can reduce adjustment expenses to the insurer and shorten the time from the first notice of loss to claim closure. "This is beneficial to the insured both in terms of claim satisfaction and reduced premiums."[7]

AI can also play an important role in rooting out fraudulent claims, which may include claims for losses that never happened, claims containing inflated losses, or claims for losses that the policyholder caused intentionally. AI can be taught to search through internal claims materials for indicia of fraud and can even look quickly through external materials, like social media, for clues.[8] Insurers may save money on these investigations because AI can investigate claims more efficiently and effectively than a human investigator. This also means that insurers can investigate more claims for fraud than previously possible, reducing the number of fraudulent claims it pays out.

While AI generally has great potential for efficiency and cost savings, it is not without risk. "Like any other software, or any other product for that matter, algorithms and AI tools begin with a design process initiated by and

5. Rick Swedloff, *The New Regulatory Imperative for Insurance*, 60 B.C. L. REV. 2031, 2034 (2020).

6. Chris Johnson et al., *AI and Claims Handling: Navigating the Next Wave of Bad Faith Suits*, FOR THE DEF., Nov. & Dec. 2024, at 55, 57–58.

7. Kathleen J. Maus & Julius F. Parker III, *How Carriers Implement Fair Claims Practices in a Hands-Off World*, FOR THE DEF., Oct. 2020, at 18, 19.

8. Swedloff, *supra* note 5, at 2081.

undertaken by humans."[9] Even expert software designers and engineers "are not ever going to be the combination of lawyers, CPAs, business administrators, logistics experts, and HR managers needed to make a good algorithm for use by corporations."[10] For any business using AI, then, expert consultation at the design phase is essential to building an algorithm that is accurate and useful.

The usefulness of AI is necessarily connected to the accuracy of the data sets used to teach the algorithm. That is, if the algorithm is given data that is inaccurate or deficient, its outcomes will be inaccurate and deficient as well.[11] AI taught through machine learning may be more prone to errors because, without the guidance of a human teacher, it is likely to be affected by improperly weighted or unrepresented data.[12] If available data is limited, then the ultimate user of the AI must be able to understand the AI's limitations in order to use it appropriately.[13] For most people, this is a tall order—algorithms are generally not particularly transparent, so it is difficult to track or observe the process it uses to accomplish its tasks.[14] Even AI experts may not fully understand how a particular algorithm operates.[15]

During the design phase, an algorithm's potential for accuracy and usefulness must be weighed against potential development and operating costs. Developing AI is not cheap, and the cost of training advanced AI systems has been increasing for years due to a rise in labor costs and the costs of necessary semiconductors, among other factors.[16] It is generally cost prohibitive to develop an algorithm that gives an accurate answer to every question, or performs every task perfectly, so some error rate should always be expected.[17] Additionally, AI developers must consider the technology's operating costs to its users. AI requires a significant amount of energy to operate—AI technology used by bitcoin businesses can use "more energy than entire

9. Cowger, *supra* note 4, at 140.

10. *Id.*

11. Michael Luca et al., *Algorithms Need Managers, Too*, HARV. BUS. REV., Jan.–Feb. 2016.

12. Cowger, *supra* note 4.

13. Luca et al., *supra* note 11.

14. *Id.*

15. Cowger, *supra* note 4, at 149.

16. Will Henshall, *The Billion-Dollar Price Tag of Building AI*, TIME MAG. (June 3, 2024, 3:22 PM), https://time.com/6984292/cost-artificial-intelligence-compute-epoch-report/.

17. *Id.* ("The push to build more computationally intense AI systems could be bottlenecked by the intense energy requirements of the largest clusters of semiconductor chips or by a lack of training data.").

nations."[18] Even a very sophisticated AI product, then, may not be viable for regular use if it requires too much energy to operate.

The algorithm's design can also be negatively affected by the biases of its designer. While many assume that AI is free of bias—it is a machine, after all—in reality, it can simply build into its operation any bias of its human designers or bias in the data set used to train the algorithm.[19] "In a worst-case scenario, if the customer wants a discriminatory result, the designer can deliver an algorithm that will produce such a result while seemingly making non-human, unbiased analyses."[20] In a marginally better scenario, data often reflects historical discrimination and, without intervention from a human designer, will teach the AI to continue or potentially expand discriminatory practices.[21]

Despite the potential for error in the algorithm design process, many human users of AI technology are biased in its favor. "Studies have repeatedly shown that humans exhibit 'automation bias' in favor of AI, which means humans tend to accept an algorithmic outcome, even if they intuitively suspect there is something wrong with the outcome. Even experts, who should have enough knowledge and experience to know when an algorithmic answer is wrong, tend to reject their own self-doubt in favor of the erroneous algorithmic-based results."[22] Thus, good human judgment is, ironically, an essential component for making the best possible use of AI.[23]

IV. WILL ARTIFICIAL INTELLIGENCE GENERATE NEW BAD FAITH CLAIMS?

As we have seen, artificial intelligence is an increasingly integral aspect of insurance claims operations. We will now consider whether, and how,

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18. Cowger, *supra* note 4, at 141.

19. Jake Silberg & James Manyika, *Tackling Bias in Artificial Intelligence (and in Humans)*, MCKINSEY GLOB. INST. (June 6, 2019), https://www.mckinsey.com/featured-insights/artificial-intelligence/tackling-bias-in-artificial-intelligence-and-in-humans ("[S]ome evidence shows that algorithms can improve decision making, causing it to become fairer in the process . . . . At the same time, extensive evidence suggests that AI models can embed human and societal biases and deploy them at scale.").

20. Cowger, *supra* note 4, at 141.

21. NIST, *Artificial Intelligence Risk Management Framework: Generative Artificial Intelligence Profile*, NIST AI 600-1 4 (2023), https://doi.org/10.6028/NIST.AI.600-1.

22. Cowger, *supra* note 4, at 140.

23. Silberg & Manyika, *supra* note 19.

the emerging role of AI may, in turn, generate bad faith claims against insurers. In particular, it is foreseeable that such claims may be brought based on: (1) faulty design of AI products that results in discriminatory or unfair results; (2) negligent human oversight of AI components; or (3) improper use or abuse of AI to deny claims.

A. DESIGN ISSUES

The risks associated with insurers' use of AI may arise from the design of the algorithm and/or from the use of the AI technology.

One important design consideration relates to the feedback the AI receives when it is used to settle claims. One author posited (without any citation or support) that "[t]he insurer likely instructs the AI to pay the lowest reasonable amount for a claim."[24] The author theorized that if these offers are regularly rejected by policyholders, the AI receives negative feedback on its settlement offers and learns to propose higher settlement amounts.[25] If, however, policyholders routinely accept the offers, the AI receives no negative feedback and, the author suggests, will offer the same or a lower amount to the next policyholder with a similar claim.[26]

A lack of complaints from policyholders may indicate that the AI's settlement offers are fair and reasonable, but this is not necessarily the case. There are many reasons why a policyholder may accept a low settlement offer: it may not be low enough for the policyholder to complain; it may be too costly to fight with the insurer or switch carriers; or the policyholder may not realize the offer is low.[27] The author fails to recognize, however, that if policyholders are dissatisfied with low offers and frustrating claims processes, corrective actions may include policyholders changing carriers and filing bad faith lawsuits alleging systematic underpayment of claims.

An insurer could also face a bad faith claim if it uses inaccurate data to train its AI or misrepresents the way its AI operates. An insurer is currently facing a bad faith suit by the State of California alleging bad faith arising from both putative practices.[28] In its complaint, filed in April 2024, the State of California alleges that Progressive violated the covenant of good faith and fair dealing by engaging in a scheme to systematically underpay its policyholders for claims of total vehicle losses. The complaint alleges that Progressive

24. Swedloff, *supra* note 5, at 2082.

25. *Id.*

26. *Id.*

27. *Id*.

28. Complaint, People v. Progressive Corp., No. 24CV073476 (Cal. Super. Ct. Almeda Cty. filed Apr. 29, 2024).

purposefully customized its loss valuation software to generate a Market Value Report (MVR) for each loss reported, and then misrepresented that amount as the Actual Cash Value (ACV) for the vehicle, knowing that the MVR would produce a lower settlement amount than the ACV. The complaint alleges that the defendants engaged in this scheme to induce policyholders to accept lower settlement amounts for their losses. The State of California is seeking statutory damages upwards of $2,500 per violation of state law, as well as disgorgement of any profits Progressive gained from this scheme. As of February 2025, the case is pending in California Superior Court in Alameda County.

A bad faith claim might also arise if the use of AI results in claims decisions based on factors that, by law, insurers are forbidden to consider. In December 2022, two named plaintiffs filed a putative class action lawsuit in Illinois federal court against insurer State Farm, alleging race-based practices in the handling of their home insurance claims.[29] The plaintiffs, who are both Black, contend that State Farm took longer to process their claims, required more paperwork, and ultimately provided less coverage than it did to their white neighbors, who were also State Farm policyholders and whose homes suffered similar damage. Rather than alleging discriminatory animus, the plaintiffs claim that State Farm used "algorithmic decision-making tools that allegedly resulted in statistically significant racial disparities in how the insurer processed claims," in violation of the Fair Housing Act (FHA).

State Farm moved to dismiss the suit, but the court found that the plaintiffs had adequately stated a claim under a disparate impact theory.[30] The court found that "State Farm's decision to use algorithmic decision-making tools to automate claims-processing" constituted a "policy" under the FHA. It further found that the plaintiffs had plausibly alleged a connection between State Farm's use of AI and statistical racial disparities in claims handling by "describing how machine-learning algorithms—especially antifraud algorithms—are prone to bias."[31] Although the plaintiffs did not assert a claim for bad faith in their complaint, the court noted that "[l]iability under the FHA for processing Black policyholders' claims differently aligns with State Farm's state-law obligation to 'effectuate prompt, fair and equitable settlement of claims' in good faith."[32] Thus, even if a plaintiff could not prevail under state or federal antidiscrimination law, a bad faith claim based on similar facts would be plausible. As of February 2025, the case is in discovery.

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29. Complaint, Huskey v. State Farm Fire & Cas. Co., No. 1:22-cv-07014 (N.D. Ill. filed Dec. 14, 2022).

30. Huskey v. State Farm Fire & Cas. Co., No 22 C 7014, 2023 WL 5848164, at *1 (N.D. Ill. Sept. 11, 2023).

31. *Id.* at *9.

32. *Id.* at *11 (quoting 215 ILL. COMP. STAT. 5/154.6(d) (2022)).

Careful vetting of AI vendors, understanding the data used to teach the AI, and appreciating how the algorithm's function can be manipulated throughout its lifecycle are essential to assessing bad faith risks. The algorithm design process may aim to use AI to efficiently produce results that are consistent with the insurance policy. A bad faith claim might allege that the insurer improperly attempted to produce results aligned with pre-loss predictions or projections, which could conflict with its contractual duty to fairly investigate and value each claim. Indeed, jurors tend to find that insurers act in bad faith when they use AI to prioritize their own cost savings over the interests of their policyholders.[33]

Working closely with algorithm designers to ensure AI functions consistently with the covenant of good faith and fair dealing may help avoid issues down the line. Similarly, incorporating policy terms into the algorithm so its decisions align with those terms may reduce the risk of bad faith allegations.

While intentionally teaching a claims handling algorithm to consider protected characteristics, such as race or gender, would violate the insurer's duty to investigate each claim fairly and in good faith, the complexity of machine learning from large data sets introduces additional challenges. For decades, proxy characteristics, which are "purportedly neutral individual characteristics" whose consideration frequently results in racial disparities, have been used where direct discrimination is prohibited.[34] The National Association of Insurance Commissioners (NAIC), in its Principals on Artificial Intelligence, recommends that insurers avoid "proxy discrimination against protected classes" in their design of AI to avoid even unintentional discrimination. Thus, working with AI designers to prevent algorithms from relying on data that might perpetuate historical discrimination, whether through the use of protected characteristics or proxies, may help avoid liability under both bad faith and anti-discrimination law.

B. OVERSIGHT CONCERNS

Courts may also hold insurers liable for not properly monitoring or auditing AI models, especially if these systems systematically underpay claims. In such cases, insurers might be required to demonstrate that their AI complies with industry best practices, ensuring unbiased and reliable decision-making. AI systems that unintentionally discriminate against

33. Johnson et al., *supra* note 6, at 58.

34. Cal. Dep't of Ins., Bulletin 2022-5, *Allegations of Racial Bias and Unfair Discrimination in Marketing, Rating, Underwriting, and Claims Practices by the Insurance Industry* (June 30, 2022).

policyholders based on factors like race, age, or location could result in bad faith claims, with policyholders arguing insurers failed to prevent biased denials.

C. CLAIMS HANDLING ISSUES

In addition to designing their AI systems with their legal and contractual obligations in mind, parties must carefully consider how and when insurers are actually using AI technology throughout the claims process. An insurer may face increased risk of a bad faith claim if it is inconsistent in its use of AI.

Back in 2010, before the advent of AI as we know it today, Allstate Insurance came under fire for its use of an internal claims handling program known as Colossus.[35] The NAIC, along with the insurance departments of forty-five states, investigated Allstate's use of Colossus and found that Allstate was inconsistent in the way it used Colossus to review and manage car accident claims.[36] The probe also found that Allstate was not transparent with its use of Colossus. Allstate settled the matter, agreeing to pay $10 million to the states involved in the probe.[37] Allstate also agreed to strengthen its internal auditing of Colossus, develop a single manual for internal use of Colossus, and refrain from establishing policies that would force Allstate's claims adjusters to settle claims based solely on recommendations from Colossus.[38]

As the Allstate settlement demonstrates, an insurer might increase its litigation exposure when it makes a claims decision, particularly a denial, based solely on AI analysis.[39] Several health insurance companies are currently defending class actions alleging that the insurers used AI to avoid obligations to give each claim individualized consideration and to improperly deny patient claims. In April 2024, four named plaintiffs filed a putative class action suit against health insurer Humana in Kentucky federal court, alleging that Humana used a predictive AI model to wrongfully deny post-acute care to elderly patients under their Medicare Advantage Plans.[40] In the complaint, the plaintiffs allege that Humana used its AI model, known as nH Predict, to

35. Ben Berkowitz, *Allstate Settles with States over Claims Software*, REUTERS, Oct. 18, 2010, https://www.reuters.com/article/world/uk/allstate-settles-with-states-over-claims-software-idUSTRE69H4DJ/.

36. *Id.*

37. *Id.*

38. *Id.*

39. Johnson et al., *supra* note 6, at 57–58.

40. First Amended Complaint, Barrows v. Humana, Inc., No. 3:23-cv-00654-RGJ (W.D. Ky. filed Apr. 22, 2024).

override the decisions of treating physicians and deny medically necessary care to patients, resulting in a high rate of wrongful deaths. The plaintiffs allege that Humana implemented nH Predict because the majority of Humana's policyholders lack the resources, capacity, or knowledge to appeal the denied claim. The complaint pleads claims of bad faith, common-law fraud, breach of contract, and various violations of state law. Humana states that the company uses "various tools, including augmented intelligence to expedite and approve utilization management requests," and "maintains a 'human in the loop' decision-making whenever AI is utilized."[41] Humana filed a motion to dismiss and as of February 2025, that motion is pending.

Nearly identical claims were filed in April 2024 in a separate suit against health insurer UnitedHealth Group in Minnesota federal court.[42] UnitedHealth filed a motion to dismiss, arguing that the plaintiffs failed to exhaust their administrative remedies by appealing UnitedHealth's coverage decisions as required by the Medicare Act.[43] UnitedHealth further argued that the plaintiffs' claims were preempted by the Medicare Act. In February 2025, the court granted UnitedHealth's motion in part and denied it in part. The court agreed that the plaintiffs were required to exhaust their administrative remedies but waived the requirement on futility grounds. The court dismissed the plaintiff's statutory claims as well as its bad faith claim, agreeing with UnitedHealth that these claims were preempted by the Medicare Act. A finding of liability on bad faith, the court found, would require it to determine whether UnitedHealth's denial of coverage was reasonable, and the reasonableness of a coverage decision related to a Medicare advantage plan was already regulated by the Medicare Act. The court allowed the plaintiff's claims for breach of contract and breach of the covenant of good faith and fair dealing to continue, finding those claims were not preempted by the Medicare Act because they only required the court to apply basic contract law principles to UnitedHealth's own written documents. For now, then, it seems that in the health insurance space, the interplay of an insurer's contractual obligations and the Medicare Act will be significant in determining how the insurer fares in a bad faith claim centered on the use of AI.

In June 2024, six named plaintiffs filed a putative class action suit against health insurer Cigna in California federal court for allegedly using AI

41. Elizabeth Napolitano, *Lawsuits Take Aim at Use of AI Tool by Health Insurance Companies to Process Claims*, MONEYWATCH (Dec. 18, 2023), https://www.cbsnews.com/news/health-insurance-humana-united-health-ai-algorithm/.

42. First Amended Complaint, Estate of Lokken v. UnitedHealth Grp., Inc., No. 0:23-cv-03514-JRT-DTS (D. Minn. filed Apr. 5, 2024).

43. Mem. Op. & Ord., Estate of Lokken v. UnitedHealth Grp., Inc., No. 0:23-cv-03514-JRT-DTS (D. Minn. filed Feb. 13, 2025).

to evade the legally-mandated individual physician review process.[44] In their complaint, the plaintiffs allege that Cigna used an algorithm, known as PXDX, to instantly and automatically deny payments for patients whose prescribed treatments did not match certain pre-set criteria. Plaintiffs allege that PXDX allowed Cigna to deny claims in batches of hundreds of thousands at a time, allowing the insurer to reject claims on medical grounds without ever giving the patient's claim individualized consideration. The complaint pleads claims under the Employee Retirement Income Security Act (ERISA) and California's unfair competition law, the latter including allegations of bad faith. Cigna moved to dismiss the claim, and that motion remains pending as of February 2025.

These examples highlight the need for selective and consistent use of AI technology, understanding that AI is not appropriate for every task in the claims handling process. Outsourcing certain tasks to AI, such as summarizing documents or processing and verifying data, likely pose little to no risk to insurers. AI may also be useful as a tool to automatically pay out simple claims, because a policyholder who quickly receives payment of insurance proceeds is unlikely to sustain damages to support a bad faith claim.[45] Outsourcing other tasks to AI, like making a coverage decision on a large or complex claim, may be much riskier. Insurers could nonetheless benefit from using AI to easily and quickly identify complex claims or those at high risk of future bad faith suits and then route them to an experienced claims handler.[46]

Referencing the transparency issue in the Allstate case discussed above, not disclosing AI use in claims processing may indicate bad faith if policyholders cannot understand, challenge, or appeal AI claims decisions. Courts could rule that lack of transparency prevents fair contestation of denials. Policyholders could argue that unexplained AI denials suggest improper adjusting. Courts might require justifiable reasons for AI-driven claims denials, similar to conventional claim denials. As such, insurers can avoid bad faith exposure by clearly explaining AI-based decisions. Another issue can arise when AI makes fully automated claims decisions without human oversight. If AI denies claims without human review or override, in some states insurers may be violating fair claims handling practices.

Insurers that are developing internal policies and claims handling manuals to guide their human adjusters to use AI appropriately may need to revisit those policies as technology advances. Denials of claims based on AI

44. Third Amended Complaint, Kisting-Leung v. Cigna Corp., No. 2:23-cv-01477-DAD-CSK (E.D. Cal. filed June 14, 2024).

45. Smith v. Allstate Ins. Co., 904 F. Supp. 2d 515, 521 (W.D. Pa. 2012).

46. Maus & Parker, *supra* note 7, at 22–23.

alone have given rise to bad faith claims against insurers.[47] Internal auditing of procedures may help confirm that they are being followed.

V. WILL ARTIFICIAL INTELLIGENCE AFFECT HOW BAD FAITH CLAIMS ARE DEFENDED?

Finally, the very complexity of AI may complicate the ability of insurers to defend against AI/bad faith claims. As such, the use of AI in insurance claims processing is likely to change or generate new insurance bad faith law in response to concerns over fairness, transparency, and accountability.

Insurers that use AI—whether in underwriting, claims, or other insurance functions—may face new challenges in the defense of bad faith claims. Many theories of liability will not be new, as bad faith claims related to the use of AI are likely to build off of claims related to the use of other types of automated software.[48] However, unique aspects of AI will bring new challenges into the courtroom.

For one, the complexity of sophisticated AI technology makes it difficult to explain to jurors.[49] Jurors historically have tended to be skeptical of AI in general because they do not understand it and prefer to see a human touch involved in the claims handling process.[50] Query, though, whether jurors who increasingly use AI in their own lives and rely on it for everything from driving directions to home temperature control will have a base level of skepticism. Nonetheless, both parties in a litigation concerning the use of AI will likely need to hire expert witnesses to testify about how the algorithm was designed and how it works.[51] Soliciting relevant and helpful testimony, even from an AI expert, is not as simple as it may seem. AI is unique from other automated software in that the "Black Box nature of the entire algorithmic process would preclude knowing exactly how, when, and why" a problem with the AI occurred.[52] Frequently, the AI engineers themselves do not know exactly how the algorithm works or even what factors it considers in its decision-making process.[53] For this reason, an AI expert who is well-suited for the courtroom may be expensive and hard to come by.

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47. Cowger, *supra* note 4, at 140.
48. Johnson et al., *supra* note 6, at 57.
49. *Id.* at 58.
50. *Id.*
51. *Id.*
52. Cowger, *supra* note 4, at 149.
53. Swedloff, *supra* note 5, at 2078.

Just how the use of AI in insurance claims processing will significantly impact how insurance bad faith cases are tried to a jury remains to be seen. With respect to the complexity of AI evidence and jury comprehension, AI-driven decision-making is highly technical, requiring expert testimony to explain how an algorithm processes claims. Jurors may struggle to understand AI mechanics, leading to reliance on simplified narratives provided by attorneys. Imagine policyholders framing AI as a "black box" that unfairly denies claims as opposed to insurers arguing that AI improves accuracy and reduces human bias. Expect more expert witnesses (data scientists, AI ethicists, insurance actuaries) to explain AI models. Policyholders may utilize simplified analogies (e.g., "the AI was like a rigged slot machine"). Judges may allow jury instructions addressing AI transparency and fairness.

There is a likelihood that the bad faith focus will shift from an individual adjuster's subjective intent to corporate AI systems and decision-making. Policyholders might argue that the insurer designed its AI system to minimize payouts, creating systemic bad faith (e.g., "institutional bad faith") rather than case-by-case misconduct. If so, insurers will need to defend AI algorithms as fair, unbiased, and compliant with industry standards.

The use of AI in insurance claims processing is anticipated to impact pretrial discovery in insurance bad faith cases, resulting in more data-intensive and complex litigation with a focus on algorithmic decision-making. Insurers should prepare for increased requests for AI-related data and internal decision logs as policyholders seek detailed records of how the AI influenced claim resolutions. Courts may require insurers to produce AI system logs, training data, and decision rationales, including correspondence between insurers and AI vendors regarding claims processing. While insurers may contend that their AI models are trade secrets and thus protected from discovery, courts could still mandate the disclosure of AI decision-making records if they directly impacted the claim decisions in question. In cases of institutional bad faith, policyholders might request emails, internal reports, and compliance audits to demonstrate that insurers were aware of AI-driven unfairness. This scenario foretells substantial e-discovery demands, including requests for training documents related to human adjusters reviewing AI-generated recommendations.

Traditional bad faith cases typically involve deposing claims adjusters; however, with AI, liability may shift to corporate decision-makers and data scientists. Consequently, policyholders may seek depositions from AI engineers, compliance officers, and corporate executives overseeing AI deployment. Conversely, insurers may argue that AI developers should not be deposed since they do not make individual claim decisions and insist that executive depositions are unnecessary unless bad faith is unequivocally established.

Litigators should consider the effects that state AI regulations may have on AI-driven bad faith discovery. For instance, in states adopting the NAIC Model Bulletin on AI Usage, insurers are required to develop, implement, and maintain written programs for the responsible use of AI systems. This includes establishing governance frameworks, risk management protocols, and internal controls to ensure AI systems are utilized responsibly throughout the insurance lifecycle, including claims adjudication.

The deployment of AI in insurance claims processing will significantly influence the role of expert witnesses in insurance bad faith cases. Historically, adjusters and claims supervisors explained the human-based decision process behind claims decisions. In contrast, AI-driven bad faith cases likely will require experts to elucidate how AI systems reached a claim decision or provided recommendations to adjusters. This shift necessitates new types of expertise, expanded roles, and more complex testimony.

Traditional insurance bad faith trials typically involve claims handling experts and industry standards experts. However, AI-driven claims processing cases will introduce new categories of expert witnesses. AI and machine learning experts may be called upon to explain the functioning of AI models, including aspects such as biases, fairness, and decision-making logic. Data scientists and algorithm auditors might analyze AI-driven claims denials, assessing whether the system systematically underpays claims. Ethical AI experts could be utilized to argue that an AI system violated fairness principles or discriminated against certain policyholders. Additionally, cybersecurity and compliance experts may support claims that an insurer failed to adhere to AI governance and regulatory standards.

All of these factors can result in more complex trials and increased costs for both policyholders and insurers. As the use of AI in insurance continues to grow, judges will need to determine the appropriate weight to assign to expert testimony concerning AI fairness, transparency, and compliance.

Ultimately, to succeed in defending a bad faith claim, the insurer must show a court that its use of AI software was reasonable.[54] Insurers might argue that AI eliminates human bias, ensuring consistent and fair claims handling. They could use AI data to show consistency in claim valuations, weakening policyholders' bad faith arguments. If AI makes fact-based, rules-driven decisions, insurers may claim it acted in good faith using objective criteria. Some courts have found that these are a question of fact best resolved by a jury, meaning it cannot be resolved on summary judgment at less expense to both parties.[55]

54. Johnson et al., *supra* note 6, at 57.

55. *See* Lewis v. Allstate Ins. Co., No. 3:15-cv-8074-HRH, 2016 WL 5408332, at *5 (D. Ariz. Sept. 28, 2016).

VI. CONCLUSION

As may be seen, the implementation of AI is not without its challenges. Insurers must ensure that their AI systems are designed and deployed responsibly, with a focus on transparency, fairness, and compliance with regulatory requirements. The potential for bias in AI algorithms is a significant concern, as it can lead to unfair treatment of certain policyholders. Therefore, insurers must take proactive measures to mitigate these risks and ensure that their AI systems operate in an ethical and lawful manner.

UNCOVERING SETTLEMENTS: PROBLEMS, OPPORTUNITIES AND SOLUTIONS FOR SETTLING LIABILITY CASES IN WHICH INSURANCE COVERAGE IS IN DISPUTE

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CONTENTS

I. INTRODUCTION

If settling liability disputes is a fine art, the resolution of cases in which the availability of insurance funds that the parties need to settle cases is contested can only be described as black art. The purpose of this article is to sketch the most common fact patterns in which these disputes arise and to discuss how certain tools and strategies can extricate settlements from coverage conflicts. In particular, we focus on potential pressure points and tools that can be used to untie these knots—including "hammer letters" and consent judgments—as well the respective roles of insureds and their insurers in working through these problems.

In the second section of this article, we consider the role of so-called "hammer letters." In the context of insurance coverage disputes, a hammer letter is a demand that an insurer contribute its policy limits to effectuate a settlement of the liability claim against its insured. Such letters may be sent by the policyholder or, as is often the case, by an excess insurer whose policy may be implicated if the case does not settle and results in a verdict in excess of the primary limits. A hammer letter can be an effective tool to alert the primary or lower-tier excess insurer to deficiencies in its case before trial, such as the need to engage a rebuttal expert or to file motions *in limine* to address a particular issue. It can also be used to document past settlement opportunities in light of jury-verdict research on issues ahead of trial in a concerning venue.

When issued by an excess insurer, a hammer letter is useful, even if it does not induce settlement, because it may support a later suit for equitable subrogation or contribution against the primary insurer for sums that the excess insurer was ultimately obliged to pay due to the primary insurer's failure to settle. In such circumstances, careful consideration should be given to the differing rules that some states follow with respect to the prerequisites for such claims. For instance, some states require the excess insurer to wait until the underlying case has settled or a judgment has been entered, while others require the insurer to preserve its rights contemporaneously through a declaratory judgment action or by intervening in the underlying action.

In the third section of this article, we consider the role of confessed judgments, also known as "consent judgments." These are agreements that a policyholder may enter into with the underlying tort claimant, confessing to liability for a sum certain in consideration of the plaintiff's agreement to seek recovery of the judgment only from the policyholder's insurance company. As will be seen, there is considerable divergence among the courts with respect to the degree of prior notice that a policyholder must give to its insurer before entering into such an agreement, especially in cases where the insurer is defending the action, and on whether the insured is relieved of its "duty to cooperate" in cases where the insurer is defending under a reservation of

rights, just as is typically the case where the insurer has denied coverage or otherwise refused to defend.

A major point of controversy in the litigation over consent judgments is the efforts by courts to balance the insured's right to safeguard itself against a case that an insurer has refused to cover with the insurer's right to be protected against excessive or otherwise unreasonable judgments that would never have resulted had the case gone to trial. In light of the fact that the insured is assenting to a judgment that it will never be asked to pay, there is certainly a risk of fraud and collusion in cases of this sort. Given this risk, some courts require independent judicial scrutiny of consent judgments before they can be effected.

In most states, however, courts apply a two-part inquiry to assess whether such an agreement is reasonable. In the first step, the tort plaintiff, who becomes the judgment creditor, must demonstrate "the overall reasonableness of the settlement," including both covered and uncovered claims. The test is whether the settlement reflects "what a reasonably prudent person in the position of the defendant would have settled for on the merits of plaintiff's claim at the time of settlement."

In the fourth and concluding section of this article, we analyze the problems relating to control of the defense and settlement in cases where there is an objective risk that the underlying claims may result in a judgment in excess of the available insurance limits. A similar problem arises in so-called "mixed cases," where the insurer has reserved its rights with respect to certain categories of damages that it says are not covered.

In general, the parties to such disputes may pursue one of three courses of action. First, the insured may proceed to defend the underlying litigation and later pursue coverage from the insurer for any excess judgment. Second, the insured may seek a waiver of consent from the insurer, allowing it to settle with the underlying claimant itself. Finally, the insured may settle without the insurer's consent.

Even when a policy requires the insurer's consent to settlement, an insured may be entitled to settle without that consent in two key circumstances. First, when an insurer that has accepted coverage unreasonably refuses to settle the underlying claim. Second, when an insurer has denied coverage or has reserved its rights to do so and refuses to either (1) withdraw its reservation of rights and accept coverage, thereby guaranteeing that it will fund any settlement or judgment within limits, or (2) waive the consent requirement, granting the insured control over settlement.

II. "HAMMER LETTERS"

A "hammer letter" is a demand that the party settle or face the consequences. When attorneys think of hammer letters, they usually envision a letter from the policyholder to the insurer demanding that the insurer tender its policy limits to settle the suit against its insured. While that is probably the most popular type of hammer letter, it is not the only hammer in the toolbox.

Another type of hammer letter comes about when a primary and an excess insurer disagree about the exposure presented by a claim against their insured. It can also arise when the insurers agree on the settlement value of a claim but disagree on how to best limit, or altogether avoid, that exposure. These situations can result in the excess insurer issuing a hammer letter to the primary insurer demanding that it either pay a settlement within its policy limits or tender those limits so the excess insurer can take over settlement negotiations for the portion of the claim that potentially implicates its limits.

Hammer letters present different considerations when prompted by a primary insurer's claimed failure to provide the excess insurer with information about the claim, including whether it has potential exposure in excess of the primary layer (and, in some instances, lower excess layers), as well as the status of settlement negotiations. These situations will often result in the excess insurer sending a hammer letter to the primary insurer (and any underlying excess insurers) demanding information so that it can meet its various obligations to the insured.

Insurers have overlapping duties in the context of the settlement of claims against their insureds. Initially, both primary and excess insurers have a duty to conduct an investigation and make a determination as to whether their policies are potentially implicated. If a policy appears to be implicated, the insurer has a duty to advise the insured whether the claim is covered or not. Additionally, depending on the status of the claim, the insurer may have a duty to respond to settlement demands from the underlying claimant and to advise the insured whether there are limitations on coverage, including the possibility that the claim may present exposure in excess of the available policy limits.

In general, excess insurers' policies are not triggered until the underlying coverage is exhausted. Thus, excess insurers may demand that a primary insurer and/or any underlying insurer accept a reasonable settlement demand within the limits of the underlying coverage if there is no meaningful dispute as to the insured's liability. This usually arises when there is a dispute amongst the primary and excess insurers as to the value of the claim. Excess insurers may also use hammer letters to pressure the primary insurer to tender its remaining limits so that the excess insurer can take over control of the defense and any settlement negotiations.

While a hammer letter from an excess insurer to a primary insurer often threatens subsequent legal action by the excess insurer against the primary and underlying insurers, it is important to note that a claim for equitable subrogation only extends to those claims available to the insured stemming from the insured's rights under the policies. In other words, an excess insurer is subject to the same limitations as the insured with respect to its ability to pursue a cause of action for bad faith failure to settle.

In order for an excess insurer to pursue claims against a primary or underlying insurer for failure to settle, there must be a reasonable demand within, or for the limits of, the underlying coverage. Absent such a settlement demand, there is no breach, and neither the insured nor the excess insurer would have a claim. All insurers owe a duty of good faith and fair dealing in responding to potentially covered claims, but a failure to settle, standing alone, does not equate to bad faith. Insurers are generally required, depending on the jurisdiction, to give equal or greater consideration to the insured's interests when evaluating reasonable settlement demands. By extension, primary and lower-tier excess insurers are generally required to give consideration to the interests of the excess insurers that sit above the limits of their policies.

There is also no claim for equitable subrogation unless the excess insurer can show that the primary and/or lower-tier excess insurers' conduct adversely impacted the value of the claim to the detriment of both the insured and the excess insurer. In other words, the excess insurer must identify a specific act or omission in the handling of the insured's defense that amounts to a breach of the controlling insurer's duties under the policy and must further show that, but for that conduct, the excess insurer(s) would not be required to pay. This is a difficult burden to prove in subsequent litigation because the excess insurer generally must be able to prove not only that there was a reasonable opportunity to settle the case within the underlying limits, or reduce the risk of excess exposure, but also that the primary or excess insurer controlling the defense and settlement acted unreasonably in conducting the defense and/or negotiating settlement of the case.

For this reason, a hammer letter can be an important piece of evidence in subsequent litigation by demonstrating that, even if the primary or lower-tier excess insurer controlling the defense and settlement was not initially aware of the potential excess exposure, it was made aware by the hammer letter while it still had the opportunity to act in a manner that would prevent the exposure. By way of example, a hammer letter can be an effective tool to alert the primary or lower-tier excess insurer to deficiencies in its case before trial, such as the need to engage a rebuttal expert or to file motions *in limine* to address a particular issue. It can also be used to document past settlement opportunities in light of jury-verdict research on issues ahead of trial in a concerning venue.

Further, a hammer letter may raise concerns about whether a proposed settlement agreement and release successfully discharges all of the claims pending against the insured in the action. Each of these scenarios effectively use a hammer letter to alert the primary or lower-tier excess insurer to the issue before it is too late. Note that a hammer letter, however, will not be effective if the primary or lower-tier excess insurer does not have any recourse to address the issue—for example, if the expert disclosure deadlines have passed, the settlement demand has expired, or if a lower-tier excess insurer has been unsuccessful in hammering the primary insurer to cede control of the defense and settlement or to tender its limits.

It is also important to note that, in some jurisdictions, the insurer may not take coverage defenses into account in evaluating the reasonableness of a settlement offer. Instead, they are required to give equal or greater consideration to the insured's interests in determining whether settlement is appropriate under the facts and circumstances presented by the claim. As a result, insurers can be exposed to bad faith claims where the failure to entertain a reasonable settlement offer leads to a judgment in excess of the limits available under their particular insurance policy. This issue arises most often when an insurer assumes the defense of claims involving a mixture of covered and uncovered damages. In such cases, insurers often focus on whether the settlement is reasonable in light of the value of the covered damages under their policy. However, in most jurisdictions, the insurer must focus on the reasonableness of the settlement regardless of any coverage defenses in order to protect its insured's interests. Because courts generally afford wide latitude in determining what is reasonable under the facts and circumstances of the case, the real question often becomes whether the insurer's conduct was blatantly unreasonable.

Given the foregoing, it is important for an excess insurer to adequately preserve its equitable rights of subrogation after an underlying insurer refuses to tender its limits or to cede control of the defense in response to an effective hammer letter. As noted, this issue arises when there is a disputed liability claim and there is disagreement amongst the excess and primary insurers as to the investigation, handling of the defense, or valuation, such that the excess insurer believes it may be prejudiced by the primary insurer's refusal to tender its limits. In these circumstances, the excess insurer risks waiver if it agrees to make payment under the excess policy prior to the exhaustion of the total limits of underlying coverage.

There are a number of ways that excess insurers can best preserve their claims for equitable subrogation against underlying insurers following an unsuccessful hammer letter.

The primary insurers should closely monitor the litigation for any events which may impact valuation, such as new evidence, amended pleadings, or rulings which may suggest settlement should be reevaluated. After an unsuccessful hammer letter, primary insurers are often less inclined to timely

report updates, which may require setting docket alerts, monitoring hearings, or scheduling routine follow-ups with the insured and defense counsel. As new developments arise, the excess insurer should issue supplemental hammer letters to the underlying insurer pointing out the new information and its potential impact on valuation and settlement. Ongoing monitoring is also helpful in the event the limits of the underlying policies are eroded by defense costs or risk exhaustion, such that the excess insurer may be triggered into action prior to verdict or settlement. Issuing supplemental hammer letters makes it clear to all that the excess insurer is not sitting idly by despite its concerns with the underlying insurers' actions or inactions.

The excess insurer should also consider providing supplemental evaluations to the insured regarding any events that could impact coverage. This helps avoid any assertion that the insured was not kept adequately informed by the excess insurer of potential excess exposure or other developments affecting coverage. In cases involving several layers of coverage and significant exposure, an insured may elect to engage independent counsel to ensure they are kept apprised of developments. Independent counsel can be beneficial to excess insurers by keeping them informed of these developments, particularly where defense counsel retained by the primary or lower-tier insurers may be less forthcoming with information and materials.

Prior to pursuing a claim for equitable subrogation against an underlying insurer, it is important to evaluate the statutory protections and notice requirements in the relevant jurisdiction. This includes notice requirements under local consumer-protection statutes that may provide additional statutory damages where the excess insurer has made every effort to settle the dispute without resorting to subsequent litigation. There may also be opportunities to negotiate a settlement by assigning claims against the underlying insurer to the plaintiff, provided the insured (through independent counsel) and the excess insurer are in agreement about the potential excess exposure.

In the event an excess insurer decides to pursue litigation against an underlying insurer, it is important to know the rules in the applicable jurisdiction. Some jurisdictions require the excess insurer to wait until the underlying case has settled or a judgment has been entered, while others require the insurer to preserve its rights contemporaneously through a declaratory judgment action or by intervening in the underlying action.

Insurers are usually able to work together to address differences in the valuation of a claim or settlement strategy. But differences of opinion do arise. When they cannot agree, a hammer letter can be an invaluable tool to alert underlying insurers to concerns, move matters forward, or, at least, preserve the rights of the excess insurer for subsequent litigation.

III. CONFESSED JUDGMENTS

Confessed judgments, also known as consent judgments, are tools that may be used to resolve a lawsuit between a plaintiff and an insured defendant, pursuant to which the plaintiff agrees to only pursue satisfaction of the judgment against the defendant's insurer, rather than against the defendant individually. Some form of this arrangement is recognized in almost every jurisdiction in the United States and is often defined by the following common features:

- the insurer declines a defense, defends under a reservation of rights, or rejects a settlement demand within limits;
- the insured and the plaintiff stipulate to a settlement where the plaintiff agrees to limit recovery or to not seek recovery from the insured in exchange for the right to pursue recovery against the insurer;
- there is typically an assignment, and sometimes a stipulation of facts, that would defeat the insurer's coverage defenses and may be presented to a court for a finding of a good faith settlement, or there is a hearing or trial resulting in a judgment; and
- the plaintiff sues the insurer for breach of contract and, in some cases, bad faith, to collect on the judgment, and the amount sought can exceed policy limits and include claims for attorneys' fees and interest.

The insurer may have one or more of the following defenses to a consent judgment: (i) the underlying claim is not covered; (ii) the insured breached its duty to cooperate or it violated a policy provision by entering into a settlement without consent or by assigning a non-assignable right; or (iii) the judgment amount is unreasonable or nonbinding, or was the product of fraud or collusion.

Under a consent judgment, the insured defendant typically suffers little or no out-of-pocket liability. Insured defendants justify this practice by asserting that, if an insurer denies coverage for a claim or suit, the insured should be able to protect itself from financial ruin by shifting the risk of loss to the insurer. On the other hand, the consent judgment process can inflate or manufacture damages, complicate determinations as to the reasonableness of settlements, and encourage collusion between the insured and the plaintiff.

The laws governing consent judgments vary across jurisdictions; accordingly, these arrangements are typically referred to by the name of the seminal case in that jurisdiction. For example, consent judgments in

Minnesota are commonly referred to as "*Miller-Shugart*" agreements;[1] in Arizona, they are known as "*Damron*", "*Morris*", or "*Damron/Morris*" agreements;[2] and in Florida, they are sometimes known as "*Coblentz*" agreements.[3] In other states, they are named after statutes. For example, in Missouri they are often referred to as "§ 537.065 agreements," based on Mo. Rev. Stat. § 537.065 (2021), and in Massachusetts they are often referred to as a "Chapter 93A claim" based on Mass. Gen. Laws ch. 93A.

Courts take varying approaches with respect to the enforcement of consent judgments against insurers. In addition to considering the circumstances of the case and the type of policy, state law varies widely in this area. Below, we address some considerations and note a few state law differences.

A. CONSENT JUDGMENTS WHEN DEFENSE IS BEING PROVIDED, AND NOTICE AND OPPORTUNITY TO PARTICIPATE PROVISIONS

A seminal case involving whether an insurer can be liable for a consent judgment when it agrees to defend is *Hamilton v. Md. Cas. Co*., 41 P.3d 128 (Cal. 2002). In this case, a liability insurer agreed to defend its insured against a lawsuit that alleged invasion of privacy rights and broadcasting of confidential communications. After the insurer refused a settlement demand within policy limits, the plaintiff and the insured—without the insurer's participation—agreed to a settlement that included a stipulated judgment in excess of policy limits, the plaintiff's agreement not to execute on the judgment against the insured, and the insured's assignment to the plaintiff of its cause of action against the insurer for breach of the duty to accept a reasonable settlement. The trial court approved the settlement as made in good faith pursuant to California Code of Civil Procedure § 877.6. The Supreme Court found the amount of the stipulated judgment was not presumptively binding on the insurer as the damages suffered by the insured as a result of the alleged breach. Instead, it held that a defending insurer cannot be bound by a settlement to which it has not agreed and in which it has not participated, even where the settlement had been approved under § 877.6. The court further found the plaintiff could not maintain an action for breach of the duty to settle against the insured because the stipulated judgment alone was insufficient to prove the insured suffered any damages from the insurer's breach of the settlement duty. The court discussed and distinguished other cases where the insurer did

1. *See* Miller v. Shugart, 316 N.W.2d 729 (Minn. 1982).

2. *See* United Servs. Auto. Ass'n v. Morris, 741 P.2d 246 (Ariz. 1987); Damron v. Sledge, 460 P.2d 997 (Ariz. 1969).

3. *See* Coblentz v. Am. Sur. Co. of N.Y., 416 F.2d 1059 (5th Cir. 1969).

not defend, the underlying action proceeded to trial, or the insured contributed payment to conclude the settlement.[4]

A recent case addressing a consent to settle provision in an excess indemnity-only policy is *Princeton Excess & Surplus Lines Ins. Co. v. Caraballo*, No. 1:21-CV-1981, 2024 WL 2294827 (N.D. Ohio May 21, 2024). In this case, the insured entered into a consent judgment and agreed to assign to the plaintiff "any and all claims she may have for indemnification, and bad faith against . . . applicable insurers." The policy had a consent to settle provision, and the court determined that the insured materially breached the policy by failing to obtain the insurer's written approval to the settlement and, therefore, the insurer owed no obligation to the assignee under the policy.

In some states, courts hold that a consent judgment is fully enforceable against an insurer so long as the insurer breached its duty to defend the underlying lawsuit that resulted in the consent judgment. For example, in Ohio, an insurer that breaches its duty to defend cannot defeat a consent judgment—even if it seeks to rely on an anti-assignment, voluntary payment, cooperation, or no-action clauses.[5] Instead, when an insurer abandons its duty to defend an insured defendant, it forfeits the right to control the underlying case and cannot escape liability for the consent judgment absent a showing of fraud.[6] Nor can it complain that the settlement amount is unreasonable.[7]

B. COVENANTS NOT TO EXECUTE VERSUS RELEASES, AND THE JUDGMENT RULE VERSUS PAYMENT RULE

Insurers will often point out that when there is a consent judgment, the insured is not liable for any portion of the judgment that exceeds its policy limits and thus it has suffered no harm. They will also often point out that a

4. *See also* New England Ins. Co. v. Barnett, 465 F. App'x 302 (5th Cir. 2012) (applying Louisiana law) (where insurer provided a defense under a reservation of rights, and the insured and plaintiff entered a consent judgment, the court found that since the insurer did not breach the duty to defend, the consent judgment was prohibited by the policy's "consent to settle clause"); *cf. United Servs. Auto. Ass'n*, 741 P.2d at 252 (an insured being defended by insurer under a reservation of rights could settle without breaching the cooperation clause); Com. Ins. Co. v. Szafarowicz, 131 N.E.3d 782, 797 (Mass. 2019) (an insurer who defends a claim under a reservation of rights is bound by the amount of a prejudgment settlement/assignment agreement where it is given notice of the agreement and an opportunity to be heard by the court, and the insured, after hearing, meets its burden of showing that the settlement is reasonable).

5. *See* Patterson v. Cincinnati Ins. Cos., 91 N.E.3d 191, 200 (Ohio Ct. App. 2017).

6. *See* Sanderson v. Ohio Edison Co., 635 N.E.2d 19, 23–24 (Ohio 1994).

7. *See* Buckeye Ranch, Inc. v. Northfield Ins. Co., 839 N.E.2d 94, 111 (Ohio Ct. Com. Pl. 2005).

plaintiff's covenant not to execute on the insured's assets functions as a release. Because an insurer's duty to indemnify is based on the insured's liability for damages, there is an argument that the release of the insured relieves the insurer of its indemnity obligation. Some courts have accepted this argument.[8]

Most courts apply the judgment rule, which holds that if an insurer is found to have acted in bad faith, then it is liable for an excess judgment regardless of whether the insured pays—or is capable of paying—to satisfy the judgement.[9] Some courts, however, apply the payment rule, which holds that an insurer cannot be liable for an excess judgment unless and until the insured pays it.[10]

C. IS THE AMOUNT OF THE CONSENT JUDGMENT BINDING?

Courts differ with respect to enforcement of cooperation, consent to settle, and assignment provisions in insurance policies. They also differ with respect to whether the amount of a consent judgment is binding on an insurer. It may make a difference if the amount was obtained after a hearing or trial. Courts further differ with respect to the factors, burdens of proof, and presumptions in determining whether the amount of a consent judgment is reasonable. These considerations are best shown by looking at particular states.

In West Virginia, the law prohibits an insurer from being bound by a consent judgment entered in a lawsuit to which it is not a party—unless the insurer agreed to be bound.[11] Similarly, in Texas, even if the insurer wrongfully refuses to defend its insured, the only liability which can be imposed on

8. *See, e.g.*, *In re* Tutu Water Wells Contamination Litig., 78 F. Supp. 2d 423, 433–34 (D.V.I. 1999); McDonough v. Dryden Mut. Ins. Co., 713 N.Y.S.2d 787, 788 (N.Y. App. Div. 2000).

9. *See e.g.*, Nunn v. Mid-Century Ins. Co., 244 P.3d 116, 122 (Colo. 2010); Stateline Steel Erectors, Inc. v. Shields, 837 A.2d 285 (N.H. 2003) (ruled an insured who has been released from the legal obligation to pay an excess judgment has a right against an allegedly negligent insurance agent, which could be assigned to others, and that the agreement at issue was a covenant not to sue or execute on the judgment, and not a release). *But see* Associated Wholesale Grocers, Inc. v. Americold Corp., 934 P.2d 65, 86 (Kan. 1997) (the insured's financial position may be relevant when evaluating the reasonableness of a consent judgment); Red Oaks Condo. Owners Ass'n v. Sundquist Holdings, Inc., 116 P.3d 404, 407 n.8 (Wash. Ct. App. 2005) (same).

10. *See, e.g.*, Romstadt v. Allstate Ins. Co., 59 F.3d 608, 616 (6th Cir. 1995) (applying Ohio law); Willcox v. Am. Home Assur. Co., 900 F. Supp. 850, 857 (S.D. Tex. 1995).

11. *See* Penn-Am. Ins. Co. v. Osborne, 797 S.E.2d 548, 553 (W. Va. 2017); Horkulic v. Galloway, 665 S.E.2d 284, 295 (W. Va. 2008).

the insurer is that which is reached after an adversarial adjudication of liability.[12]

Other courts take a middle-of-the-road approach by allowing consent judgments to be enforced against an insurer—with caveats. In Minnesota, for example, consent judgments are enforceable against an insurer so long as the consent judgments are demonstrably "reasonable."[13] Under *Miller v. Shugart* and its progeny, when an insurer has denied coverage or reserved rights to cover an underlying tort lawsuit, an insured defendant may resolve the underlying lawsuit by stipulating to a judgment in exchange for the tort plaintiff's covenant to limit its recovery on the judgment to the policyholder's insurance.[14] In general, to be enforceable against an insurer, a *Miller-Shugart* settlement must be both (i) covered under the applicable insurance policies, and (ii) "reasonable and prudent."[15]

Whether a settlement is "reasonable" is a question of fact for the court[16] and requires a two-step inquiry. In the first step, the tort plaintiff, who becomes the judgment creditor, must demonstrate "the overall reasonableness of the settlement," including both covered and uncovered claims.[17] The test is whether the settlement reflects "what a reasonably prudent person in the position of the defendant would have settled for on the merits of the plaintiff's

12. *See, e.g.*, State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696, 714 (Tex. 1996) (held an insured's assignment of his claims against his insurer to a claimant is invalid if: (1) it is made prior to an adjudication of his claim against the insured in a fully adversarial trial, (2) the insurer tendered a defense, and (3) either (a) the insurer has accepted coverage, or (b) the insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of the claim, and, in no event is a judgment for a plaintiff against the insured, rendered without a fully adversarial trial, binding on the insurer or admissible in evidence as damages in an action against the insurer); *see also* Great Am. Ins. Co. v. Hamel, 525 S.W.3d 655, 670–71 (Tex. 2017) (held judgment not enforceable against the insurer or admissible as evidence in the insurance litigation because the trial that rendered the damage judgment was not adversarial due to a pre-trial agreement not to enforce the judgment against the insured).

13. *See* Miller v. Shugart, 316 N.W.2d 729, 735 (Minn. 1982).

14. *Id.* at 736; *see also* Buysse v. Baumann-Furrie & Co., 481 N.W.2d 27, 29 (Minn. 1992) ("In an authentic *Miller-Shugart* settlement, the insurer has denied all coverage, and the abandoned insured, left on its own, agrees with the plaintiffs that judgment in a certain sum may be entered against it in return for the plaintiffs releasing the insured from any personal liability.").

15. *Miller*, 316 N.W.2d at 735; King's Cove Marina, LLC v. Lambert Com. Constr. LLC, 958 N.W.2d 310, 323 (Minn. 2021) ("The plaintiff judgment creditor bears the burden of showing that 'the settlement is reasonable and prudent.'").

16. *See* Alton M. Johnson Co. v. M.A.I. Co., 463 N.W.2d 277, 279 (Minn. 1990) ("reasonableness is not a 'question of law' here but a question of fact; it is an issue of fact, however, to be decided by the court as the factfinder.").

17. *King's Cove Marina*, 958 N.W. 2d at 323.

claims at the time of the settlement."[18] If the court determines that the overall settlement is reasonable, the inquiry proceeds to the second step: "how a reasonable person in the position of the insured would have valued and allocated the covered and uncovered claims at the time of the settlement."[19] This is a "multi-factor objective test, which requires the consideration of 'any facts that bear on the issues of liability, damages, and the risks of trial.'"[20] Specific factors include, but are not limited to, "information that was available to the parties at the time of the settlement regarding the underlying facts," "evidence of how the parties and their attorneys evaluated the claims at the time of the settlement," and "expert testimony about the value of the settled claims."[21] The tort plaintiff/judgment creditor must also prove that the allocation between covered and uncovered claims is reasonable.[22]

If a *Miller-Shugart* settlement is reasonable, then it is enforceable against the insurer; if it is deemed unreasonable, then it is unenforceable.[23] In that case, the tort plaintiff's claim against the insured defendant will be reinstated for trial.[24] The Minnesota Supreme Court deliberately selected this remedy in the hope that a trial—"with its attendant delay, expense and risk"—would deter "overreaching in the negotiation of a *Miller-Shugart* settlement,"[25] without denying the tort plaintiff a remedy if the settlement is deemed unreasonable.[26]

The burden of proof with respect to reasonableness of a consent judgment varies by jurisdiction. For example, in Illinois, the plaintiff has the burden of demonstrating the reasonableness of both the decision to settle and the

18. *Id*.

19. *Id.* at 323–24.

20. *Id.* at 324.

21. *Id*.

22. *Id*. at 325. Such a rule "is consistent with the general rule that 'the burden of proof rests upon the party claiming coverage under an insurance policy,' as well as the more specific rule that the plaintiff judgment creditor bears the burden of establishing the reasonableness of a *Miller-Shugart* settlement agreement." *Id*.

23. Alton M. Johnson Co. v. M.A.I. Co., 463 N.W.2d 277, 280 (Minn. 1990).

24. *Id.*

25. *Id.* Concerns about "overreaching" in *Miller-Shugart* settlements, including that the "exposed insured has no incentive to drive a hard bargain; to avoid personal liability, the insured has no compunction to agreeing that judgment may be entered against him for the policy limits, even if the claim is worth much less than the policy limits, if it is worth anything." *Id.*; *see also* Jorgenson v. Knutson, 662 N.W.2d 893, 905 (Minn. 2003).

26. *Alton M. Johnson Co.*, 463 N.W.2d at 280.

amount of the settlement.[27] In New Jersey, where an insurer wrongfully refuses coverage and the insured is obligated to defend itself in an action that is later held to be covered under the policy, the insurer is liable for the amount of the judgment against or the settlement reached by the insured. The amount must be reasonable, and the settlement must be entered into in good faith. The initial burden of going forward with proof of these elements rests on the insured, since it had control of the case and the opportunity for discovery. Thereafter, the insurer bears the ultimate burden of demonstrating, by a preponderance of the evidence, that it is not liable because the settlement was neither reasonable nor reached in good faith.[28]

In Montana, an insurer that breaches its duty to defend bears the burden of establishing unreasonableness.[29] In Washington, "binding the insurer to the settlement amount is subject to the insurer being given notice of the settlement and the opportunity to be heard on the issue of reasonableness."[30]

D. COLLUSION OR FRAUD DEFENSES TO LIABILITY

Most courts allow an insurer to defeat liability for a consent judgment if there is a showing of collusion or fraud. *See e.g.*, *Wolff v. Royal Ins. Co. of Am.*, 472 N.W.2d 233, 235 (S.D. 1991) (court recognized that stipulated judgments can be challenged on the grounds of collusion and bad faith and affirmed the trial court's decision that the stipulated judgment at issue was unreasonable).

Despite the varying approaches to measuring the enforceability of consent judgments across jurisdictions, the vast majority of courts hold that a consent judgment is at least somewhat enforceable against an insurer if the

27. *See* Cent. Mut. Ins. Co. v. Tracy's Treasures, Inc., 19 N.E.3d 1100 (Ill. App. Ct. 2014) (where insurer disclaimed coverage but provided a courtesy defense and filed a declaratory judgment lawsuit, and the plaintiff and insured settled for an amount enforceable only against the insurer, the court found that the insurer retained the ability to contest both the reasonableness of the settlement and whether the claims were covered and that a hearing was needed where the claimant had the burden of demonstrating both the reasonableness of the decision to settle and the amount of the settlement).

28. *See* Griggs v. Bertram, 443 A.2d 163, 173 (N.J. 1982).

29. *See* Tidyman's Mgmt. Servs. Inc. v. Davis, 330 P.3d 1139 (Mont. 2014) (where coverage was declined and the plaintiff filed a stipulation and the trial court granted a motion for summary judgment as to the amount of damages, the Supreme Court remanded for a reasonableness hearing); *see also* Abbey/Land LLC v. Interstate Mech., Inc., 345 P.3d 1032 (Mont. 2015).

30. Hawkins v. ACE Am. Ins. Co., 558 P.3d 157, 171 (Wash. Ct. App. 2024).

insurer breaches its duty to defend.[31] By the same token, an absolute defense for the insurer is a finding of no coverage.[32]

IV. CONTROL OF SETTLEMENT

Control of settlement decisions can be another significant pressure point in a coverage dispute. Although an insurer with the right and duty to defend might also have the right and duty to settle, there are several factors which can alter this power dynamic and allow the policyholder to exert additional or sole control over settlement decisions. Below, we discuss a few scenarios in which a policyholder may exert control over a settlement, as well as policyholders' tools for resolving settlement-related conflicts with insurers.

A. THE GENERAL RULE – DUTY TO SETTLE

As discussed in Section II above, when an insurer owes a duty to defend under a policy, it also owes a duty to make reasonable settlement decisions. In particular, the insurer has a duty to the insured to evaluate potential settlements and make reasonable settlement decisions with the interest of the insured as the guiding factor. This is particularly the case when there is a risk of judgment against the insured that exceeds the policy limits.[33] When the maximum liability is within limits, any savings or risks are ultimately the insurer's, such that the insurer is inherently motivated to accept a reasonable settlement. However, when the maximum liability exceeds the policy limits, the insured's money is at stake; in this circumstance, the insurer owes the

31. *See* Old Republic Ins. Co. v. Ross, 180 P.3d 427, 432–33 (Colo. 2008) ("The majority rule is that a pretrial stipulated judgment may be enforceable against a defendant's liability insurer if the insurer breaches its contractual obligation to defend the insured. Under the majority view, when an insurer improperly abandons its insured, the insured is justified in taking steps to limit his or her personal liability."), and cases cited therein.

32. *See id.* at 433 ("none of these states has enforced a pretrial stipulated judgment against an insurer where the insurer has conceded coverage and defended its insured, and where there has been no finding of bad faith against the insurer); Hunt v. Drielick, 852 N.W.2d 562, 566 (Mich. 2014) ("it is impossible to hold an insurance company liable for a risk it did not assume.").

33. *See* RESTATEMENT OF THE L., LIAB. INS. § 24 (AM. L. INST. 2019); *see also* 16 WILLISTON ON CONTRACTS § 49:107 (4th ed. 2017) ("Most courts require that an insurer act reasonably when deciding whether to settle a claim"); Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I—Excess Exposure Cases*, 78 TEX. L. REV. 599, 656–657 (2000) (concluding that "all jurisdictions require carriers to make reasonable settlement decisions.").

insured a duty to protect the insured from unreasonable exposure to a judgment which exceeds the policy limits.

For purposes of an insurer's duty to make reasonable settlement decisions, in most jurisdictions, reasonableness is judged from the perspective of a reasonable insurer bearing sole financial liability for the full amount of the potential judgment, regardless of policy limits.[34] This standard, in theory, forces the insurer to give equal consideration to the insured's interests[35] and incentivizes an insurer to accept a reasonable settlement within policy limits, rather than risk liability in excess of those limits after an adverse judgment. The factfinder may consider a variety of evidence when evaluating the reasonableness of the insurer's settlement decision, including expert and lawyer testimony, the time provided for the insurer to evaluate the settlement, the information known to the insurer at the time of settlement, the jurisdiction in which the case would have been tried, whether the insurer conducted a reasonable investigation, whether the insurer followed its own claims-handling procedures, whether the insurer followed the recommendation of the insured's defense counsel, and whether there is evidence that the claimant/plaintiff would have accepted a reasonable offer within policy limits.[36] However, because the insurer must give equal consideration to the insured's interest, the factfinder must cabin the factors considered to those relevant to the instant legal action without considering the insurer's overall business interests in minimizing its losses across its portfolio.[37] Each of these rules is designed to better align the insurer's and the insured's interests and account for the inherently misaligned incentives between the two.

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34. *See* RESTATEMENT OF THE L., LIAB. INS. § 24, Reporters' Note b (AM. L. INST. 2019); 3 PAUL E.B. GLAD, WILLIAM T. BARKER & MICHAEL BARNES, NEW APPLEMAN ON INSURANCE LIBRARY EDITION § 16.06[4][a] (Jeffrey E. Thomas & Francis J. Mootz III eds., Lexis 2017) ("The most widely used test is typically formulated as 'whether a prudent insurer without policy limits would have accepted the settlement offer.'").

35. When evaluating settlements, the insurer must give equal consideration to the insured's interest as it gives to its own interests. *See* Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1122 (1990) ("The majority of states today require the insurance company to give 'equal consideration' to the interests of the insured and the company in evaluating settlements.").

36. *See* RESTATEMENT OF THE L., LIAB. INS. § 24 cmt. b (AM. L. INST. 2019).

37. *See* RESTATEMENT OF THE L., LIAB. INS. § 24 cmt. d (AM. L. INST. 2019); *see also* Loudon v. State Farm Mut. Auto. Ins. Co., 360 N.W.2d 575, 581–82 (Iowa Ct. App. 1984) (determining that the insurer "did not give adequate attention to the interests of its insured" because the insured failed to appropriately weigh the catastrophic effect of a judgment in excess of policy limits on the insured where the insurance company "has vast resources when compared to its insured.").

B. CONTROL OF SETTLEMENT UNDER RESERVATION OF RIGHTS

Application of these general rules becomes more complicated when an insurer reserves its rights to deny coverage. When an insurer defends under a reservation of rights to deny indemnity coverage, the insurer retains its duty to make reasonable settlement decisions.[38] This duty, however, is complicated by the reality that insurers are not required to provide coverage for uncovered settlements or judgments. In practice, this means that if an insurer unreasonably withholds consent for a settlement under a reservation of rights, and it is later determined that the underlying legal action is not covered under the policy, the insurer is not liable for the settlement or the subsequent judgment. On the other hand, if an insurer believes that the policy does not provide coverage for the legal action and refuses to accept a reasonable settlement, the insurer will be liable for any excess judgment if it is determined that the policy provided coverage for the underlying legal action. In this sense, the insurer bears the risk that its coverage analysis was wrong. [39]

From the perspective of the insured, an insurer's retention of settlement control under a reservation of rights puts the insured in a challenging position. The insured must face the risk that it will not have insurance coverage for the full settlement or judgment in the underlying litigation. As a result, the insured must make difficult decisions to balance both the underlying litigation and the coverage dispute, with the ultimate goal of minimizing out-of-pocket exposure for its potential liability in the underlying litigation.

C. SETTLEMENT SCENARIOS AND INSURED'S TOOLS

When an insurer refuses to accept a settlement, particularly when it has reserved the right to deny coverage, the insured may find itself stuck between a coverage dispute and an underlying claim. This section discusses three tools available to insureds when an insurer refuses to accept a reasonable settlement. First, the insured may proceed to defend the underlying litigation and later pursue coverage from the insurer for any resulting excess judgment. Second, the insured may seek a waiver of consent from the insurer, allowing

38. *See* JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE COVERAGE § 9.05[C] (4th ed. 2016) ("It appears that the majority view holds that an insurer defending a claim must reasonably facilitate settlement on favorable terms for the policyholder even when it believes that the policy provides no indemnity coverage on the claim.").

39. *See* STEPHEN S. ASHLEY, BAD FAITH ACTIONS—LIABILITY AND DAMAGES § 4:13 (2d ed. 2017) ("In recent times the majority of jurisdictions have held that the insurer allows coverage doubts to affect its settlement decisions at its peril.").

the insured to settle directly with the underlying claimant. Finally, the insured may settle without the insurer's consent.

1. Coverage for Judgment in Excess of Limits

When the insurer refuses to accept a reasonable settlement within the insurer's limits, one option available to the insured is to accept the insurer's refusal to settle and proceed with the underlying litigation. Under this approach, the insurer would generally continue defending the insured until either (1) the insurer enters into a subsequent settlement with the claimant, or (2) the underlying action results in a judgment.[40] If the insurer refuses a reasonable settlement and the subsequent judgment is within limits, the insurer would then be responsible for paying the judgment, assuming the policy provided coverage for the underlying claim. If, however, the insurer refuses a reasonable settlement and the subsequent judgment exceeds the policy limits, the insurer is still liable for the full judgment, regardless of policy limits, because the insurer previously refused to accept a reasonable settlement within limits.[41]

If the insurer does not dispute coverage, it would likely pay its policy limits, and the insured would be forced to proceed against the insurer to recover the remaining judgment in excess of those limits. If, however, the insurer disputes coverage, the insured would be forced to pay the entire judgment and then proceed against the insurer for both the policy limits and the excess judgment. Although these paths may seem straightforward enough in theory, the insured might not have enough capital to pay the policy limits or the excess judgment and the costs of a coverage dispute at the same time. As discussed in Section III above, one alternative for insureds to avoid simultaneously paying the excess judgment and chasing the insurer is to enter into a

40. Alternatively, if the insurer later issued a reservation or rights, the insured may be entitled to independent counsel. *See* RESTATEMENT OF THE L., LIAB. INS. § 16 (AM. L. INST. 2019) ("When an insurer [reserves its right to contest coverage] and there are facts at issue that are common to the legal action for which the defense is due and to the coverage dispute, such that the action could be defended in a manner that would benefit the insurer at the expense of the insured, the insurer must provide an independent defense of the action.").

41. *See, e.g.*, Luke v. Am. Fam. Mut. Ins. Co., 476 F.2d 1015, 1021 (8th Cir. 1972) ("[T]he vast number of jurisdictions which have considered the question hold that when an offer of settlement within the policy limits has been made and ignored, a good faith refusal to defend is not a valid defense to a claim in excess of the policy limits"); Med. Mut. Liab. Ins. Soc. of Md. v. Evans, 622 A.2d 103, 114 (Md. 1993) ("[T]he majority rule, is that the measure of damages in a bad faith failure to settle case is the amount by which the judgment rendered in the underlying action exceeds the amount of insurance coverage.").

confessed judgment with the claimant, thereby assigning its breach-of-settlement claim to the claimant.

2. Waiver of Consent

Another tool in an insured's toolkit when an insurer has refused to settle the underlying claim is to request that the insurer waive the voluntary payment or consent to settle provision in the policy, if there is one, and allow the insured to settle without the insurer's consent. This tool might come into play when an insurer refuses to accept or consent to a settlement because the insurer contends it has not had adequate time or sufficient information to evaluate coverage and/or the settlement offer. Although the insurer may not be prepared to settle, the insured may believe that it is in its best interest to settle the claim because the claim could result in a settlement or judgment in excess of limits should the insured fail to accept the current settlement offer. In this situation, the insurer and the insured may reach an agreement in which the insurer waives its right to assert lack of consent to the settlement as a defense to coverage—sometimes coupled with an acknowledgment of the settlement's reasonableness—but retains its right to challenge coverage on all other available grounds. It is also possible for the insurer to waive the consent provision through its conduct, such as through its unreasonable delay or silence in response to a request for consent.[42]

In practice, an insurer's waiver of consent results in the insured settling the claim, paying the settlement, and then seeking reimbursement from the insurer. This can be an excellent option for the insured because it allows the insured to tackle one conflict at a time. The insured is able to resolve the underlying claim with a beneficial settlement. It can then focus on the coverage dispute, without being forced to juggle coverage and underlying liability challenges—possibly in parallel litigations—simultaneously. Many insureds, however, do not have sufficient resources to pay settlements without the insurance money—that is, after all, the primary reason they purchased the insurance policy. As discussed in Section III above, when an insurer's failure to accept a settlement results in an excess judgment, an insured may instead enter into a confessed judgment with the claimant, assigning the insurance recovery rights to the claimant, rather than pursuing the insurance coverage action itself.

42. *See, e.g.*, MBIA Inc. v. Fed. Ins. Co., 652 F.3d 152, 169 (2d Cir. 2011) ("By an insurer's unreasonable delay, silence, or conduct, it can either waive a consent requirement or acquiesce in a settlement.").

3. Settlement without Consent

The final tool available to insureds is settling without the insurer's consent. Even when a policy requires the insurer's consent to settlement, an insured may be entitled to settle without that consent in two key circumstances. First, when an insurer that has accepted coverage unreasonably refuses to settle the underlying claim.[43] Second, when an insurer has denied coverage or has reserved its rights to do so and refuses to either (1) withdraw its reservation of rights and accept coverage, thereby guaranteeing the insurer will fund any settlement or judgment within limits, or (2) waive the consent requirement, granting the insured control over settlement.[44] In both circumstances, an increasingly common, but not universally adopted, rule is that the insured may settle without the insurer's consent, even where the policy contains a voluntary payment clause requiring the insurer's consent to any settlement.[45]

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43. *See, e.g.*, SwedishAm. Hosp. Ass'n of Rockford v. Ill. State Med. Inter-Ins. Exch., 916 N.E.2d 80, 96–97 (Ill. App. Ct. 2009) ("If the circumstances at the time of settlement establish that the potential loss and the proposed settlement by far exceed . . . the limits of the policy, the insured need not await the outcome of the trial and may proceed to make a prudent settlement"); Cont'l Cas. Co. v. Rsrv. Ins. Co., 238 N.W.2d 862, 864, 867 (Minn. 1976) ("[W]hen a primary insurer breaches its good-faith duty to settle within policy limits . . . the insured should certainly be able to protect itself by settling a claim against it within primary policy limits, and then recovering from its primary insurer who refused to settle in bad faith.").

44. *See* Patrons Oxford Ins. Co. v. Harris, 905 A.2d 819, 828 (Me. 2006) ("[A]n insured being defended under a reservation of rights is entitled to enter into a reasonable, noncollusive, nonfraudulent settlement with a claimant, after notice to, but without the consent of, the insurer."); *Miller*, 316 N.W.2d at 734 ("[T]he insureds did not breach their duty to cooperate with the insurer, which was then contesting coverage, by settling directly with the plaintiff."); Chaussee v. Md. Cas. Co., 803 P.2d 1339, 1342 (Wash. Ct. App. 1991) (applying rule that an insured can settle a claim when the insurer that is defending under a reservation of rights has refused to do so, but holding that the insureds failed to demonstrate that the settlement was reasonable); Babcock & Wilcox Co. v. Am. Nuclear Insurers, 131 A.3d 445, 462 (Pa. 2015) ("[W]e adopt a variation on the *Morris* fair and reasonable standard limited to those cases where an insured accepts a settlement offer after an insurer breaches its duty by refusing the fair and reasonable settlement while maintaining its reservation of rights."). *But see* Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co., 445 F.3d 381, 385 (5th Cir. 2006) (applying Texas law) (predicting that, under Texas law, "an insurer which tenders a defense with a reservation of rights is entitled to enforce a consent-to-settle clause."); Klepper v. ACE Am. Ins. Co., 999 N.E.2d 86, 97 (Ind. Ct. App. 2013) ("To hold otherwise, would, effectively require us to write the 'voluntary payment' and 'legally obligated to pay' provisions out of the Policy, which we cannot do.").

45. This is the rule adopted by the Restatement. *See* RESTATEMENT OF THE L., LIAB. INS. §§ 25, 27 (AM. L. INST. 2019).

When an insured settles without the insurer's consent, the insurer's liability, barring a bad faith claim, is generally capped at the policy limits.[46] Additionally, although the insurer may not contest coverage on the grounds that the insurer did not consent to settlement, the insurer might be able to contest coverage on the grounds that the underlying legal action was not covered by the policy.

Settling without the insurer's consent may be a good option when the insurer refuses to waive consent, and the insured (1) faces a significant risk of a judgment far exceeding policy limits, and (2) is able to fund the settlement before pursuing coverage from the insurer. This approach also allows the insured to resolve the underlying liability dispute before pursuing coverage, rather than being forced to manage both the liability and coverage disputes simultaneously.

Settling without the insurer's consent likely involves a greater financial burden and risk to the insured, so it is likely not a feasible option for insureds without substantial assets. Although there are various tools that an insured may employ when an insurer does not consent to settlement, each of the tools is substantially more difficult to wield for insureds who do not have the financial freedom to pay a settlement or judgment out of pocket before resolving coverage disputes with the insurer. The financial pressure alone can force insureds to assume greater liability risk from third parties and cede greater control to their insurers.

V. CONCLUSION

It is worth pointing out that none of the problems outlined in this article arise in cases where the claim tendered for a defense is covered, activating the insurer's duties to defend and to make reasonable settlement decisions. These problems do arise, however, in cases where the parties disagree about the amount of the insured's liability exposure—especially whether that exposure exceeds the primary insurer's policy limits—and/or whether some aspects of the possible judgment would not be covered at all.

In this article, we have reviewed some of the most common strategies that insureds may employ to protect themselves against personal exposure from excess or otherwise uncovered judgments. As we have shown, each of these strategies requires careful consideration of legal standards that vary significantly by jurisdiction, including the right of the insured to act with or without the knowledge or consent of its insurer(s), as well as the applicable questions concerning the burdens of proof and standards for assessing "reasonableness" that courts will apply to any resulting agreements.

46. *See* RESTATEMENT OF THE L., LIAB. INS. § 25 cmt. e (AM. L. INST. 2019).

No matter the strategy pursued, the likelihood of success is greatly heightened by timely action and thorough documentation. Thus, hammer letters may play an important role in pushing the parties towards settlement when timely issued and, even where unsuccessful, provide a contemporaneous statement of the case for a court to consider in later litigation.

The same is true of the defenses that insurers may raise against such claims. An insurer that is pursuing a diligent defense of a case that defense counsel believes should be tried will be in a superior position if the insured nonetheless overrides the insurer's objections and settles the case for reasons of its own.

AN ETHICS CONUNDRUM: WHAT AM I? COVERAGE COUNSEL OR CLAIM INVESTIGATOR OR BOTH?

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CONTENTS

I. INTRODUCTION: WHEN IS A LAWYER A LAWYER OR A CLAIM INVESTIGATOR?

The question of whether a lawyer involved in an insurance dispute is acting in the capacity of coverage counsel or as an insurance claims investigator is one that should concern insurers and policyholders alike. In such cases, the parties often want to see the files that the other party created prior to the coverage denial. While it is true that the cases more often focus on the insured's requests for production and the insurer's refusal to produce—typically on attorney-client-privilege or work-product grounds—insurers also have an interest in seeing what is in the insured's files. As the cases point out, investigations of the facts of a claim often are conducted by nonlawyers. When such investigations are conducted by lawyers, are their investigations automatically protected? As this paper will show, the answer often is "no." But the cases also recognize that the line between legal work and nonlegal investigation work is often blurry.

The purpose of this paper, then, is to provide practitioners with some guidance so that they can reduce the risk of finding out that information they previously assumed was privileged is discoverable. It will also consider the impact these issues have on the work of defense counsel in third-party liability cases.

These issues implicate several doctrines: the ABA Model Rules of Professional Conduct, the Attorney-Client Privilege, and the Attorney Work Product Doctrine. Also implicated, of course, are applicable federal and state rules of evidence.

II. THE ABA MODEL RULES OF PROFESSIONAL CONDUCT

The ABA Model Rules of Professional Conduct primarily applicable to this topic are as follows:

- *Rule 1.1. Competence*

This Rule states that "[a] lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation."[1]

A failure to give due consideration to the issues regarding confidentiality and privilege increases the risk that documents and communications previously thought to be protected from discovery will *not* be protected. Such due consideration may require the lawyer "to refer the matter to, or associate

1. MODEL RULES OF PRO. CONDUCT r. 1.1 (AM. BAR ASS'N 1983).

or consult with, a lawyer of established competence in the field in question."[2] The importance of this Rule cannot be stressed enough.

- *Rule 1.2. Scope of Representation and Allocation of Authority between Client and Lawyer*

Subsection (a) of this Rule provides in pertinent part: "a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4 [Communication], 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. A lawyer shall abide by a client's decision whether to settle a matter."[3]

And subsection (c) provides that "[a] lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent."[4]

In the coverage context—as this article will show—it is critical that the lawyer take seriously her responsibility to consult with the client to clarify just what the scope of the lawyer's role will be. As more fully discussed below, questions that need to be addressed include whether the lawyer is being engaged to do a factual investigation, give business or legal advice, and so on. A failure to give due consideration to the need to be clear about the scope of the engagement may taint the lawyer-client relationship and be damaging to the client's case.

- *Rule 1.3. Diligence*

This Rule provides that "[a] lawyer shall act with reasonable diligence and promptness in representing a client."[5]

The comments to this Rule refer to such concepts as "commitment and dedication"; that the "client's interests often can be adversely affected by the passage of time"; or when a lawyer overlooks a legal principle that could destroy the client's legal position.[6] It is the last of these that is most pertinent here. A failure to give due consideration to the issues presented in this paper does have the potential to damage the client's legal position.

2. MODEL RULES OF PRO. CONDUCT r. 1.1 cmt. 1 (AM. BAR ASS'N 1983).
3. MODEL RULES OF PRO. CONDUCT r. 1.2(a) (AM. BAR ASS'N 1983).
4. MODEL RULES OF PRO. CONDUCT r. 1.2(c) (AM. BAR ASS'N 1983).
5. MODEL RULES OF PRO. CONDUCT r. 1.3 (AM. BAR ASS'N 1983).
6. *See* MODEL RULES OF PRO. CONDUCT r. 1.3 cmt. 1–3 (AM. BAR ASS'N 1983).

- *Rule 1.4. Communications*

  This Rule provides:

  > (a) A lawyer shall:
  >
  > (1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e), is required by these Rules;
  >
  > (2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;
  >
  > (3) keep the client reasonably informed about the status of the matter;
  >
  > (4) promptly comply with reasonable requests for information; and
  >
  > (5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of professional Conduct or other law.
  >
  > (b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.[7]

This Rule hardly needs much in the way of explanation or emphasis, other than to remind the reader that the duty of communication goes hand in hand with Rules 1.1 through 1.3. In other words, for example, the duty upon the lawyer to explain the perils that may arise from misjudging the lawyer's role in a coverage matter, cannot be overstated.

- *Rule 1.6. Confidentiality*

Confidentiality is central to the subject of this paper, which goes into considerable detail the many ways in which a client's confidences can be lost or compromised. Accordingly: (a) read Rule 1.6 and all its Comments; and (b) read this paper.

- *Rule 1.7. Conflict of Interest*

This Rule concerns the concepts of independent judgment and loyalty. It arises in this context when parties create situations—inadvertently or otherwise—that put lawyers in difficult situations. As more fully discussed below, this can be particularly problematic for lawyers retained (or tasked) to defend third-party liability cases, or to investigate claims. Once a lawyer's independence and/or loyalty are compromised, the client's interests may be significantly impaired. It also follows that third parties who pay for a client's

7. MODEL RULES OF PRO. CONDUCT r. 1.4 (AM. BAR ASS'N 1983).

defense should be admonished not to interfere with the lawyer's independence of professional judgment.[8]

- *Rule 3.3. Candor Before the Tribunal*

  This Rule provides in pertinent part:

  > (a) A lawyer shall not knowingly:
  >
  > (1) make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;
  >
  > (2) fail to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel; or
  >
  > (3) offer evidence that the lawyer knows to be false. If a lawyer, the lawyer's client, or a witness called by the lawyer, has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence . . . that the lawyer reasonably believes is false.[9]

As this article will discuss in some depth, the issue here is whether the lawyer knows that the client intends to withhold evidence that the lawyer knows or reasonably should know should be presented or disclosed. And, as Comment [1] advises, this Rule applies even during an "ancillary proceeding conducted pursuant to the tribunal's adjudicative authority, such as a deposition."[10]

Violating this Rule, or even creating the appearance of possibly violating this Rule, can have personal consequences to the lawyer (such as a complaint to the bar or other forms of discipline) or sanctions imposed by the court on the lawyer and possibly on the client as well.

- *Rule 4.1. Truthfulness in Statements to Others*

This Rule provides that, "[i]n the course of representing a client a lawyer shall not knowingly: (a) make a false statement of material fact or law to a third person; or (b) fail to disclose a material fact when disclosure is necessary to avoid assisting a criminal or fraudulent act by a client, unless disclosure is prohibited by Rule 1.6 [Confidentiality]."[11]

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8. *See* MODEL RULES OF PRO. CONDUCT r. 1.8(f) & 5.4(c) (AM. BAR ASS'N 1983).

9. MODEL RULES OF PRO. CONDUCT r. 3.3 (AM. BAR ASS'N 1983).

10. MODEL RULES OF PRO. CONDUCT r. 3.3 cmt. 1 (AM. BAR ASS'N 1983).

11. MODEL RULES OF PRO. CONDUCT r. 4.1 (AM. BAR ASS'N 1983).

The standard here is "knowing." A lawyer that knowingly makes a false statement of material fact—for example, for purposes of this paper, the role of the lawyer with respect to the investigation of a claim—can be said to violate this Rule. Rule 4.3 (Dealing with Unrepresented Person) may constitute a particular peril for insurer-side lawyers who are communicating with an insured whom the lawyer knows (or reasonably suspects) is unrepresented.[12]

- *Rule 5.1. Responsibilities of Partners, Managers, and Supervisory Lawyers*
- *Rule 5.3. Responsibilities Regarding Nonlawyer Assistance*

These Rules make it the responsibility of a lawyer in a supervisory capacity to make sure that individuals who report to her conduct themselves in conformity with the Rules of Professional Conduct. These Rules are particularly applicable in the insurance-coverage context, where lawyers and nonlawyers alike are involved in claim analysis, claim investigation, and claim management. While it is reasonable to assume that the burdens of these Rules are more likely to fall upon insurers, that is not always the case. Larger and more sophisticated insureds also are likely to have teams of lawyers and nonlawyers engaged in claim analysis, claim investigation, and claim management.

Obviously, these are not the only Model Rules of Professional Conduct that might be at issue in situations that are the subject of this paper; these are just the ones this author thinks are most applicable. The reader is strongly advised to consult all the Rules of Professional Conduct in every jurisdiction in which she practices or appears, and to consult with experts in professional responsibility, as necessary.

III. THE ATTORNEY-CLIENT PRIVILEGE

The attorney-client privilege is the oldest of the privileges known to the common law pertaining to confidential communications.[13] Its purpose is to "encourage full and frank communication between attorneys and their clients and thereby promote broader public interest in the observance of law and the administration of justice."[14] The privilege recognizes that "sound legal advice or advocacy serves public ends and that such advice or advocacy

12. MODEL RULES OF PRO. CONDUCT r. 4.3 (AM. BAR ASS'N 1983).

13. Hunt v. Blackburn, 128 U.S. 464, 470 (1888); Upjohn Co. v. United States, 449 U.S. 383, 389 (1981).

14. *Upjohn*, 449 U.S. at 389; Trammel v. United States, 445 U.S. 40, 51 (1980).

depends upon the lawyer's being fully informed by the client."[15] But the privilege is contrary to the general rule under United States common law that allows for full discovery of facts; accordingly, the privilege must be "strictly confined within the narrowest possible limits consistent with the logic of its principle."[16]

Accordingly, the burden of establishing the privilege and all of its elements falls on the party asserting the privilege.[17]

A. ELEMENTS OF THE ATTORNEY-CLIENT PRIVILEGE

The elements of the attorney-client privilege have been stated thus:

> The privilege is available "(1) [w]here legal advice of any kind is sought (2) from a professional legal adviser in his capacity as such, (3) the communications relating to that purpose (4) are made in confidence (5) by the client, (6) are at his instance permanently protected (7) from disclosure by himself or by the legal adviser, (8) except the protection be waived."[18]

More recently, it has been stated that:

> The privilege applies only if (1) the asserted holder of the privilege is or sought to become a client; (2) the person to whom the communication was made (a) is a member of the bar of a court, or his subordinate and (b) in connection with this communication is acting as a lawyer; (3) the communication relates to a fact of which the attorney was informed (a) by his client (b) without the presence of strangers (c) for the purpose of securing primarily either (i) an opinion on law or (ii) legal services or (iii) assistance in some legal proceeding, and not (d) for the purpose of committing a crime or tort; and (4) the privilege has been (a) claimed and (b) not waived by the client.[19]

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15. *Upjohn*, 449 U.S. at 389.

16. N. L. R. B. v. Harvey, 349 F.2d 900, 907 (4th Cir. 1965) (quoting 8 WIGMORE, EVIDENCE § 2292 (McNaughton rev. 1961); United States v. Nixon, 418 U.S. 683, 710 (1974).

17. United States v. Jones, 696 F.2d 1069, 1072 (4th Cir. 1982); Weil v. Inv./Indicators, Rsch. & Mgmt., Inc., 647 F.2d 18, 25 (9th Cir. 1981); *In re* Miller, 584 S.E.2d 772, 787 (N.C. 2003); Commonwealth v. Edwards, 370 S.E.2d 296, 301 (Va. 1988).

18. EDNA SELAN EPSTEIN, THE ATTORNEY-CLIENT PRIVILEGE AND THE WORK-PRODUCT DOCTRINE 84 (6th ed. 2017) (quoting WIGMORE, *supra* note 16).

19. *Id.* at 84–85 (quoting United States v. United Shoe Mach. Corp., 89 F. Supp. 357, 358–59 (D. Mass. 1950)).

Finally, the Restatement simplifies the definition by stating that the following four elements are required to establish the existence of the attorney-client privilege:

> Except as otherwise provided in this Restatement, the attorney-client privilege may be invoked as provided in § 86 with respect to:
>
> (1) A communication;
>
> (2) made between privileged persons;
>
> (3) in confidence;
>
> (4) for the purpose of seeking, obtaining, or providing legal assistance to the client.[20]

At least one commentator has observed that a "review of each of the elements of the privilege demonstrates why the privilege will seldom apply to an insurer's request for documents or other information during the insurer's investigation of a claim, but is often applicable to requests for documents generated by coverage counsel for the insurer and at least parts of the insurer's

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20. *Id.* at 85; RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 68 (AM. L. INST. 2020). Section 86—Invoking the Privilege and Its Exceptions—provides:

> (1) When an attempt is made to introduce in evidence or obtain discovery of a communication privileged under § 68:
>
> (a) A client, a personal representative of an incompetent or deceased client, or a person succeeding to the interest of a client may invoke or waive the privilege, either personally or through counsel or another authorized agent.
>
> (b) A lawyer, an agent of the lawyer, or an agent of a client from whom a privileged communication is sought must invoke the privilege when doing so appears reasonably appropriate, unless the client:
>
> (i) has waived the privilege; or
>
> (ii) has authorized the lawyer or agent to waive it.
>
> (c) Notwithstanding failure to invoke the privilege as specified in Subsections (1)(a) and (1)(b), the tribunal has discretion to invoke the privilege.
>
> (2) A person invoking the privilege must ordinarily object contemporaneously to an attempt to disclose the communication and, if the objection is contested, demonstrate each element of the privilege under § 68.
>
> (3) A person invoking a waiver of or exception to the privilege (§§ 78-85) must assert it and, if the assertion is contested, demonstrate each element of the waiver or exception.

claim file."[21] But, as we shall see in this presentation, that is not necessarily the case, for regardless of whether it is the insurer seeking information from the policyholder or the other way around, the question always will come back to whether the lawyer who conducted the investigation was "acting as a lawyer."

1. Acting as a Lawyer

"In order for the privilege to apply, the client must have consulted with the attorney for the purpose of obtaining legal advice or services, rather than nonlawyer services."[22] "Courts have held that communications from a client seeking business advice, rather than legal advice, are not privileged."[23] "Similarly, communications made to aid an attorney acting as a business negotiator are not privileged."[24] As one court has said:

> Accordingly, "a number of courts have determined that the attorney-client privilege does not protect client communications that relate only to business or technical data." However, "[c]lient communications intended to keep the attorney apprised of business matters may be privileged if they embody 'an implied request for legal advice based thereon.'"[25]

As the Seventh Circuit has said:

> Once the attorney-client relationship is established, inquiry will focus upon the nature of the communication or information sought. The relationship itself does not create "[a] cloak of protection [which is] draped around all occurrences and conversations which have any bearing, direct or indirect, upon the relationship of the attorney with his client." The privilege "protects only those disclosures necessary to obtain informed legal advice which might not have been made absent the privilege."[26]

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21. Michael Keeley & Tracy Archbold, *The Attorney-Client Privilege and the Work Product Doctrines—The Boundaries of Protected Communications Held by Insureds and Insurers*, 14 FID. L.J. 1, 5 (2008).

22. Keeley & Archbold, *supra* note 21, at 10 (citing Montgomery Cnty. v. MicroVote Corp., 175 F.3d 296 (3d Cir. 1999)).

23. *Id.* (citing United States v. Ackert, 169 F.3d 136 (2d Cir. 1999)).

24. *Id*. *See also* J. P. Foley & Co. v. Vanderbilt, 65 F.R.D. 523, 526 (S.D.N.Y. 1974).

25. Pacamor Bearings, Inc. v. Minebea Co., 918 F. Supp. 491, 510–11 (D.N.H. 1996) (citations omitted).

26. Matter of Walsh, 623 F.2d 489, 494 (7th Cir. 1980) (citations omitted).

Thus, the question necessarily becomes whether the lawyer was retained to provide legal advice or to act as an investigator whose function solely was to gather facts. The case of *Seibu Corp. v. KPMG LLP* addresses this in the context of investigative documents produced by KPMG's in-house counsel and whether they were (or were not) protected by the attorney-client privilege:

> Although these documents may have been generated during an investigation undertaken by KPMG's in-house counsel, they are not necessarily privileged. The critical inquiry is not whether the investigation was conducted at the behest of a lawyer, but whether any particular communication in connection with that investigation facilitated the rendition of legal advice to the client. A review of the documents fails to establish this critical element of KPMG's privilege claim . . . Even if lawyers were involved in making this decision, it is primarily an exercise of business judgment. The fact that counsel initiated the investigation that led to [certain KPMG partner's] withdrawal does not cloak every communication made in that context with attorney-client privilege. KPMG still must prove that the communication was made for the purpose of facilitating the rendition of legal services to the client.[27]

When it comes to insurance cases, the *Texas Farmers Insurance Exchange* case is instructive. There, insureds under a fire policy sought discovery of an investigative report prepared by an attorney hired by the insurer, but evidence was unclear regarding the capacity in which the attorney was hired. The attorney testified that he was hired solely to conduct examinations under oath and was not involved in the investigation of the claim. He also provided contradictory testimony that he was hired to conduct the examinations and to *then* provide the insurer with a legal opinion concerning potential litigation issues. The insurer, on the other hand, alleged that the lawyer's "sole responsibility prior to the filing of the lawsuit was the taking of Plaintiff's Examination Under Oath and report the results of same to Farmers." The trial court found that the lawyer was acting solely as an investigator, not as an attorney. The case went up on appeal, where the appellate court found that the trial court's findings were not clearly erroneous and, therefore, that the lawyer could be questioned at a deposition on his investigation and the examinations he conducted. The court stated:

> [A]lthough the attorney-client privilege would apply to communications between [the lawyer] and Farmers concerning legal strategy, assessments, and conclusions, the privilege does not operate as a blanket privilege covering all of the communications between

27. Seibu Corp. v. KPMG LLP, No. 3-00-CV-1639-X, 2002 WL 87461, at *3 (N.D. Tex. Jan. 18, 2002).

> the two. For instance, the privilege would not apply to those communications concerning bare facts. If we were to so hold, insurance companies could simply hire attorneys as investigators at the beginning of a claim investigation and claim privilege as to all of the information gathered.[28]

While this case resulted in an unhappy outcome for the insurer, policyholder lawyers should recognize that the court's reasoning could just as easily apply to insureds.[29]

2. The Dominant, Primary, or Predominate Purpose Test

A number of courts have applied the "dominant purpose" test when examining (and endeavoring to determine) the lawyer's role in the case. As one pair of commentators has noted, several "courts have resolved disputes over discovery of attorney-client communications by asking whether the communications themselves were 'primarily or predominantly of a legal character.' If the answer to that question is yes, the communications are deemed protected."[30] As these commentators have pointed out, these cases can be quite fact specific, providing an example of a case that held for the insurer and one for the insured:

> The New York Supreme Court Appellate Division applied [the "primarily or predominant purpose"] test in *Bertalo's Restaurant, Inc. v. Exchange Ins. Co.*, 240 A.D.2d 452 (N.Y. App. Div. 1997). In that case, the insured sought coverage for fire damage to its restaurant and ultimately sued the insurer for breach of contract after it denied the claim. The insured alleged, among other things, that the insurer made an internal decision to deny coverage, but failed to inform the insured of its decision while continuing to solicit the insured's cooperation in its investigation.
>
> During discovery, the insured moved to compel production of certain reports and correspondence the insurer's outside counsel had prepared before the lawsuit was filed; the communications related to the investigation of the loss. The Appellate Division's analysis began with a rather hard and fast rule: "Reports by attorneys upon examining property damage claims which are made before an

28. *In re* Tex. Farmers Ins. Exch., 990 S.W.2d 337, 341 (Tex. App.1999).

29. *Accord* Keeley & Archbold, *supra* note 21, at 13 ("Although *In re Texas Farmers* addresses the privilege as raised by the insurer, it applies equally to the insured's investigation.").

30. Jeffrey J. White & Gregory P. Varga, *The Lawyer as 'Superadjuster': Erosion of Protections for Privileged Communications*, 47 FOR THE DEF. 40 (2005).

> insurance carrier has decided to deny coverage are not protected from disclosure either as work product or materials prepared in anticipation of litigation." *Id.* at 454. Building from this general rule, the court concluded that the reports at issue were not "primarily or predominantly of a legal character," but were made in the ordinary course of the insurer's business (*i.e.*, paying or rejecting insurance claims), and therefore, were not protected by the attorney-client privilege or work product doctrine. *Id.* at 454-55.
>
> Application of the "predominant purpose" test yielded a different result in *Reliance Ins. Co. v. American Lintex Corp.*, [No. 00 CIV 5568 WHP KNF, 2001 WL 604080,] 2001 U.S. Dist. LEXIS 7140 (S.D.N.Y. 2001). In that case, Reliance sought reimbursement for overpayment of a property insurance claim. Relying on *Bertalo's Restaurant*, the insured sought to compel production of communications that outside counsel had sent to the insurer, claiming that the documents were investigatory in nature and had been generated in the "ordinary course of [the insurer's] business." *Id.* at *6-7. The communications consisted of: (1) legal advice regarding the extent, if any, to which the insured's claim was covered by the relevant policy; (2) advice concerning correspondence to be sent to the insured; (3) legal opinions regarding claims that might be asserted by the client; and (4) invoices for legal services. *Id.* at *6-7. The district court determined that these documents were entitled to protection under the attorney-client privilege because they were primarily of a legal character and did not "address the quantity, value, or degree of damage sustained by the property insured under the [insurer's policy]." *Id.* at *7.[31]

Many other courts have applied the "dominant purpose" or "predominant purpose" test, including:

- *Cont'l Cas. Co. v. Marsh*, No. 01 C 0160, 2004 WL 42364 (N.D. Ill. Jan. 6, 2004) (concluding that factual summaries, progress reports as to other lawsuits, and interview of insured are *not* privileged since they relate to law firm's role as claims investigator; coverage discussion section, however, *is* privileged as it relates to intertwined role of firm as claims investigator *and* legal advisor).
- *Aetna Cas. & Sur. Co. v. Superior Ct.*, 153 Cal. App. 3d 467, 476 (Cal. Ct. App. 1984) (finding that the "dominant" purpose for retaining attorney was to interpret insurance policy and investigate events surrounding claim in order to advise insurer as to whether coverage should be provided).

31. *Id.* (closing square brackets in original).

- *Stephenson Equity Co. v. Credit Bancorp., Ltd.*, No. 99 CIV 11395IRWS, 2002 WL 59418, at *3 (S.D.N.Y. Jan. 16, 2002) ("The privilege does not apply here because [the law firm] appears to have been hired to investigate the facts surrounding the two claims and make a recommendation to the Insurers. The documents at issue here were part of the regular course of business for an insurance company. In determining whether to pay a claim, the Insurers hired an outside investigator, here a law firm, to investigate the claim. Courts have held that reports prepared by attorneys investigating insurance claims on behalf of an insurance company are not privileged, 'because the reports, although prepared by attorneys, are prepared as part of the "regular business" of the company' . . . . Because the Insurers have not submitted evidence which establishes that [the law firm] created the challenged documents in the course of providing legal advice, as opposed to its investigation of the facts surrounding the prior claims, the documents will be produced.").
- *Menapace v. Alaska Nat'l Ins. Co.*, No. 20-CV-00053-REB-STV, 2020 WL 6119962 (D. Colo. Oct. 15, 2020). In this case, insurer retained local Colorado counsel during the claim-adjustment process on account of the insurer's relative unfamiliarity with Colorado law. Local counsel assisted in taking an examination under oath, oversaw the request for an independent medical examination, coordinated a mediation with opposing counsel, and became opposing counsel's primary contact with the insurer. Plaintiff sued the insurer, alleging, among other things, bad-faith breach of contract. Plaintiff sought discovery of correspondence between the insurer and Colorado counsel during the claims process. In opposing plaintiff's request, insurer raised the attorney-client and work-product privilege. The U.S. District Court, looking to Colorado precedent, held that an insurer waives the privilege with respect to correspondence, documentation, or other materials that are the result of its counsel occupying, in whole or in part, the ordinary role of an insurance adjuster. Functions this court found in precedent as falling within the ordinary role of an adjuster are: (1) investigating the underlying facts of the claim; (2) asserting, concluding, or otherwise analyzing whether an insured's claim should be paid or denied; and (3) requesting claimant's medical records and summarizing those records (where the associated legal advice regarding potential liability based on those records was privileged). Ultimately, this court held that the evidence be addressed on a document-by-document basis, and that portions that related to the ordinary functions of a claims adjuster would *not* be protected by the attorney-client privilege.
- *In re Vioxx Prods. Liab. Litig.*, 501 F. Supp. 2d 789, 798 (E.D. La. 2007). Here, the court applied the "primary purpose" test, stating:

> "The test for the application of the attorney-client privilege to communications with legal counsel in which a mixture of services are sought is whether counsel was participating in the communications primarily for the purpose of rendering legal advice or assistance."

3. The Predominantly Legal Test

The "dominant purpose" or "predominant purpose" test is not the only one. Another is the "predominately legal" test, examples of which include:

- *Welch v. Eli Lilly & Co.*, No. 1:06-CV-0641-RLY-JMS, 2009 WL 700199, at *12 (S.D. Ind. Mar. 16, 2009) ("[T]he advice given must be predominately legal, as opposed to business, in nature.").
- *Faloney v. Wachovia Bank, N.A.*, 254 F.R.D. 204, 209 (E.D. Pa. 2008) ("Communications by in-house counsel are privileged only where the 'communication's primary purpose is to gain or provide legal assistance.'").

4. The "But For" Test

And there is the "but for" test:

- *Spiniello Cos. v. Hartford Fire Ins. Co.*, No. CIV A. 07–CV–2689DMC, 2008 WL 2775643, at *2 (D.N.J. July 14, 2008) ("[T]he court . . . should require the claimant to 'demonstrate that the communication would not have been made but for the client's need for legal advice or services.'").

B. ATTORNEY AS CLAIMS ADJUSTER

The Epstein treatise on Attorney-Client Privilege discusses the role of "Attorney as Claims Adjuster" in considerable length, but otherwise worth setting forth here (including all of Ms. Epstein's trenchant comments, unredacted!):

> To the extent that an attorney is evaluating a claim and functioning as a claims adjuster, no privilege will attach to communications between the attorney and the insurance company, the lawyer's client. Once again, the fact that an attorney is playing a role generally played by a non-attorney and is basically giving business advice—namely, whether to honor a claim and in what amount, although inextricably bound up with a legal assessment as to whether the

claim is covered by the insurance policy, generally has not served to immunize the communication from discovery.

• *First Aviation Servs., Inc. v. Gulf Ins. Co.*, 205 F.R.D. 65 (D. Conn. 2001). Where attorney acted as a claims adjuster, the attorney was making a business decision and therefore all claim file documents were ordered produced, but any legal analysis could be redacted. The insurance company's contention that it hired outside counsel because it foresaw coverage problems was not successful in protecting the documents from disclosure.

• *Arkwright Mut. Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 1994 U.S. Dist. LEXIS 13216, No. 90 Civ. 7811 (AGS), 1994 WL 510043, at *5 (S.D.N.Y. Sept. 16, 1994). An insurance company "may not insulate itself from discovery by hiring an attorney to conduct ordinary claims investigations."

• *Amerisure Ins. Co. v. Laserage Tech. Corp.*, 1998 WL 310750, at *11 (W.D.N.Y. Feb. 12, 1998). "To the extent an attorney acts as a claims adjuster, claims process supervisor, or claims investigation monitor, and not as a legal advisor, the attorney-client privilege does not apply."

It never ceases to amaze that counsel tend to interpose the most astonishingly frivolous privilege objections to the least objectionable of deposition questions, including asking an accident investigator—attorney or not—whether it is his practice to try to ascertain a cause of an accident. I kid you not.

• *Folz v. Union Pac. R.R. Co.*, 2014 U.S. Dist. LEXIS 85960 (S.D. Cal. June 23, 2014). "Is it your custom or practice to try to find out from the witness whether or not they had an act or omission for which caused the accident [sic!]." Opposing counsel interposed an attorney/client and work-product privilege and instructed the witness not to answer it. Is anyone reading this book surprised that the judge ruled that the question posed had nothing to do with either privilege? So the deposition had to be taken again to allow an answer. The court did not award costs or fees. Other courts have. [Cross reference to Sanctions section of EPSTEIN Treatise omitted.] Perhaps more of them should put an end to such subpar lawyering.

a. Attorney Carbon Copied

Carbon copying an attorney on communications, which are not privileged, standing alone, does not transform the communication into a privilege-protected one.

• *Willnerd v. Sybase, Inc.*, 2010 U.S. Dist. LEXIS 135781, at *14 (D. Idaho Dec. 22, 2010). "Although the emails bear the attorney-

client privilege label, and Curiale attorneys were copied on some of these emails, Chapin and White-Ivy [two of defendant's employees] testified that they copied the attorneys as a routine matter, and not to secure legal advice. And a review of the e-mails' contents supports this characterization: the emails forward information to other Sybase employees about Willnerd, and the attorneys were merely copied."

b. Attorney Present at a Meeting

The mere fact that an attorney is present at the meeting of a corporation, of a public body, or of the managerial personnel of a business does not, *ipso facto*, transform the meeting into a communication between a client and the client's attorney for the purpose of obtaining the attorney's legal advice. If there is a privilege-protected portion of the meeting, the courts may and do, carve out such a portion of the meeting from the ordinary conduct of business.

• *Kodish v. Oakbrook Terrace Fire Prot. Dist.*, 235 F.R.D. 447, 2006 U.S. Dist. LEXIS 23987, at *16 (N.D. Ill. Apr. 20, 2006). An attorney was present at a closed session meeting of a governmental body to discuss termination of an employee. Any discussion of that employee's performance and the reasons for the termination were discoverable and were not privilege protected. "In this case, the attorney-client privilege does not provide blanket protection from discovery. Although the Defendant's attorney was present at all times during the closed-door meeting, his presence does not render all communications privileged. The discussion by members of the Fire District's board of trustees regarding Plaintiff's work history, Sebesta's [employee's supervisor] reasons for moving to terminate Plaintiff, and Sebesta's discussion of what is desirable from an employee are examples of the type of information that is discoverable."

• *Larson v. Harrington*, 11 F. Supp. 1198, 1200–01, 1998 U.S. Dist. LEXIS 10445, at *4–5 (E.D. Cal. June 29, 1998). The plaintiff moved to compel the deposition testimony of county board members regarding discussions held in closed session. The defendant objected to questions pertaining to the closed session on the ground that the county counsel was present at the meetings. The court disagreed. "At these meetings the board, as client, may have communicated information to Batchelder, as attorney, in furtherance of obtaining legal services. But such discrete communications would nevertheless not be within the privilege unless made in confidence, viz. not unnecessarily disclosed to bystanders. The record does not show who was present at the meetings and thus does not

support a finding that this element of the privilege was satisfied. Even if it were, however, the fact that confidential communications within the privilege may have been made at the board meetings does not cloak the entire proceeding in secrecy. The agendas for the pertinent board meetings in April 1996 show that they were closed not to obtain legal advice but to consider disciplining a public employee and those discussions are certainly not within the attorney-client privilege."

c. In-House Counsel

There is no question that in the United States the attorney-client privilege extends to in-house counsel. Issues arise, however, as to whether in-house counsel, who often sit on operating committees or give business-related advice, are, when they are giving such advice, giving legal or business advice. This then becomes a proof issue for the proponent of the privilege.

Thus, where the default assumption is that outside counsel is being asked to render advice, it is legal in nature and thus privilege protected. That is not the default assumption when communications to and from in-house counsel are at issue. The proponent of the privilege must generally bear the burden of proof and persuasion that the communication at issue is legal in nature and thus privilege protected. Needless to say, the claim often fails.

• *United States v. Chevron Texaco Corp.*, 241 F. Supp. 2d 1065, 1076 (N.D. Cal. 2002). "[T]he presumption that attaches to communications with outside counsel does not extent to communications with in-house counsel . . . [b]ecause in-house counsel may operate in a purely or primarily business capacity in connection with many corporate endeavors."

• *Lenz v. Universal Music Corp.*, 2009 U.S. Dist. LEXIS 105180, at *6 (N.D. Cal. Oct. 29, 2009). "The fact that the communications are related to information provided to or by attorneys who work for Universal does not in itself make the communications privileged . . . Universal has not shown that the primary purpose of any communications reflecting Universal's practices with respect to takedown notices was to render legal advice. As Magistrate Judge Seeborg found, 'it is entirely plausible that . . . such notices may be dispatched as part of a business strategy to appease clients.' Without more, the magistrate judge's determination is not clearly erroneous."

It will come as a surprise to most U.S. lawyers that in the European Union, whose laws may be applicable on choice of law principles [cross reference to Choice of Law section of EPSTEIN Treatise

> omitted] in litigation in the U.S. courts involving foreign corporations or foreign subsidiaries of domestic corporations, no privilege attaches to communications with in-house attorneys.
>
> • *Akzo Nobel Chem. Ltd v. Commc'n*, No. C-550/07P (Sept. 14, 2010). The European Court of Justice held that communications between corporate employees and in-house counsel were ***not*** privilege protected under the European Union's version of the privilege. The rationale was that an attorney's highest duty is to the judicial system, not to the client, and that such primary legal duty was compromised by the loyalty that in-house counsel owed to the employer.[32]

1. Other Issues

Even where it is determined that the attorney-client privilege attaches to the documents sought to be protected, the privilege can be lost. Here are some examples.

a. Waiver of Privilege

The privilege can be waived despite the fact that the waiver was unknowing, involuntary, or unintentional. It can occur by actions taken—or not taken—by the privilege holder or its representative. Although the privilege belongs to the client, waiver may be attributed to the privilege holder even when it was the client's lawyer who caused the waiver.[33] According to Wigmore, "[a] privileged person would seldom be found to waive, if his intention not to abandon could alone control the situation. There is always also the objective consideration that when his conduct touches a certain point of disclosure, fairness requires that the privilege shall cease whether he intended that result or not."[34] Accordingly, the loss of the privilege need not be intentional or knowing; rather the loss of the privilege may result from inadvertent disclosure by the client or the client's lawyer or from any position taken in litigation that would make it unfair for the client to assert the privilege.[35]

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32. EPSTEIN, *supra* note 18, at 504–07. The unavailability of the privilege with respect to in-house counsel under EU law is well established. *See also* Case 155/79, *AM & S Eur. Ltd. v. Comm'n of the Eur. Cmtys.*, ECLI:EU:C:1982:157 (May 18, 1982), the first case on this issue.

33. *See* EPSTEIN, *supra* note 18, at 508.

34. WIGMORE, *supra* note 16, at § 2327.

35. *See*, *e.g.*, EPSTEIN, *supra* note 18, at 508; *see generally* Richard L. Marcus, *The Perils of Privilege: Waiver and the Litigator*, 84 MICH. L. REV. 1605 (1986).

b. Dissemination within Organization

It is generally true that disseminating privileged information to third parties waives the privilege. Disseminating privileged information within an organization, however, does not by itself waive the privilege.[36] In addressing whether the privilege has been lost, some courts have articulated a "need to know" test. For example:

> In general, whether the dissemination of privileged communications to corporate employees vitiates the privilege is decided by applying a "need to know" standard: did the recipient need to know the content of the communication in order to perform her job effectively or to make informed decisions concerning, or affected by, the subject matter of the communication?[37]

Two cases illustrate how courts that have applied the "need to know" test; one upholding the privilege and the other not.

In the first case, the plaintiff sought the production of emails involving in-house counsel and other employees of the defendant that related to the drafting and negotiation of a contract at issue in the case, the plaintiff asserted that any potential privilege was waived "because the documents were too widely disseminated," but the court found that the privilege was not waived:

> The e-mail was sent to those that needed to stay informed. Three of the individuals involved in the communication were members of Caremark's in-house legal staff and the other three individuals were those who were intimately involved with the SEPTA contract negotiation and formation. Because this email was not widely disseminated and was only sent to individuals who had a "need to know" the legal advice, Caremark has satisfied its burden of establishing that the privilege has not been waived.[38]

In the case of *Robbins & Myers, Inc. v. J.M. Huber Corp.*,[39] however, the court found that the privilege had been waived through over-dissemination. In *Robbins*, the defendant sought production of emails and notes involving in-house counsel and six other employees of the plaintiff company that related to the drafting of a public service announcement. Plaintiff asserted that disseminating the information to the six other employees did not waive the

36. *See* D. Larry Kristinik, III, *Preserving the Attorney-Client Privilege when Communicating with Corporate Counsel*, IN-HOUSE DEF. Q., Summer 2020, at 6 (citing Strougo v. BEA Assocs., 199 F.R.D. 515, 519–20 (S.D.N.Y. 2001)).

37. Scholtisek v. Eldre Corp., 441 F. Supp. 2d 459, 464 (W.D.N.Y. 2006).

38. Se. Pa. Transp. Auth. v. Caremarkpcs Health, L.P., 254 F.R.D. 253, 260 (E.D. Pa. 2008).

39. 274 F.R.D. 63 (W.D.N.Y. 2011).

privilege because they were "'few' in number and 'directly involved with the Public Safety Notice.'"[40] The court disagreed, holding that Plaintiff did *not* satisfy its burden of establishing that the employees who received the information were persons who *needed to know* that information. The court stated that the recipients of the information must serve as *policymakers* with a *need to know*. Merely claiming that they were "involved" was *not* enough to satisfy the proponent's burden.[41]

c. "Advice of Counsel" Defense

When a party relies on an "advice of counsel" defense, that party likely will be deemed to have waived the attorney-client privilege, with the result that all communications related to that defense becomes potentially (or actually) discoverable.[42] The scope or extent of the waiver typically remains an issue. For example, in *Robertson v. Allstate Ins. Co.*,[43] the court held that reliance on the advice of *outside* counsel as a defense did *not* require a finding of waiver of communications involving *in-house* counsel.

Federal Rule of Evidence 502 provides a standard for determining scope of the waiver when litigation is pending *and* when an intentional waiver of *part* of the privileged communication has occurred. This Rule is exemplified in *Ariz. ex rel. Goddard v. Frito-Lay, Inc.*,[44] where the court stated that Rule 502 suggests that courts limit the waiver to communications about "the same subject matter as the communication constituting the waiver."[45] The court further held that the plaintiff waived *any* attorney-client privilege in its investigations, advice given, and communications related to reaching its determination and drafting of the document in which privilege was intentionally waived.[46]

That case is all well and good when privilege was waived intentionally, but what about when the privilege was waived inadvertently? As one commentator has framed the question, "[a] more difficult situation for insurers is when they do not expressly assert the advice-of-counsel defense but are

40. *Id.* at 94.

41. *Id.*

42. *See*, *e.g.*, Kristinik, *supra* note 36 (citing Lindley v. Life Invs. Ins. Co. of Am., 267 F.R.D. 382, 392 (N.D. Okla. 2010)).

43. No. CIV. A. 98-4909, 1999 WL 179754 (E.D. Pa. Mar. 10, 1999).

44. 273 F.R.D. 545 (D. Ariz. 2011).

45. *Id.* at 556.

46. *Id.*

still found to have *implicitly* waived the attorney-client privilege."[47] As another court has explained, "in cases such as this in which the *litigant* claiming the privilege *relies* on and advances as a claim or defense a subjective and allegedly reasonable evaluation of the law—but an evaluation that necessarily incorporates what the litigant learned from its lawyer—the communication is discoverable and admissible."[48]

2. Privilege Issues During Claim Handling Process

As discussed above, the concern is whether an attorney involved in the claim-handling process will be deemed to have been performing the same business function as an insurance adjuster. As at least one court has said, "[t]o the extent th[e] attorney act[s] as a claims adjuster, claims process supervisor, or claim investigation monitor, and not as a legal advisor, the attorney-client privilege would not apply."[49] As one commentator states, "[t]his is a risk for both in-house attorneys and outside counsel who assist claims examiners and adjusters in the proper handling of their duties."[50] From this author's point of view, that problem exists for insureds as well; perhaps at a lower frequency, but it exists nevertheless.

The case of *Cutrale Citrus Juices USA, Inc. v. Zurich Am. Ins. Grp.* states the rule thus: "In the insurance context, 'no privilege attaches when an attorney performs investigative work in the capacity of an insurance claims adjuster, rather than as a lawyer, [but] simply because [the attorney's] assigned duties were investigative in nature' does not preclude an assertion of the attorney-client privilege. Therefore, '[t]he relevant question is not whether [the attorney] was retained to conduct an investigation, but rather, whether

47. *See* Kristinik, *supra* note 36 (citing Lexington Ins. Co. v. Swanson, No. C05-1614MJP, 2007 WL 2121730, at *3 (W.D. Wash. July 24, 2007) ("A number of courts have concluded that an insurer waives the attorney-client privilege between it and its coverage counsel when the insurer, in response to a bad-faith action, implicitly relies on counsel's legal advice as a justification for non-payment of claims.").

48. State Farm Mut. Auto. Ins. Co. v. Lee, 13 P.3d 1169, 1175 (Ariz. 2000). *See also* Mendoza v. McDonald's Corp., 213 P.3d 288 (Ariz. Ct. App. 2009) (holding that a defense of subjective reasonability puts the advice of counsel constituting the foundation of that belief in question, regardless of whether the advice is expressly or impliedly relied upon) (emphasis in original); Hunton v. Am. Zurich Ins. Co., No. CV-16-00539-PHX-DLR, 2017 WL 3712445, at *2 (D. Ariz. Aug. 29, 2017) (quoting *Mendoza*, 213 P.3d at 303) ("[b]y electing to defend this case based on the subjective, not just objective, reasonableness of its adjuster's actions, Defendant placed at issue its 'subjective beliefs and directly implicated the advice and judgment [it] had received from [the defendant's] ICA counsel incorporated in those actions.'").

49. Harper v. Auto-Owners Ins. Co., 138 F.R.D. 655, 671 (S.D. Ind. 1991).

50. *See* Kristinik, *supra* note 36.

this investigation was related to the rendition of legal services. If it was . . . the privilege is not waived.'"[51]

With respect to whether *in-house* counsel involved in handling insurance claims are acting in a legal capacity, thereby enjoying protection of the privilege, the following cases are of note:

a. In-House Counsel: Privilege Found

- *Certain Underwriters at Lloyd's v. Nat'l R.R. Passenger Corp.*, No. 14-CV-4717 (FB), 2016 WL 2858815 (E.D.N.Y. May 16, 2016) (finding that the privilege protected work-product created by in-house counsel because counsel provided legal advice pertaining to the handling and settlement of bodily injury claims).
- *Bacchi v. Mass. Mut. Life Ins. Co.*, 110 F. Supp. 3d 278, 283 (D. Mass. 2015) (holding the privilege applicable when in-house counsel confers, subject to a confidentiality agreement, with counsel for an insurance association regarding the association's amicus brief).
- *Lacaretta Rest. v. Zepeda*, 115 So. 3d 1091, 1093 (Fla. Dist. Ct. App. 2013) (finding that the privilege protected paperless internal communications between in-house counsel and the employer and carrier when communications were made in the rendition of legal services).
- *Penn Mut. Life Ins. Co. v. Rodney Reed 2006 Ins. Tr.*, No. 09-CV-0663 (JCJ), 2011 U.S. Dist. LEXIS 46825 (D. Del. Apr. 25, 2011) (holding that the privilege was applicable where the plaintiff provided evidence that the in-house attorney was acting in his legal capacity at all relevant times).
- *Allstate Ins. Co. v. Levesque*, 263 F.R.D. 663, 668 (M.D. Fla. 2010) ("correspondence and communications between an insurer's employees or agents and the insurer's in-house counsel are privileged and not subject to production.").
- *Robertson v. Allstate Ins. Co.*, No. CIV. A. 98-4909, 1999 WL 179754, at *5 (E.D. Pa. Mar. 10, 1999) (finding communications between employees and in-house counsel privileged "in light of Allstate's representation that the communications at issue did not contain business advice, but rather involved legal advice about how to proceed with the UIM arbitration.").
- *Quaciari v. Allstate Ins. Co.*, No. CIV. A. 97-2028, 1997 U.S. Dist. LEXIS 13834, at *2–3 (E.D. Pa. Sept. 3, 1997) ("I find that the

51. No. 5:03-CV-420-OC-10GRJ, 2004 WL 5215191, at *3 (M.D. Fla. Sept. 10, 2004) (quoting Conn. Indem. Co. v. Carrier Haulers, Inc., 197 F.R.D. 564, 572 (W.D.N.C. 2000)) (in turn quoting *In re* Allen, 106 F.3d 582, 602–03 (4th Cir. 1997)).

redacted portions of the documents labeled as 'diary entries' on Allstate's Privilege Log relate to communications between Allstate's claims adjuster and Allstate's counsel or other personnel in counsel's office and are therefore protected by the attorney-client privilege.").

b. In-House Counsel: Privilege Denied

- *Sell v. Country Life Ins. Co.*, 189 F. Supp. 3d 925, 936 (D. Ariz. 2016) ("The mere identification of a lawyer as a recipient or sender of an email, in and of itself, does not cause the content of that email to be privileged.").

c. In-House Counsel: Mixed

- *Spiniello Cos. v. Hartford Fire Ins. Co.*, No. CIV A. 07-CV-2689DMC, 2008 WL 2775643 (D.N.J. July 14, 2008) (finding *no* privilege for an email to the plaintiff's counsel with copy of reaffirmance of a denial letter that merely carbon copied in-house counsel, *but* finding privilege *was* applicable to emails to in-house counsel seeking legal advice).
- *United Servs. Auto. Ass'n v. Crews*, 614 So. 2d 1213, 1214 (Fla. Dist. Ct. App. 1993) ("Contrary to the trial court's ruling, the evidence clearly established that the 'in-house' counsel, at least some of the time, were functioning as attorneys, giving protected legal advice to USAA.").

d. Outside Counsel: Privilege Found

- *Parisi v. State Farm Mut. Auto. Ins. Co.*, No. CV 3:16-179, 2017 WL 4403326, at *5 (W.D. Pa. Oct. 2, 2017) ("This Court is not aware of any authority that limits the attorney-client privilege to communications with outside counsel, as opposed to in-house counsel, and Plaintiff has cited none. Therefore, this Court rejects Plaintiffs' claim that the attorney-client privilege could not have attached before Attorney McDonnell was retained as outside counsel to handle Plaintiffs' claim.").
- *Bertelsen v. Allstate Ins. Co.*, 796 N.W.2d 685, 701 (S.D. 2011) ("Allstate's retention of counsel was for the 'purpose of facilitating the rendition of professional legal services,' which is a 'classic example of a client seeking legal advice from an attorney.'").
- *Transamerica Life Ins. Co. v. Moore*, 274 F.R.D. 602, 606 (E.D. Ky. 2011) ("The purpose of the report was to provide legal advise [*sic*]

regarding Transamerica's potential changes to its claims processing . . . the communications at issue are protected by the attorney-client privilege and not discoverable unless waived or subject to an exception.").

- *Conn. Indem. Co. v. Carrier Haulers, Inc.*, 197 F.R.D. 564 (W.D.N.C. 2000) (finding the attorney-client privilege applicable when outside counsel corresponded with insurer's senior examiner regarding the results of the investigation of an outside adjuster for purposes of preparing coverage opinion).

e. Outside Counsel: Privilege Denied

- *Great Am. Ins. Co. v. J. Aron & Co.*, 94 Civ. 4420 (RSW), 1995 U.S. Dist. LEXIS 7427, at *5 (S.D.N.Y. May 30, 1995) ("Nor will the attorney/client privilege protect documents prepared by outside counsel hired to monitor the progress of [the] case to the extent that attorneys act as claims adjusters, claims process supervisors, or claims investigation monitor rather than legal advisors.").
- *Harper v. Auto-Owners Ins. Co.*, 138 F.R.D. 655, 671 (S.D. Ind. 1991) ("Outside counsel was hired five days after the fire to monitor the progress of the case, ensure compliance with the Indiana arson reporting requirements, and conduct the examination under oath of the plaintiff and his wife as provided in the policy . . . . To the extent that this attorney acted as a claims adjuster, claims process supervisor, or claim investigation monitor, and not as a legal adviser, the attorney-client privilege would not apply.").
- *Mission Nat'l Ins. Co. v. Lilly*, 112 F.R.D. 160, 163 (D. Minn. 1986) ("To the extent that Cozen & O'Connor acted as claims adjusters, then, their work-product, communications to client, and impressions about the facts will be treated herein as the ordinary business of plaintiff, outside the scope of the asserted privileges.").

C. Conclusion

Regardless of whether counsel is in-house or outside, and regardless of whether counsel is retained or tasked by insurer or insured, the questions that will come up every time one party wants to discover the other party's file include: was the attorney doing the work that a non-lawyer would be doing?; and/or what was the primary, predominate, or dominant purpose of the engagement or task?

Being able to address these questions in advance will help the parties avoid or reduce the risk of a costly discovery dispute concerning the attorney-client privilege.

IV. ATTORNEY-WORK PRODUCT DOCTRINE

The attorney-client privilege and the attorney-work-product doctrine (sometimes also referred as a "protection" or an "immunity"; it really is not a "privilege") are independent principles. The attorney-client privilege sounds in the law of evidence; the attorney-work-product doctrine sounds in the law of civil procedure.

The doctrine was first articulated by the United States Supreme Court in *Hickman v. Taylor*.[52] The doctrine recognizes that certain requests for documents, if granted, would "contravene the public policy underlying the orderly prosecution and defense of legal claims."[53] In cases in federal court, the doctrine has been codified by Rule 26(b)(3) of the Federal Rules of Civil Procedure, which provides in pertinent part:

> **(b) Discovery Scope and Limits.**
>
> **(3) Trial Preparation; Materials.**
>
> (A) Documents and Tangible Things. Ordinarily, a party may not discover documents and tangible things that are prepared in anticipation of litigation or for trial by or for another party or its representative (including the other party's attorney, consultant, surety, indemnitor, insurer, or agent). But, subject to Rule 26(b)(4), those materials may be discovered if:
>
> (i) they are otherwise discoverable under Rule 26(b)(1); and
>
> (ii) the party shows that it has substantial need for the materials to prepare its case and cannot, without undue hardship, obtain their substantial equivalent by other means.
>
> (B) Protection Against Disclosure. If the court orders discovery of those materials, it must protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of a party's attorney or other representative concerning the litigation.[54]

52. 329 U.S. 495 (1947).

53. *Id.* at 510.

54. FED. R. CIV. P. 26(b)(3).

In sum, then, Rule 26(b)(3) provides qualified immunity from discovery where materials are: (1) documents and tangible things otherwise discoverable; (2) prepared in anticipation of litigation or for trial; and (3) by or for another party or by or for the other party's representative.[55] Special protection is given to a lawyer's mental impressions, conclusions, opinions, or legal theories concerning the litigation.[56]

Under what circumstances, if any, would this doctrine come into play in a coverage matter? One would assume, for example, that an insured seeking coverage for a first-party claim would want to provide the insurer with all the information the insured has that would support its contention that the loss was caused by a covered cause and that the insured can support its damages claim. If, however, within the process of adjusting the claim it started to become apparent to the insured that the insurer is likely to deny or otherwise limit the claim, then the insurer might retain counsel "in anticipation of litigation." As might the insurer.

Accordingly, unlike the situations that implicate the attorney-client privilege—that is, whether the lawyer was acting in her capacity as such or as a claim adjuster, or was retained more to provide business rather than legal advice—the question on facts like these addressed in the previous paragraph does not implicate the attorney-client privilege as much as it implicates the attorney-work-product doctrine, once, that is, that litigation becomes anticipated.[57]

This begs the next question; namely: what does it mean to create a document "in anticipation of litigation"? Unsurprisingly, the tests among the courts vary.[58] Some have held that a document prepared under "substantial and imminent" or "fairly foreseeable" threat of litigation is prepared "in anticipation of litigation."[59] Other courts look at the totality of the circumstances regarding the creation of the document to determine whether the document

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55. *Id.*

56. FED. R. CIV. P. 26(b)(3)(B).

57. It is important to point out that, in California, the attorney-work-product doctrine is not limited to work prepared in anticipation of litigation or for trial. The California rule is more expansive. It affords the work product protection to any document prepared by an attorney in connection with his or her work as an attorney, regardless of whether litigation is contemplated. Rumac, Inc. v. Bottomley, 143 Cal. App. 3d 810, 815–16 (Ct. App. 1983) ("We strongly believe there is no less need for the lawyer's professional competence in matters unrelated to litigation and observe the California Rules of Professional Conduct make no distinction between the trial and nontrial lawyer, applying to each with equal force.").

58. For a broader examination of issues concerning the attorney-work-product doctrine, *see* Keeley & Archbold, *supra* note 21, at 28–42; EPSTEIN, *supra* note 18.

59. *See*, *e.g.*, Kidwilder v. Progressive Paloverde Ins. Co., 192 F.R.D. 536, 542 (N.D.W. Va. 2000).

was created "because of" anticipated litigation.[60] As of this writing, two courts have determined that the "because of" standard will protect so-called dual purpose documents; that is, documents that were produced while the party had an objectionably reasonable belief in imminent litigation but also in a situation where the document would have been produced in the ordinary course of the party's business in the absence of "anticipation of litigation."[61] And then there are courts, which have employed the "because of" standard, that have held that if a document would have been produced in the ordinary course of business, the fact that litigation was anticipated does *not* render that document protected by the doctrine.[62]

In sum, both insurer-side and policyholder-side practitioners should be aware of the attorney-work-product doctrine, what it protects and what it does not, and the approach the various tests courts utilize to determine whether the doctrine should apply at all.

V. IMPACT ON DEFENSE COUNSEL

Regardless of whether defense counsel is practicing in a "one client" or a "two client" jurisdiction, no lawyer can serve two masters whose interests materially diverge.[63]

ABA Model Rule 1.7(a) provides in pertinent part that "a lawyer shall not represent a client if the representation involves a concurrent conflict of interest." The Rule goes on to explain that a "concurrent conflict of interest exists if: (1) the representation of one client will be directly adverse to another client; or (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another

60. *See*, *e.g.*, *In re* Grand Jury Subpoena (Mark Torf/Torf Env't Mgmt.), 357 F.3d 900, 908 (9th Cir. 2004); *accord* PepsiCo, Inc. v. Baird, Kurtz & Dobson LLP, 305 F.3d 813 (8th Cir. 2002).

61. *See In re* Grand Jury Subpoena, 357 F.3d at 908–09. According to the 9th Circuit, the "because of" standard looks at the totality of circumstances surrounding the document's creation, and does not consider whether litigation was the "primary" or "secondary" motive. *Id.* at 908.

62. *See*, *e.g.*, Cont'l Cas. Co. v. Marsh, No. 01 C 0160, 2004 WL 42364 (N.D. Ill. Jan. 6, 2004); St. Paul Reinsurance Co., Ltd. v. Com. Fin. Corp., 197 F.R.D. 620, 629 (N.D. Iowa 2000).

63. *See*, *e.g.*, Richard L. Neumeier, *Serving Two Masters: Problems Facing Insurance Defense Counsel and Some Proposed Solutions*, 77 MASS. L. REV. 66 (1992); Douglas R. Richmond, *A Professional Responsibility Perspective on Independent Counsel in Insurance*, 33 INS. LITIG. REP. 5 (2011) (especially Sections I.e. ("Ensuring Independent") and I.f. ("Lawyer's Duty of Honesty") (and collecting applicable cases and secondary sources)).

client, a former client or a third person or by a personal interest of the lawyer." Further, Rule 1.8(f) provides that "[a] lawyer shall not accept compensation for representing a client from one other than the client unless: (1) the client gives informed consent; (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and (3) information relating to representation of a client is protected as required by Rule 1.6 [Confidentiality]." And Rule 5.4(c) provides that "[a] lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services."

In the insurance-coverage context, especially in situations when practitioners have failed to be clear about the respective roles of all the lawyers involved in the matter, it should be readily apparent that defense counsel easily can find herself conflicted. As the cases cited in this paper and in other sources show, these are situations that arise more often than they should. When they do, they potentially reflect a failure on the part of lawyers and their clients to take care to see to it that everyone's roles are clear.

THE LIABILITY INSURER'S DUTY TO DEFEND "SUITS"

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I. INTRODUCTION

Insurance policies are contracts.[1] Standard liability insurance policies state that the insurer "will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which [the policy] applies" and that the insurer "will have the right and duty to defend the insured against any 'suit' seeking those damages."[2] As caselaw has long made clear, the duty to defend is a critical aspect of the liability insurance bargain.[3] Indeed, the duty to defend is so vital to the insurer-insured relationship that courts often describe liability insurance as "litigation insurance."[4] But as vital as a liability insurer's duty to defend may be, it is not boundless. Fundamentally, an insurer's duty to defend is limited to "suits" against an insured seeking covered "damages." This article will examine recent controversies with respect to different types of claims and "suits" that may trigger an insurer's duty to defend.

II. THE REQUIREMENT OF A "SUIT"

Again, liability insurance policies typically provide that the insurer will defend any "suit" seeking covered "damages." To use a common example, a standard CGL policy states that the insurer "will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which [the policy] applies" and that the

1. Phila. Indem. Ins. Co. v. Bellin Mem'l Hosp., 126 F.4th 532, 542 (7th Cir. 2025) (discussing Illinois law); Cravens v. Montano, 567 P.3d 745, 749 (Ariz. 2025); Foresee v. Metro. Grp. Prop. & Cas. Ins. Co., 572 P.3d 754, 757 (Idaho Ct. App. 2025); Safeway Ins. Co. of La. v. Nat'l Gen. Ins. Co., 413 So. 3d 537, 541 (La. Ct. App. 2025); French v. Auto-Owners Ins. Co., 23 N.W.3d 696, 702 (Neb. Ct. App. 2025).

2. Ins. Servs. Off., Inc., Commercial General Liability Coverage Form (CG 00 01 04 13), at 1 (2012) [hereinafter ISO CGL Policy].

3. *See, e.g.*, Campbell v. Super. Ct., 52 Cal. Rptr. 2d 385, 392–93 (Cal. Ct. App. 1996) ("[O]ne of the primary benefits of an insurance policy is that the insured can expect the insurer to defend against third-party claims."); Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co., 279 S.W.3d 650, 655 (Tex. 2009) ("A defense of third-party claims provided by the insurer is a valuable benefit granted to the insured by the policy, separate from the duty to indemnify."); Woo v. Fireman's Fund Ins. Co., 164 P.3d 454, 459–60 (Wash. 2007) ("The duty to defend is a valuable service paid for by the insured and one of the principal benefits of the liability insurance policy.").

4. *See, e.g.*, Stoncor Grp., Inc. v. Peerless Ins. Co., No. 16-cv-4574 (LAK), 2022 WL 3701640, at *4 (S.D.N.Y. Aug. 26, 2022); Ill. Tool Works, Inc. v. Travelers Cas. & Sur. Co., 26 N.E.3d 421, 431 (Ill. App. Ct. 2015).

insurer "will have the right and duty to defend the insured against any 'suit' seeking those damages."[5] The term "suit" is generally understood to refer to a lawsuit filed in a court.[6] The meaning of "suit" may further be controlled by the terms of the insurance policy under which a defense is sought. A standard CGL policy defines a "suit" as follows:

> "Suit" means a civil proceeding in which damages because of "bodily injury", "property damage" or "personal and advertising injury" to which this insurance applies are alleged. "Suit" includes:
>
> a. An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent; or
>
> b. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent.[7]

Because a standard CGL policy defines the term "suit," a court interpreting the policy must apply that definition.[8] The court cannot disregard the policy's definition of a "suit" in favor of a definition it prefers. Reliance on defined terms in an insurance policy is necessary to ascertain the parties' intent and essential to the application of basic principles of contract interpretation to the policy.[9] As discussed later, however, courts have been willing to

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5. ISO CGL Policy, *supra* note 2, at 1.

6. *See, e.g.*, Trident Fasteners, Inc. v. Selective Ins. Co. of S.C., 533 F. Supp. 3d 560, 565 (W.D. Mich. 2021) (stating that under Michigan law, the duty to defend "does not arise until a lawsuit is actually filed"); Aztec Abstract & Title Ins., Inc. v. Maxum Specialty Corp., 302 F. Supp. 3d 1274, 1281 (D. N.M. 2018) ("New Mexico caselaw indicates that a lawsuit must be filed in a court before a duty to defend arises."); Ill. Tool Works, Inc. v. Ace Specialty Ins. Co., 142 N.E. 3d 227, 232 (Ill. App. Ct. 2019) (stating that it is "well settled that the term 'suit' in an insurance policy is unambiguous, and 'requires the commencement of some action in a court of law'" to trigger an insurer's duty to defend (quoting Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co., 655 N.E.2d 842, 847 (Ill. 1995))).

7. ISO CGL Policy, *supra* note 2, at 16.

8. Maxie v. Bates, 338 So. 3d 564, 570 (La. Ct. App. 2022); M.P. *ex rel.* Zipfel v. Trexis One Ins. Corp., 652 S.W.3d 685, 689 (Mo. Ct. App. 2022); N.C. Farm Bureau Mut. Ins. Co. v. Young, 916 S.E.2d 571, 576 (N.C. Ct. App. 2025); Twigg v. Admiral Ins. Co., 568 P.3d 156, 164 (Or. 2025); Julio & Sons Co. v. Cont'l Cas. Co., 692 S.W.3d 877, 882 (Tex. App. 2024).

9. Provident Life & Accident Ins. Co. v. Knott, 128 S.W.3d 211, 219 (Tex. 2003).

deem some actions to be the functional equivalent of a "suit" sufficient to create a duty to defend.[10]

The term "damages" describes a monetary award to compensate a plaintiff for harm caused by an insured.[11] Standard CGL, homeowners, and auto insurance policies do not define "damages."

If an insured is involved in a dispute where either or both of these contractual terms are not satisfied, the insurer should not owe a duty to defend.[12] Thus, insurers generally have no duty to defend insureds in criminal

10. *See, e.g.*, Houser Holdings CA, LLC v. Tokio Marine Specialty Ins. Co., 738 F. Supp. 3d 1226, 1233–36 (N.D. Cal. 2024) (holding that a county-initiated abatement cost recovery hearing was a "suit" the insurer was required to defend).

11. *See* Glob. Modular, Inc. v. Kadena Pac., Inc., 222 Cal. Rptr. 3d 819, 833 (Ct. App. 2017) ("The policy does not define damages, but courts generally interpret the term to mean payments made to compensate a party for direct and consequential injuries caused by the acts of another."); City of Maple Lake v. Am. States Ins. Co., 509 N.W.2d 399, 404 (Minn. Ct. App. 1993) ("The term 'damages' refers to compensation for an injury caused by a violation of a legal right."); Farm Bureau Ins. Co. v. Witte, 594 N.W.2d 574, 582 (Neb. 1999) (describing "damages" as sums the insured "becomes legally obligated to pay because of injury caused to a third party by acts of the insured").

12. *See, e.g.*, Modular Steel Sys. Inc. v. Westfield Ins., No. 21-1766, 2022 WL 832048, at *3 (3d Cir. Mar. 21, 2022) (finding no "suit" or "damages" where the insured voluntarily fixed damage caused by construction defects even though the project's owner never pursued related legal action); Allegheny Design Mgmt., Inc. v. Travelers Indem. Co. of Am., 572 F. App'x 98, 101–02 (3d Cir. 2014) (holding that an informal assertion by the claimant's legal department that the insured was responsible for property damage did not trigger the insurer's duty to defend); Kinsale Ins. Co. v. R.P. Ruiz Corp., 764 F. Supp. 3d 935, 939 (C.D. Cal. 2025) ("[E]stablished California jurisprudence does not require a commercial general liability insurer to defend or indemnify anyone before there is a 'suit.'"); W. Nat'l Mut. Ins. Co. v. Speedway, Inc., 507 F. Supp. 3d 1071, 1075–76 (D. Minn. 2020) (explaining that a pedestrian's notice to the insured of her injury from falling on the insured's property was not a "suit" that triggered the insurer's duty to defend); Glob. Caravan Techs., Inc. v. Cincinnati Ins. Co., 135 N.E.3d 584, 593 (Ind. Ct. App. 2019) (concluding that the insured's voluntary intervention in a case where there was never a claim for damages made against it was not a "suit" that implicated the insurer's duty to defend).

cases,[13] declaratory judgment actions,[14] a declaratory judgment action filed by the insurer to determine the insurer's obligations under the policy issued to the insured,[15] guardianship proceedings,[16] juvenile cases,[17] mandamus actions,[18] actions to approve settlements,[19] cases seeking only restitution or

13. *See, e.g.*, Perzik v. St. Paul Fire & Marine Ins. Co., 279 Cal. Rptr. 498, 500–01 (Cal. Ct. App. 1991) (explaining that federal criminal proceedings were not a suit for damages); Hoyle v. Utica Mut. Ins. Co., 48 P.3d 1256, 1263 (Idaho 2002) (reasoning that any restitution the state might seek did not constitute damages, so the criminal case against the insured was not a suit for damages); Derdarian v. Essex Ins. Co., 44 A.3d 122, 129 (R.I. 2012) (concluding that criminal indictments neither initiated a civil proceeding nor alleged damages). *But see* Tahbaz v. Vigilant Ins. Co., 778 F. Supp. 3d 480, 490 (D. Conn. 2025) (citations omitted) ("The Policies do not define 'suit.' . . . The parties each posit a rational meaning of the term. For the Plaintiffs, it is reasonable enough to construe 'suit' as encompassing a criminal proceeding. . . . Likewise, it is also reasonable to understand 'suit' to encompass only civil actions or enforcement efforts. . . . However, had Defendants wanted or intended to exclude coverage for costs or losses deriving from criminal proceedings, they could have done so. As a result, the Court concludes that the term is ambiguous.").

14. *See* Prince George Parish of Prince George Winyah v. GuideOne Mut. Ins. Co., 839 F. App'x 779, 780 (4th Cir. 2020) (applying South Carolina law); Moore v. State Farm Mut. Auto. Ins. Co., 304 F. App'x 329, 331 (5th Cir. 2008) (stating that claims seeking declaratory relief were not covered because they did not seek monetary damages); Fin. Res. Network, Inc. v. Brown & Brown, Inc., 754 F. Supp. 2d 128, 144 (D. Mass. 2010) ("A declaratory judgment is not a claim for monetary damages. It is a claim for non-pecuniary relief in the form of a declaration.").

15. *See, e.g.*, Boatright v. Old Dominion Ins. Co., 695 S.E.2d 408, 413 (Ga. Ct. App. 2010) ("A liability policy that . . . obligates an insurer to defend an insured against actions arising from bodily injury does not obligate the insurer also to defend the insured in a declaratory judgment action seeking to determine the insurer's liabilities and obligations under the policy.").

16. *See, e.g.*, Felice v. St. Paul Fire & Marine Ins. Co., 711 P.2d 1066, 1069–70 (Wash. Ct. App. 1985) ("The petition did not contain allegations concerning . . . damages nor a prayer for monetary relief. . . . It sought [Felice's] removal as guardian and repayment of [his] attorney fees. Hence, we hold the policy language at issue here was not intended to cover situations where third parties seek to discharge an attorney as guardian.").

17. *See, e.g.*, United Pac. Ins. Co. v. Hall, 245 Cal. Rptr. 99, 102 (Ct. App. 1988) (stating that because the juvenile proceeding sought no damages, the insurer had no duty to provide a defense).

18. *See, e.g.*, City of Maple Lake v. Am. States Ins. Co., 509 N.W.2d 399, 403 (Minn. Ct. App. 1993) ("An action for mandamus is not a suit 'seeking damages' as required in a liability insurance policy.").

19. *See, e.g.*, NL Corp. v. Seneca Specialty Ins. Co., No. 28927, 2021 WL 1828100, at *5 (Ohio Ct. App. May 7, 2021) ("The probate case in Missouri was a 'civil proceeding,' but it did not seek damages, being merely a proceeding to approve the settlement. Therefore, Seneca was not obligated to appoint counsel for NL.").

disgorgement of funds improperly obtained,[20] actions exclusively seeking injunctive relief,[21] cases where fines or civil penalties are assessed rather than damages being awarded,[22] in mediations or settlement negotiations preceding litigation or unrelated to pending litigation,[23] when presented with a cease and

20. *See, e.g.*, Prince George Parish of Prince George Winyah v. GuideOne Mut. Ins. Co., 839 F. App'x 779, 780 (4th Cir. 2020) (applying South Carolina law); Allstate Ins. Co. v. Rosfeld as Trs. of the Rosfeld Living Tr. Dated Oct. 29, 2003, 619 F. Supp. 3d 1050, 1063 (D. Haw. 2022) (applying Hawaii law); Bank of the W. v. Super. Ct., 833 P.2d 545, 546 (Cal. 1992) ("[O]ne may not insure against the risk of being ordered to return money or property that has been wrongfully acquired. Such orders do not award 'damages' as that term is used in insurance policies."); Vigilant Ins. Co. v. Credit Suisse First Boston Corp., 782 N.Y.S.2d 19, 20 (App. Div. 2004) ("Restitution of ill-gotten funds does not constitute 'damages' or a 'loss' as those terms are used in insurance policies[.]"). *But see* Wayne Mut. Ins. Co. v. McNabb, 45 N.E.3d 1081, 1089 (Ohio Ct. App. 2016) (reasoning that the term "damages" is broad enough to include sums ordered to be paid as restitution).

21. *See, e.g.*, Nat'l Union Fire Ins. Co. v. Dish Network, L.L.C., 17 F.4th 22, 32 (10th Cir. 2021) (applying Colorado law); Moore v. State Farm Mut. Auto. Ins. Co., 304 F. App'x 329, 331 (5th Cir. 2008) (stating that injunctive relief claims were not covered because they did not seek monetary damages); MJCM, Inc. v. Hartford Cas. Ins. Co., No. 8:09-CV-2275-T-17TBM, 2010 WL 1949585, at *7 (M.D. Fla. May 14, 2010) (stating that a lawsuit seeking only injunctive relief is not a "suit" under a liability insurance policy); One Gateway Assocs. v. Westfield Ins. Co., 184 F. Supp. 2d 527, 533 (S.D. W. Va. 2002) (determining that the insurer owed no duty to defend because only injunctive relief was sought); Bloomfield Rd., LLC v. DeMichele, No. 2007AP2396, 2008 WL 4923582, at *1–2 (Wis. Ct. App. Nov. 19, 2008) (holding that the insurer had no duty to defend where the plaintiff sought declaratory and injunctive relief to force adjacent lakefront property owners to re-position their docks, meaning the insured would not have to pay monetary damages). In some jurisdictions, however, an insured's costs in complying with an injunction may constitute "damages." *See, e.g.*, *In re* Certification of Question of Law from United States Dist. Ct., 960 N.W.2d 829, 836 (S.D. 2021). Also, if the insured pleads its entitlement to "other relief deemed appropriate" or something similar in addition to seeking injunctive relief, the request for such other relief likely qualifies as a request for damages sufficient to trigger the insurer's duty to defend. *See, e.g.*, Country Mut. Ins. Co. v. Bible Pork, Inc., 42 N.E.3d 958, 964 (Ill. App. Ct. 2015).

22. *See, e.g.*, Bullock v. Md. Cas. Co., 102 Cal. Rptr. 2d 804, 813 (Cal. Ct. App. 2001) (finding no duty to defend where both an ordinance and the city's complaint described the sums to be paid as "penalties"); A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am., 475 N.W.2d 607, 626 (Iowa 1991) (holding that civil penalties imposed for violating RCRA were not "damages"); State Farm Fire & Cas. Co. v. Martinez, 995 P.2d 890, 896 (Kan. Ct. App. 2000) (concluding that public policy prevents a wrongdoer from insuring against civil penalties imposed for violating the Kansas Consumer Protection Act).

23. *See, e.g.,* Sioux Steel Co. v. Ins. Co. of the State of Pa., 127 F.4th 1113, 1122 (8th Cir. 2025) (explaining that the insurer did not breach its duty to defend by not defending the insured in informal settlement proceedings); Sanders v. Phoenix Ins.

desist letter,[24] or when objecting to proofs of claim in bankruptcy cases.[25] But there are other types of actions or proceedings that may implicate an insurer's duty to defend.

A. ARBITRATION PROCEEDINGS

An insured may be named as a defendant or respondent in an arbitration proceeding. This may come about in one of three ways. First, the insured may be sued in court and thereafter successfully move to compel arbitration based on a provision in a contract with the plaintiff. Second, the party aggrieved by the insured's alleged misconduct may initiate arbitration with the insured by filing a demand for arbitration with an alternative dispute resolution provider, such as the American Arbitration Association, rather than suing the insured in a court. Third, the insured and the other party may voluntarily agree to arbitrate their dispute rather than vindicating their rights in court.

Regardless of how the parties end up in arbitration, it generally should be clear that the insurer has a duty to defend the insured in that proceeding just as it would if the dispute were instead in court. Arbitration is a substitute for litigation. Indeed, arbitration *is* litigation, just in a different forum. An arbitration demand or notice of claim is analogous to a complaint or petition in a civil case in court.[26] Lay and expert witnesses testify in arbitrations and

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Co., 843 F.3d 37, 45–46 (1st Cir. 2016) (rejecting the insured's claim that a voluntary mediation was the functional equivalent of a "suit"); Meyers Warehouse, Inc. v. Canal Indem. Co., 614 F. App'x 719, 722 (5th Cir. 2015) (referring to an informal settlement negotiation that precedes the commencement of any civil action); Hurricane Elec., LLC v. Nat'l Fire Ins. Co. of Hartford, No. 20-cv-05840-CRB, 2020 WL 6743926, at *5–6 (N.D. Cal. Nov. 17, 2020) (highlighting the insured's failure to obtain the insurer's consent to the mediation); Recall Total Info. Mgmt., Inc. v. Fed. Ins. Co., 83 A.3d 664, 671 (Conn. App. Ct. 2014) ("[W]e cannot conclude that the term 'suit' or phrase 'other dispute resolution proceeding' was meant to encompass the mere negotiations that took place in this case. . . . [T]o construe 'suit' to include mere negotiations following a demand, would obliterate the distinction between 'suit' and 'claim.' This construction must be rejected."); Ill. Tool Works, Inc. v. Ace Am. Ins. Co., 142 N.E.3d 227, 233 (Ill. App. Ct. 2019) (explaining that the mediation was neither a "suit" nor a continuation of another lawsuit).

24. *See, e.g.*, Hurricane Elec., 2020 WL 6743926, at *4 (stating that a cease and desist letter was not a "suit" and was at most a "claim," so it did not trigger the insurer's duty to defend).

25. *See, e.g.*, USA Gymnastics v. Ace Am. Ins. Co. (*In re* USA Gymnastics), 624 B.R. 443, 451–53 (Bankr. S.D. Ind. 2021) (explaining why a bankruptcy case is not a "suit" under a CGL policy).

26. *See, e.g.*, DeWitt Constr. Inc. v. Charter Oak Fire Ins. Co., 307 F.3d 1127, 1137 (9th Cir. 2002) (stating that the insurer's duty to defend was triggered by the filing of the arbitration demand); Century Sur. Co. v. S & R Dev., Inc., 483 F. Supp.

the parties introduce evidence for the arbitrators to consider. Parties seek monetary damages in arbitrations. In short, when evaluating the duty to defend, there is no principled basis to distinguish an arbitration proceeding in which the insured is aligned as a defendant and a lawsuit against the insured. Indeed, insurers regularly defend their insureds in arbitrations without questioning the forum's or process's effect on their duty to defend.

Under a standard CGL policy, the insurer's definition of "suit" generally compels it to defend the insured in arbitration.[27] If the insured is not required to submit to arbitration, the insured must obtain the insurer's consent to arbitration.[28] An insurer may waive an insured's failure to obtain consent to arbitration as a defense to coverage just as it may waive other coverage defenses based on an insured's noncompliance with policy terms.[29]

B. ENVIRONMENTAL ENFORCEMENT PROCEEDINGS

1. Introduction

An insurer's duty to defend under a CGL policy has often been litigated in relation to enforcement actions under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA). Briefly, CERCLA establishes financial responsibility for cleaning up hazardous waste sites. The U.S. Environmental Protection Agency (EPA) is authorized to clean up hazardous waste sites. To enable EPA to fulfill this responsibility, CERCLA created the Hazardous Substances Trust Fund, better known as "Superfund," to pay for remediation efforts. CERCLA empowers EPA to recover "all costs of removal or remedial action" it incurs in remediating a Superfund site from potentially responsible parties, or PRPs.[30] Ominously, CERCLA imposes strict liability for response costs.[31] In addition to cleanup costs, PRPs may be strictly liable for damages for injury to, destruction of, or

3d 400, 405 (S.D. Miss. 2020) (treating the arbitration demand and supplemental arbitration demand as the "operative complaint" in determining the insurer's duty to defend); Wm. C. Vick Constr. Co. v. Pa. Nat'l Mut. Cas. Ins. Co., 52 F. Supp. 2d 569, 578–79 (E.D.N.C. 1999) (using the "comparison test" used to determine an insurer's duty to defend a lawsuit in connection with an arbitration proceeding).

27. *See* ISO CGL Policy, *supra* note 2, at 16.

28. *Id.*

29. *See* Auto-Owners Ins. Co. v. High Country Coatings, Inc., 388 F. Supp. 3d 1328, 1334–35 (D. Colo. 2019) (applying Colorado law).

30. 42 U.S.C. § 9607(a)(4)(A) (2018).

31. *Id.*

loss of natural resources resulting from the release of hazardous substances.[32] Beyond CERCLA, some states have adopted their own statutory regimes for remediating hazardous waste sites.

2. PRP Letters and Related Administrative Proceedings as "Suits"

An insured often learns of its potential Superfund liability through a general "Notice of Liability" letter from EPA, commonly described as a "PRP letter." A PRP letter informs the recipient that it has been identified as a PRP at a Superfund site and that it may be liable for cleanup costs at the site. The letter further explains the process for negotiating a related settlement with EPA. The letter also includes information on the Superfund program and the specific site and may request information from the insured.

The issue then becomes whether the PRP letter (or a similar notice from a state agency) qualifies as a "suit" within the meaning of the party's CGL policy for purposes of the insurer's duty to defend. More particularly, must the insurer defend the insured in the administrative proceedings that follow the PRP letter? The great majority of courts that have considered the issue have held that a PRP letter is the first step in an adversarial administrative process that is functionally equivalent to a lawsuit, and that EPA's threatened use of legal process to coerce conduct or payment by the insured is sufficient to trigger the duty to defend.[33] The same result generally follows where a state

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32. *Id.* at § 9607(a)(4)(C).

33. *See, e.g.*, Ash Grove Cement Co. v. Liberty Mut. Ins. Co., 649 F. App'x 585, 587–88 (9th Cir. 2016) (stating that a PRP letter is a coercive information demand that is an attempt to gain an end through legal process and is thus a "suit" under Oregon law (quoting Anderson Bros., Inc. v. St. Paul Fire & Marine Ins. Co., 729 F.3d 923, 932–33, 935 (9th Cir. 2013))); Land O' Lakes, Inc. v. Emps. Ins. of Wausau, 728 F.3d 822, 827–29 (8th Cir. 2013) (interpreting Minnesota and Oklahoma law); Century Indem. Co. v. Marine Grp., LLC, 648 F. Supp. 2d 1238, 1255–56 (D. Or. 2012) ("Here, administrative communications, including the 104(e) letter and notifications of PRP status, provided clear notice of the need to affirmatively defend allegations of liability for environmental contamination and were sufficient to trigger Defendants' duty to defend. Accordingly, the court finds that, at least as early as the 104(e) notices, the agency actions and communications gave rise to a 'suit' as a matter of law."); Travelers Cas. & Sur. Co. v. Ala. Gas Corp., 117 So. 3d 695, 708 (Ala. 2012) ("The authority given the EPA in regard to determining liability on the part of PRPs, while not absolute, is very nearly so. Given the severe penalties for failure to cooperate and other enforcement tools available to the EPA, a decision by the EPA to designate an insured as a PRP cannot on any practical level be understood as anything less that the initiation of a 'legal action' constituting a 'suit'. . . ."); Compass Ins. Co. v. City of Littleton, 984 P.2d 606, 622 (Colo. 1999) ("We find that the term 'suit' is ambiguous, and we hold that an EPA action under CERCLA is sufficiently

agency, rather than EPA, notifies an insured of its potential environmental liability.[34]

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coercive to constitute a 'suit' as that term is used in the insurance policies."); R.T. Vanderbilt Co. v. Cont'l Cas. Co., 870 A.2d 1048, 1060 (Conn. 2005) (citation omitted) (concluding that "because a PRP letter is an 'attempt to recover a right or claim through legal action' . . . under CERCLA's statutory scheme, it constitutes a suit within the meaning of a [CGL] insurance policy"); A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am., 475 N.W.2d 607, 628–29 (Iowa 1991) (concluding that the EPA administrative process gave rise to a duty to defend and stating that a "suit" includes "any attempt to gain an end by legal process"); Hartford Accident & Indem. Co. v. Dana Corp., 690 N.E.2d 285, 296–97 (Ind. Ct. App. 1997) ("[W]e hold that § 104 requests coupled with a specific allegation of liability, § 106 orders, § 107 demands, and § 122(e) offers, as well as analogous proceedings by state and local agencies, are 'suits,'. . . . Less coercive actions, however, do not rise to the level of 'suit.' These would include mere notification or investigation when no enforcement action is contemplated."); Aetna Cas. & Sur. Co. v. Commonwealth, 179 S.W.3d 830, 837–38 (Ky. 2005) (refusing to let the insurance company "cling[] to an archaic definition of 'suit'"); Hazen Paper Co. v. U.S. Fid. & Guar. Co., 555 N.E.2d 576, 580 (Mass. 1990) ("We conclude that the litigation defense protection that Hazen purchased from USF&G would be substantially compromised if USF&G had no obligation to defend Hazen's interests in response to the EPA letter."); Dutton-Lainson Co. v. Cont'l Cas. Co., 778 N.W.2d 433, 449 (Neb. 2010) ("The term 'suit' can be readily understood to apply to actions that are the functional equivalent of a suit filed in a court of law. The PRP letter advised Dutton that it was immediately at risk. If Dutton declined the necessary response, its substantive rights and ultimate liability were affected from the receipt of the PRP letter. . . . [A]n ordinary person would believe that the receipt of a PRP letter was in effect the commencement of a suit. . . ."") (citations omitted); Coakley v. Me. Bonding & Cas. Co., 618 A.2d 777, 786–87 (N.H. 1992) ("While it is true that the PRP notice does not purport to establish the Coakleys' liability . . . , CERCLA liability is strict. . . . The predominant question . . . is not whether a PRP is liable, but rather *for how much*. . . . One would not expect a traditional tort defendant to concede the 'damages' portion of a case, and it likewise would be myopic to conclude that the Coakleys' rights are not substantially determined by the administrative process described in the PRP notice. . . . We therefore find that the EPA's action fits the . . . definition of [a] 'suit'. . . .") (citations omitted); McGinnes Indus. Maint. Corp. v. Phoenix Ins. Co., 477 S.W.3d 786, 787 (Tex. 2015) (agreeing with most courts that Superfund cleanup proceedings are a "suit"); Johnson Controls, Inc. v. Emps. Ins. of Wausau, 665 A.2d 257, 285 (Wis. 2003) (concluding an insurer has a duty to defend an insured who receives a PRP letter seeking remediation or remediation costs).

34. *See, e.g.*, Pac. Hide & Fur Depot v. Great Am. Ins. Co., 23 F. Supp. 3d 1208, 1213–18 (D. Mont. 2014) (finding a duty to defend under Montana's analog to CERCLA); Nucor Corp. v. Emps. Ins. of Wausau, 296 P.3d 74, 83 (Ariz. Ct. App. 2012) (concluding that a letter from the Arizona Department of Environmental Quality triggered the insurer's duty to defend); SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305, 315 (Minn. 1995) (concluding that a "Request for Information" from the Minnesota Pollution Control Agency qualified as a "suit" for purposes of the duty to defend), *overruled on other grounds by* Bahr v. Boise Cascade Corp., 766 N.W.2d 910, 919 (Minn. 2009); C.D. Spangler Constr. Co. v. Indus. Crankshaft & Eng'g Co.,

McGinnes Industrial Maintenance Corp. v. Phoenix Insurance Co.[35] reflects the majority rule. In the 1960s, McGinnes Industrial Maintenance Corp. (McGinnes) dumped paper mill waste into disposal pits in Pasadena, Texas. In 2005, the EPA began investigating environmental contamination at the site. In November 2007, EPA sent a PRP letter to McGinnes's parent company and invited it to enter into negotiations over cleaning up the site and reimbursing EPA's costs. In December 2008, EPA sent a similar letter to McGinnes. The PRP letter to McGinnes contained burdensome requests for information regarding McGinnes's role at the site. The letter also noted that a failure to respond could result in daily penalties of up to $32,500.[36]

In July 2009, EPA sent McGinnes a special notice letter in which it announced that it had determined that McGinnes was responsible for cleaning up the site and demanded that McGinnes pay nearly $379,000 in costs.[37] The letter further required McGinnes to make a good faith settlement offer within 60 days. When McGinnes did not comply, EPA issued an administrative order directing McGinnes to conduct a remedial investigation and feasibility study. The letter warned McGinnes that its willful failure to do so would subject it to daily civil penalties of $37,500, as well as punitive damages.[38]

In May 2008, McGinnes asked its CGL insurers from the 1960s, Phoenix Insurance and Travelers Indemnity, to defend it in the EPA proceedings. The insurers refused on the basis that there was no "suit" under their policies.[39] McGinnes then sued them in a Texas federal court. The district court awarded the insurers partial summary judgment, holding that they had no duty to defend McGinnes, but certified its order for interlocutory appeal. On appeal, the U.S. Court of Appeals for the Fifth Circuit certified the following question to the Texas Supreme Court: "Whether the EPA's PRP letters and/or unilateral administrative order, issued pursuant to CERCLA, constitute

388 S.E.2d 557, 570 (N.C. 1990) ("Because this Court must give effect to reasonable interpretations which favor the policyholder, we conclude that the term 'suit' as used in the policies covers the [state] compliance orders.") (citations omitted); Certain Underwriters at Lloyd's London v. Mass. Bonding & Ins. Co., 230 P.3d 103, 120–21 (Or. Ct. App. 2010) (involving a letter from the Oregon Department of Environmental Quality about cleaning up a site); Pa. Mfrs.' Ass'n Ins. Co. v. Johnson Matthey, Inc., 243 A.3d 298, 310 (Pa. Commw. Ct. 2020) (concluding that a PRP letter issued by the Pennsylvania Department of Environmental Protection triggered the insurer's duty to defend); State v. CNA Ins. Cos., 779 A.2d 662, 667 (Vt. 2001) (stating that because of the "coercive adversarial nature" of a state agency's requests for information, the following administrative proceedings were a "suit").

35. 477 S.W.3d 786 (Tex. 2015).

36. *Id.* at 790.

37. *Id.*

38. *Id.*

39. *Id.*

a 'suit' within the meaning of the CGL policies, triggering the duty to defend."[40]

The Texas Supreme Court agreed with the insurers that the term "suit" generally refers to a court proceeding.[41] But the court further reasoned that "suit" as used in a CGL policy must include CERCLA enforcement proceedings:

> When the policies at issue were written, the main avenue of redress for pollution was by suing in court on common law or statutory claims. One effect of CERCLA was to authorize the EPA to conduct on its own what otherwise would have amounted to pretrial proceedings, but without having to initiate a court action until the end of the process. The PRP notice letters serve as pleadings. The EPA obtains discovery through requests for information, indistinguishable from interrogatories under the rules of civil procedure. It engages in mediation through its invitations to settle. A unilateral administrative order resembles summary judgment. The fines and penalties for willful non-cooperation in the process are like sanctions in a court proceeding, only prescribed by statute. And part of the judicial function is ceded to the EPA by limiting a PRP's opportunity for review until the end of the process, and then limiting that review to an abuse of discretion by the EPA, based on its own record.
>
> McGinnes argues that EPA proceedings are the functional equivalent of a suit, but in actuality, they are the suit itself, only conducted outside a courtroom. Had the EPA wanted to force McGinnes to clean up the Site before 1980, it would have been required to sue first, and the CGL policies would have obligated the Insurers to defend . . . all without fear of being sanctioned at the very end for not having cooperated with the opponent. CERCLA effectively redefined a "suit" on cleanup claims to mean proceedings conducted by one of the parties, the EPA, followed by an enforcement action in court, if necessary. McGinnes's rights under its policies should not be emasculated by the enactment of a statute intended not to affect insurance, but to streamline the EPA's ability to clean up pollution.[42]

40. *Id.* (footnote omitted).

41. *Id.* at 791.

42. *Id.* (footnote omitted).

The insurers argued that to hold that their duty to defend applied to EPA enforcement proceedings would extend their duty to every demand letter.[43] The court disagreed. According to the *McGinnes* court, a demand letter foreshadowing a lawsuit is nothing like a PRP letter or unilateral administrative order, which mandate compliance.[44] The court also rejected the insurers' argument that a PRP letter or unilateral administrative order is merely a claim rather than a suit because EPA's demands and directives, which are backed by threatened penalties, resemble interlocutory rulings more than they do claims.[45] The insurers' contention that EPA proceedings are really pre-suit settlement mechanisms rather than suits failed because before CERCLA was enacted, EPA's only course lay in judicial proceedings.[46]

Retreating, the insurers contended that if the term "suit" encompassed CERCLA proceedings, it necessarily subsumed all administrative proceedings.[47] The court again disagreed. In comparison to most administrative actions, "EPA enforcement proceedings are unusual: not only are they like judicial proceedings, they were judicial proceedings before CERCLA was enacted."[48]

Finally, the *McGinnes* court observed that 13 of the 16 state supreme courts that had considered the insurers' urged interpretation of "suit" in this context had rejected it.[49] Stressing the importance of uniformity when identical insurance policy terms will be interpreted in various jurisdictions, the court concluded that Texas insureds should not be deprived of the coverage enjoyed by insureds in 13 other states.[50] The court therefore answered the Fifth Circuit's certified question "yes."[51]

In contrast, a handful of courts have concluded that a PRP letter and state analogs do not introduce a "suit" and, consequently, do not implicate an

43. *Id.* at 792.
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.* at 793.
50. *Id.* at 794.
51. *Id.*

insurer's duty to defend.[52] *Professional Rental, Inc. v. Shelby Insurance Co.*[53] is instructive. There, an Ohio court reasoned that it was necessary to elevate substance over form in deciding whether Professional Rental, Inc. (Professional) was subjected to a "suit" or its functional equivalent.[54] The court concluded that the term "suit" includes "substantial efforts which force the insured to take action or suffer serious consequences if the insured fails to cooperate."[55] With that in mind, the court determined that the PRP letters Professional received from EPA did not constitute a "suit" for purposes of a liability insurance policy.

> If the PRP chooses not to respond to the initial PRP letter, the EPA will take one of several steps: (1) seek an injunction in district court forcing the PRP to act; (2) issue a Section 104(e) or 106(a) administrative order either demanding information or forcing PRP cleanup; or (3) send additional notice letters, known colloquially as "drop dead" letters, informing the PRP's that they must follow the EPA's suggested cleanup "voluntarily"—otherwise, the government will expurgate the pollution itself, and thereafter demand reimbursement through a CERCLA Section 107 cost recovery action.
>
> The EPA's strategy is confrontational, and seemingly coercive, as identified PRPs must either abide by what the EPA desires or the agency may clean up the pollution itself, typically at a higher cost. By sending a PRP notification, "the agency in effect has issued an ultimatum of 'settle on the government's terms or litigate and lose.'"

52. *See, e.g.*, Liberty Mut. Ins. Co. v. FAG Bearings Corp., 335 F.3d 752, 765–66 (8th Cir. 2003) (applying Missouri law); Foster-Gardner, Inc. v. Nat'l Union Fire Ins. Co., 959 P.2d 265, 279 (Cal. 1998) ("The insurers assert that the word 'suit' . . . means a civil action commenced by filing a complaint. Anything short of this is a 'claim.' . . . We agree with the insurers."); Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co., 655 N.E.2d 842, 848 (Ill. 1996) ("Neither the initial letter from the EPA, the draft consent order nor the 'no-action" letter initiated a suit. None was filed in a court of law and none accomplished service of process. . . . Rather, the draft consent order and ultimately the 'no-action' letter were mechanisms used to encourage Lapham-Hickey to voluntarily investigate the contamination at the facility. Though the tone . . . may have been confrontational, these documents . . . are not complaints and do not impose liability."); Patrons Oxford Mut. Ins. Co. v, Marois, 573 A.2d 16, 20 (Me. 1990) (finding that a state administrative proceeding was not a "suit" seeking damages).

53. 599 N.E.2d 423 (Ohio Ct. App. 1991).

54. *Id.* at 427–28.

55. *Id.* at 428.

> Nevertheless, receiving a PRP notification, by itself, does not impose liability. Moreover, failing to respond to a PRP notification does not, *by itself*, authorize the EPA to assess fines or provide a basis for punitive damages. Rather, it is necessary for the EPA to do "something more" in order to *force or compel* the insured to take action or suffer serious consequences. The "something more" is present when the EPA issues an *administrative order*, pursuant to CERCLA Sections 106(a) or 104(e), making the PRP susceptible to stiff fines or punitive damages for failure to abide by the terms of the order. Moreover, the same degree of compulsion is present when the EPA seeks an injunctive order in federal district court under CERCLA Section 106(a), or institutes a cost recovery action under CERCLA Section 107.[56]

The *Professional Rental* court calculated that despite EPA's confrontational posture, Professional was not faced with the functional equivalent of a lawsuit.[57] The PRP letters were in essence "claims" of liability and demands for restitution, coupled with threats of unilateral action if Professional failed to join in remedial action. EPA's threats, demands, and warnings did not force Professional to settle or suffer severe financial repercussions.[58]

The court acknowledged that because CERCLA liability is strict, a party's receipt of a PRP letter may be perceived as an apocalyptic event; however, the severity of the claim does not transform a PRP letter into a "suit."[59] When EPA enforces CERCLA's strict liability against the insured, however, the situation changes. EPA has then signaled "that the *force* of its powers under CERCLA" is being asserted in a fashion that "threatens the insured with probable and imminent financial consequences."[60] The *Professional Rental* court accordingly held that a "suit" is initiated for purposes of an insurer's duty to defend when EPA "issues an administrative order which the PRP is legally obligated to obey, or otherwise attempts to enforce liability through an injunctive action or cost recovery action filed in a court of law."[61]

Given CERCLA's peculiar regulatory scheme and the liabilities the statute creates for PRPs, courts that recognize a duty to defend upon an insured's receipt of a PRP letter have a solid rationale for reaching that result,

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56. *Id.* at 429–30 (footnotes omitted).
57. *Id.* at 430.
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*

but a notice of potential liability is still not a suit. The *Professional Rental* court's approach to the duty to defend is a logical compromise.

C. RIGHT TO REPAIR STATUTES

1. Background

Some states have enacted "right to repair" statutes that come into play in construction defect cases.[62] These statutes typically require a claimant to notify a contractor of alleged deficiencies and satisfy specified procedural requirements before suing the contractor. The contractor is afforded the opportunity to respond to the notice and repair the defect or settle the claim. A failure to respond to a notice may have various consequences for the contractor.

2. Approaches to the Duty to Defend under Right to Repair Statutes

In some states, the effect of a claimant's notice of defect for duty to defend purposes prescribed.[63] In California, for example, a homeowner's notice to a builder has "the same force and effect as a notice of commencement of a legal proceeding."[64] In Nevada, if a contractor, subcontractor, supplier, or design professional receives written notice of a construction defect, it may present the claim to its liability insurer, which "(a) [m]ust treat the claim as if a civil action has been brought against the [insured]; and (b) [m]ust provide coverage to the extent available under [its] policy . . . as if a civil action has been brought against the contractor, subcontractor, supplier or design professional."[65]

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62. *See, e.g.*, ALASKA STAT. §§ 09.45.881–09.45.899 (2025) ("Action for Dwelling Design, Construction, or Remodeling Claims"); ARIZ. REV. STAT. §§ 12-1361–1366 (2025) ("Purchaser Dwelling Actions"); CAL. CIV. CODE §§ 895–945.5 (2025) ("Requirements for Actions for Construction Defects"); COLO. REV. STAT. §§ 13-20-801–808 (2025) ("Construction Defect Action Reform Act"); FLA. STAT. §§ 558.001–558.005 (2025) ("Construction Defects"); NEV. REV. STAT. §§ 40.600–40.695 (2025) ("Actions Resulting from Construction Defect"); TEX. PROP. CODE ANN. §§ 27.001–27.007 (2025) ("Residential Construction Liability").

63. *See, e.g.*, COLO. REV. STAT. § 13-20-808(7)(a) (2025) ("An insurer's duty to defend a construction professional or other insured under a liability insurance policy issued to a construction professional shall be triggered by a potentially covered liability described in: (I) A notice of claim made pursuant to section 13-20-803.5. . . .").

64. CAL. CIV. CODE § 910(a) (2025).

65. NEV. REV. STAT. § 40.649 (2025).

In other states, whether a statutory notice triggers the duty to defend is a question for the courts. If there is any judicial consensus on this issue, it is that right to repair notices are not lawsuits but may qualify as "suits" under some policies on the basis that they are alternative dispute resolution proceedings.[66] *Altman Contractors, Inc. v. Crum & Forster Specialty Insurance Co.*[67] and *Cincinnati Insurance Co. v. AMSCO Windows*[68] exemplify courts' reasoning.

In *Altman*, Altman Contractors, Inc. (Altman) was the general contractor for the construction of the high-rise Sapphire Condominium (Sapphire) on Florida's east coast. Altman was insured under several consecutive CGL policies issued by Crum & Forster Specialty Insurance Co. (C & F). In 2012, Sapphire served Altman with several chapter 558 notices of claim, which cumulatively asserted hundreds of construction defects.[69] In early 2013, Altman notified C & F of Sapphire's claims and demanded that C & F defend and indemnify it. C & F denied that Sapphire's notices of claim invoked its duty to defend because they were not a "suit."[70] Altman ultimately settled Sapphire's claims on its own.

Altman Sued C & F in a Florida federal court seeking a declaration that C & F owed a duty to defend and indemnify it against Sapphire's construction defect claims. Altman lost at summary judgment. Altman then appealed to the U.S. Court of Appeals for the Eleventh Circuit, which certified the following question to the Florida Supreme Court: "Is the notice and repair process set forth in Chapter 558, Florida Statutes, a 'suit' within the meaning of the commercial general liability policy issued by C & F to Altman?"[71] The Florida Supreme Court answered affirmatively on the basis that the chapter

66. *See, e.g.*, Hardesty Builders, Inc. v. Mid-Continent Cas. Co., No. C-10-142, 2010 WL 5146597, at *7–8 (S.D. Tex. Dec. 13, 2010) (applying Texas law); Melssen v. Auto-Owners Ins. Co., 285 P.3d 328, 334–35 (Colo. App. 2012).

67. 232 So. 3d 273 (Fla. 2017).

68. 593 F. App'x 802 (10th Cir. 2014) (applying Utah law).

69. A "558 notice" is sent to satisfy chapter 558 of the Florida statutes which concerns construction defects. *See* FLA. STAT. § 558.003 (2025) ("A claimant may not file an action subject to this chapter without first complying with the requirements of this chapter. . . ."); FLA. STAT. § 558.004(1)(a) ("In actions brought alleging a construction defect, the claimant shall, at least 60 days before filing any action . . . serve written notice of claim on the contractor, subcontractor, supplier, or design professional, as applicable. . . ."); FLA. STAT. § 558.004(1)(b) ("The notice of claim must describe in reasonable detail the nature of each alleged construction defect and, if known, the damage or loss resulting from the defect.").

70. *Altman*, 232 So. 3d, at 275.

71. *Id.* at 274.

558 pre-litigation process is an "alternative dispute resolution proceeding" under a CGL policy's definition of a "suit."[72]

The court began its analysis by outlining the Chapter 558 process that a claimant must follow before suing a contractor for an alleged construction defect:

> Specifically, a claimant must "serve written notice of claim on the contractor, subcontractor, supplier, or design professional, as applicable" before the claimant may file an action for a construction defect. . . .
>
> Upon receipt of a chapter 558 notice of claim, the recipient "must serve a written response to the claimant" within the statutorily specified time-period, providing either an offer "to remedy the alleged construction defect at no cost to the claimant," "to compromise and settle the claim by monetary payment," "to compromise and settle the claim by a combination of repairs and monetary payment," a statement disputing the claim, or a statement that any monetary payment will be determined by the recipient's insurer. . . . Once the claimant "receives a timely settlement offer," the claimant "must accept or reject the offer" in writing. . . .
>
> "[T]he claimant may, without further notice, proceed with an action" against the recipient if the parties either agree to "a partial settlement or compromise of the claim," the recipient "disputes the claim and will neither remedy the defect nor compromise and settle the claim," or the claimant does not receive a response "within the time provided." . . . If the offeror satisfies the parties' agreement within a reasonable period of time, "the claimant is barred from proceeding with an action for the claim described in the notice of claim or as otherwise provided in the accepted settlement offer." . . . "[A]ny offer or failure to offer . . . to remedy an alleged construction defect or to compromise and settle the claim by monetary payment does not constitute an admission of liability with respect to the defect and is not admissible" in a subsequent lawsuit. . . . "If a claimant initiates an action without first accepting or rejecting the offer, the court shall stay the action upon timely motion until the claimant complies with this subsection."[73]

72. *Id.*

73. *Id.* at 276–77 (citations to statutes and footnotes omitted).

With that background, the court next quoted the definition of "suit" in Altman's CGL policies with C & F:

> "Suit" means a civil proceeding in which damages because of "bodily injury," "property damage" or "personal and advertising injury" to which this insurance applies are alleged. "Suit" includes:
>
> a. An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent; or
>
> b. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent.[74]

The *Altman* court concluded that the chapter 558 process could not be considered a "civil proceeding" because the recipient's participation in the chapter 558 settlement process is not mandatory or adjudicative.[75] The recipient of a notice of a claim may choose to not respond and thereby force the claimant to sue to recover for the alleged deficiency. Chapter 558 does not obligate the insured to participate in the process. The chapter 558 framework is merely a voluntary dispute resolution process despite its mandate that the claimant serve the insured with a notice before suing. Moreover, the chapter 558 process does not take place in court or before an adjudicatory body, nor does it produce legally binding results. Rather, chapter 558 provides a structure for parties to resolve a claim through a negotiated settlement or voluntary repairs short of litigation. The court thus concluded that the chapter 558 process is not a "civil proceeding" within the policy definition of "suit."[76]

The determination that the chapter 558 process did not constitute a "suit" did not end the inquiry, however, because the C & F policies defined "suit" to include "'[a]ny other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with [C&F's] consent.'"[77] The court interpreted "alternative dispute resolution" to mean "'[a] procedure for settling a dispute by means other than litigation.'"[78] The court reasoned that chapter 558 fell within this definition as a statutorily required pre-suit process intended to encourage the claimant and insured to settle short of litigation. Indeed, the Florida legislature had explicitly described chapter 558 as "'[a]n effective alternative dispute resolution

74. *Id.* at 277 (quoting the C & F policies).

75. *Id.* (quoting FLA. STAT. § 558.004(5)–(6) (2012)).

76. *Id.* at 278.

77. *Id.* (quoting the C & F policies).

78. *Id.* (quoting *Alternative Dispute Resolution*, BLACK'S LAW DICTIONARY 91 (9th ed. 2009)).

mechanism,' intended to be beneficial for reducing construction defect litigation."[79] The court therefore concluded that the chapter 558 process was an alternative dispute resolution proceeding under the policies, just as mediation would be.[80]

The policies' definition of "suit" also required that covered damages be claimed in the alternative dispute resolution proceeding for C & F to owe a duty to defend. This requirement was easily satisfied because chapter 558 explicitly allows claimants to seek damages and provides for "monetary payment" as a means of resolving a claim.[81]

Finally, the *Altman* court noted that the policies required C & F's consent to Altman's submission to an alternative dispute resolution proceeding to trigger C & F's duty to defend. There was no need for the court to address whether C & F consented to Altman's participation in the chapter 558 process, however, because it was beyond the scope of the certified question and because it was a disputed issue of fact in the case.[82]

In *Cincinnati Insurance Co. v. AMSCO Windows*,[83] the insured, AMSCO Windows (AMSCO), manufactured windows. One of its dealers, J & L, sold its windows for installation in homes in Nevada. Some Nevada homeowners sued the contractors who built their homes and alleged that defective windows and their improper installation damaged their homes. The contractors then sued J & L and others, who, in turn, asserted claims against AMSCO.

Some of the homeowners' claims arose under "Chapter 40," a Nevada statute that governs residential construction defect claims.[84] Under Chapter 40, before suing over construction defects, a claimant must provide written notice to the contractor, stating in detail the alleged defects and the nature and extent of the resulting damage. The claimant must then give the contractor a reasonable opportunity to inspect the home and repair any damage. The contractor must forward the claimant's notice to each supplier or subcontractor that the contractor reasonably believes is responsible for a given defect. At the conclusion of this process, any unresolved claims may be litigated in a Nevada state court.

AMSCO tendered its defense of the Nevada homeowners' claims to its CGL insurer, Cincinnati Insurance Co. (Cincinnati), which refused to

79. *Id.* (quoting FLA. STAT. § 558.001 (2012)) (internal quotation marks omitted).

80. *Id.*

81. *Id.*

82. *Id.*

83. 593 F. App'x 802 (10th Cir. 2014).

84. *Id.* at 804.

defend AMSCO. Instead, Cincinnati filed a declaratory judgment action in a Utah federal court seeking a determination that it had no duty to defend or indemnify AMSCO against the Nevada homeowners' claims under Utah law, which governed the interpretation of its policies.[85] Applying Utah law, the district court ruled that Cincinnati had no duty to defend AMSCO in any Chapter 40 proceedings because they were not "suits." AMSCO appealed the district court's decision to the Tenth Circuit.

The *AMSCO Windows* court began its analysis by observing that Cincinnati's duty to defend extended only to "suits," which the policy defined as "civil proceedings," including certain arbitrations and alternative dispute resolution proceedings.[86] AMSCO argued that "civil proceedings" encompassed the Chapter 40 process because Chapter 40 proceedings (1) are not "criminal," so they must be "civil"; (2) relate to private rights and remedies; (3) involve formal statutory requirements; and (4) involve special masters, mediators, and potentially judges.[87] The Tenth Circuit, however, pointed out that AMSCO had overlooked the key difference between civil proceedings and the Chapter 40 process: while Chapter 40 ostensibly mandates participation by contractors, subcontractors, and suppliers, their failure to join in does not result in any adverse judgment or obligation; rather, it imposes limited consequences in any later litigation.[88] As the court further explained:

> Chapter 40 uses language traditionally interpreted as mandatory—specifically, the terms "must" and "shall"—to require contractors or suppliers to take certain actions in response to homeowner construction defect claims. . . .
>
> However, parties who fail to comply with Chapter 40 face only limited consequences when a claimant's action eventually proceeds to state court. For example, under § 40.650, if a contractor or supplier fails to send a written response to a claimant—responding to each alleged construction defect and stating whether he has elected to repair the defect, offer monetary compensation, or disclaim liability for the defect—then Chapter 40's limitations on damages and defenses to liability in subsequent lawsuits are nullified. *Id.* § 40.650. If a contractor or supplier fails to appear in mediation or refuses to mediate in "good faith," the mediator may choose to issue

85. *Id.* at 805. Cincinnati insured AMSCO for a five-year period through a series of one-year renewable CGL policies, *id.* at 804.

86. *Id.* at 809.

87. *Id.*

88. *Id.*

> a report that is admissible in subsequent litigation. *Id.* § 40.680(8).
>
> These results, although serious, are not parallel to the often case-determinative consequences of noncompliance in the context of lawsuits or mandatory arbitrations. Indeed, there are instances when a cost-benefit analysis would lead a contractor to "opt[ ] not to exercise its opportunity to repair" and encourage the claimant to commence litigation.[89]

AMSCO also argued that Cincinnati's provision of coverage in Nevada required it to comply with Nevada law, including a Chapter 40 section stating that an insurer must treat a Chapter 40 claim like a civil action.[90] The district court had rejected this argument on the basis that the parties' agreement that Utah law governed the construction of the Cincinnati policies neutered "Nevada's attempt to dictate the meaning of insurance policy language 'by legislative fiat.'"[91] The *AMSCO Windows* court agreed with the district court.[92] Utah law governed the interpretation of the policies. A rule of construction imposed by a Nevada statute did not bind the court even though that rule related to the disputed policy provision.[93] Nor did the Nevada legislature's policy decisions about how to encourage compliance with its pre-litigation procedures apply in Utah. This was especially true given other courts' conclusions that similar proceedings were not "suits" as defined in standard CGL policies.[94]

Finally, even if the court were to conclude that the Chapter 40 process was a "civil proceeding," it would be an "alternative dispute resolution proceeding" as defined in the Cincinnati policies.[95] That determination would not benefit AMSCO, however, because the policies obligated Cincinnati to defend AMSCO in such proceedings only if Cincinnati had consented to AMSCO's participation, which was not the situation here.[96]

In the end, the *AMSCO Windows* court affirmed the district court. The court declined AMSCO's request to certify the issues raised in the appeal to the Utah Supreme Court.

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89. *Id.* at 809–10 (footnote omitted).

90. *Id.* at 810.

91. *Id.* (quoting the district court).

92. *Id.*

93. *Id.*

94. *Id.* (citing Hardesty Builders, Inc. v. Mid-Continent Cas. Co., No. C-10-142, 2010 WL 5146597, at *7–9 (S.D. Tex. Dec. 13, 2010)).

95. *Id.* at 811.

96. *Id.*

3. Summary

Evaluating an insurer's duty to defend in connection with a notice sent under a right to repair statute starts with the statutory language. In *AMSCO Windows*, for example, the result would have been quite different had Nevada law rather than Utah law controlled the dispute. Absent contrary statutory language, however, a notice under a right to repair statute is not analogous to a lawsuit because such notices are not coercive like a complaint or petition, nor is the related procedure as consequential as litigation.

If the right to repair process can be said to fall within the CGL definition of a "suit," it can only be as an "alternative dispute resolution proceeding" in which the claimant seeks damages because of "property damage." In that instance, the insurer still must consent to the insured's participation in the process for there to be a duty to defend. Whether an insured should participate in the process, whether the insured should seek the insurer's consent to its participation to obtain a defense, and whether the insurer should consent to the insured's participation and furnish a defense, are case- and fact-specific inquiries.

D. Other Administrative Actions or Proceedings

Insureds may be named as respondents or defendants in a wide range of administrative proceedings. Whether an insurer must defend its insured in any administrative proceeding requires case-by-case analysis. Courts frequently hold that an insurer owes no duty to defend based on a straightforward reading of policy language.[97]

In *Maine State Academy of Hair Design, Inc. v. Commercial Union Insurance Co.*,[98] Amber Martin complained that she was sexually harassed and discriminated against while employed by the Maine State Academy of Hair Design (the Academy) and was fired when she told a supervisor that she

97. *See, e.g.*, Dupuis v. Utica Mut. Ins. Co., No. 250766, 2006 WL 1084336, at *5–6 (Mich. Ct. App. Apr. 25, 2006) (concluding that a license revocation proceeding before the insurance commissioner was neither a "suit" nor a "claim," and the proceeding sought a penalty rather than damages); Campbell Soup Co. v. Liberty Mut. Ins. Co., 571 A.2d 1013, 1021 (N.J. Super. Ct. Ch. Div. 1988) ("Campbell Soup Co. . . . is in the conciliation phase of the EEOC process. No suit has been instituted against it by the EEOC. No adjudicatory proceeding has been held. . . . Campbell need not participate in that process if it does not voluntarily agree to so do. It is only after a suit is brought in the federal district court by the EEOC, or the aggrieved employee or prospective employee, that an adjudicatory process commences. It is then, for the first time, that the obligation of the insurer to defend should properly be raised."), *aff'd*, 571 A.2d 969 (N.J. Super. Ct. App. Div. 1990).

98. 699 A.2d 1153 (Me. 1997).

was contemplating a lawsuit over her unlawful treatment. She later filed a complaint with the Maine Human Rights Commission (MHRC). The Academy was insured under a CGL policy issued by Commercial Union Insurance Co. (Commercial Union). The Academy asked that Commercial Union defend it in the MHRC proceeding but Commercial Union refused. The Academy consequently sued Commercial Union in state court but lost at summary judgment. The Academy then appealed to the Maine Supreme Court.

On appeal, the Academy argued that Commercial Union's duty to defend was limited only by the policy's definition of "suit."[99] The Academy further argued that Commercial Union had a duty to defend because the MHRC proceeding was a civil proceeding in which damages were alleged.[100] The Academy was twice wrong.

First, the Commercial Union policy—like any standard CGL policy—clearly stated that the insurer's duty to defend was limited to suits seeking damages covered by the policy, and not just any "suit" included within the policy definition.[101] An MHRC proceeding does not lead to a damage award; rather, the claimant may seek damages only in a subsequent action in a state trial court.[102] Second, an MHRC proceeding is not a prerequisite to a lawsuit based on the same conduct. Instead, filing an MHRC complaint is merely a prerequisite to obtaining attorney fees and civil penal damages in a subsequent lawsuit.[103] Commercial Union thus had no duty to defend the Academy in Martin's MHRC proceeding.[104]

Broughton v. Ohio Casualty Insurance Co.[105] arose out of a dispute before the Trademark Trial and Appeal Board (TTAB). A furniture company, Fyrn, and its chief product designer, Roskear Broughton, asserted that Fyrn's CGL insurer, Ohio Casualty, wrongfully refused to defend Broughton in a TTAB proceeding brought by a competing furniture company, FSL, to cancel Broughton's registration of the FYRN trademark. A key issue was whether Ohio Casualty owed a defense under Coverage B in its policy, which provided that it would "pay those sums that the insured becomes legally obligated to pay as damages because of 'personal and advertising injury' to which this insurance applies" and stated that it would "have the right and duty to defend the insured against any 'suit seeking those damages.'"[106]

99. *Id.* at 1159.
100. *Id.*
101. *Id.* at 1160.
102. *Id.*
103. *Id.*
104. *Id.*
105. 533 F. Supp. 3d 838 (N.D. Cal. 2021).
106. *Id.* at 841–42 (quoting the Ohio Casualty policy).

In alleging that Ohio Casualty breached its duty to defend, Fyrn and Broughton focused on the policy's definition of "suit," which meant "a 'civil proceeding in which damages because of bodily injury, property damage, or personal and advertising injury to which this insurance applies are alleged.'"[107] They maintained that this language required only that damages be alleged in the underlying "suit," and that the TTAB proceeding satisfied this definition because FSL claimed that it was damaged by the FYRN trademark.[108] Fyrn and Broughton also contended that any ambiguity regarding whether Coverage B required that damages must be sought or merely alleged should be resolved in their favor.[109] The *Broughton* court flatly rejected their arguments.

The *Broughton* court succinctly explained that the Ohio Casualty policy clearly and explicitly required a "suit" seeking "those damages," meaning damages because of personal and advertising injury.[110] Although FSL claimed that it was damaged by Fyrn's trademark infringement, it did not seek damages in the TTAB proceeding, and controlling Ninth Circuit authority established that the TTAB had no power to award damages.[111] Accordingly, the TTAB proceeding was not a "suit" seeking covered damages and Ohio Casualty had no duty under Coverage B to defend Broughton or Fyrn in the TTAB proceeding.[112]

In *Ameron International Corp. v. Insurance Co. of the State of Pennsylvania*,[113] on the other hand, the California Supreme Court held that a proceeding before an administrative law judge of the former U.S. Department of Interior Board of Contract Appeals (IBCA), which involved a multi-day trial, witness testimony, the introduction of evidence, and a determination of the insured's monetary liability was "a 'suit' as a reasonable insured would understand the term."[114] As a result, the insurers had a duty to defend the insured, Ameron International Corp. (Ameron), in the IBCA proceeding.[115] The IBCA proceeding was a result of Ameron appealing a decision by a contracting officer of the Department of the Interior's Bureau of Land Reclamation (the

107. *Id.* at 845 (quoting the Ohio Casualty policy).

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.* (first quoting Rhoades v. Avon Prods., Inc., 504 F.3d 1151, 1158 (9th Cir. 2007); then quoting V.V.V. & Sons Edible Oils Ltd. v. Meenakshi Overseas, L.L.C., 946 F.3d 542, 546 (9th Cir. 2019)).

112. *Id.* at 846.

113. 242 P.3d 1020 (Cal. 2010).

114. *Id.* at 1022.

115. *Id.* at 1030. The CGL policies at issue in Ameron did not define the term "suit." *Id.* at 1022.

Bureau) that concrete siphons Ameron made were flawed and that Ameron and its indemnitee consequently owed $40 million in damages to the government.

In concluding that the IBCA proceeding was a "suit," the court compared the IBCA's complaint requirements to those found in the California Code of Civil Procedure. The court also examined Congress's intent in establishing the IBCA, and considered the structure of the IBCA proceedings themselves.

The IBCA was created under the federal Contract Disputes Act of 1978, with statutory authority to conduct trials, determine liability, and award money damages. Congress intended the IBCA to serve as a vehicle for resolving contract disputes quickly, informally, and inexpensively. Congress created concurrent jurisdiction in the U.S. Court of Claims (now the U.S. Court of Federal Claims) and the IBCA to hear appeals from federal contracting officers' decisions. Ameron thus had a choice of forums in which to appeal the decision of the Bureau's contracting officer and it selected the IBCA.[116]

IBCA procedures required a contractor appealing a Bureau contracting officer's decision "to file a complaint, 'setting forth simple, concise, and direct statements of each claim, alleging the basis with appropriate reference to contract provisions for each claim, and the dollar amount claimed.'"[117] An IBCA complaint must "'fulfill the generally recognized requirements of a complaint.'"[118] Although the contractor initiates an IBCA proceeding, the purpose of the proceeding is to resolve the claim against the contractor, who is thus cast as a defendant.[119] Moreover, the Code of Federal Regulations (C.F.R.) labels the required IBCA pleading a "complaint" and the requirements for that complaint serve the same notice purpose as California's civil complaint requirement.[120]

It was clear to the court that the IBCA pleading requirements met the standards for a complaint under the California Code of Civil Procedure.[121] The specificity required of an IBCA complaint afforded an insurer as much, if not more, notice regarding claims against an insured than did the specificity mandated by the California Code of Civil Procedure.[122] If there were any doubt whether Congress intended an IBCA complaint to serve the same purpose as a complaint in a court of law, the C.F.R. dispelled it: "'This pleading

116. *Id.* at 1028.

117. *Id.* (quoting 43 C.F.R. § 4.107(a) (2009)).

118. *Id.* (quoting 43 C.F.R. § 4.107(a) (2009)).

119. *Id.* at 1028–29.

120. *Id.* at 1029.

121. *Id.*

122. *Id.*

shall fulfill the generally recognized requirements of a complaint.'"[123] Long story short, it would exalt form over substance to find that an IBCA complaint did not qualify as a "suit" simply because the IBCA was not a court of law, especially where, as here, the insurers argued that they rely on the substantive contents of a complaint to make coverage decisions.[124]

Finally, the *Ameron* court considered Ameron's reasonable expectations in concluding that the IBCA proceeding was a "suit." To start, relevant sections of the United States Code used the term "suit" to describe the IBCA complaint process. Based on those references, the court explained, a reasonable policyholder would believe that an insurance policy providing coverage for a "suit" would cover an IBCA proceeding.[125] In addition, an IBCA proceeding affords a contractor its "day in court."[126] Ameron's IBCA hearing spanned 22 days, during which witnesses testified and evidence was introduced. The parties then mediated their dispute and reached a settlement in which Ameron agreed to pay the government $10 million. Certainly, a reasonable policyholder would recognize such proceedings as a suit and would expect to be defended and, if necessary, indemnified by its insurer.[127]

E. PRE-SUIT DEMAND LETTERS

We have discussed PRP letters and similar notices from government agencies, but those are not "demand letters" as that term is commonly understood in litigation.[128] Potential plaintiffs often send demand letters to insureds before filing suit. A demand letter usually seeks a monetary payment to

123. *Id.* (quoting 43 C.F.R. § 4.107(a) (2009)).

124. *Id.*

125. *Id.* at 1030.

126. *Id.* (internal quotation marks omitted).

127. *Id.*

128. Courts distinguish PRP letters and analogous letters from state agencies from demand letters sent in other contexts (sometimes described as "conventional," "garden variety" or "simple" demand letters), thereby clearly implying—if not outright stating—that a letter in the latter category is not a "suit." *See, e.g.*, N. Sec. Ins. Co. v. Mitec Telecom, Inc., 38 F. Supp. 2d 345, 349 (D. Vt. 1999) (distinguishing a "conventional demand letter" from a PRP letter); A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am., 475 N.W.2d 607, 628 (Iowa 1991) (stating that an EPA demand letter "is not the same as a conventional demand letter based on a personal injury claim"); Hazen Paper Co. v. U.S. Fid. & Guar. Co., 555 N.E.2d 576, 581 (Mass. 1990) ("The EPA letter was not the equivalent of a conventional demand letter based on a personal injury claim."); McGinnes Indus. Maint. Corp. v. Phoenix Ins. Co., 477 S.W.3d 786, 792 (Tex. 2015) (footnote omitted) ("[A] simple demand letter threatening or prefacing a lawsuit is nothing like a PRP letter or unilateral administrative order, which, to use the United States Supreme Court's choice of words, 'command' compliance.").

compensate the putative plaintiff for claimed harm attributable to the insured's alleged misconduct and threatens litigation if the parties cannot resolve the matter informally. Courts generally do not treat such demand letters as a "suit" that triggers an insurer's duty to defend.[129] That is the correct approach. Although an insured may need to inform its insurer that it received a demand letter to comply with the notice requirement in its policy, the insured's rights or liability generally will not be affected by a failure to respond to the demand letter. For that matter, a party's decision to ignore a demand letter that threatens litigation will not necessarily result in litigation. A demand letter is simply not sufficiently coercive or consequential to count as the functional equivalent of a lawsuit. In addition, a demand letter is neither an alternative dispute resolution proceeding in and of itself nor does it represent the initiation of one, even if it invites the insured to negotiate a settlement.

Sanders v. Phoenix Insurance Co.[130] is the leading case on demand letters in connection with the duty to defend. In *Sanders*, a lawyer described only as John Doe had a sexual relationship with a client, Nancy Andersen, who he knew suffered from severe depression and anxiety. When Doe's ardor cooled and he did not meet Andersen at her apartment as he had promised, Andersen became distraught and drank herself to death. The executor of Andersen's estate, Harry Sanders, sent Doe a demand letter pursuant to a Massachusetts statute commonly known as Chapter 93A.[131] A party who fails to

129. *See, e.g.*, Houston Cas. Co. v. Swinerton Builders, No. 20-cv-03558-NYW, 2022 WL 523434, at *13–16 (D. Colo. Feb. 22, 2022) (applying Colorado law and concluding that a demand letter is neither a "suit" nor an "alternative dispute resolution proceeding"); Nat'l Mech. Servs., Inc. v. Kinsale Ins. Co., 634 F. Supp. 3d 907, 909 (S.D. Cal. 2022) (applying California law); Crescent City Baptist Church v. Church Mut. Ins. Co., No. CIV.A. 05-2200, 2006 WL 508060, at *5 (E.D. La. Feb. 22, 2006) ("Under the unambiguous terms of the . . . policy, a demand letter is not a 'suit.' 'Suit' requires the existence of a civil proceeding, a forced or consented to arbitration, or a consented to alternative dispute resolution proceeding. A demand letter does not remotely constitute any of these. As a result, even if the . . . demand letter asserted demand for monetary relief, it still would not trigger the duty to defend . . . because it is not a 'suit.'"); Monarch Greenback, LLC v. Monticello Ins. Co., 118 F. Supp. 2d 1068, 1075 (D. Idaho 1999) ("[A] demand letter from a private corporation does not fall into the policy's definition of 'suit.' Even using the most liberal construction of a 'civil proceeding' favoring [the insured], a demand letter from a private organization does not meet the requirements of a civil proceeding. A demand letter does not qualify as a proceeding in front of a court, agency, tribunal, bureau, or someone authorized by the court to do so. . . ."); Samson v. Allstate Ins. Co., 949 F. Supp. 748, 752–53 (N.D. Cal. 1996) (explaining that a "garden variety" demand letter was not a "suit" that triggered the insurer's duty to defend); Zecco, Inc. v. Travelers, Inc., 938 F. Supp. 65, 68–69 (D. Mass. 1996) (applying Massachusetts law and explaining why the demand letter was not a "suit").

130. 843 F.3d 37 (1st Cir. 2016).

131. *Id.* at 41.

respond to a Chapter 93A demand letter or make a reasonable settlement offer in certain kinds of cases may be exposed to double or treble damages, attorney fees, and costs.[132]

Because some of his romantic interludes with Andersen occurred at his home, Doe notified his homeowner's insurer, Phoenix Insurance Co. (Phoenix), about Sanders's letter. Phoenix denied coverage. Eventually, Doe agreed that his liability to Sanders amounted to $500,000 and assigned to Sanders all his rights under his policy with Phoenix as a result of its alleged failure to defend or indemnify him.[133] Sanders then sued Phoenix in a Massachusetts state court. Phoenix removed the suit to federal court and successfully moved to dismiss the case. Sanders promptly appealed to the First Circuit.

On appeal, Sanders argued that Phoenix owed Doe a defense on the theory that a Chapter 93A letter is akin to a PRP letter because the failure to respond to a Chapter 93A letter or to make a reasonable settlement offer can expose an insured to multiple damages, attorney fees, and costs.[134] The First Circuit, however, reasoned that Chapter 93A demand letter is more like a demand letter in a personal injury case, which does not trigger an insurer's duty to defend.[135] An insured's failure to participate in the administrative process a PRP letter launches would eviscerate its case. Ignoring a Chapter 93A demand letter, on the other hand, will not substantially impair the insured's position; a failure to respond has much lesser consequences than stiff-arming EPA.[136] Notably, Doe's liability could not have been affected by the Chapter 93A letter and his exposure to statutory damages, attorney fees, and costs would only come to pass if a court found him liable for Andersen's death.[137]

In the end, the *Sanders* court equated Chapter 93A demand letters "to demand letters sent in anticipation of garden-variety personal injury litigation."[138] After addressing some other issues, the First Circuit affirmed the district court's judgment for Phoenix.

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132. MASS. GEN. LAWS ch. 93A, § 9(3)–(4) (2025).

133. Sanders also demanded a settlement from Doe's law firm. The firm agreed to pay Sanders $500,000 to settle the estate's claims against the firm. That still left Doe personally liable, however, hence his admission of liability in the amount of the Phoenix policy limits and his assignment of rights. *See Sanders*, 843 F.3d at 43.

134. *Id.* at 44.

135. *Id.* (quoting Hazen Paper Co. v. U.S. Fid. & Guar. Co., 555 N.E.2d 576, 581 (Mass. 1990)).

136. *Id.* (quoting Hazen Paper, 555 N.E.3d at 580).

137. *Id.*

138. *Id.* at 45.

Sanders is noteworthy because the court adhered to "the general rule that there is no duty to defend before the filing of a suit"[139] even though Doe's failure to respond to Sanders's Chapter 93A demand letter had greater potential ramifications than would ignoring any other pre-suit demand letter outside the environmental liability context.[140] Again, typical demand letters simply are not so coercive nor are the consequences of ignoring them so immediate or severe that they can be equated with a lawsuit. That is true even where the would-be defendant's failure to respond to the demand letter may expose it to liability for prejudgment interest, attorney fees, or enhanced damages if it loses a subsequent lawsuit.

III. CLAIMS VERSUS SUITS

In addition to imposing duties on the insurer with respect to a suit brought against an insured, standard liability insurance policies also refer to the insurer's duties concerning a "claim" made against an insured. For instance, the CGL form states that the insurer "will have the right and duty to defend the insured against any 'suit' seeking [covered] those damages" but may, at its discretion "investigate any 'occurrence' and settle any claim or 'suit' that may result."[141] Similarly, a standard homeowners policy provides:

> If a claim is made or a suit is brought against an "insured" for damages because of "bodily injury" or "property damage" caused by an "occurrence" to which this coverage applies, we will:
>
> * * *
>
> 2. Provide a defense at our expense by counsel of our choice, even if the suit is groundless, false or fraudulent. We may investigate and settle any claim or suit that we decide is appropriate. Our duty to settle or defend ends when our limit of liability for the "occurrence" has been exhausted by payment of a judgment or settlement.[142]

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139. *Id.* at 43.

140. *But see* Cytosol Labs., Inc. v. Fed. Ins. Co., 536 F. Supp. 2d 80, 87 (D. Mass. 2008) (stating that a Chapter 93A demand letter triggered the insurer's duty to defend).

141. ISO CGL Policy, *supra* note 2, at 1.

142. Ins. Servs. Off., Inc., Homeowners 3 – Special Form (HO 00 03 03 22), at 19 (2021) [hereinafter ISO 2021 HO-3 Policy].

Standard liability insurance policies do not define the term "claim." In liability insurance, the term "claim" ordinarily involves both "an identifiable injury and an express assertion of liability or demand for redress by the aggrieved party."[143] Or, as the Fifth Circuit explained when interpreting an excess policy that did not define the term, "a 'claim' involves a 'demand' or an 'assertion' made by a claimant against a party who could satisfy it."[144] "Claim" is not synonymous with "suit"; the terms refer to different actions or events. A California court contrasted claims and suits this way:

> A suit is a formal proceeding initiated in a court of law under established procedures, where it is tried before a judge or jury subject to traditional rules of evidence and which results in a judgment. A "claim" can be any number of things, none of which rise to the formal level of a suit—it may be a demand for payment communicated in a letter, or a document filed to protect an injured party's right to sue a governmental entity, or the document used to initiate a wide variety of administrative proceedings. While a claim may ultimately ripen into a suit, "claim" and "suit" are not synonymous.[145]

Nor is it arguable that the term "suit" encompasses a claim as the latter term is used in this context. Such a construction of the policy would make the reference to a claim superfluous and would leave a court "with no explanation for the disjunctive use of the two words," a result that would contradict accepted rules of contract interpretation.[146]

A CGL or homeowners insurer has no duty to defend a claim against an insured.[147] The standard homeowners policy makes this principle clear when it states that the insurer will "[p]rovide a defense at our expense by counsel of our choice, even if *the suit* is groundless, false or fraudulent."[148] The standard CGL policy also drives home this point: "We will have the right and *duty to defend the insured against any 'suit'* seeking [covered] damages. . . . We may, at our discretion, investigate any 'occurrence' and settle any

143. ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 508 (7th ed. 2025) (quoting Zurich Am. Ins. Co. v. Syngenta Crop Prot. LLC, 314 A.3d 665, 676 (Del. 2024) (defining a "claim for damages")).

144. Jordan v. Evanston Ins. Co., 23 F.4th 555, 561–62 (5th Cir. 2022).

145. Fireman's Fund Ins. Co. v. Super. Ct., 78 Cal. Rptr. 2d 418, 425 (Cal. Ct. App. 1997).

146. *Id.* at 424.

147. *See* Sanders v. Phoenix Ins. Co., 843 F.3d 37, 43 (1st Cir. 2016).

148. ISO 2021 HO-3 Policy, *supra* note 142, at 19 (emphasis added).

claim or 'suit' that may result."[149] With respect to claims, an insurer has the right to investigate or settle a claim as the insurer deems appropriate.[150]

Of course, when a claim is made against an insured, an insurer may decide to provide the insured with defense counsel. In many cases, that may be a wise strategic choice. But the insurer's voluntary provision of a defense in the absence of a suit should not be mistaken for a duty to do so in that case or any other.

IV. CONCLUSION

An insurer's duty to defend generally does not arise until the insured is sued. This result frequently is dictated by the policy's definition of "suit," although even in the absence of a definition, "suit" as used in a liability policy is generally understood to describe a lawsuit filed with a court.

There are a few recurring exceptions to the general rule that the term "suit" confines an insurer's duty to defend to a lawsuit against an insured filed in a court: (1) obviously, any other actions or proceedings explicitly provided for in a policy; (2) PRP letters sent by EPA and state agencies; and (3) if characterized as alternative dispute resolution proceedings, notices under right to repair statutes. Of course, apart from those expressly provided for in a policy, not all courts recognize all these exceptions. More broadly, whether an administrative proceeding constitutes a "suit" or is the functional equivalent of one depends on the nature of the proceeding. The more the proceeding resembles a lawsuit in a court of law, the more likely it is that it will be deemed a "suit" for duty to defend purposes.

Finally, an insurer may choose to assume an insured's defense before a suit is filed. In some situations, that may be a wise strategic choice. An insurer's voluntary assumption of an insured's defense in the absence of a "suit," however, should not be mistaken for a duty to do so.

149. ISO CGL Policy, *supra* note 2, at 1 (emphasis added).

150. ISO 2021 HO-3 Policy, *supra* note 142, at 19.

WHAT IS THE AVAILABILITY OF INSURANCE COVERAGE FOR CLAIMS OF SEXUAL MISCONDUCT AND ABUSE?

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Contents

I. INTRODUCTION: UNDERSTANDING SEXUAL ABUSE AND MISCONDUCT CLAIMS

Since the 1980s, claims of sexual abuse and related misconduct have exploded in their numbers. These claims have arisen in countless different types of circumstances, notably in cases where the defendant had custody over the alleged victim (e.g. nursing homes) or some other means of physical or psychological control (e.g. employers, sports trainers, doctors, clergy) as well as domestic situations involving abuse by parents or other family members. While the defendants in these cases may sometimes be the actual perpetrator of the alleged abuse, the issues of insurance coverage arising from these claims more often involve parties that did not actually participate in the abusive conduct but are alleged to be legally liable for having allowed it to occur.

In this article, we will first review the fact patterns in which sexual abuse and misconduct claims most often arise. Such claims may arise in the employment context, or in other situations such as legacy abuse claims involving churches or schools. Next, the article will explore the different theories of liability that plaintiffs have asserted against defendant entities, including statutory and vicarious theories of liability, negligence claims and indirect/derivative claims as well. Lastly, we will address the key insurance issues that such claims present, starting with the types of insurance policies that my respond to these claims and ending with how carriers address competing or overlapping coverage obligations through primary and excess insurance clauses, "other insurance" provisions, and contribution demands between insurers.

II. TYPES OF SEXUAL ABUSE AND MISCONDUCT CLAIMS

A. EMPLOYMENT-RELATED CLAIMS

Despite the public's perception that sex or gender-based discrimination in the workplace has decreased in recent year, it is still common to encounter what might be termed workplace "sexual abuse" in certain industries, including the hospitality and the entertainment industries. The legal claims arising from this kind of misconduct vary by jurisdiction, naturally, but typically they present both statutory claims under both federal and state anti-discrimination laws and common-law claims for assault and battery, infliction of emotional distress, and other torts.

B. SEXUAL ABUSE CLAIMS OUTSIDE OF EMPLOYMENT CONTEXT

1. Legacy Claims

Outside of the employment context, sexual abuse claims generally fall into one of two categories that are relevant to the availability of insurance coverage for such claims: "legacy" claims and "contemporary" claims.

Legacy claims are claims brought years and sometimes decades after the abuse or misconduct occurred. Frequently, the plaintiffs were children or young adults when the alleged abuse occurred. Certain state legislatures have expanded the statutes of limitation for these types of claims, in some instances dramatically, leading in some states to a flood of new claims arising from decades-old incidents.[1]

Outside of the employment context, such claims often arise from incidents at churches (e.g. Catholic Archdiocesan claims), camps (e.g. BoysTown), athletic teams (e.g. USA Gymnastics) outdoor organizations (e.g. Boy Scouts), and schools (e.g. Catlin Gabel in Portland, Oregon). Such claims also occasionally are brought in cases where the alleged victim was the customer of a business.

2. Contemporary Claims

Although many of the most high-profile cases have involved multiple plaintiffs alleging widespread historical abuse, and mind-boggling cover-ups that lasted decades, we do see claims for recent abuses arising out of all of the foregoing kinds of organizations.

C. THEORIES OF LIABILITY AGAINST ENTITY DEFENDANTS

Claims arising out of sexual abuse or misconduct are frequently brought not only against the alleged perpetrator, but also against the organization(s) through which the perpetrator and the victim met or interacted: the employer, the church, the school, the league, the film studio. Understanding the theories of liability asserted against these entities is essential if we are to analyze what types of insurance might apply.

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1. For an overview of various states laws passing "lookback" or "revival" windows, extending the statute of limitations for survivors of child sexual abuse, see ALICE NASAR HANAN, REVIVAL LAWS FOR CHILD SEX ABUSE (2024) https://childusa.org/wp-content/uploads/2024/06/US-WindowsRevival-Laws-for-CSA-Since-2002-6.7.24-AH.pdf. These statutes are known in many states as the Child Victims Act (CVA).

Statutory liability: Most federal and state employment- discrimination statutes make the employer or potential employer liable for the wrongful or discriminatory acts—including physical abuse or misconduct—of their employees. There is generally very little that an employer can do to avoid liability on this basis even if the employer protests that the wrongdoer's actions were outside of the course and scope of employment because they were not done to advance the employer's goals, but for personal gratification only.

Vicarious liability: If there is no statutory claim, an employer or other organization may be vicariously liable for the actions of its employee, volunteer, clergy, etc. under state common law. The elements of vicarious liability are, generally speaking, a legal relationship between the person responsible (e.g. employer) and the actor (e.g. employee), negligence, and scope of relationship (e.g. within and during scope of employment).

Negligence theories: Finally, employers and other organizations may be sued for their own negligence via claims such as negligent hiring or negligent training. The plaintiff generally must prove that the organization failed to meet the applicable standard of care in terms of vetting a new employee or volunteer, or in providing training to supervisors that would enable them to recognize and prevent potential wrongdoers from committing sexual abuse. There are a number of different formulations of these kinds of claims.

D. DERIVATIVE OR OTHERWISE INDIRECT CLAIMS

Aside from claims by victims, entities are often the subject of what may be called "indirect" or derivative claims, from shareholders or other similarly situated parties. This has occurred where sex abuse claims have resulted in drops in share price (or other enterprise value).

These claims have included "stock drop" claims under securities laws, and more generalized breach of fiduciary duty claims. In some instances, a lawsuit will involve both claims. For example, in 2021 shareholders in Activision filed a class action securities fraud action against the company and several directors and officers alleging that the company had failed to prevent "endemic" sexual harassment and gender-based discrimination, had failed to disclose internal and regulatory investigations (by, among others, the SEC) into the company's culture and handling of employee complaints of sexual misconduct, and misled investors about the impact of these events on the company's financial outlook due to high-profile executives being forced out, and other impacts.[2] In 2019, investors in Wynn Resorts reached a settlement in a derivative action arising out of company CEO Steve Wynn's alleged

2. Cheng v. Activision Blizzard, Inc., No. CV-6240, 2022 WL 2101919, at *2 (C.D. Cal. Apr. 18, 2022) https://www.dandodiary.com/wp-content/uploads/sites/893/2022/04/Activision-Order.pdf.

"longstanding pattern of sexually harassing and assaulting Wynn employees on company property." The settlement amount of over $90 million reportedly included $21 million paid by insurers.[3]

III. POTENTIALLY APPLICABLE COVERAGES & THEIR FEATURES

A. EMPLOYMENT PRACTICES LIABILITY INSURANCE

Employment Practices Liability ("EPL") policies cover claims by employees (or potential employees) for a broad range of employment-related "wrongful acts" including sexual harassment and gender-based discrimination. Some policies also cover claims by customers for the same range of wrongful acts (see "Third Party EPL" below).

EPL coverage is almost always written on a "claims made" or "claims made and reported" basis, meaning that the policy in effect when the claimant first makes a demand for relief is the policy that will respond to the claim. EPL policies may therefore cover wrongful acts that took place long before the claim is made, if the statute of limitations is long, but these policies also frequently have a "retroactive date" that sets a backward-looking limitation on coverage. That "retroactive date" is often set at the first date on which the company purchased EPL insurance. To give an example, if a claim is made today for a wrongful act that took place ten years ago (May 1, 2015), but the retroactive date is set at January 1, 2020 (which is when the company started buying EPL), the policy may not cover the claim. EPL coverage is sometimes included as part of a "management liability" package policy that may also include Directors and Officers coverage (see below) and fiduciary liability coverage.

EPL coverage is also often written on a "burning limits" or "eroding limits" basis, meaning that after the self-insured retention is satisfied, any defense costs paid by the insurer will reduce the remaining policy limits available to settle the claim or pay a judgment.

EPL policies commonly contain exclusions that come into play in litigation over sexual abuse, including exclusions for assault and battery.

3. *Wynn Resorts, Ltd. Derivative Litigation*, COHENMILSTEIN, https://www.cohenmilstein.com/case-study/wynn-resorts-ltd-derivative-litigation/.

B. THIRD-PARTY EPL INSURANCE

A related but different EPL coverage is third-party employment practices liability ("Third-Party EPL") coverage, which is available if procured, because coverage for claims by non-employees is not provided under EPL or commercial general liability ("CGL") policies.

Like EPL policies, Third-Party EPL coverage is typically written with "burning limits" and on a claims-made or claims-made and reported basis. It is most often provided as a separate coverage grant under EPL policies or offered for additional premium by endorsement. It is a coverage that is a parallel to EPL coverage but for claims by non-employees (e.g., vendors, customers bringing claims).

C. COMMERCIAL GENERAL LIABILITY INSURANCE

Commercial general liability ("CGL") policies typically cover bodily injury and "personal and advertising injury" both of which may come into play in a lawsuit over sexual abuse. "Personal and advertising injury" is typically defined by reference to certain enumerated offenses, such false arrest, detention or imprisonment, slander, libel, and invasion of privacy and is written on an "offense" basis requiring that the offense committed by the insured (e.g. the false imprisonment) to take place during the policy period.

By contrast, CGL coverage for "bodily injury" is written on an "occurrence" basis, meaning that the policy in place when the bodily injury or personal injury happened and is caused by an accident is the policy that responds. Where bodily injury has continued through multiple policy periods policyholders will often argue that multiple policies are triggered, including each policy in effect on the date of each abuse.[4]

In addition to the necessity of an occurrence to trigger coverage, general liability policies will often contain provisions limiting the amount of coverage per occurrence and/or subjecting coverage to a per occurrence deductible or self-insured retention. The issue then becomes, in instances of sexual abuse occurring over an extended period of time, how many occurrences are

4. *Compare* Western World Ins. Co. v. Lula Belle Stewart Center, Inc., 473 F. Supp.2d 776, 780 (E.D. Mich. 2007) ([C]overage is not limited to the policy in effect when the sexual abuse began. Where abuse was ongoing over a number of years, the policyholder can access successive years of coverage.), *with* Pa. State Univ. v. Pa. Manufacturers' Ass'n. Ins. Co., 57 Pa. D. & C.5th 193, 212 (2016) ("To the extent that PSU's negligence enabled Sandusky to abuse his victims, such bodily injury manifested when the first abuse of each victim occurred. With respect to each victim, the policy in place at the time the first act of abuse occurred is the only one that potentially provides coverage.").

triggered in order to determine how many limits, deductibles, and SIRs are triggered.

CGL policies usually are written such that defense costs are "outside" of limits—in other words, insurer-paid defense costs do not reduce the amount of policy limits available to settle or pay a judgment.

CGL policies often contain an exclusion for "knowing violation" of the law or the victim's rights, and a "criminal acts" exclusion.[5] In addition, CGL typically contain a broad exclusion by endorsement for employment-related claims, and an exclusion by endorsement for "sexual abuse and molestation." For example, a standard abuse and molestation exclusionary clause provides that insurance under a CGL policy does not apply to:

> (1) The actual or threatened abuse or molestation by anyone of any person while in the care, custody or control of any insured; or
>
> (2) The negligent employment, investigation, supervision, reporting or failure to report, or retention of a person for whom any insured is or ever was legally responsible and whose conduct would otherwise be excluded under (1) above.

The widespread adoption of these exclusionary endorsements has substantially narrowed the applicability of CGL coverage to sexual abuse cases, at least under more recent policies. Entities with well-known risk of sexual abuse or molestation claims are now typically required to purchase specific, and often sub-limited, coverage for that hazard.

D. Directors and Officers Insurance – Private Company

Directors and Officers insurance ("D&O") for private companies typically provides broad coverage for claims arising out of "wrongful acts" by the entity, or its directors, and executives.

D&O policies are typically written on a claims-made basis, and on a "burning limits" basis (see above discussion of EPL). "Wrongful acts" is typically defined very broadly to include nearly any act or omission in the conduct of the business.

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5. *See, e.g.,* United States Fire Ins. Co. v. Fea, No. 1:16-cv-00173, 2016 WL 7395691 (D. Haw. Dec. 2, 2016), *report and recommendation adopted*, No. 16-00173, 2016 WL 7387406 (D. Haw. Dec. 21, 2016) (applying "knowing violation" and "criminal acts" exclusions in sex abuse lawsuit).

D&O policies often have exclusions for employment practices-related claims—particularly where EPL coverage is part of the same "management liability" package policy—and an exclusion for professional liability.

D&O coverage is also often limited by exclusions that may be applicable in sex abuse litigation, including an abuse and molestation exclusion, criminal acts, and knowing violation of rights of another.

E. Errors and Omissions Insurance

Errors and Omissions ("E&O") coverage, sometimes called "Professional Liability" or colloquially "malpractice" coverage, provides coverage for claims arising from wrongful acts within an entity's designated professional service. This coverage is purchased by a wide range of service providers ranging from architects and engineers to medical providers to real estate brokers to software developers.

This coverage is typically written on a "claims made" basis. In some policies coverage for defense costs is on a "burning limits" basis, but it is common for defenses costs to be "outside" of limits.

E&O policies often contain exclusions similar to CGL policies including sexual abuse and molestation, criminal acts, knowing violation of rights of another, assault and battery, and employment-related claims.

IV. STRATEGIC ISSUES

In the event of a claim or lawsuit being filed on any of the many bases discussed above, a prudent policyholder will assess which insurance policies could potentially provide coverage (including coverage for defense costs) and will likely put all potentially implicated insurers on notice of the claim, with either targeted demands for defense or a broad request that all insurers participate in the defense. But where from there does the claim for coverage go?

A. Which Insurer Defends?

If more than one insurer agrees that it may have an obligation to defend, those insurers may still dispute whether they in fact are currently "on the hook" for defense costs on the theory that the "other insurance" clause in their policy means that their policy is not "primary" when it comes to defending—and that another insurer should pay first dollar or apply as primary insurance. This may be the case for both defense costs and indemnity. And it all depends on the terms of each policy, including "other insurance" conditions in the policies.

B. PRIMARY VERSUS EXCESS – "OTHER INSURANCE"

Once it has been determined that multiple insurance policies may apply to a claim for sexual abuse/misconduct, questions may arise regarding the order in which the policies may pay for the defense and indemnity of the claim. Most insurance policies contain some kind of "other insurance" provision that describes how a policy responds when it is one of many policies involved in a claim. Some preliminary issues must be resolved before the effect of such provisions themselves becomes relevant. First, the policies must insure the same interest, subject matter, and risk as each other.[6] Second, the parties should distinguish between policies written on a "true excess" basis and ones that only purport to be excess in their "other insurance" provisions. Another is whether an insured's self-insured retention constitutes "other insurance" for purposes of such provisions.[7] A few states allow an insured to "target" one insurer for defense and indemnity of an underlying lawsuit to the exclusion of other potentially applicable policies notwithstanding any "other insurance" provisions.[8] If all conditions are satisfied and the policies truly provide co- insurance for the claim, the next questions are how the policies' "other insurance" provisions should be applied and how conflicts among them should be resolved.

One other point to make up front regarding "other insurance" provisions is that courts generally hold that such provisions only affect insurers' rights among themselves; they do not affect an insured's right to recovery under each policy.[9] Accordingly, disputes regarding priority of insurance most often arise in contribution actions by insurance companies seeking to allocate loss amounts among themselves.

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6. *See* Pacific Indemnity Co. v. Linn, 766 F.2d 754, 767 (3d Cir. 1985) ("[O]ther. . . insurance exists only where there are two or more insurance policies covering the same interest, the same subject matter and [insuring] against the same risk.").

7. *Compare* Burgraff v. Menard, Inc., 875 N.W.2d 596, 604–05 (Wis. 2016) (an insured's SIR qualified as "other applicable liability insurance" under an insurance policy's "other insurance" clause), *with* Consolidated Edison Co. of New York, Inc. v. Liberty Mut., 749 N.Y.S.2d 402, 405 (Sup. Ct. N.Y. 2002) (noting that "at least under the circumstances presented here, Con Edison's 'self-insurance' does not qualify as 'co-insurance.'").

8. *See* Kajima Constr. Svcs., Inc. v. St. Paul Fire & Marine Ins. *Co*., 227 Ill.2d 102 (2007); Mut. of Enumclaw Ins. Co. v. USF Ins. Co., 191 P.3d 866, 878 (2008).

9. *See* Zurich Ins. Co. v. Raymark Indus., Inc., 494 N.E.2d 634, 650 (Ill. 1986); Lac D'Amiante Du Quebec, Ltee. v. Am. Home Ins. Co., 613 F. Supp. 1549, 1563 (D. N.J. 1985); Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1050 (D.C. Cir. 1981).

1. Preliminary Issues

a. Insurance for the Same Interest, Subject Matter, and Risk

A typical "other insurance" provision states that it applies if the insured has "other valid and collectible insurance" that applies to a loss covered by the first policy. Courts have found that this and similar language means that an "other insurance" provision is relevant if the policies cover the same interest, subject matter, and risk.[10] If different policies insure different risks, there is no basis to allocate or limit liability based on the policies' "other insurance" provisions.[11]

A number of factors may be relevant to whether policies cover the same risk. "The provisions of liability insurance policies pertaining to the effect of other or additional liability insurance coverage for the same loss relate to concurrent coverages of a single occurrence."[12] Thus, "other insurance" provisions may not apply to claims involving multiple "occurrences," to the extent that different policies cover different "occurrences." Some courts have found that "other insurance" clauses do not apply among policies issued consecutively rather than concurrently.[13]

The policies need not provide identical or completely coextensive coverage in order for them to insure the same interest, subject matter, and risk.[14] Courts have found that a "material overlap" in coverage between the two policies is sufficient. For example, in *Chestnut Hill Acad.*,[15] the court found that the two policies before it—one covering employee benefit programs and the other covering employment practices—provided sufficiently

10. *See* Sport Rock Int'l, Inc. v. Am. Cas. Co. of Reading, Pa., 878 N.Y.S.2d 339, 344 (N.Y. App. Div. 2009); Chestnut Hill Acad. v. Graphic Arts Mut. Ins. Co., No. 04-1560, 2005 U.S. Dist. WL 1715660, *35 (E.D. Pa. July 22, 2005); Taco Bell Corp. v. Cont'l Cas. Co., 388 F.3d 1069, 1078–79 (7th Cir. 2004).

11. *See* 4 New Appleman Law of Liability Insurance § 41.01 ("The other insurance clause will be applied only if the policies cover the same interest and same specific risk"); Chi. Hosp. Risk Pooling Program v. Ill. Med. Inter-Ins. Exch., 758 N.E.2d 353, 363 (Ill. App. Ct. 2001); Pines of La Jolla Homeowners' Ass'n v. Indus. Indem., 7 Cal. Rptr. 2d 53, 58 (Cal. Ct. App. 1992), *overruled on other grounds*, Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 901 (Cal. 1993); Cherokee Ins. Co. v. United States Fire Ins. Co., 559 S.W.2d 337, 339 (Tenn. Ct. App. 1977).

12. Cont'l Cas. Co. v. Med. Protective Co., 859 S.W.2d 789, 791 (Mo. Ct. App. 1993).

13. *See, e.g.,* Taco Bell, *supra* note 10, at 1079.

14. *See* Liberty Mut. Ins. Co. v. Home Ins. Co., 583 F. Supp. 849, 854 (W.D. Pa. 1984).

15. Chestnut Hill Acad., *supra* note 10, at *37.

similar insurance to trigger the policies' respective "other insurance" clauses.[16] The court noted that:

> [B]oth policies cover the same organization; both cover losses relating to personal injury, including defamation, and mental or emotional distress resulting from personal injury; both policies cover losses caused by directors, executive officers, and employees acting within the scope of their duties; and both incorporate a duty to defend or to pay defense costs for suits arising from covered losses.[17]

Similarly, an E&O policy for "Managed Care Activities" insures the same risk as a D&O policy issued to the same insured.[18] On the other hand, courts have found that CGL and D&O policies do not cover the same risks for purposes of "other insurance" provisions in a variety of contexts.[19]

b. Primary Versus "True Excess" Policies

A majority of courts have held that "other insurance" provisions are only relevant to policies on the same "level" of insurance as each other. In these jurisdictions, as between a primary policy and a "true excess" policy, the primary policy must respond to a loss first, regardless of what its "other insurance" provision may state.[20] A "true excess" policy is one in which the insurer has agreed to provide insurance above a specified amount of underlying insurance.[21] The minority view is that "other insurance" provisions are competing if the primary policy is not the specified policy above which the excess insurer agreed to provide coverage.[22]

c. Self-Insurance Versus "Real" Insurance

Certain types of insureds, including health care, education and municipalities, often do not have traditional liability insurance contracts issued

16. *Id.* at *37-38.

17. *Id.* at *37.

18. *See* Bedivere Ins. Co. v. Blue Cross & Blue Shield of Kan., Inc., No. 18-2371-DDC-JPO, 2019 U.S. Dist. 2019 WL 47520518, *66 (D. Kan. Sept. 30, 2019).

19. *See, e.g.,* Gemini Ins. Co. v. Kukui'ula Dev. Co. (Hawaii), LLC, 855 F. Supp. 2d 1125, 1143 (D. Haw. 2012); Fed. Ins. Co. v. Firemen's Ins. Co., 769 F. Supp. 2d 865, 876 (D. Md. 2011).

20. *See* Bedivere Ins., *supra* note 18, at *48–52 (discussing and adopting the majority view).

21. *Id.* at *49.

22. *Id.*

by traditional insurance companies. Instead, the insureds form risk pooling associations, in which groups of insureds band together to provide insurance for each other. The insureds in such risk management associations essentially are self-insured for the covered risks. At the same time, an insured member of a risk management association may have other, traditional policies that cover different but related risks and liabilities. When a claim may be covered by a self-insurance arrangement and a traditional liability policy, the traditional insurer often argues that its "other insurance" provision makes it excess of the self- insurance.

Most courts that have considered this argument have found that self-insurance under a risk management pooling arrangement is not "other insurance."[23] A minority of courts have found to the contrary, however.[24] If a policy expressly states that "self-insurance" constitutes "other insurance," a court likely will apply this express language and find that the insured's self-insurance must be considered in the application of the policy's "other insurance" provision.[25]

d. Effect of the "Targeted Tender" Doctrine

Courts in Illinois, Montana and Washington have adopted a doctrine known as "targeted" or "selected" tender that impacts how insurance policy "other insurance" provisions are applied. When multiple, concurrently issued primary policies cover a lawsuit, the targeted tender doctrine allows the insured to select one policy to defend and indemnify the insured, to the exclusion of the other policies. The courts have held that the insured's right to target one policy precludes that insurer from relying on an "other insurance" provision in that policy and seek contribution from the other insurer(s).

These same courts, however, have resisted insureds' efforts to expand the targeted tender doctrine beyond the relatively narrow circumstance of concurrently issued primary policies. The courts have held that all available

23. *See, e.g.,* Statewide Ins. Fund v. Star Ins. Co., 289 A.3d 448, 454 (N.J. 2023); Travelers Lloyds Ins. Co. v. Pac. Emps. Ins. Co., 602 F.3d 677, 685 (5th Cir. 2010); Chi. Hosp. Risk Pooling Program v. Ill. Med. Inter-Ins. Exch., 758 N.E.2d 353, 362 (discussing majority view); St. John's Regional Health Ctr. v. Am. Cas. Co. of Reading, Pa., 980 F.2d 1222, 1224 (8th Cir. 1992); Physicians Ins. Co. of Ohio v. Grandview Hosp. & Med. Ctr., 542 N.E.2d 706, 707 (Ohio Ct. App. 1988).

24. *See, e.g.,* Am. Cas. Co. of Reading, Pa. v. Tenet Healthsystem Hosp., Inc., No. 04-3270, 2006 WL 2631936, at *2 (E.D. La. Sept. 13, 2006); Air Liquide Am. Corp. v. Cont'l Cas. Co., 217 F.3d 1272, 1280 (10th Cir. 2000).

25. *See, e.g.,* Redeemer Covenant Church of Brooklyn Park v. Church Mut. Ins. Co., 567 N.W.2d 71, 79 (Minn. Ct. App. 1997); Nabisco, Inc. v. Transport Indem. Co., 192 Cal. Rptr. 207, 209 (Cal. Ct. App. 1983).

primary insurance must be exhausted before any excess or umbrella insurance is triggered, even though the insured targeted only one primary policy for defense and indemnity. An insured also cannot target one primary policy among consecutively issued policies. As a result, the targeted tender doctrine is most effectively applied when only one policy period is triggered and the insured is reasonably certain that the limits of the targeted policy will be sufficient to completely pay for a judgment or settlement.

2. Applying "Other Insurance" Provisions

a. Types of "Other Insurance" Provisions

There are three main types of "other insurance" provisions in liability policies: (1) *pro rata* clauses; (2) excess clauses; and (3) escape clauses. *Pro rata* clauses state that, if other insurance exists, the insurer with the *pro rata* clause will pay its *pro rata* share of a loss based on equal shares or the limits of each policy.[26] Under *pro rata* by limits, each insurer pays based on the ratio of its limit of liability to the total limits of liability provided by all policies.[27] Excess clauses state that the policy applies only as excess over other valid and collectible insurance, except insurance that is specifically written as excess over the policy with the excess clause.[28] Escape clauses seek to avoid all liability by stating that the insurer's liability is extinguished to the extent that other insurance applies to a loss.[29] Insurers are, of course, free to create "other insurance" provisions different from these three main types, including combinations thereof.[30]

b. Resolving Conflicting Provisions

The different types of "other insurance" provisions do not always work harmoniously together. If two policies both have *pro rata* clauses, there usually is no issue as both insurers have agreed to contribute *pro rata* by equal shares or by limits. On the other hand, two excess clauses often create a

26. *See* Am. Cas. Co. of Reading, Pa. v. PHICO Ins. Co., 702 A.2d 1050, 1053 (Pa. 1997).

27. *Id.*

28. *See* Mo. Pub. Entity Risk Mgmt. Fund v. Am. Cas. Co. of Reading, Pa., 399 S.W.3d 68, 80 (Mo. Ct. App. 2013).

29. *See* Peerless Ins. Co. v. St. Paul Surplus Lines Ins. Co., No. 09 CV 5 JLS, 2010 WL 2486795, at *8–9 (S.D. Cal. June 15, 2010).

30. *See generally* SCOTT M. SEAMAN AND JASON R. SCHULZE, ALLOCATION OF LOSSES IN COMPLEX INSURANCE COVERAGE CLAIMS, § 5.3 (13th ed. 2024).

conflict because the two policies cannot be excess of each other. The same is true of two escape clauses. Courts also may be called upon to resolve the priority of payment between an insurance policy with an excess clause and one with an escape clause.

When both policies contain an excess "other insurance" clause, many courts find that the clauses cancel each other out and revert to *pro rata* allocation between the policies, either by equal shares or by limits.[31] Courts often reach the same result where the policies have competing escape clauses.[32] If policies contain different types of "other insurance" provisions—*pro rata* and escape, escape and excess, etc.—courts vary quite a bit in their approaches. Some courts find the provisions to be mutually repugnant and allocate the losses on a *pro rata* basis.[33] Others seek to determine which policy is "closest to the risk" or more specifically insures the risk at issue and hold that policy to be primary.[34]

Most courts attempt to harmonize the provisions and decide which policy is primary based on what they perceive to be the intent behind the provisions.[35] This generally results in a policy with an excess clause being excess over a policy with a *pro rata* clause,[36] an escape clause taking precedence over a *pro rata* clause,[37] and a policy with an escape clause being primary to a policy with an excess clause.[3838] The courts are hardly uniform in their approaches and outcomes, though, and the practitioner faced with this issue would be well advised to find out how the courts in the applicable jurisdiction have resolved the question.

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31. *See, e.g.,* U.S. Specialty Ins. Co. v. Harleysville Worcester Ins. Co., No. 20 Civ. 7691, 2021 WL 4043457, at *12 (S.D.N.Y. Sept. 3, 2021); Brice Bldg. Co., Inc. v. Clarendon Am. Ins. Co., 378 Fed. Appx. 915, 916 (11th Cir. 2010); Ohio Cas. Ins. Co. v. Oak Builders, Inc., 869 N.E.2d 992, 996 (Ill. App. Ct. 2001).

32. *See, e.g.,* Commerce & Indus. Ins. Co. v. Chubb Custom Ins. Co., 89 Cal. Rptr. 2d 415, 418–19 (Cal. Ct. App. 1999); Allstate Ins. Co. v. Executive Car & Truck Leasing, Inc., 494 So.2d 487, 489 (Fla. 1986).

33. *See, e.g.,* Lamb-Weston, Inc. v. Oregon Auto. Ins. Co., 341 P.2d 110, 119 (Or. 1959).

34. *See, e.g.,* Auto Owners Ins. Co. v. Northstart Mut. Ins. Co., 281 N.W.2d 700, 704 (Minn. 1979).

35. *See, e.g.,* Connolly Bros., Inc. v. Nat'l Fire & Marine Ins. Co., No. 06cv11673-NG, 2008 WL 5423198, *5 (D. Mass. Sept. 30, 2008).

36. *See, e.g.*, Travelers Home and Marine Ins. Co. v. Central Mut. Ins. Co., No. 14-cv-02028-RPM, 2014 WL 4947319, at *4 (D. Colo. Oct. 2, 2014); Am. Fam. Mut. Ins. Co. v. Regent Ins. Co., 846 N.W.2d 170, 194 (Neb. 2014).

37. *See, e.g.,* Am. Int'l Specialty Lines Ins. Co. v. Canal Indem. Co., 352 F.3d 254, 262–63 (5th Cir. 2003).

38. *See, e.g.,* Great Am. Assur. Co. v. Am. Cas. Co. of Reading, Pa., 511 Fed. App'x. 431, 437 (6th Cir. 2013).

C. SETTLEMENT STRATEGIES

From the policyholder's perspective, it is typically interested in the defense and resolution of the claim or suit with the policyholder paying no retention or the lowest retention possible and an insurer or insurers paying as much of the defense costs and indemnity possible. And if there are overlapping coverages, the financial exposure to the policyholder may drive its interest in pressing that one insurer pays before another or that the insurers resolve priority of coverage among themselves. But the policyholder's ultimate strategy typically is to effectuate a settlement to take it out of harm's way.

From the insurers' perspective, they will focus on the plain language of the policies and the claims and causes of action in issue to parse what is and is not covered—and potentially covered—under their respective policies. The duty to defend stage most likely will be a different analysis than the duty to indemnify stage, considering that the latter is based on actual not alleged facts. In addition, because sometimes it is the same insurer that issued the various possibly applicable coverages—in either package policies or separate policies issued concurrently—the determination regarding which is the applicable coverage for the types of claim in issue may be a narrower analysis. But portfolio considerations may come into play with insurers, as they issue these various types of coverage with an underwriting intent for them to operate in lock step (e.g. why CGL policies exclude EPL, etc.).

D. CONTRIBUTION

If one insurance company defends and indemnifies an insured in connection with a sexual abuse/misconduct lawsuit, it may seek to reallocate some or all of the defense costs and judgment or settlement to the insured's other carriers. The legal theories involved are usually equitable contribution or equitable subrogation. In both cases, the paying insurer argues that it paid a disproportionate share of the defense costs and/or indemnity amounts.[39] An insurer may obtain equitable contribution from another insurer if their policies insure the same subject matter and the same "risk" for the insured.[40] Equitable subrogation requires the two insurers to have paid for the same "loss."[41] As

39. *See* Fireman's Fund Ins. Co. v. Maryland Cas. Co., 77 Cal. Rptr. 2d 296, 301 (Cal. Ct. App. 1998); Royal Globe Ins. Co. v. Aetna Ins. Co., 403 N.E.2d 680, 682 (Ill. App. Ct. 1980).

40. *See* Mo. Pub. Entity Risk Mgmt. Fund v. Am. Cas. Co. of Reading, Pa., 399 S.W.3d 68, 80 (Mo. Ct. App. 2013); Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Hartford Ins. Co. of Midwest, 677 N.Y.S.2d 105, 110 (N.Y. App. Div. 1998).

41. *See* Home Ins. Co. v. Cincinnati Ins. Co., 821 N.E.2d 269, 280–81 (Ill. 2004) (Equitable contribution focuses "prospectively on the 'risk' that the parties set out to cover," while equitable subrogation "looks retrospectively at the loss suffered.").

discussed above, the competing policies' "other insurance" provisions can play a key role in determining the priority of payment among multiple insurers in this situation. Given that equity governs the outcome, rather than contractual language alone, courts strive to reach a "fair" result and may consider a variety of factors in doing so. For example, an insurer may be precluded from recovering from another carrier to whom the insured had failed to provide adequate or timely notice of an underlying lawsuit.[42]

V. CONCLUSION

The rise in sexual abuse and related misconduct claims has brought about a commensurate increase in challenging insurance coverage issues that claimants, insured entities, and insurance carriers must tackle. The issues can hinge, in part, on the type of insurance policies that may respond to a specific claim, including employment practices policies, professional liability and commercial general liability policies and/or directors and officers coverage. Each has unique terms and conditions which may overlap, or be repugnant to, other insurance coverages. Litigants and insurance professionals must be mindful of the impact each type of policy may have on a particular claim or lawsuit. Confronting these challenges at an early stage will greatly assist parties in assessing risk, evaluating exposures and ultimately resolving sexual abuse and related misconduct claims.

Equitable contribution most often applies to insurers on the same level (e.g., two primary insurers), but an excess insurer may pursue equitable subrogation against a primary insurer.

42. *See* AMCO Ins. Co. v. Erie Ins. Exch., 49 N.E.3d 900, 914–15 (Ill. App. Ct. 2016).