

CHAPTER 1
BASIC LIABILITY INSURANCE CONTRACT RULES

§ 1. Definitions

As used in this Restatement:

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

(2) A “deductible” is the amount specified in a liability insurance policy by which coverage under the policy is reduced after the coverage amount is finally determined for the claim or claims to which the deductible applies. Unless otherwise stated in the insurance policy, none of the insurer’s duties with respect to defense or indemnification are contingent upon the insured’s payment of the deductible.

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

(4) An “insured” is a natural person or entity with a right to coverage under an insurance policy.

(5) An “insuring clause” is a term in ~~a liability~~an insurance policy that grants insurance coverage.

(6) A “legal action” is a demand for redress of the kind that fits within the usual framework of insured liabilities. ~~Which~~The demand can be formal or informal, and includes demands made before formal legal actions are commenced. The liability insurance policy defines which legal actions are insured under ~~any particular liability insurance is defined by~~ that policy.

(7) “Liability insurance” is insurance that exclusively or primarily covers risks related to the liability of an insured to third parties, including the liability insurance coverage part of an insurance policy that includes other forms of coverage.

(8) A “mandatory rule” is a rule of contract law or insurance law that cannot be changed by agreement of the parties.

(9) A “non-mandatory rule,” otherwise known as a “default rule,” is a rule of contract law or insurance law that can be changed by agreement of the parties.

(10) A “policyholder” is the natural person or entity that acquires an insurance policy. In the liability insurance context, the policyholder typically is an insured under the policy, but there often are other persons or entities that also qualify as insureds.

(11) A “policy limit” is a term in an insurance policy that identifies the maximum amount that the insurer is obligated to pay under the policy for the claim or claims subject to which the policy limit ~~applies~~.

(12) A “self-insured retention” is the amount specified in a liability insurance policy that must be paid by or on behalf of the insured ~~must pay~~ for a covered loss before coverage under the policy begins to apply for the claim or claims to which the self-insured retention applies. Unless otherwise stated in the insurance policy, an insurer has no duty to defend or indemnify the insured until the insured has paid any applicable self-insured retention.

(13) A “standard-form term” is a term that appears in, or is taken from, an insurance- policy form (including an endorsement) that an insurer makes available for a non-predetermined number of transactions in the insurance market.

(14) An insurance- policy “term” is a word or set of words in an insurance policy that perform a discrete function in the policy. In the context of this Restatement, “term” typically refers to the word or set of words whose meaning or application is at issue in determining the coverage that is available in relation to a legal action brought against an insured.

Comment:

a. Condition. Conditions are addressed in § 34.

b. Exclusion. Exclusions are addressed in § 32.

c. Insuring clause. Insuring clauses are addressed in § 31.

d. Deductibles and self-insured retentions. A deductible or self-insured retention (~~an~~ “SIR”) in a liability insurance policy leaves some of the costs of covered losses on the insured, serving two main functions: (1) reducing moral hazard by preserving insureds’ incentive to avoid loss and thereby more closely aligning the incentives of insurer and insured, and (2) reducing costs by allowing policyholders to manage or absorb the loss of smaller claims themselves, so that policyholders incur the administrative costs associated with risk transfer only for larger claims for which they benefit from the loss spreading provided by insurance. Both functions are

most important in the commercial liability insurance market. Consumer and small commercial liability insurance policies often do not have a deductible, or have a very low deductible, because these insureds do not have the capacity to manage liability actions on their own, and insurers have found that such policies do not create an unacceptable moral-hazard problem. Large commercial enterprises frequently arrange their insurance programs to include large self-insured retentions in order to reduce premiums, increase policy limits, or retain greater control over claims adjustment and defense.

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

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

e. Liability insurance. This Restatement applies to all forms of liability insurance, including the liability insurance coverage parts of multiline package policies sold to consumers, such as homeowner's insurance and personal automobile insurance. Liability insurance may be

offered through an insurance policy that exclusively provides liability insurance coverage or through an insurance policy that includes other forms of coverage as well. For example, homeowner's and automobile-insurance policies typically provide both liability and property-insurance coverage. The property-insurance component of such combination policies protects the insured against financial losses relating to damage to or destruction of covered property. These rules are drafted for application only to the liability insurance features of such policies (although some of the rules may also be usefully applied to other forms of insurance).

f. Mandatory and non-mandatory rules. Many rules of contract and insurance law can be divided into two categories: those that can be waived or altered by the parties and those that cannot. Those that can be waived or altered are referred to in recent contract-law scholarship and case law as “default rules,” and those that cannot be waived or altered by agreement of the parties are referred to as “mandatory rules.” Examples of default liability insurance law rules include the rules relating to (a) the scope of the right to defend in § 10, (b) the recoupment of defense and settlement costs in §§ 21 and 25(2), (c) exhaustion and drop down in § 39, (d) indemnification from multiple policies in §§ 40 and 41, and (e) the insurance of known liabilities in § 46.

Like other common-law rules, a common-law insurance rule cannot be fully mandatory, because the party who is the beneficiary of a mandatory private-law rule has the power to decide not to attempt to enforce the rule. A liability insurance law rule is “mandatory” only in the sense that it gives the beneficiary of the rule the option to engage the legal system to require that the rule be enforced without regard to what is stated in the liability insurance policy. Although courts typically have not used the label “mandatory rule” in the insurance context, they have treated certain insurance-law rules as mandatory, by applying these rules even when the liability insurance policy contains a contrary term. Examples of liability insurance rules that courts have treated as mandatory in this manner (or, in the language more familiar to courts, as nonwaivable legal rules) include the rules relating to: (a) waiver and estoppel ~~and waiver~~ in §§ 5-6 (which are enforced notwithstanding an anti-waiver clause in the policy); (b) the obligation to provide an independent defense in § 16 (which is enforced notwithstanding the common term granting the insurer the right to control the defense); (c) the duty to make reasonable settlement decisions in § 24 (which is enforced notwithstanding the common term granting the insurer the discretion whether or not to settle); and (d) the prejudice rule regarding certain conditions in §§ 34 and 36. There are other liability insurance rules that courts are likely to treat as mandatory or

nonwaivable, especially for consumers and other mass-market policyholders, should an insurer attempt to include a contrary term in a liability insurance policy. These rules include ~~the~~certain rules regarding contract interpretation and the rules based on the implied duty of good faith and fair dealing. Courts have long recognized the special importance of the duty of good faith and fair dealing in the liability insurance context; and the mandatory nature of insurance-interpretation rules promotes the development of uniform, reasoned meanings of insurance- policy terms.

g. Policy limit. A single liability insurance policy may contain more than one policy limit. For example, a policy that states a policy limit for a single occurrence may also state the maximum amount of money that the insurer is obligated to pay for all occurrences, commonly referred to as an “aggregate limit.” See § 37. Under the default rule stated in § 14, the costs of defense of a legal action are borne in addition to the policy limits by an insurer that issues a duty-to-defend policy, unless the policy states to the contrary.

h. Term. In this context, “term” is a synonym for “provision.” Depending on the context, an insurance- policy term may be coextensive with a section, clause, or paragraph of an insurance policy.

i. Standard-form term. A term is a standard-form term if it appears in, or is taken from, an insurance- policy form (including an endorsement) that an insurer makes available for a non-predetermined number of transactions. Unless the circumstances clearly indicate to the contrary, any term that is not specifically negotiated by the parties for inclusion in the insurance policy at issue is a standard-form term. A term contained in an insurance- policy form approved for use by an insurance regulatory authority for any insurer is a standard-form term, unless the circumstances clearly indicate the contrary. Similarly, a term that is a standard-form term in one insurance policy is a standard-form term in another policy. An insurance- policy term created by an insurance broker or other entity may become a standard-form term through such sufficiently regular use in the market that the term is treated by market participants as one of the standard options available for use in the market. A term does not have to be contained in the forms of multiple insurers for it to be a standard-form term.

Illustrations:

1. A standard-form professional-liability insurance policy provides coverage for losses arising out of “professional services.” The declarations page of the policy contains

a blank next to the term “definition of professional services,” which the insurer fills by inserting into each policy a description of services from an online profile of the policyholder. The definition of professional services contained in this policy is not a standard-form term.

2. A liability insurance policy is issued with an endorsement that, at the policyholder’s request, replaces the “prior and pending litigation” exclusion in the insurer’s standard policy with a version of the exclusion taken from a standard policy sold by another company. The prior-and-pending-litigation exclusion in this endorsement is a standard-form term.

3. A broker drafts a new definition of “occurrence” that is incorporated by endorsement into an insurance policy issued to the broker’s client. The definition is not a standard-form term.

REPORTERS’ NOTE

d. Deductibles and self-insured retentions. Black’s Law Dictionary defines a deductible as “the portion of the loss to be borne by the insured before the insurer becomes liable for payment” and defines a “self-insured retention” as “[t]he amount of an otherwise-covered loss that is not covered by an insurance policy and that usually must be paid before the insurer will pay benefits.” BLACK’S LAW DICTIONARY 501, 1566 (10th ed. 2014). For a general discussion of deductibles and retentions and their functions and effects, see 5-47 JEFFREY E. THOMAS, [NEW APPLEMAN ON INSURANCE LAW AND PRACTICE LIBRARY EDITION](#) § 47.03 (Lexis ~~2015~~2017). For a discussion of the differences between deductibles and self-insured retentions, see 3-16 JEFFREY E. THOMAS, [NEW APPLEMAN ON INSURANCE LAW AND PRACTICE LIBRARY EDITION](#) § 16.09[b][i] (Lexis ~~2012~~2017):

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

(Internal footnotes omitted). Cf. *Am. Safety Indem. Co. v. Admiral Ins. Co.*, 162 Cal. Rptr. 3d 699, 708 (Cal. Ct. App. 2013), review denied, 2013 Cal. LEXIS 10507 (Cal. Dec. 18, 2013) (holding that trial court did not err in determining that insureds were not required to satisfy the SIR as a condition of obtaining a defense, when the SIR did not expressly and unambiguously make the duty to defend subject to payment of the SIR). For a discussion on the rules regarding per-accident and per-occurrence deductible clauses, see 12 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 172:12 (3d ed. ~~2011~~2017) (“Any analysis of these issues should start with an inquiry of how many claims are involved, the extent and nature of the injury, the number of causal accidents involved and the continuity, if any, between the injury and accident. Once these factors are determined, the practitioner can turn to the application of the policy provisions to the facts.”).

f. Mandatory and non-mandatory rules. An essential question when adopting a rule of contract law generally or insurance law in particular is whether the rule should be made mandatory or non-mandatory. Can the rule be varied by agreement of the parties or not? Contract-law rules are sometimes mandatory and sometimes non-mandatory. For example, under the Uniform Commercial Code, although parties engaged in a sales transaction can generally limit the remedies that are available for the breach of expressed or implied terms, they may not contractually limit the consumer’s right to recover consequential damages for personal injury in transactions involving the sale of goods by commercial sellers to consumers. U.C.C. UCC § 2-719(3) (AM. LAW INST. & UNIF. LAW COMM’N). Put differently, the UCC creates an implicit term in the contract of sale for every consumer product which provides that the consumer can, under the appropriate circumstances (and depending on the applicable tort law in the relevant jurisdiction), recover consequential damages against the commercial seller of the product in the event of a product-related personal injury; that implicit contract term is mandatory or nonwaivable. See also *Henningsen v. Bloomfield Motors*, 161 A.2d 69, 84 (N.J. 1960) (holding that disclaimer of the implied warranty of merchantability would not be enforced in that case). Whether a particular rule of contract law, or insurance law, is made mandatory or non-mandatory typically depends on factors such as the presence of significant externalities, whether the parties are commercially sophisticated, and whether they have approximately equal bargaining power. See Tom Baker ~~and~~ & Kyle Logue, *Mandatory Rules and Default Rules in Insurance Contracts*, in THE LAW & ECONOMICS OF INSURANCE (Daniel Schwarcz & Peter Siegelman eds., ~~THE LAW & ECONOMICS OF INSURANCE~~ (2015)).

For authority identifying the waiver and estoppel rules designated in the Comment as mandatory or nonwaivable, see, e.g., *Chase v. Nat’l Indem. Co.*, 278 P.2d 68, 72 (Cal. Dist. Ct. App. 1954) (“It has long been established in this state that a general agent has the authority to waive conditions in an insurance policy by mere parol, even though the policy itself requires waivers to be in writing.”); *Van Dyne v. Fidelity-Phenix Ins. Co.*, 244 N.E.2d 752, 759 (Ohio Ct. App. 1969) (“An insurance company cannot, by a nonwaiver provision in its policy, disable itself from subsequently modifying its own contract, or prevent its future conduct from having the

force and effect which the law says it shall have.”); *Britt v. Fid. & Cas. Co. of New York*, 235 F. Supp. ~~150, 153~~ 150 (E.D. Tenn. 1964) (applying Tennessee law); *Copeland v. Dwelling-House Ins. Co.*, 43 N.W. ~~991, 993-994~~ 991 (Mich. 1889).

Regarding the mandatory nature of the independent counsel rules in §§ 16 and 17, while courts have not emphasized this point, homeowner’s, automobile-liability, and commercial general-liability policies generally include standard-form terms that explicitly grant the insurer the right to control the defense of any covered claim. Because courts routinely require insurers to provide independent counsel under such policies, notwithstanding these terms, it can therefore be concluded that the rule is mandatory. [See sources cited in Reporters’ Note to Comment a of § 17.](#) Regarding the mandatory nature of the duty to make reasonable settlement decisions, the fact that liability insurance policies routinely state that the insurer has the “discretion” to settle has not prevented insureds from enforcing that duty. [See sources cited in Reporters’ Note to Comment e of § 24.](#) Therefore it can be concluded that this rule is mandatory as well when the insurer has control over settlement.

Regarding the mandatory nature of the rules governing insurance policy interpretation, the *contra proferentem* rule has been called the “first principle of insurance law.” Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 531 (1996). Perhaps this is why it is difficult to find a reported case involving an insurance policy that contains a provision that attempts to alter that rule of interpretation. Even if such a policy term were proposed by an insurer, it is likely that it would not be permitted by most insurance regulators. ~~A few~~ [Some have claimed that there are published](#) judicial opinions ~~appear to that~~ enforce contract terms purporting to reject the application of the ordinary *contra proferentem* rule, but ~~close analysis of those opinions generally reveals~~ [we have been unable to find any such published opinions. If such opinions do exist, it is our suspicion](#) that the contracts in question were jointly drafted by both parties, such that the *contra proferentem* rule would not have applied in any event, regardless of the presence or absence of a contract term purporting to reject the *contra proferentem* rule. If a term is jointly drafted, there can be no single drafter against whom to interpret any lingering ambiguity. ~~There~~ [It has also been asserted that there](#) are a small number of cases that ~~do~~ suggest, primarily in dicta, that a policyholder can waive the *contra proferentem* rule, provided that the parties to the contract are commercially sophisticated and represented by legal counsel. This Section does not endorse that idea, because it interferes with the authority of the courts over the interpretation of insurance contracts. At most, a term in an insurance policy purporting to waive the *contra proferentem* rule could be evidence regarding the negotiation and drafting of the insurance policy; it would not be binding on a court. The authority of the court over the rules of insurance- policy interpretation promotes the development of uniform, reasoned meanings of insurance- policy terms.

For insurance-law cases that use the specific language of “mandatory rules” and “default rules” in the way that this Section does, though in contexts not addressed by this Section, see, e.g., *Swainston v. Am. Family Mut. Ins. Co.*, 774 N.W.2d 478, 484-485 (Iowa 2009) (expressly holding that state ~~UM~~ [uninsured-motorist](#) anti-stacking rule was “default rule” rather than

“mandatory rule”); *Cagle v. Bruner*, 112 F.3d 1510, 1520-1521 (11th Cir. 1997) (holding that the “make whole” doctrine in subrogation cases is a default rule rather than a mandatory rule); ~~*Greater N.Y. Ins. Co. v. ABC Prof'l Tree Serv., Inc.*, No. CV095010601, 2011 WL 6934599, at *2 (Conn. Super. Ct. Dec. 6, 2011)~~[*DiLullo v. Joseph*, 792 A.2d 819, 822 \(Conn. 2002\)](#) (“This strong public policy [disfavoring economic waste] convinces us that it would be inappropriate to create a default rule that allocates to the tenant the responsibility of maintaining sufficient insurance to cover a claim for subrogation by his landlord’s insurer.”). See also Gilson S. Riecken, *The Duty to Defend Under Non-Insurance Indemnity Agreements*, 50 SANTA CLARA L. REV. 825, 832 (2010) (noting that, although California courts have found a default duty to defend in any indemnity contract, parties “may freely negotiate both indemnity and defense terms . . .”).

i. Standard-form term. For an example of a broker-drafted definition of “occurrence,” see *World Trade Ctr. Props., LLC v. Hartford Fire Ins. Co.*, 345 F.3d ~~154, 160~~[154](#) (2d Cir. 2003) (applying New York law), abrogated by *Wachovia Bank v. Schmidt*, 546 U.S. 303 (2006) (~~discussing the Willis form~~[addressing location of a national bank](#)). Illustration 2 reflects the common practice in the Directors-~~&~~[and](#) Officers’ liability insurance market for policyholders to request specific terms. See TOM BAKER & SEAN GRIFFITH, *ENSURING CORPORATE MISCONDUCT* 186, 193 (2010). For recent research demonstrating the proliferation of differences among standard-form policies in the consumer- insurance market, see Daniel B. Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1266 (2011) (finding variations in terms of homeowner’s insurance policies with most divergent forms more favorable to insurers than the Insurance Services Office (ISO) forms).

TOPIC 1 INTERPRETATION

§ 2. Insurance- Policy Interpretation

(1) Insurance- policy interpretation is the process of determining the meaning of the terms of an insurance policy. Whether those terms as so interpreted are enforceable is determined by reference to other legal rules.

(2) Insurance- policy interpretation is a question of law.

(3) Except as this Restatement or applicable law otherwise provides, the ordinary rules of contract interpretation apply to the interpretation of liability insurance policies.

Comment:

a. Scope. Interpretation is the first substantive topic of this Restatement because of its importance for insurance coverage. Most of the parties' rights and obligations under an insurance policy are set forth in the policy. Courts primarily determine those rights and obligations by interpreting the terms in that policy. This Restatement takes a textualist, or linguistic, approach to interpretation. In interpreting insurance- policy terms, courts are bound by the words in the policy. Insurance- policy terms must be given meanings to which the words in the policy are reasonably susceptible. Courts may in certain circumstances impose terms on the parties that contravene the language in insurance policies, or refuse to enforce terms in policies, but such decisions are not properly regarded as interpretation.

~~Sections 3 and 4 address a range of possible interpretive situations. At one end of the range, there are terms with a single, undisputed meaning when applied to the claim in question. At the other end, there are terms with facially obvious multiple meanings as applied to the claim. The first kind of term can be said to have a "plain meaning." The second kind can be said to be ambiguous on its face. In between these two, there are terms with meanings that may not be obvious to a court, but that would be obvious to the contracting parties in context. Section 3 states a presumption in favor of the plain meaning of a term but allows a court to consider whether there is extrinsic evidence that reveals a nonobvious meaning that a reasonable person would clearly give the term in context. Section 4 states the rules that apply when a term has multiple possible meanings on its face when applied to the claim in question.~~

b. A question of law. The interpretation of an insurance policy is a question of law, even when interpretation involves the consideration of evidence beyond the insurance policy. Interpreting an insurance- policy term ordinarily does not present questions of fact. Judicial decisions regarding the interpretation of standard-form terms provide guidance regarding the application of the terms in other cases. Judicial decisions are subject to de novo review on appeal and provide *stare decisis*. They provide reasons that the parties can understand and that participants in the insurance market can use to predict future decisions. Such guidance is a public benefit that is not provided by jury decisions. On rare occasions, there may be a pure question of fact relating to interpretation of an insurance policy, such as a factual dispute regarding what happened during negotiations or course of performance that bears upon the contractual intent of the parties, especially regarding a non-standard-form term, but, ordinarily, the application of extrinsic evidence to determine the meaning of a term is a question of law for the court to determine. If there is such a question of fact, the court could instruct the jury on the legal consequences of the possible alternative findings of fact; alternatively, the jury could be asked to provide a special verdict with its findings of fact that the court would then use to resolve the coverage dispute.

Illustrations:

1. An adjoining property owner files a tort action against an automobile service station that is insured under a commercial general-liability insurance policy. The complaint alleges that toxic chemicals, released on a gradual basis from the service station over a long period of time, have contaminated the plaintiff's property. The service station's liability insurance policy contains a standard-form pollution exclusion that excludes coverage of liability for harm arising out of the discharge, dispersal, or release of toxic chemicals and other designated substances, with an exception for a discharge that is "sudden and accidental." The insurer agrees to defend the legal action but reserves the right to deny coverage based on the pollution exclusion.

The insurer contends that "sudden and accidental" includes a temporal requirement, such that liability arising out of gradual releases that take place over a long period of time is not covered. The service station counters that the exclusion is ambiguous. It argues that the drafting history of the pollution exclusion, administrative-agency filings made by the insurance industry, and other circumstances surrounding the

drafting and approval of the exclusion contradict the interpretation proffered by the insurer. The interpretation of the pollution exclusion in these circumstances is a question of law for the court, whether or not it considers the extrinsic evidence.

2. A medical-records-processing business is sued for negligently overcharging for copies. The business is insured under a liability insurance policy that provides coverage for liability arising out of “any actual or alleged negligent act or omission committed in the rendering or failure to render the Professional Services stated in the Declarations.” The declarations of the policy define the term “professional services” as “Medical Records Processor,” a definition that was specially inserted into the declarations in the course of negotiations for the policy. The insurer denies coverage for the legal action on the grounds that charging for copies is not a “professional service” that involves a specialized skill that distinguishes a particular occupation from another occupation. The records processor files a breach-of-contract action alleging that documents and discussions from the parties’ negotiation of the policy demonstrate that the parties intended the definition of “professional services” to include all of the essential components of the medical-records-processing business, including the determination of the fees to be charged, without regard to whether any particular component could also be regarded as an ordinary commercial activity. The parties’ intent regarding this specially negotiated term is a question of fact that, if relevant and disputed, is appropriate for resolution by the trier of fact.

c. Objectives of liability-insurance-policy interpretation. The appellate oversight and public guidance provided by judicial decisions interpreting liability insurance policies promote the objectives of liability-insurance-policy interpretation. These objectives include: effecting the dominant protective purpose of insurance; facilitating the resolution of insurance-coverage disputes and the payment of covered claims; encouraging the accurate description of insurance policies by insurers and their agents; and providing clear guidance on the meaning of insurance-policy terms in order to promote, among other benefits, fair and efficient insurance pricing, underwriting, and claims management. These objectives provide guidance for the interpretation of insurance policies.

d. The importance of consistent meanings of standard-form insurance-policy terms. Insurance policies generally are standard-form contracts sold on a mass-market basis. This is

universally the case for personal-lines insurance policies sold to individuals, such as personal-automobile and homeowner's insurance (the liability-coverage parts of which are the most widely distributed forms of liability insurance coverage in the United States). Even in the commercial insurance market, the vast majority of insurance policies are standard-form contracts. A prospective policyholder generally is able to customize the coverage only by selecting among the forms offered by the insurer. Adjudication of the meaning of a standard-form term in one case has consequences for the scope of the risks insured under all similar policies. Interpretive rules that give the same meaning to an insurance-policy term in all contexts facilitate the orderly operation of the insurance market and, accordingly, are preferred. Although it is unlikely that most consumers are directly aware of the results of adjudication, those results inform insurers and insurance intermediaries in the pricing and marketing of insurance policies.

To the extent that this process results in clearly worded, understandable insurance policies, those policies may in some cases provide useful information to consumers in the purchasing process, although it must be noted that current practices in the consumer insurance market make it unlikely that a consumer will receive a complete copy of a liability insurance policy before purchase. It is not assumed or expected that consumers ordinarily read their insurance policies, nor that legal rules can do very much to change consumer behavior in that regard.

e. Financial responsibility. Liability insurance coverage often sets practical boundaries on the ability to enforce liability. Individuals and firms frequently are obligated to purchase liability insurance, either as a matter of statutory law or contract, in order that they will be able to compensate third parties whom they injure through breach of a legal duty. This financial-responsibility objective informs and stimulates demand for liability insurance and, therefore, is part of the justification for the traditional insurance-law approach to insurance-policy interpretation. This objective does not mean, however, that insurance-policy terms should be given strained or unreasonable meanings in order to provide compensation to injured parties.

f. Interpretation and application. Once the court determines the meaning of an insurance-policy term, the term is then applied to the claim to determine, for example, whether the claim is covered. In many cases the facts relevant to a coverage determination are not in question and, thus, there will be no need for a trial. In other cases there is a factual dispute regarding some aspect of the claim such that interpretation of the insurance policy is not sufficient to make the

coverage determination. In those cases, the trier of fact applies the term to the claim. If the trier of fact is a jury, the court instructs it on the meaning of the insurance-policy term.

Illustration:

3. Same facts as Illustration 1, except that the service station also contends that some or all of the toxic chemicals were released as a result of specific accidents that occurred at discrete moments. If the court determines that “sudden and accidental” includes a temporal component, questions such as whether these releases were accidental, whether they occurred at discrete moments and, if so, how much of the damage is attributable to them are questions of application that, if disputed, are for the jury to determine based on instructions from the court regarding the meaning of “sudden and accidental.”

g. Construction and interpretation. Construction is sometimes distinguished from interpretation, with construction referring to the process of determining the legal effect of the terms in the contract, and interpretation referring to the process of determining the meaning of the document that sets forth the terms of a contract. In most insurance cases, construction collapses into interpretation. The insurance policy is almost always regarded as setting forth all of the terms of the insurance contract, except for terms that are implied in law, such as the duty of good faith and fair dealing, or a term that is implied in law in the contract unless the parties specify a contrary term (commonly referred to as a default term). The legal effect of an insurance-policy term ordinarily is the same as its meaning. In the event that an insurance policy does not contain a term to which the parties agreed, the contract-law doctrine of reformation will supply that term, which is then subject to interpretation. The rules stated in this interpretation Topic do not affect any of the legal rules regarding the enforceability of insurance-policy terms (such as unconscionability or prohibitions on terms that are against public policy).

h. Relationship to contract law. Although the rules of insurance-policy interpretation may be understood as a subset of the general law of contracts, the insurance context is sufficiently different from those that inform the general contract-law paradigm that insurance-policy-interpretation rules are properly considered to be distinct from general contract-interpretation rules in some respects. The vast majority of insurance policies are standard-form, mass-market products; they are not negotiated agreements as to which the

purchasers can be understood to have a well-developed intent. All insurance contracts are aleatory, meaning that the policyholder pays for the insurer’s promise to perform in the future, based on the occurrence of an event that is uncertain at the time of purchase, and following the occurrence of which it is too late for the policyholder to take other meaningful steps to obtain the purchased protection. Moreover, the insurance business represents one of the most important, longstanding, and self-conscious efforts to harness private markets to promote the public good. Of course there are other kinds of contracts that share some or all of these features, but there are few, if any, other kinds of contracts with these features that are so deeply entwined with the civil-justice system and so commonly before the courts that an analytically distinct set of common-law doctrines could have developed from this process, as is the case with the common law of insurance.

i. Administrative approval of insurance- policy forms. Statutory law commonly requires insurers to obtain approval of a standard-form insurance policy (including the revision of a term in the policy) or other standard form from a designated insurance regulatory agency before using the policy or form in the market. Such statutory law may in some circumstances have significance for the enforceability of terms in insurance policies. However, the mere approval or non-approval of an insurance policy or other form has no significance for the meaning of the terms in the policy or form (though materials submitted to the administrative agency may be relevant extrinsic evidence of meaning in the event that extrinsic evidence may be considered). For example, the fact that the appropriate administrative agency approved a policy form has no bearing on whether a term in the policy has a plain meaning or is ambiguous, or whether the plain meaning, if there is one, is the proper interpretation of the term. The primacy of the courts in the interpretation of the terms of an insurance policy follows from the legal status of insurance policies as contracts. In approving an insurance- policy form, insurance administrative agencies generally do not issue legally definitive rulings or other statements regarding the meaning of terms in the policy.

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b. A question of law. For a general discussion of the role of courts, as opposed to juries, in interpreting insurance policies, see ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW [153-133](#) (45th ed. [2007-2012](#)) (reporting that courts typically retain insurance- policy interpretation “for their own determination” even when interpretation

requires assessment of extrinsic evidence); 1 JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE CONTRACTS COVERAGE § 4.08 (3d4th ed. 20112016) (“Contract interpretation is normally regarded as a question of law . . . The court also therefore decides and treats as a matter of law the question of whether a contract term is ambiguous . . . [and] where . . . determination of ambiguity or meaning depends on uncontested facts, the question remains one of law for the court.”). Compare *Harbor Ins. Co. v. Schnabel Foundation Co.*, ~~Inc.~~, 946 F.2d 930, 934 n.1 (D.C. Cir. 1991) (applying District of Columbia law) (noting that summary judgment may be appropriate—and a factfinder therefore unnecessary even when extrinsic evidence is needed in the policy interpretation—so long as the extrinsic evidence “demonstrates only one view is reasonable”) and *Transport Indem. Co. v. Dahlen Transport InsInc.*, 161 N.W.2d 546, ~~548~~550 (Minn. 1968) (explaining that contract construction is “a question of law for the court” when “extrinsic evidence is conclusive and undisputed and renders the meaning of the contract clear” (quoting *Leslie v. Minneapolis Teachers Ret. Fund Ass’n.*, 16 N.W.2d 313, 315 (Minn. 1944))) with *Anderson v. Brown*, 176 N.W.2d 457, 459-460 (Mich. Ct. App. 1970) (“Words that are clear in their meaning when standing alone in a contract often give rise to ambiguity when they are applied to a given set of facts, and this ambiguity in turn gives rise to a question of fact” that is appropriately left to the jury.). Although the legal status of insurance policies as contracts is well established, it has long been recognized that insurance policies do not in fact fit easily within an ordinary contract model. See, e.g., Edwin S. Patterson, *The Delivery of a Life Insurance Policy*, 33 HARV. L. REV. 198, ~~199~~200 (1919) (discussing how the delivery of an insurance contract “may have legal significance in three ways”); see also Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 635 (1943) (“[T]he courts pay merely lip service to the dogma that the common law of contracts governs insurance contracts.”). As a result, insurance policies are not subject to all of the rules of ordinary contract doctrine. See generally Kenneth S. Abraham, *Four Conceptions of Insurance*, 163 U. PA. L. REV. 653 (2013). The rules stated in Chapter 1 reflect what Professor Abraham refers to as the “contract conception” of insurance, but some of the rules in other Chapters are strongly influenced by the other conceptions of insurance. Illustration 2 is adapted from *Med. Records Assocs., Inc. v. Am. Empire Surplus Lines Ins. Co.*, 142 F.3d ~~512~~, ~~515~~512 (1st Cir. 1998) (applying Massachusetts law).

c. Objectives of liability-insurance-policy interpretation. In the insurance field, courts typically refer to the dominant purpose of indemnity or protection. See, e.g., *Kalell v. Mut. Fire and Auto. Ins. Co.*, 471 N.W.2d 865, 868 (Iowa 1991) (citation omitted) (“This interpretation is consistent with the general rule that insurance policies are read to effect the policy’s dominant purpose of indemnity or payment to the insured.”); *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 471 (Ind. 1985) (“In order to achieve the objectives in Indiana law, of giving effect to the policies’ dominant purpose of indemnity, we hold that coverage is triggered . . . This holding comports with the rule of interpretation that the courts should strive to give effect to the reasonable expectations of the insured.”).

d. The importance of consistent meanings of standard-form insurance-policy terms. In the contracts literature, insurance policies are the paradigmatic mass-market, standard-form contract of adhesion. See, e.g., Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1269 (1983) (“Insurance contracts of this sort are doubtless contracts of adhesion.”). Insurance-law commentators generally agree that “the typical purchaser of insurance takes a packaged product.” ROBERT E. KEETON, *BASIC TEXT ON INSURANCE LAW* 63 (1971); see also ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 159-140 (45th ed. 2007-2012) (“Although the insured can choose from a variety of available coverages, the insured cannot negotiate the substance of the contract with the insurer. . . . The insured is confronted with a ‘take or leave’ choice.”); 1 JEFFREY W. STEMPER & ERIK S. KNUITSEN, *STEMPEL AND KNUITSEN ON INSURANCE CONTRACTS-COVERAGE* § 4.06[B] (3d-4th ed. 2011-2016) (“The typical insurance policy sale is marked by formality and routinization. Consequently, insurance policies almost always are both standardized contracts and contracts of adhesion . . .”). For examples of cases reiterating the observation that insurance contracts are contracts of adhesion, see, e.g., *Nelson v. Progressive Cas. Ins. Co.*, 162 P.3d 1228, 1235 (Alaska 2007) (“ . . . [A]n insurance policy is a contract of adhesion.”); *Farmers Ins. Co. of Idaho v. Talbot*, 987 P.2d 1043, 1047 (Idaho 1999) (“ . . . [I]nsurance contracts are adhesion contracts.”). For an illustration of the difficulty of obtaining copies of consumer liability insurance policies for the purposes of comparing the terms of different policies, see Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1319-1320 (2011).

e. Financial responsibility. See generally Tom Baker, *Insurance as Tort Regulation: Six Ways that Liability Insurance Shapes Tort Law*, 12 CONN. INS. L.J. 1 (2006); see also JEFFREY E. THOMAS, *New Appleman on Insurance Law Library Edition* § 5.06[2] (Lexis 2012-2017) (writing that public policy, including the public policy to compensate third-party victims, directly and indirectly influences insurance-contract interpretation). Forty-nine states now require that automobile drivers demonstrate the financial responsibility to cover accident costs, including many that mandate the purchase of insurance. See ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 960-936 (45th ed. 2007-2012).

f. Interpretation and application. ~~JOHN D. CALAMARI & JOSEPH M. PERILLO, CONTRACTS 165-135 (3d-7th ed. 1987-2014)~~ (“The distinction is, for the most part, not dwelled upon by the courts, with the result that it is difficult to tell which process is being employed. ~~It is even difficult to tell whether the Restatement definition of interpretation refers to interpretation or construction or both.~~ For these reasons the distinction will not be pursued here.”). On the ordinary rules of contract interpretation, see, e.g., *Restatement Second, Contracts* § 202 (AM. LAW INST. 1981) (setting forth “rules in aid of interpretation”).

§ 3. The Plain Meaning Rule

(1) The plain meaning of an insurance policy term is the single meaning to which the language of the term is reasonably susceptible when applied to facts of the claim at issue in the context of the entire insurance policy.

(2) If an insurance policy term has a plain meaning when applied to the facts of the claim at issue, the term is interpreted according to that meaning.

(3) An insurance policy term is ambiguous if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the facts of the claim at issue in the context of the entire insurance policy. An ambiguous term is interpreted as specified in § 4.

Comment:

a. The two traditional approaches to interpretation. There are two main approaches to the interpretation of contracts that find support in the common law of insurance: the contextual approach and the plain meaning approach. Under the contextual approach, which was adopted in the Restatement Second of Contracts, courts interpret insurance policy terms in light of all the circumstances surrounding the drafting, negotiation, and performance of the insurance policy. Under the plain meaning approach, which is typically followed in insurance law, courts interpret an insurance policy term on the basis of its plain meaning, if it has one. This Section does not follow the Restatement Second of Contracts contextual rule because a substantial majority of courts in insurance cases have adopted a plain meaning rule. Moreover, because of the mass market nature of ~~liability~~liability insurance, there is value in a rule that rewards and encourages the drafting of insurance policy terms that have a plain meaning. The plain meaning approach promotes consistency of interpretation of insurance policies using the same language in similar contexts, giving the parties to standardized insurance policies greater confidence that they will be uniformly enforced.

b. Generally accepted sources of plain meaning. Generally accepted sources that courts consult when determining the plain meaning of an insurance policy term include: dictionaries, court decisions, statutes and regulations, and secondary legal authority such as treatises and law review articles. Such sources of meaning are not “extrinsic evidence” under any definition of that

term. Rather, they are legal authorities that courts consult when determining the plain meaning of an insurance policy term, which is a legal question.

c. Custom, practice, and usage. Many courts that follow a strict plain meaning rule also consider custom, practice, and usage when determining the plain meaning of insurance policies entered into between parties who can reasonably be expected to have transacted with knowledge of that custom, practice, or usage. ~~This is the better approach because informed~~ When such sources of meaning can be discerned from public sources and with only limited discovery (such as through an affidavit of an expert in the trade or business, who is subject to deposition, but without the need for extensive document requests), this is the better approach. Informed insurance market participants conduct their business in light of custom, practice, and usage in the insurance market and in the trade ~~of the~~or business being insured. Like the sources of meaning listed in Comment *b*, custom, practice, and usage inform the court’s determination of the objective meaning of insurance policy terms in the relevant market, as distinguished from the specific or subjective intent of a particular party. Efforts to ensure that insurance policy terms are interpreted in a manner that is consistent with those sources of meaning promote certainty in the insurance market. Moreover, in jurisdictions in which the meaning of an ambiguous term is a question for the jury, consideration of custom, practice, and usage at the plain meaning stage of the analysis can help the court resolve an apparent ambiguity and thereby allow the court to determine the meaning of the term on summary judgment.

Consideration of custom, practice, and usage at the plain meaning stage does not open the door to extrinsic evidence such as drafting history, course of dealing, or precontractual negotiations. In that regard, it is important to note that the term “extrinsic evidence” does not include all sources of meaning that are extrinsic to the policy. The facts of the claim at issue are extrinsic to the policy, as are custom, practice, and usage. Yet, all courts that follow the plainmeaning rule permit consideration of claim facts and many of those courts also permit consideration of trade custom, practice, and usage when determining whether a term has a plain meaning and, if so, what that meaning is.

While courts do not generally conduct a cost-benefit analysis when considering whether to permit consideration of custom, practice, and usage at the plain meaning stage of the analysis, the costs of considering these sources of meaning should generally be low because, by definition, a custom, practice, or usage will be widely known in the insurance market, or in the trade ~~of~~

~~the~~or business being insured, and, thus, capable of being documented and presented to the court without burdensome discovery. There should be no need to take discovery to discern, prima facie, the existence of a custom, practice, or usage. Each party should be knowledgeable of custom, practice, and usage in its own trade or business; insurers should have access to information outside of discovery regarding custom, practice, and usages in the trades or businesses that they insure; and insureds should have access outside of discovery to insurance brokers and others with knowledge of the insurance industry. Discovery necessary to impeach an opposing party's evidence is a matter that trial judges have the capacity to manage. Note that custom, practice, and usage may be used only against a party who can reasonably be charged with knowledge of that custom, practice, or usage. Thus, for example, if there is a special, insurance-trade understanding of a term, and if the policyholder is an organization that would reasonably be expected to be aware of that trade understanding, then the term should ordinarily be given that meaning.

Illustrations:

1. A stock exchange is sued by a class of retail investors for actions taken in connection with a troubled initial public offering. The exchange's errors and omissions (E&O) insurer agrees to pay for the defense. The exchange's directors' and officers' (D&O) insurer denies coverage based on a professional services exclusion in the policy that excludes coverage for any claim "by or on behalf of a customer or client of the" exchange. After settlement of the class action, the exchange and its E&O carrier bring an action against the D&O insurer seeking to recover a share of the costs of defense and settlement of the claim, arguing that the exchange's customers are brokers-dealers, not retail investors. Finding that the custom and usage of the term "customers" in the securities markets demonstrates that retail investors are customers of a stock exchange, the court grants summary judgment for the D&O insurer.

2. A fuel delivery company is sued when fuel oil leaks out of a truck while parked overnight. The company seeks coverage from its auto liability insurer, which regularly insures fuel delivery companies and is familiar with custom and practice in that trade. The insurer denies coverage based on an exclusion for release of pollutants "being stored ... upon the covered auto." The fuel delivery company brings a breach of contract action, on

the grounds that it had purchased a pollution liability endorsement that provided coverage for damages arising out of the release of pollutants “being transported” by covered vehicles or “otherwise in the course of transit by or on behalf” of the company. The fuel company demonstrates to the court that the established custom in the fuel delivery business is to leave fuel in trucks while parked between deliveries, including overnight, and such activity is not regarded as storage in the truck. The court determines that fuel that is left in a truck while parked between deliveries overnight is “otherwise in the course of transit by” the company and grants summary judgment for the insured.

d. What sources of meaning may not be considered when determining whether a term is ambiguous. Courts that follow a plain -meaning rule may consider the sources of meaning described in Comments *b* and *c* when determining whether a term is ambiguous, but they may not consider precontractual negotiations, course of dealing, or other forms of extrinsic evidence. These ~~other~~latter sources of meaning may be considered only if the court first makes the threshold determination that the insurance policy term is ambiguous when applied to the facts of the claim at issue. This more restrictive rule reflects a judgment by courts that the additional costs of considering such evidence when making the threshold ambiguity determination (such as the increased costs of discovery and a reduced likelihood that the case will be resolved before discovery) outweigh the benefits of considering such evidence (such as an increase in the accuracy of the court’s assessment of a term’s meaning). Although courts rarely make such a cost-benefit calculation explicitly, the implicit judgment is that the costs will be incurred in many cases, whereas the benefits will be realized only in a small fraction of those cases.

Courts generally agree that, once a court determines that a term is ambiguous, it may consider a wide range of potential sources of meaning in the effort to resolve the ambiguity. See Comment *h* to § 4. Courts differ on whether these types of evidence should be discoverable before the court has determined that the term at issue is ambiguous. Because discoverability implicates civil -procedure concerns that are beyond the scope of this Restatement, this Section does not ~~propose~~state a rule regarding discovery of such evidence. Courts in some states have articulated a broad “latent ambiguity” rule that, unlike the rule followed in this Section, permits courts to consider a similarly broad range of circumstances at the threshold, ambiguity-determination stage, reasoning that this approach better protects the reasonable

expectations of insurance purchasers—and that the additional administrative costs are worth incurring as a result. This Restatement does not adopt this latent-ambiguity rule.

e. Purpose. A policy term that might otherwise be subject to a wide range of meanings can sometimes be given greater precision by reference to the purpose of the term in the context of the policy as a whole. For standard-form terms, the purpose inquiry is entirely objective. The objective purpose of a standard-form term often can be determined from the sources listed in Comments *b* and *c*, in which case ~~the~~ the purpose of the policy term can inform the court’s determination of the plain meaning of the term.

f. Definition of ambiguity. An ambiguous policy term is a term that has at least two interpretations to which the language of the term is reasonably susceptible when applied to the facts of the claim in question. This definition follows the traditional insurance-law approach pursuant to which the competing interpretations need not be equally reasonable for a term to be ambiguous. All that is required is that the language of the policy be reasonably susceptible to the coverage-promoting interpretation urged by the insured. The concept of ambiguity in insurance law can include what is sometimes called vagueness: a lack of clarity in application that does not easily reduce to multiple competing interpretations. A term that has a plain meaning when applied to one claim may not have a plain meaning when applied to another claim.

Illustrations:

3. A policyholder is sued for negligent infliction of emotional distress. The complaint alleges that the distress resulted in headaches, stomach pains, nausea, and body pains. The insurer denies coverage for the suit on the grounds that the suit does not seek “damages because of . . . bodily injury,” as required by the liability insurance policy. The insurance policy defines “bodily injury” as “bodily injury, sickness or disease.” The insurer argues that the suit is for damages because of emotional distress, not because of bodily injury; the alleged aches and pains were a consequence of the emotional distress, and not the basis for the suit. The policyholder argues that the aches and pains are “bodily injury” and that the suit seeks “damages because of . . . bodily injury”; the plaintiff is using the existence of the aches and pains as evidence of the seriousness of the emotional distress and as a basis for the alleged damages. The court determines that the language of the policy is reasonably susceptible to both interpretations. “Bodily injury” does not have

a plain meaning in the context of this suit; it is ambiguous in relation to allegations of emotional injury that produces these physical manifestations.

4. Same facts as Illustration 3, except the complaint alleges that the distress resulted in “pain and suffering, including humiliation, loss of self-esteem, irritability, and sleeplessness.” The policyholder argues that the suit seeks “damages because of . . . bodily injury” because irritability and sleeplessness are physical manifestations that demonstrate the seriousness of the emotional distress. The court determines that, when used in a liability insurance policy, the term “bodily injury” is not reasonably susceptible to an interpretation that includes irritability and sleeplessness arising out of the negligent infliction of emotional distress. Thus, the term is not ambiguous when applied to the suit. The suit is not covered.

5. A tour company is sued for negligence that allegedly caused a patron to drown while snorkeling during an eco-tour excursion in the Florida Keys. The company’s liability insurer agrees to defend the action while reserving the right to deny coverage based on an exclusion for bodily injury to any person “while participating in any sports or athletic activity.” The insurer files a declaratory-judgment action seeking to terminate the defense and then files for summary judgment on the grounds that the injury occurred while the patron was “participating in any sports or athletic activity.” The court determines that the term “sports or athletic activity” does not have a plain meaning when applied to death while snorkeling on an eco-tour.

6. A tour company is sued for negligence that allegedly caused a patron to injure her back while participating in a touch ₪football game during an eco-tour excursion in Costa Rica. The company’s liability insurer declines to defend the action based on an exclusion for bodily injury to any person “while participating in any sports or athletic activity.” The company files an action alleging that the insurer breached the duty to defend. The court determines that the term “sports or athletic activity” does have a plain meaning when applied to a touch ₪football game. The suit is not covered.

g. In the context of the entire policy. Other parts of the insurance policy are an important source of guidance regarding the plain meaning of an insurance policy term, particularly when the term contains a word used elsewhere in the policy. It must be recognized, however, that

insurance policies may consist of components that evolve over time along different paths, are amended or retained because of understandings that develop in the market and in judicial interpretations, or make explicit rights or obligations that the law would imply in any event. Accordingly, while courts should avoid an interpretation that renders a term meaningless, insurance policies may contain what might be considered redundancies or surplusage. Reading a term in the context of the policy as a whole does not require giving a term an unnaturally restrictive meaning simply because it overlaps with another term in the policy.

h. Relationship to reasonable expectations. The rules stated in this Section and in § 4 are broadly consistent with the principle that insurance policy terms are to be interpreted according to the reasonable expectations of the insured, provided that the understanding of what makes an expectation “reasonable” incorporates the concept of plain meaning. The term “reasonable expectations” is not used in the black letter of this or other Sections because of the wide variation in the way that courts have employed that term. By requiring that the meaning be one to which the words are reasonably susceptible, this Restatement does not follow the strong formulation of the reasonable-expectations doctrine, pursuant to which an insurance policy is to be interpreted according to the reasonable expectations of the insured even if the insurance policy language is to the contrary. So stated, the reasonable-expectations doctrine is not actually a rule of interpretation. Rather, it is a rule regarding the enforceability of terms that are inconsistent with the reasonable expectations of the insured. As stated in § 2, the enforceability of insurance policy terms is governed by legal rules other than those regarding interpretation.

i. The parol e-evidence rule. While the plain e-meaning rule applied in insurance law cases and the parol e-evidence rule have underlying conceptual similarities, the two rules are not identical. See Restatement Second, Contracts § 213 (parol e-evidence rule).

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a. The two traditional approaches to interpretation. For examples of opinions from the courts that follow the ~~majority~~, plain e-meaning rule, see *Am. Family Mut. Ins. Co. v. Hansen*, 375 P.3d 115, 117 (Colo. 2016) (“An ambiguity must appear in the four corners of the document before extrinsic evidence can be considered”); *Heyman Associates No. 1 v. Insurance Co. of the State of Pennsylvania*, 653 A.2d 122, 135 (Conn. 1995) (“Because we determine that the plain meaning of ‘pollutant’ includes fuel oil that has been spilled into a waterway such as Stamford Harbor, we may not look to extrinsic evidence of the exclusion’s drafting history to find a contrary meaning”); *Eagle Indus., Inc. v. DeVilbiss Health Care, Inc.*, 702 A.2d 1228, 1232 (Del.

1997) (“[i]f a contract is unambiguous, extrinsic evidence may not be used to interpret the intent of the parties, to vary the terms of the contract or to create an ambiguity.”); *May v. Cont’l Cas. Co.*, 936 A.2d 747, 751 (D.C. 2007) (citation omitted) (“In determining whether a contract is ambiguous, we examine the document on its face, giving the language used its plain meaning.”); *Dimmitt Chevrolet, Inc. v. Southeastern Fid. Ins. Corp.*, 636 So. 2d 700, 705 (Fla. 1993) (“Because we conclude that the policy language is unambiguous, we find it inappropriate and unnecessary to consider the arguments pertaining to the drafting history of the pollution exclusion clause.”); *Henn v. Am. Family Mut. Ins. Co.*, 894 N.W.2d 179, 181 (Neb. 2017) (“While an ambiguous insurance policy will be construed in favor of the insured, ambiguity will not be read into policy language which is plain and unambiguous in order to construe against the preparer of the contract.”); *Bates v. Phenix Mut. Fire Ins. Co.*, 943 A.2d 750, 753 (N.H. 2008) (citation omitted) (“We need not examine the parties’ reasonable expectations of coverage when a policy is clear and unambiguous; absent ambiguity, our search for the parties’ intent is limited to the words of the policy”); *Selective Ins. Co. of Am. v. County of Rensselaer*, 47 N.E.3d 458, 461 (N.Y. 2016) (citation omitted) (“[U]nambiguous provisions of an insurance contract must be given their plain and ordinary meaning”); *Hanneman v. Cont’l W. Ins. Co.*, 575 N.W.2d 445 (N.D. 1998); *Natl. Union Fire Ins. Co. of Pittsburgh, Pa. v. Shane & Shane Co., L.P.A.*, 605 N.E.2d 1325, 1328 (Ohio Ct. App. 1992) (“[A]n insurance policy, like any other written contract, is interpreted from the four corners of the agreement unless a necessity arises which compels a court to go outside the four corners of the written agreement to prevent injustice.”); *Hoffman Const. Constr. Co. of Alaska v. Fred S. James & Co. of Oregon*, 836 P.2d 703, 706 (Or. 1992), as affirmed by *North Pacific Ins. Co. v. Hamilton*, 22 P.3d 739, 741-742 (Or. 2001) (“[A] term is ambiguous . . . only if two or more plausible interpretations of that term withstand scrutiny, i.e., continues to be reasonable, after the interpretations are examined in the light of, among other things, the particular context in which that term is used in the policy and the broader context of the policy as a whole.”); *Kelley-Coppedge, Inc. v. Highlands Ins. Co.*, 980 S.W.2d 462, 464 (Tex. 1998) (“If a written contract is so worded that it can be given a definite or certain legal meaning, then it is not ambiguous. Parol evidence is not admissible for the purpose of creating an ambiguity.”); *Salzi v. Virginia Farm Bureau Mut. Ins. Co.*, 556 S.E.2d 758, 760 (Va. 2002) (“[A]n ambiguity, if one exists, must be found on the face of the policy.” (citation omitted)); *Bethke v. Auto-Owners Ins. Co.*, 825 N.W.2d 482, 488 (Wis. 2013) (noting that “Ambiguity may exist in the language of an insurance policy either on its face or as applied to the extrinsic facts to which it refers” and referring to an influential insurance-law treatise and opinions from other jurisdictions); *Colorado Cas. Ins. Co. v. Sammons*, 157 P.3d 460, 465 (Wyo. 2007). See also La. Civ. Code Ann. art. 2046 (“When the words of a contract are clear and explicit and lead to no absurd consequences, no further interpretation may be made in search of the parties’ intent.”).

Examples of opinions from courts that follow a contextual approach include: *Peterson v. Wirum*, 625 P.2d 866, 871 (Alaska 1981) (“extrinsic evidence regarding the intent of the parties may be used to interpret a contract regardless of whether the contract appears to be ambiguous on its face or not.”); *Am. Nat’l Fire Ins. Co. v. Esquire Labs of Arizona*, 694 P.2d 800, 811 (Ariz.

Ct. App. 1984) (instructing the trial court to consider “evidence on surrounding circumstances, including negotiation, prior understandings, subsequent conduct and the like” without regard to whether the contract is ambiguous); *Pac. Gas & Elec. Co. v. G.W. Thomas Drayage Co.*, 442 P.2d 641, 644 (Cal. 1968) (“The test of admissibility of extrinsic evidence to explain the meaning of a written instrument is not whether it appears to the court to be plain and unambiguous on its face, but whether the offered evidence is relevant to prove a meaning to which the language of the instrument is reasonably susceptible.”); *London Mkt. Insurers v. Super. Ct.*, 53 Cal. Rptr. 3d 154, 160-164 (Ct. App. 2007) (applying *Pacific Gas* to a liability-insurance-coverage action and considering, inter alia, some of the drafting history of the term in question and noting the relevance of that drafting history to the decision of the trial court on remand); *Peak v. Adams*, 799 N.W.2d 535, 544 (Iowa 2011) (citation omitted) (“When interpreting contracts, we may look to extrinsic evidence, including the situation and relations of the parties, the subject matter of the transaction, preliminary negotiations and statements made therein, usages of trade, and the course of dealing between the parties.”) (note that because Iowa adheres to the strong version of the reasonable-expectations doctrine in insurance law, which is rejected in this Restatement, the question of latent ambiguity has not arisen in insurance cases decided under insurance law since the landmark case of *C&J Fertilizer, Inc. v. Allie Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975)); and *Clendenin Bros. v. U.S. Fire Ins. Co.*, 889 A.2d 387, 395 (Md. 2006) (citation omitted) (“Maryland state courts examine the character of the contract, its purpose, and the facts and circumstances of the parties at the time of execution.”).

Many legal commentators have long advocated a more contextual approach. See, e.g., Oliver Wendell Holmes, *The Theory of Legal Interpretation*, 12 HARV. L. REV. 417, 417 (1899) (“A word generally has several meanings, even in the dictionary. You have to consider the sentence in which it stands to decide which of those meanings it bears in the particular case, and very likely will see that it there has a shade of significance more refined than any given in the word-book.”). Modern contract law as embodied in the Restatement Second, Contracts, and the Uniform Commercial Code also supports a contextual approach. See UCC § 2-202, Comment 2 (AM. LAW INST. & UNIF. LAW COMM’N) (“[W]ritings are to be read on the assumption that the course of prior dealings between the parties and the usages of trade were taken for granted when the document was phrased. Unless carefully negated they have become an element of the meaning of the words used.”); Restatement Second, Contracts § 212, Comment *b* (AM. LAW INST. 1981) (“It is sometimes said that extrinsic evidence cannot change the plain meaning of a writing, but meaning can almost never be plain except in a context.”). For commentary supporting the contextual approach in insurance law cases, see 1 JEFFREY W. STEMPEL & ERIK S. KNUTSEN, *STEMPEL & KNUTSEN ON INSURANCE COVERAGE* § 4.03[C] (4th ed. 2016) (“Correctly decided cases consider the context of the insurance or other contract transaction in determining the meaning of contract terms. This can include information as to technical terminology, trade usage, and even the prior course of dealing of the parties.”)

Professor Clarke has usefully described the role of context in the interpretation of insurance policies as follows:

The ordinary meaning of words is the meaning when read not in isolation but in context. The context is a series of circles: the phrase, the sentence, the paragraph, the part of the policy, the whole of the policy, and then, outside the policy itself, the past dealings of the parties, the trade context, and the objects which the policy was intended to achieve.

MALCOLM A. CLARKE, *THE LAW OF INSURANCE CONTRACTS* § 15-3, at 419 (4th ed. 2002). As Professor Clarke’s description illustrates, the difference between the plain meaning approach and the contextual approach lies, not in the consideration of context altogether, but rather in the extent of the context that is considered. As explained in Comments *b* and *c*, the plain meaning rule allows the court to consider the policy, the purpose of the policy, dictionaries, primary and secondary legal authorities, and trade usage.

b. Generally accepted sources of plain meaning. For examples of courts citing dictionaries, see *Arizona Prop. & Cas. Ins. Guar. Fund v. Helme*, 735 P.2d 451, 456 ([Ariz.](#) 1987) (citing Webster’s dictionary to establish that “a ‘related’ act or omission . . . is one that has a logical *or* causal connection with another act or omission”); *Colorado Cas. Ins. Co. v. Sammons*, 157 P.3d 460, 467-468 (Wyo. 2007) (relying on dictionary definitions of “replace” and “necessarily” to supply the plain meanings of those terms); *Doe Run Res. Corp. v. Am. Guarantee & Liab. Ins.*, 531 S.W.3d 508, 512-513 (Mo. 2017) (relying on the dictionary definitions of “irritant” and “contaminant” to establish the plain meaning of those terms in a pollution exclusion); *Mut. Serv. Cas. Ins. Co. v. Wilson Twp.*, 603 N.W.2d 151, 153-154 (Minn. Ct. App. 1999) (citing dictionaries’ definitions of “business” to aid the interpretation of the phrase “in the business of”). For examples of courts citing statutes or regulations, see *Heyman Assocs. No. 1 v. Ins. Co. of State of Pa.*, 231 Conn. 756, 773 (1995) (citing “statutory definitions of ‘pollutant’ or ‘pollution’” to help establish that the plain meaning of “pollutant” in an absolute pollution exclusion applies to oil spilled into a harbor); *St. Paul Mercury Ins. Co. v. Tri-State Cattle Feeders, Inc.*, 628 S.W.2d 844, 847 (Tex. App. 1982) (holding that, because “[t]he policy does not define theft,” its meaning must include all forms of theft “set out in . . . the Texas Penal Code”); *West v. S. Cty. Mut. Ins. Co.*, 427 S.W.3d 576, 579 (Tex. App. 2014) (relying on Texas Workers’ Compensation Act to aid policy interpretation because “[a]n auto insurance provider would be familiar with the regulations governing the types of damages that an auto policy may cover. Additionally, a reasonable insurance consumer would likely consult the Texas Workers’ Compensation Act to determine which employees are not entitled to workers’ compensation”). *Concord Gen. Mut. Ins. Co. v. Woods*, 824 A.2d 572, 575-576 ([Vt.](#) 2003) (holding that the term “motorized land conveyance . . . not subject to motor vehicle registration” includes ATVs because “ATVs are specifically excluded from the statutory definition of motor vehicle”). For examples of courts citing secondary legal authority, see *Jackson v. Wisconsin Cty. Mut. Ins. Corp.*, 354 Wis. 2d 327, 331 (2014) (citing Couch on Insurance’s definition of “use” to support the holding that a person preparing to guide a driver from outside a vehicle was not using the vehicle); *Travelers Prop. Cas. Co. of Am. v. Peaker Servs., Inc.*, 855 N.W.2d 523, 529 ([Mich. Ct. App.](#) 2014) (citing “a review of relevant legal treatises” to support the finding that “the plain

meaning of the phrase ‘assumption of liability’ can reasonably be construed to mean the act of taking on the legal obligations or responsibilities of another”); Nike, Inc. v. Nw. Pac. Indem. Co., 999 P.2d 1197, 1203 (Or. Ct. App. 2000) (citing Couch on Insurance to show that “discovery” of a loss occurs “when the insured gains sufficient knowledge, greater than mere suspicion, which would justify a reasonable and prudent person to believe” the loss occurred); Sylvester Bros. Dev. Co. v. Great Cent. Ins. Co., 480 N.W.2d 368, 376-377 (Minn. Ct. App. 1992) (“We find nothing improper in the operator’s submission of law review articles and relevant cases from other jurisdictions. These materials are not evidence outside the record, but rather are legal resources.”).

c. Custom, practice, and usage. For courts stating that custom, practice, and usage can be considered when deciding whether a term has a plain meaning (and, if so, what that plain meaning is), see, e.g., Auto-Owners Ins. Co. v. Anderson, 756 So. 2d 29, 36 (Fla. 2000) (interpreting an insurance policy in light of an “established custom in the insurance industry” to hold that the policy’s omission of customary anti-stacking language means that the policy did not limit stacking in the manner customarily achieved through such language); City Fuel Corp. v. Nat’l Fire Ins. Co. of Hartford, 846 N.E.2d 775, 776 (Mass. 2006) (“An insurance policy is to be construed with reference to the customs of the trade or course of business respecting which it is issued.” (ellipsis omitted)); Slonim v. Globe Indem. Co., 90 A.2d 138, 140 (N.J. Super. Ct. Law Div. 1952) (“The conclusion herein reached as to the proper construction of the policy in suit finds support in various insurance trade publications While these articles are in no sense binding, they certainly constitute aids to the construction of the contract which should not be ignored by a court of law.”); Sunbeam Corp. v. Liberty Mut. Ins. Co., 781 A.2d 1189, 1193, 1195 (Pa. 2001) (holding that an insurance-industry memorandum to an insurance regulator may evince a custom establishing that the policy language “sudden and accidental” includes gradual events that are “unexpected and unintended,” and that any such custom must be considered in determining the language’s plain meaning because “If words have a special meaning or usage in a particular industry, then members of that industry are presumed to use the words in that special way, whatever the words mean in common usage and regardless of whether there appears to be any ambiguity in the words.”); Beazley Ins. Co., ~~Inc.~~ v. ACE Am. Ins. Co., 880 F.3d 64, 71 (2d Cir. 2018) (“[W]hen considered against the background of the customs, practices, usages and terminology as generally understood in the particular trade or business, the term ‘customers’ of NASDAQ unambiguously includes retail investors.” (internal quotation marks omitted)); Johnson v. U.S. Fid. & Guar. Co., 91 S.E.2d 779, 783 (Ga. Ct. App. 1956) (“[T]echnical words, or words of art, or used in a particular trade or business, will be construed, generally, to be used in reference to this peculiar meaning . . . in interpreting insurance policies.”); World Trade Ctr. Props. LLC v. Travelers Indem. Co., 2002 U.S. Dist. LEXIS 9863, at *12 (S.D.N.Y.) (“A term is ambiguous when it is capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business.” (internal quotation marks omitted)); accord Williams v. Gov’t

Employees Ins. Co. (GEICO), [762 S.E.2d 705, 710 \(S.C. 2014\)](#); *Dalton v. Cellular S., Inc.*, 20 So. 3d 1227, 1232 (Miss. 2009) (same). See also 2 Couch on Ins. § 22:53 (explaining that “a general usage may be effectively overridden by a different usage in a particular trade which is so prevalent that it may be said to be a general usage in that trade”). For statements of the same rule outside the insurance context, see, e.g., *Galardi v. Naples Polaris, LLC*, 301 P.3d 364, 367 (Nev. 2013) (“Modernly, courts consult trade usage and custom not only to determine the meaning of an ambiguous provision, but also to determine whether a contract provision is ambiguous in the first place”). For authority that custom, practice, and usage may be used only against a party who can reasonably be charged with knowledge of that custom, practice, or usage, see, e.g., *Mall Gift Cards, Inc. v. Wood*, 261 So. 2d 31, 33 (Ala. 1972) (“[U]sage or custom, to be admissible in explanation of the terms of a contract which are ambiguous or doubtful in signification . . . must be brought home to the knowledge of the party sought to be charged, either by proof of actual notice, or by proof of its existence sufficiently long to raise a presumption of knowledge.”); *Gen. Refractories Co. v. First State Ins. Co.*, 94 F. Supp. 3d 649, 661 (E.D. Pa. 2015) (custom, practice, and usage “may be used as a mode of interpretation on the theory that the parties knew of its existence, and contracted with reference to it.”) ~~-. Cf., rev’d on other grounds, 855 F.3d 152, 160 (3d Cir. 2017)~~ (“Although we find the language of the policy to be clear on its face, our inquiry does not immediately end when the plain meaning of the provision is unambiguous. Evidence of industry custom or trade usage “is always relevant and admissible in construing commercial contracts,” and does not depend on the existence of ambiguity in the contractual language.”). Cf. *Farmland Indus., Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 359 F. Supp. 2d 1144, 1152 (D. Kan. 2005). Cf. *Saleh v. Farmers Ins. Exch.*, 133 P.3d 428, 434 (Utah 2006) (rejecting alleged custom and practice when it could not be linked to an interpretation that is “plausible and reasonable in light of the language used,” thus leaving open the possibility that custom and practice could be used in other cases).

Additional support for the consideration of custom, practice, and usage comes from the jurisdictions listed in the Reporters’ Note to Comment *a* that follow the more expansive, contextual approach of the Restatement Second of Contracts and from the jurisdictions that follow the latent ambiguity approach to the plain meaning rule listed in the Reporters’ Note to Comment *d*. See, e.g., *AIU Ins. Co. v. Superior Court*, 51 Cal. 3d 807, 822, 799 P.2d 1253, 1264 (1990) (“The clear and explicit meaning of these provisions, interpreted in their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage, controls judicial interpretation.” (internal quotation marks and citations omitted)). Illustration 1 is based on *Beazley Ins. Co. v. ACE Am. Ins. Co.*, 880 F.3d 64 (2d Cir. 2018). ~~Illustration~~ Illustration 2 is based on *City Fuel Corp. v. Nat’l Fire Ins. Co. of Hartford*, 846 N.E.2d 775 (Mass. 2006).

d. What sources of meaning may not be considered when determining whether a term is ambiguous. Examples of courts articulating a latent ambiguity rule in insurance cases include: *Greene v. Hanover Ins. Co.*, 700 So. 2d 1354, 1356 (Ala. 1997) (allowing an affidavit and deposition as extrinsic evidence to clarify latent ambiguity in insurance policy’s exclusion

endorsement); *Aetna Cas. & Sur. Co. v. Haas*, 422 S.W.2d 316 (Mo. 1968) (recognizing the concept of “latent ambiguity” in an insurance-coverage case and relying on extrinsic evidence to determine that a latent ambiguity exists); *City of Grosse Pointe Park v. Michigan Mun. Liab. & Prop. Pool*, 702 N.W.2d 106, 115, 119 (Mich. 2005) (“[E]xtrinsic evidence is admissible to prove the existence of the ambiguity, and, if a latent ambiguity is proven to exist, extrinsic evidence may then be used as an aid in the construction of the contract.”); ~~*Newport Associates Development Co. v. Travelers Indem. Co. of Illinois*, 162 F.3d 789, 792~~ *Pennbarr Corp. v. Insurance Co. of N. Am.*, 976 F.2d 145, 151 (3d Cir. ~~1998~~) (“1992) (applying New Jersey law) (In determining whether a contract is ambiguous, a court “must “consider the words of the agreement, alternative meanings suggested by counsel, and extrinsic evidence offered in support of those meanings.”” ~~*Pennbarr Corp. v. Insurance Co. of N. Am.*, 976 F.2d 145, 151 (3d Cir. 1992) (applying New Jersey law)~~”); *Jefferson-Pilot Life Ins. Co. v. Smith Helms Mulliss & Moore*, 429 S.E.2d 183 (N.C. Ct. App. 1993) (“If there is a latent ambiguity in the contract, preliminary negotiations and surrounding circumstances may be used to determine what the parties intended. *Miller v. Green*, 112 S.E. 417, 417-~~184~~18 (N.C. 1922). ‘A latent ambiguity may arise where the words of a written agreement are plain, but by reason of extraneous facts the definite and certain application of those words is found impracticable.’ *Id.*”); *Blue Diamond Coal Co. v. Holland-Am. Ins. Co.*, 671 S.W.2d 829, 833-834 (Tenn. 1984) (“The ambiguity [here] exists ‘from the ambiguous state of extrinsic circumstance to which the words of the instrument refer,’ thereby creating a latent ambiguity. The language of the policy taken together with extrinsic facts lends itself to more than one reasonable inference of the intent of the parties.” (citation omitted)); *Compton v. Houston Cas. Co.*, 393 P.3d 305, 311 (Utah 2017) (“In making the determination as to whether an ambiguity exists—that is, whether both of these proposed readings of ‘for a fee’ are reasonable—we look to the language of the contract as well as the circumstances surrounding its formation.”); *Webb v. U.S. Fidelity and Guaranty Co.*, 605 A.2d 1344, 1346 (Vt. 1992) (“‘[a]mbiguity will be found where a writing in and of itself supports a different interpretation from that which appears when it is read in light of the surrounding circumstances, and both interpretations are reasonable’”). The results in some of these cases could be said to be consistent with a strict plain m-meaning rule because it was the *context of the claim* that revealed the ambiguity of the term.

Note that Georgia has a statute adopting the latent a-ambiguity rule. See OCGA § 13-2-2(1) (“All the attendant and surrounding circumstances may be proved and, if there is an ambiguity, latent or patent, it may be explained. . . .”); OCGA § 24-3-3(b) (“Parol evidence shall be admissible to explain all ambiguities, both latent and patent.”).

e. Purpose. The general rule that contracts are interpreted in light of the principal purpose for contracting is discussed in Restatement Second, Contracts § 202 (AM. LAW INST. 1981). For a discussion of this principle in the insurance context, see 2 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 22:46 (3d ed. 2017) (“the policy should be construed . . . having in view the purposes for which it is ordinarily used...”). For an example of a court interpreting a policy provision in light of its purpose, see

New York Cent. Mut. Fire Ins. Co. v. Jennings, 195 A.D.2d 541, 542 (N.Y. App. Div. 1993) (finding coverage under a nonowned-vehicle provision by examining the objective purpose of the provision—“to provide protection to the insured for the occasional or infrequent use of vehicle not owned by him or her”); see also Longobardi v. Chubb Ins. Co. of New Jersey, 582 A.2d 1257, 1262 (N.J. 1990) (interpreting the materiality of the breach of a provision in a D&O policy requiring an insured to submit to an investigation under oath in light of the objective purpose of such a provision—“to enable the insurance company to acquire knowledge or information that may aid it in its further investigation”).

f. Definition of ambiguity. Under “the hornbook statement of *contra proferentem*,” a provision is ambiguous if it is “reasonably susceptible to more than one interpretation by the ordinary reader of the policy.” Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 538 (1996). For a judicial statement of the rule that interpretation is an objective inquiry, see *Miller v. Amica Mut. Ins. Co.*, 931 A.2d 1180, 1182 (N.H. 2007) (“We construe the language of an insurance policy as would a reasonable person in the position of the insured based on a more than casual reading of the policy as a whole.”); see also *Computer Corner, Inc. v. Fireman’s Fund Ins. Co.*, 46 P.3d 1264, 1266 (N.M. Ct. App. 2002) (“In construing standardized policy language, our focus must be upon the objective expectations the language of the policy would create in the mind of a hypothetical reasonable insured, who, we assume, will have limited knowledge of insurance law.”); *St. John’s Home of Milwaukee v. Cont’l Cas. Co.*, 434 N.W.2d 112, 119 (Wis. Ct. App. 1988) (“When construing an insurance contract, an objective test is applied. The objective test requires that a policy be construed as it would be understood by a reasonable person in the position of the insured.”). Illustration 3 is based on *Voorhees v. Preferred Mut. Ins. Co.*, 607 A.2d 1255 (N.J. 1992). Illustration 4 is based on *SL Indus., Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266 (N.J. 1992). Both opinions were issued on the same day. Illustrations 5 and 6 are variations on the facts in *Hawaiian Isle Adventures, Inc. v. North Am. Capacity Ins. Co.*, 623 F. Supp. 2d 1189 (D. Haw. 2009).

g. In the context of the entire policy. For cases holding that insurance policy terms should be interpreted in a manner that makes full use of the language in the policy, see, e.g., *Laird v. Allstate Ins. Co.*, 221 P.3d 780, 783 (Or. Ct. App. 2009), rev. denied, 233 P.3d 817 (Or. 2010) (“When a term is undefined in an insurance policy, ‘we identify the ordinary meaning of the term and examine both the immediate context in which it is used and the broader context of the policy as a whole to determine whether there remains any ambiguity about what the parties [to the policy] intended.’” (citation omitted).); *Fontana Builders, Inc. v. Assurance Co. of Am.*, 882 N.W.2d 398, 412 (Wis. 2016) (“A term that is potentially ambiguous when read in isolation may be clarified by reference to the policy as a whole, and we will, therefore, examine the effect of individual terms within the context of the entire policy when resolving claimed ambiguities.” (citation omitted).).

h. Relationship to reasonable expectations. Consideration of the reasonable-expectations doctrine is complicated by the variation in the ways that courts use the term “reasonable

expectations” in insurance cases. Robert Keeton articulated the doctrine in its strong version as follows: “The objectively reasonable expectations of the applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.” Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970). In no state have the courts employed this version of the doctrine to invalidate a large number of insurance policy provisions. It appears that the courts in only two states—Hawaii and Alaska—currently endorse the doctrine in this formulation. See, e.g., *Nelson v. Progressive Cas. Ins. Co.*, 162 P.3d 1228, 1235 (Alaska 2007) (reaffirming the principle that “we need not find ambiguity . . . to construe the policy under the ‘reasonable expectations’ doctrine,” but nevertheless holding that the insured’s interpretation was unreasonable); *Del Monte Fresh Produce (Hawaii), Inc. v. Fireman’s Fund Ins. Co.*, 183 P.3d 734, 745 (Haw. 2007) (internal citation omitted) (“It is well settled in Hawai‘i that ‘the objectively reasonable expectations of [policyholders] and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.’”).

The courts in most states currently employ the doctrine only as a guide to the interpretation of ambiguous terms. See *Safeway Ins. Co. of Ala., Inc. v. Herrera*, 912 So. 2d 1140, 1143-1145 (Ala. 2005) (stating that “the court must enforce the insurance policy as written if the terms are unambiguous” and thus “the doctrine of ‘reasonable expectation’ is unavailable to [the insured].”); *Steigler v. Ins. Co. of N. Am.*, 384 A.2d 398, 401 (Del. 1978) (citation omitted) (approving the basic principle that “an insurance contract should be read to accord with the reasonable expectations of the purchaser so far as the language will permit.”); *A.W. Chesterton Co. v. Mass. Insurers Insolvency Fund*, 838 N.E.2d 1237, 1250 (Mass. 2005) (stating that the court could not revise the words of the policy, but, if in doubt of the proper interpretation, could consider the reasonable expectations of what the “objectively reasonable insured, reading the relevant policy language, would expect to be covered.” (internal quotations omitted)); 1-22 RANDY MANILOFF & JEFFREY STEMPEL, *GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE* § 22 (3d ed. 2015) (reporting that this approach is the majority rule and very few jurisdictions apply the strong Keeton formulation, and then only rarely). Even the courts in those states that occasionally employ the doctrine more broadly largely use the doctrine as a guide to the interpretation of ambiguous terms. See, e.g., *First Am. Title Ins. Co. v. Action Acquisitions, LLC*, 187 P.3d 1107 (Ariz. 2008); *Bank of the West v. Super. Ct.*, 833 P.2d 545, 552 (Cal. 1992) (“[A] court that is faced with an argument for coverage based on assertedly ambiguous policy language must first attempt to determine whether coverage is consistent with the insured’s objectively reasonable expectations.”); *Carlson v. Allstate Ins. Co.*, 749 N.W.2d 41 (Minn. 2008); *Zacarias v. Allstate Ins. Co.*, 775 A.2d 1262 (N.J. 2001).

~~Most of the courts~~Courts in those states that have affirmatively rejected the reasonable-expectations doctrine appear to have rejected only the broad Keeton formulation of the doctrine, not the principle that ambiguous terms are to be interpreted in a manner that is

consistent with what a reasonable insured would expect. See, e.g., *Casey v. Highlands Ins. Co.*, 600 P.2d 1387, 1391 (Idaho 1979) (“In declining to adopt the doctrine of reasonable expectations in Idaho, we follow the rationale of the dissenting opinion in *Corgatelli*.”) (overruling *Corgatelli v. Globe Life & Accident Ins. Co.*, 533 P.2d 737, 740 (Idaho 1975) (supporting Keeton formulation of the doctrine of reasonable expectations)); *Ex parte United Servs. Auto. Ass’n*, 614 S.E.2d 652, 654 (S.C. Ct. App. 2005) (“The doctrine of reasonable expectations, which is essentially that the objectively reasonable expectations of insureds as to coverage will be honored even though a careful review of the terms of the policy would have shown otherwise, has been rejected in South Carolina.”); *Dakota, Minnesota & Eastern R.R. Corp. v. Heritage Mut. Ins. Co.*, 639 N.W.2d 513, 519 (S.D. 2002) (holding that the doctrine of reasonable expectations did not apply to clear policy language, and declining to decide if it could ever apply in the presence of ambiguity). Courts in a very few jurisdictions, however, seem to have gone further in rejecting the use of reasonable expectations even as a means of interpreting ambiguous contract terms. See, e.g., *Deni Assocs. of Fla., Inc. v. State Farm Fire & Cas. Ins. Co.*, 711 So. 2d 1135, 1140 (Fla. 1998) (“We decline to adopt the doctrine of reasonable expectations. There is no need for it if the policy provisions are ambiguous because in Florida ambiguities are construed against the insurer. To apply the doctrine to an unambiguous provision would be to rewrite the contract and the basis upon which the premiums are charged.”); *Wilkie v. Auto-Owners Ins. Co.*, 664 N.W.2d 776, 787 (Mich. 2003) (overruling over three decades of decisions employing the reasonable-expectations doctrine in a variety of forms and holding that the doctrine “clearly has no application to unambiguous contracts,” and further holding that “stating that ambiguous language should be interpreted in favor of the policyholder’s reasonable expectations adds nothing to the way in which Michigan courts construe contracts, and the rule of reasonable expectations should be abolished”). Note that ~~this Restatement does not reject § 211~~ because “the ordinary rules of contract interpretation apply to the interpretation of liability insurance policies.” § 211(3) of the Restatement Second, Contracts, ~~which adopts~~ supplies an important rule regarding the enforceability of standard-form terms: “Where the other party has reason to believe that the party manifesting such assent [to a standard-form contract] would not do so if he knew the writing contained a particular term, the term is not part of the agreement.”

i. The ~~parol-evidence rule~~ evidence rule. The terms “parol evidence” and “extrinsic evidence” are sometimes used loosely as if they mean the same thing. They do not in all cases. “Parol evidence” can be a narrower concept that refers to extrinsic evidence used to contradict a term of a contract. So understood, the parol-evidence rule should have no effect on the interpretation of insurance-policy terms under any of the approaches to interpretation that permit consideration of evidence beyond the insurance policy, because this version of the parol-evidence rule would not exclude evidence that is relevant to the meaning of a contract term. This evidence is used to determine what the language of the term means. It informs the court’s interpretation of the term; it does not contradict that term. See, e.g., Restatement Second, Contracts § 213, Comment *b* (AM. LAW INST. 1981) (permitting the use of extrinsic evidence to determine the meaning of a term, with the caveat that the term “must be given a meaning to which its language

is reasonably susceptible when read in the light of all the circumstances”). Cf. 5-24 JOSEPH M. PERILLO, CORBIN ON CONTRACTS § 24-7 (2017) (“It is therefore invariably necessary, before a court can give any meaning to the words of a contract and can select a single meaning rather than other possible ones as the basis for the determination of rights and other legal effects, that extrinsic evidence be admitted to make the court aware of the ‘surrounding circumstances,’ including the persons, objects, and events to which the words can be applied and which caused the words to be used.”). For a conceptual discussion of the relationship between plain meaning and parol evidence, see generally Eric A. Posner, *The Parol Evidence Rule, the Plain Meaning Rule, and the Principles of Contractual Interpretation*, 146 U. PA. L. REV. 533 (1998) (providing a law-and-economics justification for one-sided use of extrinsic evidence in the case of standard-form contracts).

§ 4. Ambiguous Terms

When an insurance policy term is ambiguous as defined in § 3(b)(3), the term is interpreted ~~in favor of the party that did not supply the term, unless~~ against the party that supplied the term, unless that party persuades the court that a reasonable person in the policyholder’s position would not give the term ~~this~~ that interpretation.

Comment:

a. Interpretation against the supplier of the term. The rule that an ambiguous contract term should be interpreted against the party that supplied the term is commonly referred to in insurance-law sources by its Latin name, *contra proferentem*, which means “against the offeror.” In the context of standard-form insurance policy terms, the insurer is so regularly the party supplying the form that courts often describe the *contra proferentem* rule as meaning that an ambiguous policy is interpreted in favor of coverage. The standard justification for the *contra proferentem* rule builds on the idea that the supplier of a term in a contract is generally in the best position to avoid ambiguity in the wording of the term, since the supplier drafted or, at the very least, chose to offer a contract containing that term. This rationale applies especially to situations involving standard-form terms, when one party supplies the terms and the other party either accepts or rejects them but is not given the option of suggesting alternative wording. The *contra proferentem* rule gives the supplier of the terms the incentive to take all reasonable steps to eliminate ambiguity in the drafting of terms.

It should be noted, however, that the aim of the rule is not the elimination of all ambiguity. Here the analogy to tort law is helpful. Just as it is not possible for the incentive

provided by a tort-liability rule to eliminate all possibility of accidents, it is not possible for the incentive provided by a *contra proferentem* rule to eliminate all possibility of ambiguity. Even insurance policy terms that are relatively simple and clear on their face can become ambiguous when applied to a particular claim. The cost, to insurers and policyholders, of attempting to draft policies that specifically and unambiguously address every conceivable contingency would be prohibitive. Over time, insurance policies would become unacceptably long and, by their very length and complexity, inhibit rather than promote clear meaning. Thus, the *contra proferentem* rule, even when creating positive drafting incentives, should not be expected to eliminate all ambiguity.

b. Residual risk of unavoidable ambiguity. In addition to creating positive drafting incentives, the *contra proferentem* rule allocates to the party supplying the term the residual risk of unavoidable ambiguity. This allocation of risk is especially appropriate in the insurance context, where the parties supplying terms generally are insurance companies whose primary function is the spreading of risks. Thus, the risk of unavoidable ambiguity in insurance policy terms is, through the application of the *contra proferentem* rule, ultimately spread over all policyholders rather than borne by any individual insured. There is also a fairness argument that supports imposing the costs of ambiguity upon the party that benefited from having its preferred term in the insurance policy. This fairness argument applies even when the doctrine works against the insured and, thus, against risk spreading.

c. The mechanical application of the contra proferentem rule. Some courts apply a more mechanical version of the *contra proferentem* rule, in which the insurer that drafted or supplied the policy always loses whenever a term is found to be facially ambiguous when applied to the claim in question. This mechanical version of the rule is problematic because it sometimes produces outcomes that the policyholder could not have reasonably expected, in circumstances in which the insurer could not reasonably have eliminated the ambiguity. Under the rule in this Section, an insurer has the opportunity to use extrinsic evidence to demonstrate to the court that the coverage-promoting interpretation of an ambiguous term is unreasonable in the circumstances, meaning that a reasonable person in the policyholder's position would not give the term that interpretation. In addition to being more likely to result in outcomes that are consistent with the reasonable expectations of the policyholder, this approach to *contra proferentem* is also consistent with what many courts in fact do, by engaging in the analytical

effort needed to identify whether the coverage-promoting interpretation is unreasonable in the circumstances.

d. A reasonable person in this policyholder's position. When the question is plain meaning, the inquiry focuses on identifying the single meaning that a reasonable person would assign to the language if that person had read the term and the insurance policy reasonably carefully. The rule in this Section applies only when the term in question has no single plain meaning when applied to the claim in question; rather, the term is ambiguous. In that case, the question becomes whether the coverage-promoting interpretation is one that a reasonable person in the policyholders' position would give to the term in the circumstances. The legally relevant circumstances include the observable, objective characteristics of the policyholder that identify the policyholder as a member of a relevant class of insurance purchasers, with greater or lesser experience and expertise in the insurance market (or greater or lesser capacity to obtain expert advice in that regard). Taking these circumstances into account assists the court in arriving at the traditional objective of contract interpretation in general, giving a term in a contract the meaning that a reasonable person would ascribe to it under the circumstances. This tailored objective standard takes into account the level of sophistication and insurance-purchasing experience expected of the party buying the policy, but not that party's subjective understanding.

It is important to emphasize that the concept of “a reasonable person in this policyholder's position” is no less a legal construct than the “reasonable person” concept that courts employ when determining the plain meaning. Hence, interpreting an ambiguous insurance policy term in light of the circumstances is ordinarily just as much a question of law as determining the plain meaning of an insurance policy term. The exception would be the unusual situation in which there is an outcome-determinative factual dispute about the circumstances that the court cannot resolve through summary proceedings. A determination that an insurance policy term is ambiguous does not ineluctably lead to the conclusion that the meaning of the term is a question for the trier of fact to determine.

e. No sophisticated-policyholder exception. Some courts have suggested, and some commentators have recommended, that the *contra proferentem* doctrine not be applied to insurance policies entered into by sophisticated commercial policyholders—for example, large corporations that are represented by counsel. This Section does not endorse the idea of a sophisticated-policyholder exception to the *contra proferentem* doctrine. By placing the

responsibility for residual ambiguity on the party that is most in control of the language of the policy, the *contra proferentem* rule provides an important incentive to draft terms clearly regardless of the sophistication of the policyholder. The rule that an ambiguous insurance policy term is given the meaning that a reasonable person in the position of the policyholder would give the term takes the sophistication of the policyholder into account, while preserving *contra proferentem* as the residual decision rule. See Comments *d* and *h*.

f. The subjective understanding of the policyholder. Because the meaning of an insurance policy is determined on an objective basis, the subjective understanding of the policyholder ordinarily does not have any significance for the interpretation of an insurance policy term. By definition, the plain meaning of an insurance policy term is independent of any individual person's situation or understanding. Similarly, the understanding of a reasonable person in this policyholder's position is an objective determination. This does not mean that subjective knowledge of the policyholder could never have relevance for the interpretation of ambiguous terms. If the court determines that both the policyholder and the insurer subjectively intended a specific meaning of a particular, ambiguous term, that term could be reformed to reflect that shared understanding. Alternatively, a policyholder that expressed that specific meaning to the insurer could be estopped from asserting an alternative meaning, provided that the requirements of § 6 are met. Finally, a policyholder's actual knowledge of a trade usage or some other circumstance could be taken into account in determining whether that usage or circumstance could be used to resolve the ambiguity in situations in which a reasonable person in that policyholder's position would not ordinarily possess such knowledge.

g. Purpose. As explained in Comment *e* to § 3, a policy term that might otherwise be subject to a wide range of meanings can sometimes be given greater precision by reference to the purpose of the term in the context of the insurance policy as a whole. When the purpose of a standard-form term can be determined from the sources listed in Comments *b* and *c* to § 3, that purpose can inform the court's determination of the plain meaning of the policy term. Purpose is also an important consideration when a term is ambiguous. Considering the objective purpose of an insurance policy term may help a court determine that one or more of the proposed meanings of the term is unreasonable in the circumstances.

h. Other sources of meaning to resolve an ambiguity. Courts agree that a party's subjective understanding of an insurance policy term is not relevant to the interpretation of the

policy. Courts also agree that, if a policy term is ambiguous on its face, then any relevant source of meaning can be used to determine its meaning. Commonly considered sources of meaning include: precontractual negotiations; the parties' course of performance under the policy at issue; the course of dealing between the parties with regard to other policies; the drafting history of insurance policy terms at issue; documents filed with state administrative agencies regarding an insurance policy or term at issue; other versions of the relevant term available on the market; other forms of insurance available on the market; publications and expert testimony regarding the history, purpose, and function of policy terms and forms of insurance coverage; and publications and expert testimony regarding custom and practice in the insurance industry. (Note that custom, practice, and usage can also be a relevant consideration at the initial, plain meaning stage of interpretation. See § 3, Comments *c* and *d*.)

Because the objective of using these sources of meaning is to understand the meaning that a reasonable person in this policyholder's position would ascribe to the term, such evidence may only be used against an insured when the policyholder could reasonably be expected to have been aware of it. There are differences among policyholders in this regard based on the knowledge that they reasonably should have regarding the form of insurance in question. For example, a large commercial policyholder that employs a risk manager, uses a broker (who can identify how a term varies from other versions of the term available on the market), has access to counsel (who can identify how the term has been applied by courts), and has purchased similar policies in the past may be considered to have such knowledge and understanding of the meaning of standard-form terms of insurance policies within the insurance trade as could be obtained by these agents through reasonable investigation, commensurate with the risks transferred. By contrast, individual consumer and small commercial policyholders ordinarily would not be expected to have been aware of such specialized meanings.

Extrinsic evidence can likewise only be used against the insurer when the insurer could reasonably be expected to have been aware of it. Insurers are presumed to be sophisticated and knowledgeable about matters of insurance, including the drafting history of standard-form terms, even if the particular insurer involved was not itself involved in the drafting of that term. This presumption is consistent with how *contra proferentem* is applied, as ambiguous terms in standard-form policies are construed against insurers even if the particular insurer did not supply the term. Some extrinsic evidence—such as prior negotiations and course of dealing between the

parties—may go to the intent of both the insurer and the policyholder and may reveal a controlling mutual intent.

Illustrations:

1. Insurer issues a general liability policy to Named Insured that designates “Acme, 123 Main Street” as an additional insured. Acme Logistics, which has been sued in connection with an accident caused by Named Insured, requests coverage under the policy. Insurer denies coverage on the grounds that Acme Logistics is not an insured under the policy. In a coverage action, Acme Logistics introduces evidence showing it has had an office at that address for 20 years and, therefore, it is the additional insured under the policy issued by Insurer. Insurer introduces undisputed evidence showing that (a) Acme Products also has an office at that same address, (b) Acme Products has a commercial relationship with Named Insured pursuant to which Named Insured was obligated to obtain liability insurance coverage for Acme Products, and (c) Acme Logistics has no such commercial relationship with Named Insured. The additional insured term is ambiguous when applied to the facts of the claim for coverage because, on its face, the term could reasonably be read to refer to either of two entities. The court nevertheless issues a judgment for Insurer because the extrinsic evidence shows that no reasonable policyholder would interpret the additional insured term to refer to Acme Logistics.

2. An insured restaurant owner is sued by a patron who was injured when a waiter accidentally splashed hot-pepper oil in the patron’s eye. The insurer denies coverage under the pollution exclusion in the policy, which states that the policy “does not apply to . . . bodily injury or property damage arising out of the actual, alleged, or threatened discharge, dispersal or release or escape of ‘pollutants’” The term “pollutants” is defined in the policy to mean:

Any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

The court determines that the word “irritant” contained in the exclusion is ambiguous when applied to hot-pepper oil, because it is capable of being read narrowly so that it

does not include food items spilled on a patron in a restaurant and broadly so that it includes such items. Considering extrinsic evidence indicating that the purpose of the exclusion is to avoid coverage for liability for environmental damage and toxic torts, the court determines that a reasonable policyholder in the restaurant's position would not interpret the term "irritant" to include hot-pepper oil accidentally splashed in a restaurant patron's eye.

i. When a term could have been more clearly drafted. In determining the meaning of an ambiguous term, it is appropriate to consider the difficulty of redrafting the insurance policy to more plainly express the meaning urged by the drafting party, ordinarily the insurer, taking into account that some residual risk of ambiguity is to be expected. The easier it would be for the drafter to state that meaning more plainly, the more likely it is that the other party's proposed meaning is the meaning that a reasonable policyholder would give to the term. ~~Like the presumption in favor of plain meaning, this~~ This approach creates an incentive for insurers to draft insurance policy terms that provide clear guidance regarding the scope of the risks insured under their policies. This approach does not apply to the language of a term that is legally mandated to appear in an insurance policy, however, because the insurer does not have the option of redrafting such a term.

Illustration:

3. A state environmental-protection agency issues an order requiring the policyholder to remedy hazardous conditions at a waste site. The policyholder requests coverage for these remediation expenses under a liability insurance policy that obligates the insurer "to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of . . . property damage to which this insurance applies, caused by an occurrence." The term "damages" is not defined in the policy. The insurer denies coverage on the grounds that the obligation to incur remediation expenses does not constitute an obligation to pay "damages." The insurer asserts that the term "sums which the insured shall become legally obligated to pay as damages," when used in the liability insurance policy, refers to amounts paid as monetary compensation for injuries to third parties and not to amounts paid to comply with injunctive orders such as the remediation order at issue. The policyholder files a

breach-of-contract action against the insurer, alleging that the legal action should be covered because the term “damages” can reasonably be interpreted to cover any legal action asserted against the insured arising out of property damage that requires the expenditure of money, regardless of whether the action can be characterized as legal or equitable in nature. In determining the meaning of the term “damages,” the court should take into account the fact that the term is not defined in the policy and that the insurer could have included a definition that incorporated the distinction between legal and equitable remedies urged by the insurer.

j. When a policyholder requests an insurer to use a different standard-form term available in the market. Commercial liability insurers compete, among other ways, on the basis of their willingness to match terms provided by other insurers in the market. A standard-form insurance policy term should not ordinarily have a different meaning depending on which party supplied or requested the term for use in the insurance policy in question, because the insurance market benefits when an insurance policy term develops a uniform meaning. Moreover, when an insurer competes for business, in whole or in part, on the basis of its willingness to match a policy term offered by another insurer, it would be unreasonable for the insurer to later assert that it can give that term a different meaning than the term would have in a policy purchased from the insurer that drafted the term.

Thus, for example, the fact that a policyholder requested that one insurer use a standard-form term taken from an insurance policy drafted by another insurer should not as a matter of course result in the application of the *contra proferentem* rule against the policyholder in the event of a dispute regarding the meaning of that term. Doing so in every such case would defeat the purpose of the inclusion of such terms in insurance policies, which is to obtain the coverage that the terms are understood in the insurance market to provide. While it is possible that the replacement of the insurer’s ordinary term in an insurance policy with another standard-form term could produce an ambiguity in some circumstances, the insurer ordinarily will have more experience with and a better understanding of the policy than the policyholder and, thus, is in a better position to anticipate and avoid such ambiguity. This is the primary justification for the *contra proferentem* rule.

When a policyholder assembles an insurance policy out of standard-form terms that are not ordinarily combined in a single policy, however, any ambiguities resulting from the combination of those terms can fairly be attributed to the policyholder, who should be regarded as the drafter or supplier of the policy. If a policyholder requests an insurer to use a standard-form term that the insurer does not ordinarily use, the parties can choose to apply the ordinary contract-law *contra proferentem* rule to that term, pursuant to which the term would be interpreted against the policyholder. To avoid dispute, the parties' intention to adopt such a different interpretive rule for a standard-form term selected by the policyholder should be incorporated in the endorsement to the insurance policy or in another writing clearly assented to by the parties. In no event should the *contra proferentem* rule be applied against an insured unless the policyholder in fact drafted or supplied the term. With respect to a ~~specifically negotiated term, which by definition is not a standard form term~~ term that is created for a specific policy, the doctrine of *contra proferentem* ~~also~~ applies against whichever party, if either, ~~supplied the term~~ created the term. If the term was jointly created (such as if one party modified a term supplied by another), then the rule of *contra proferentem* would not apply against either party.

While courts have not explicitly recognized this rule, neither have they rejected it. For example, the fact that the traditional practice in certain markets for the broker to assemble the form using standard terms available in the market and present it to the underwriters for approval does not ordinarily change the rule that ambiguities are interpreted in favor of the policyholder. The circumstances in which courts have interpreted a policy provision against an insured are ones in which the provision was drafted by the policyholder or its broker.

Illustrations:

4. A D&O liability insurance policy issued to a publicly traded corporation contains an endorsement that, at the policyholder's request, replaces the "prior and pending litigation" exclusion in the insurer's standard policy with a version of the exclusion taken from a standard policy sold by another company. Neither the liability insurance policy, nor any communication between the parties in relation to this insurance policy, refers to rules regarding how to interpret the policy. The prior-and-pending-litigation exclusion in this policy is a standard-form term that is interpreted as if it were supplied by the insurer.

5. Same facts as Illustration 4, except that, at the insurer’s request, the endorsement requested by the policyholder is amended to contain the following term:

The terms of this endorsement are included in the Policy at the request of the Named Insured. The Named Insured is deemed to be the drafter of the terms of this endorsement, which are subject to the general contract-law rule of interpretation against the drafter in the event of ambiguity.

The endorsement is to be interpreted according to this term. Because the policyholder supplied the endorsement, the parties were free to contract so that the ordinary *contra proferentem* rule would be applied against the policyholder.

k. Relationship to reasonable expectations. See Comment *h* to § 3.

REPORTERS’ NOTE

a. Interpretation against the supplier of the term. *Contra proferentem* is a general rule of contract-law interpretation. Restatement Second, Contracts § 206 (AM. LAW INST. 1981) (“In choosing among the reasonable meanings of a promise or agreement or a term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.”). The rule is most frequently applied in contexts involving standard-form terms. 11 RICHARD A. LORD, WILLISTON ON CONTRACTS § 32:12 (4th ed. 2017) (“Indeed, any contract of adhesion, which is a contract entered without any meaningful negotiation by a party with inferior bargaining power, is particularly susceptible to the rule that ambiguities will be construed against the drafter.”). The rule is applied especially frequently in the interpretation of insurance contracts, where the standard-form terms are drafted generally by the insurer. *Id.* (“These principles are often applied to insurance policies, which are drafted solely by the insurer.”). Courts have long justified the *contra proferentem* rule on the ground that it puts the burden of avoiding ambiguity on the party with control over the drafting process. *Id.* (“Since the language is presumptively within the control of the party drafting the agreement, it is a generally accepted principle that any ambiguity in that language will be interpreted against the drafter.”). Professors Abraham and Schwarcz write that, in the context of insurance:

The most frequently employed principle of interpretation . . . is *contra proferentem*, which roughly translated means ‘against the drafter’ or ‘against the offeror.’ This is the rule that an ambiguous provision in an insurance policy—one that is subject to two reasonable interpretations—is interpreted against the drafter. Since the drafter of an insurance policy is almost always the insurer, for practical purposes this translates into a rule that ambiguous policy

language is interpreted in favor of coverage. Literally thousands of reported decisions have applied this rule.

KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 41 (6th ed. 2015); see also 2 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 22:14 (3d ed. 2017) (“The words, ‘the contract is to be construed against the insurer’ comprise the most familiar expression in the reports of insurance cases. It purports to be an application of the rule *contra proferentem*. If an insurer uses language that is uncertain, any reasonable doubt will be resolved against it. . . .”); 1 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 5.02 (Lexis 2017) (“The rule of *contra proferentem* has been described as ‘the first principle of insurance law.’ In short, it provides that ambiguous provisions are to be construed against the insurer. *Contra proferentem* has been cited and used in thousands of insurance cases.”).

b. Residual risk of unavoidable ambiguity. For the proposition that allocating the residual risk of unavoidable ambiguity to insurers rather than insureds is efficient, see RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 108 (7th ed. 2007).

c. The mechanical application of the contra proferentem rule. It is increasingly common for courts to treat *contra proferentem* as a decision rule of last resort, applying it only after all other tools of interpretation have been exhausted. 11 RICHARD A. LORD, *WILLISTON ON CONTRACTS*

§ 32:12 (4th ed. 2017) (“The rule of *contra proferentem* is generally said to be a rule of last resort and is applied only where other secondary rules of interpretation have failed to elucidate the contract’s meaning.”); 2 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 22:16 (3d ed. 2017) (“Further, since the rule of strict construction of an ambiguous policy against the insurer is a rule of last resort, and not to be permitted to frustrate parties’ expressed intention if such intention could be otherwise ascertained, where there is extrinsic evidence of parties’ intention, which is proffered and admissible, and which resolved ambiguity, albeit in favor of noncoverage, the rule of strict construction need not be applied.”); 1 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 5.02[2][d] & n.74 (Lexis 2017) (citing insurance cases “that use the *contra proferentem* doctrine as a tie-breaker consistent with its contract version . . . and use all means, including extrinsic evidence, to ascertain the intentions of the parties”). For a discussion of how many courts purport to apply a mechanical “strict liability” version of *contra proferentem* but in fact often apply a version of the doctrine that takes into account other factors, such as the relative reasonableness of competing interpretations, the ease with which the language could be corrected, and whether or not a majority of insureds would be willing to pay the premium for the coverage provided under the insured’s preferred interpretation, see generally Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996).

For a critique of the *contra proferentem* doctrine’s overuse by modern courts, see Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1127 (2006) (“compulsive application of *contra proferentem* to clauses that are not

ambiguous, but rather simply disputed, can . . . belittle the role of language”); see also 1 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 5.02[2][b][v] (Lexis 2017) (reporting that the “broad discretion courts have in applying the *contra proferentem* doctrine, and the accompanying inconsistency, has also led to recommendations for reform”); Peter Nash Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 *TORT & INS. L.J.* 729, 737 (2000) (“A large and growing number of other courts, however, have held . . . the *contra proferentem* rule interpreting ambiguous policy language in favor of the insured should be relied upon only as a ‘last resort’ interpretive tiebreaker.”). For examples of courts reserving *contra proferentem* for instances of last resort, see *State Farm Mutual Auto. Ins. Co. v. Pridgen*, 498 So. 2d 1245, 1248 (Fla. 1986) (internal citation omitted) (“[o]nly when a genuine inconsistency, uncertainty, or ambiguity in meaning remains after resort to the ordinary rules of construction is the rule [of *contra proferentem*] apposite”); *Tinker v. Continental Ins. Co.*, 410 A.2d 550, 553-554 (Me. 1980) (“Where contractual language [of an insurance policy] at issue in a case is ambiguous in its meaning . . . extrinsic evidence may be considered to assist in interpreting the meaning of the language at issue as the expression of the intent of the parties The rule of strict construction, therefore, is a rule of last resort which must not be permitted to frustrate the intention the parties have expressed, if that can otherwise be ascertained.”).

d. A reasonable person in this policyholder’s position. See 1 DAVID L. LEITNER ET AL., *LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION* § 1:13 (2017) (“Traditional contract law requires that ambiguous provisions of insurance policies, like other contracts, be interpreted according to the ordinary meaning afforded those terms by an objectively reasonable layperson, taking into account the surrounding circumstances.”). See, e.g., *Twin City Fire Ins. Co. v. Alfa Mut. Ins. Co.*, 817 So. 2d 687, 692 (Ala. 2001) (“Where the parties disagree on whether the language in an insurance contract is ambiguous, a court should construe language according to the meaning that a person of ordinary intelligence would reasonably give it.”); *U.S. Fire Ins. Co. v. Clover*, 600 P.2d 1, 3 (Alaska 1979) (rejecting the insured’s argument that the policy was ambiguous because the court was “unable to agree that the relevant exclusion clauses in the insurance contracts, when taken together, could be reasonably interpreted by a lay-person as providing coverage for damages to the insured’s work product”); *Nautilus Ins. Co. v. Jabar*, 188 F.3d 27, 30 (1st Cir. 1999) (applying Maine law, citation omitted) (“Maine courts have also found policy language ambiguous ‘if an ordinary person in the shoes of an insured would not understand that the policy did not cover claims such as those brought’ . . . [T]he total pollution exclusion clause is ambiguous . . . because an ordinarily intelligent insured could reasonably interpret the pollution exclusion clause as applying only to environmental pollution.”).

e. No sophisticated policyholder exception. For an expression of support for the sophisticated-policyholder exception to *contra proferentem*, see BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE AND COVERAGE DISPUTES* § 1.05 (18th ed. 2016). For critiques of the exception and arguments that *contra proferentem* should apply even in cases involving sophisticated policyholders, see generally Hazel Glenn Beh, *Reassessing the*

Sophisticated Insured Exception, 39 TORT TRIAL & INS. PRAC. L.J. 85 (2003), and Jeffrey W. Stempel, *Reassessing the “Sophisticated” Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 807 (1993). Some scholars point to *Eagle Leasing Corp. v. Hartford Fire Ins. Co.*, 540 F.2d 1257, 1261 (5th Cir. 1976) (applying Missouri law) as the “historical ‘birth’” of the sophisticated-policyholder concept. JEFFREY W. STEMPEL, PETER N. SWISHER & ERIK S. KNUITSEN, *PRINCIPLES OF INSURANCE LAW* 159 (4th ed. 2011). These scholars contrast the two views on the exception by comparing *Shell Oil Co. v. Winterthur Swill Ins. Co.*, 15 Cal. Rptr. 2d 815, 830 (Cal. Ct. App. 1993) (read by some as supporting the exception to *contra proferentem*), with *A.I.U. Ins. Co. v. Super. Ct.*, 799 P.2d 1253, 1267 (Cal. 1990) (rejecting the exception). Some courts have also addressed the question whether there should be a sophisticated-policyholder exception in connection to the doctrine of reasonable expectations, when that doctrine applies. See, e.g., *JEP Mgmt., Inc. v. Fed. Ins. Co.*, No. 4170, 2006 WL 2372961, at *3 (Pa. Ct. Com. Pl. Aug. 8, 2006), *aff’d*, 988 A.2d 737 (Pa. Super. Ct. 2009) (denying the equitable doctrine of reasonable expectations to the plaintiffs, in part because they were commercial insureds represented by a “sophisticated insurance broker”). See generally 1 JEFFREY W. STEMPEL & ERIK S. KNUITSEN, *STEMPEL AND KNUITSEN ON INSURANCE COVERAGE* § 4.09[D] (4th ed. 2016) (reporting that reasonable expectations are “seldom invoked where the policy holder is a large company with insurance experience and sophistication”). Cf. *First Am. Title Ins. Co. v. Action Acquisitions, LLC*, 187 P.3d 1107, 1113-1114 (Ariz. 2008) (declining to reach the question whether “the reasonable expectations doctrine should not apply here because the policy was negotiated and it was issued to sophisticated business entities that are not within the class of insureds the doctrine is meant to protect”).

f. The subjective understanding of the policyholder. As with most questions of contract interpretation, the interpretation of insurance policies is based on how an objectively reasonable person would interpret the language. For a discussion of the historical development and the current status of the contract doctrine imposing an objective- or apparent-intent requirement for a binding waiver, see E. ALLAN FARNSWORTH ET AL., *CONTRACTS* § 5.5 (7th ed. 2008) (discussing the rise of the objective theory of intent). In the insurance context, see, e.g., *Haber v. St. Paul Guardian Ins. Co.*, 137 F.3d 691, 695 (2d Cir. 1998) (applying New York law) (internal quotations omitted) (“Once a contract is found to be ambiguous, a court must examine ambiguous terms from the vantage point of the reasonable expectations and purposes of the ordinary person.”); *Powerine Oil Co., Inc. v. Super. Ct.*, 118 P.3d 589, 598 (Cal. 2005) (stating that when language in a standard-form insurance policy is clear, the language must be read accordingly, and when it is not, the language must be read in the sense that satisfies the hypothetical insured’s objectively reasonable expectations); *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 35 (D.C. 1996) (observing that courts generally interpret ambiguous provisions in a manner consistent with the reasonable expectations of the purchaser of the policy). However, it is also the case that, if it can be shown that both parties to the contract subjectively intended something other than the meaning that would be attributed to an objectively reasonable reader of the plain language, the remedy of reformation is available. See, e.g., *Am. Cas. Co. of Reading,*

Pa. v. Baker, 22 F.3d 880, 887-888 (9th Cir. 1994) (applying California law) (holding that because the parties attached the same meaning to the terms, that meaning would be given effect); Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc., 854 A.2d 378, 397 (N.J. 2004) (“[w]e, therefore, will not adhere to the text’s literal limitation because to do so here would nearly vitiate the coverage that both parties clearly contemplated”); Restatement Second, Contracts § 201 (AM. LAW INST. 1981) (stating that in contract law generally, “[w]here the parties have attached the same meaning to a promise or agreement or a term thereof, it is interpreted in accordance with that meaning”).

g. Purpose. Understanding the purpose of a term may allow a court to avoid the mechanical application of the *contra proferentem* rule to an ambiguous term. See, e.g., Ariz. Prop. & Cas. Ins. Guar. Fund v. Helme, 735 P.2d 451, 457 (Ariz. 1987) (en banc) (expressing a preference for “examining the purpose of the clause” over *contra proferentem* in order “to determine the meaning of a clause which is subject to different interpretations or constructions”).

h. Other sources of meaning to resolve an ambiguity. For cases using extrinsic evidence to resolve an ambiguity, see, e.g., Alabama Plating Co. v. U.S. Fid. & Guar. Co., 690 So. 2d 331, 335-336 (Ala. 1996) (using the history of a pollution exclusion to resolve ambiguity in its use of the word “sudden”); Sentry Select Ins. Co. v. Royal Ins. Co. of Am., 481 F.3d 1208 (9th Cir. 2007) (relying on expert testimony regarding the usual meaning of the term “unloading” in the maritime context to hold that “[t]he ambiguous use of ‘unloading’ in this case is resolved by the applicable extrinsic evidence as to the parties’ intent”); Mut. Fire, Marine & Inland Ins. Co. v. Fla. Testing & Eng’g Co., 511 So. 2d 360, 362-363 (Fla. Dist. Ct. App. 1987) (relying on the undisputed testimony of the agent who prepared an endorsement and a letter from an insurance producer to determine which one of multiple insureds the endorsement was intended to affect); Nat’l Farmers Union Prop. & Cas. Co. v. Anderson, 372 N.W.2d 71, 75 (Minn. Ct. App. 1985) (resolving ambiguity over the severability of a policy issued to two named insureds in light of the “particular circumstances” under which the contract was formed). See also 12th St. Gym, Inc. v. Gen. Star Indem. Co., 93 F.3d 1158, 1166 (3d Cir. 1996) (instructing the lower court on remand to use extrinsic evidence to interpret an ambiguous Sexually Transmitted Disease Exclusion); ConAgra Foods, Inc. v. Lexington Ins. Co., 21 A.3d 62, 72 (Del. 2011) (instructing lower court on remand to interpret an ambiguous endorsement in light of extrinsic evidence of its negotiation).

i. When a term could have been more clearly drafted. The attention of courts to whether ambiguity could have been reasonably avoided is discussed in Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. at 534 (labeling it the “perfectibility standard” and discussing “[t]wo versions . . . embedded in the case law”). See, e.g., Progressive Cas. Ins. Co. v. Hurley, 765 A.2d 195, 202 (N.J. 2001) (citation omitted) (“When construing an ambiguous clause in an insurance policy, courts should consider whether clearer draftsmanship by the insurer would have put the matter beyond reasonable question.”). Illustration 3 is based on Minnesota Mining & Mfg. Co. v. Travelers Indem. Co., 457 N.W.2d 175, 181 (Minn. 1990) in which the court observed that “[i]f a narrow, technical definition of the term ‘damages’ was

intended by the insurance companies, it was their duty to make that intention clear.”; see also *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1013 (10th Cir. 2004), abrogated by *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (disability-insurance case involving the interpretation of a preexisting-condition exclusion; the court compared the version at issue with another version on the market that more precisely stated the position of the insurer in this case and observed that the insurer “had every opportunity to add the words” that were present in the other version on the market); *Pan Am. World Airways, Inc. v. Aetna Cas. & Sur. Co.*, 505 F.2d 989, 1000 (2d Cir. 1974) (applying New York law) (“*Contra proferentem* has special relevance as a rule of construction when an insurer fails to use apt words to exclude a known risk.”).

j. When a policyholder requests an insurer to use a different standard-form term available in the market. Some support for this rule can be discerned from the fact that courts do not interpret insurance policies issued by syndicates at Lloyds against the policyholder, even though the practice in the Lloyds’ market is for the broker to prepare the forms for approval by the underwriter. See, e.g., *Thiokol Corp. v. Certain Underwriters at Lloyd’s, London*, 1997 WL 33798359, at *6 (D. Utah May 6, 1997):

Lloyd’s also contends that even if the court finds the provisions’ meanings to be ambiguous, the Policy should not be construed against them because Lloyd’s is not the drafting party. This contention is premised upon Lloyd’s assertion that the London broker involved in the placement of the Policy, Fenchurch Insurance Brokers Limited (“Fenchurch”), was not acting on Lloyd’s’ behalf, but rather on behalf of the insured in preparing the draft policy. This is a remarkable argument in light of the undisputed fact that the service of suit clause, as well as the arbitration clause, is a standard boilerplate clause in Lloyd’s policies.

See also *Jefferson Block 24 Oil & Gas, L.L.C. v. Aspen Ins. UK Ltd.*, 652 F.3d 584, 598 (5th Cir. 2011) (reversing district-court decision, rejecting Lloyd’s Underwriters’ arguments, and applying the contra-insurer rule construing ambiguous policy terms in favor of the insured even when the insured’s broker completed a form incorporated into the ambiguous policy provision); *Taylor v. Lloyd’s Underwriters*, No. 90-1403, 1994 WL 118303, at *15, *24 (E.D. La. Mar. 24, 1994) (construing an ambiguous policy exclusion against Lloyd’s Underwriters and in favor of insured/coverage because the insurer drafted the CGL policy and could have made the relevant provision unambiguously exclude punitive damages from coverage); *Brush Wellman, Inc. v. Certain Underwriters at Lloyds, London*, No. 03-CVH-089, 2006 WL 5878040, at *28-31 (¶¶36-37) (Ohio Ct. Com. Pl. Aug. 30, 2006) (resolving ambiguities in favor of coverage when London Insurers “were in the best position to avoid ambiguity and uncertainty” and should not benefit “from an ambiguity of [its] own creation”). But see *McDermott Int’l, Inc. v. Lloyds Underwriters of London*, 944 F.2d 1199, 1207 (5th Cir. 1991) (“By having its agent decide upon both the slip and the policy, McDermott forfeits any benefit from the policy drafter principle.”). Illustration 4 reflects the common practice in the D&O insurance market for insureds to request specific terms. See TOM BAKER & SEAN GRIFFITH, *ENSURING CORPORATE MISCONDUCT* 186,

193 (2010). Illustration 5 adapts to the endorsement context a standard term from a liability insurance policy issued in Bermuda.

TOPIC 2**WAIVER AND ESTOPPEL****§ 5. Waiver**

A party to an insurance policy waives a right under the policy if

(1) that party, with actual or constructive knowledge of the facts giving rise to that right, expressly relinquishes the right, or engages in conduct that would reasonably be regarded by the counterparty as an intentional relinquishment of that right, and

(2) the relinquishment or conduct is communicated or known to the counterparty.

Comment:

a. The function of waiver. Waiver is a general contract-law doctrine that permits the enforcement of terms different from those in the original contract (or, as is more common in the insurance context, permits the non-enforcement of terms that are in the original contract) without requiring all of the elements of a new contract (such as consideration) or all of the elements of estoppel (such as detrimental reliance). A party to a contract can waive only terms that benefit the waiving party. Thus, for example, an insurer, but not an insured, can waive a condition in the policy. A party to an insurance policy can waive a policy term expressly by stating its intent to waive the term. A party can waive a term impliedly by taking actions that, from the perspective of an objectively reasonable person in the circumstances of the counterparty, manifest the intent to waive the term. Enforcing express waivers of contract terms serves a similar function to that of enforcing contracts generally, by enabling parties to make legally binding commitments that others can trust will be honored. Enforcing some waivers also protects the reliance interests of non-waiving parties. Such reliance interests can be and sometimes are also protected by the doctrine of estoppel. See § 6. However, estoppel can provide insufficient protection of reliance interests when proving reliance is difficult or impossible. The treatment of waiver retractions provides an example of how waiver serves the function of protecting the reliance interests of non-waiving parties. See Comment *h*.

b. Agency law applied to waiver. Because of the important role of insurance intermediaries in selling and administering insurance policies, waiver cases often present questions about whether the intermediary can waive the right of an insurer. These questions are complicated by the imperfect fit between the law of agency and insurance business titles, such as “insurance agent” and “insurance broker.” The law of agency determines which people can enter into contracts or otherwise act on behalf of other parties and under what circumstances. An agent can act on behalf of a principal when both the principal and the agent manifest assent for the agent to act for the principal and subject to the principal’s control. Thus, the law of agency determines who can enter into contracts on behalf of whom and who can waive contractual rights on behalf of whom. In the insurance context, agency law dictates that an insurer’s or policyholder’s agent can typically waive the rights of its principal when it has either actual or apparent authority to do so, or when the principal later ratifies its agent’s actions. An agent has actual authority to act for a principal when the principal’s manifestations, to a reasonable person with the agent’s knowledge and in the agent’s circumstances, designate or imply that course of action. By contrast, an agent has apparent authority when the agent lacks actual authority but a third party the agent transacts with reasonably believes, in a manner traceable to the principal’s manifestations, that the agent has authority to act for the principal. Agency law also applies to estoppel. See § 6, Comment *f*. Although an “insurance broker” is usually the agent of the policyholder under agency law, an insurance broker can be the agent of the insurer for at least some purposes (for example, when accepting premiums). Similarly, although many “insurance agents” are agents of the insurer under agency law, there are also insurance agents that can be agents of the policyholder under agency law for some purposes. The application of agency law is highly fact-specific and not necessarily controlled by the business title of the person involved.

c. Waiver and estoppel compared. Both waiver and estoppel raise two important practical concerns. First, both doctrines reduce insurers’ ability to maintain control over the risks that they assume, by allowing their agents to obligate insurers to assume risks that the insurers do not wish to assume. This loss of insurer control in the long run increases the price of insurance for all policyholders. Second, both doctrines create the risk that some policyholders will misrepresent what an agent said to them in order to obtain coverage. In the worst case, insurers may have to go to trial to enforce even the most basic terms in the insurance policy, as the credibility of witnesses is a fact question that requires resolution by a jury. Balanced against these two

concerns is the concern that insureds will be harmed by false or incorrect assurances of coverage made by insurers' agents.

Estoppel requires insureds to prove that such harm in fact occurred, in the form of a showing of detrimental reliance. See § 6. Such proof is not required by the waiver doctrine. The detrimental-reliance requirement of estoppel doctrine serves two purposes. First, it limits insurers' involuntary assumption of risk to cases in which the insured can prove that the countervailing concern—harm to the insured—in fact occurred. Second, it serves an evidentiary role. The fact of detrimental reliance makes more credible the insured's assertion that the agent made the promise that the insured seeks to enforce. ~~For that reason, estoppel has broader application than waiver. See § 6, Comment g.~~

d. There is no general rule against post-loss waiver. In the context of first-party insurance, the general rule is that, although the words or actions of an insurance company's representative that take place at the time of contracting (and before an insured loss has occurred) may, under the right circumstances, effect a waiver of a condition or exclusion in the policy, no such waiver can occur after the loss has occurred. This rule does not, however, generally apply in the context of liability insurance. Statements or actions by an insurer that take place after the loss that gives rise to the underlying legal action can provide a basis for waiver. One obvious example is when an insurer waives a ground for contesting coverage by undertaking the defense of a legal action without reserving the right to contest coverage. See § 15 and accompanying Comments. Two other examples are an insurer that waives a coverage defense in order to retain control over settlement under the rule in § 25(3) and an insurer that waives its coverage limits in order to avoid exposure to consequential damages for breach of the duty to make reasonable settlement decisions.

See § 24, Comment b. Post-loss estoppel is available in both the liability and the first-party context. See § 6, Comment g.

e. Use of extrinsic evidence. Proof of the elements of waiver typically requires the court to admit and consider evidence beyond the insurance policy and the facts of the underlying legal action. Such evidence can include, but is not limited to, testimony on the part of the policyholder and the insurer with respect to express or implied representations that were made by the parties to each other. Evidence regarding the actions of the parties that is indicative of objective intent also is permissible. Proving estoppel also typically requires the court to consider such evidence. See §

6, Comment *d*. For a discussion of the use of extrinsic evidence in connection with the interpretation of insurance-policy terms, see § 3, Comment *fd*.

f. Express and implied waiver. A waiver may be express or implied. In either event, however, the words or other conduct alleged to constitute the waiver are examined from an objective perspective. As in contract law generally, objective manifestation of the intent to waive is sufficient. Therefore, if the statement or other action of the insurer would be understood by a reasonable person in the insured's circumstance as manifesting an intent on the part of the insurer to waive a right of the insurer, then the insurer has waived the right, provided the other requirements of this Section are met.

g. The knowledge requirement. Although waiver is sometimes defined as “a voluntary relinquishment of a known right,” the waiving party need not have detailed knowledge of the specific right being waived. Rather, it is enough that the waiving party knows or should know the facts on which the waiver is based and knows or should know of the terms of the contract and of any actions or omissions on the part of the non-waiving party that might implicate a right under the contract. Thus, it is possible for a party to waive a legal right about which there is some uncertainty. This rule has the effect of imposing on the waiving party, which in most insurance cases is the insurer, the risk associated with not having perfect knowledge of rights or obligations under the contract—an allocation of risk that is especially appropriate when the waiving party is the insurer that supplied the insurance-policy term creating the right being waived.

h. Communication and retraction. A waiver must be communicated to the non-waiving party or to the party's agent. Once that communication has occurred, the waiver is binding on the waiving party, unless the waiver is effectively retracted. Effective retraction requires communication of the retraction, the presence of sufficient time or other conditions necessary for the other party to satisfy the original contractual requirement, and the absence of detrimental reliance on the waiver by the other party. If there has been such detrimental reliance, the waiver cannot be retracted; and the waiver would also satisfy the requirements of estoppel. This would be a case in which the results under a waiver and estoppel rule are indistinguishable.

Illustrations:

1. A liability insurance policy states that the policy can be cancelled for nonpayment of premiums if a premium payment is received more than 30 days after the

insurer has sent the policyholder a letter informing him or her of the overdue premium and warning of the impending cancellation of the policy if the premium is not remitted. The policyholder calls the insurer five days before the 30-day deadline arrives and says that the premium will not be submitted by the deadline. The insurer agrees orally to extend the deadline for one additional week beyond the original 30-day late-payment period. The insurer has expressly waived the original late-payment deadline.

2. Same facts as Illustration 1, except that, after the insurer orally agrees to extend the 30-day deadline by an additional week but before the original 30-day deadline passes, the insurer contacts the policyholder and indicates that it has changed its mind and the waiver is being retracted. Such a retraction of the waiver is effective, and the original 30-day condition is restored, so long as the policyholder, at the time of the retraction, has a reasonable opportunity to satisfy that original condition. If, for example, the insurer waits to issue the retraction until it was too late for the policyholder to satisfy that condition, whether because there is not enough time or because the policyholder has relied to its detriment on the waiver, that retraction is ineffective and the waiver of the deadline remains in effect.

3. Same facts as Illustration 1, except that the policyholder does not communicate with the insurer regarding the late payment, but rather simply sends the check for the premium to the insurer 38 days after the date of the notice-of-overdue-premium letter—that is, eight days beyond the original 30-day grace period. The insurer, upon receiving the premium check, deposits the check. The policyholder receives notice of that deposit through an automatic email message sent by the bank. The insurer has impliedly waived the 30-day payment condition for that premium payment only. The action of depositing the check, which was communicated to the policyholder, is inconsistent with the intent to rescind the policy. The insurer in this case cannot retract the waiver, because the time for satisfying the timely payment condition has already passed.

4. Same facts as Illustration 3, except that the insurer has so regularly accepted late premium payments (payments received after the 30-day grace period following the notice-of-overdue-premium letter) that a reasonable policyholder would understand that the insurer has waived the timely payment term in the insurance policy on a prospective basis as well. In this case, the insurer has waived the 30-day period on a prospective

basis. This prospective waiver, however, can also be retracted, if the insurer communicates with the policyholder acknowledging the past practice of accepting late premium payments but stating that, beginning with the next billing cycle, the company will henceforth strictly enforce the timely-payment-of-premium terms set out in the notice-of-overdue-premium letter and will cancel policies for nonpayment when the payments are received more than 30 days late. Assuming that the policyholder receives this letter in time to comply with the timely-payment-of-premium term for the next billing cycle, the insurer has retracted the prospective waiver of that term.

i. Waiver of policy terms. Under general contract law, waiver doctrine is often applied to what some consider relatively minor or technical conditions within the contract, such as conditions of coverage. In the insurance context as well, courts often invoke waiver in such situations, for example in relation to provisions setting deadlines for filing a notice of claim or for paying the premium. (See the Illustrations above.) The doctrine of waiver, however, should not be limited to “minor” or “technical” conditions, for several reasons. First, there is the practical and theoretical difficulty of determining what constitutes a technical condition. When an insurer denies a claim based on the failure to satisfy a condition in an insurance policy, that condition is no longer accurately characterized as minor. Even a requirement that the premium be paid by a certain date is not a minor condition when coverage turns on that requirement. Second, in the case of express waivers, the insurer benefits from being able to bind itself legally to a decision to waive any type of insurance- policy provision, just as the insurer benefits from being able to be bound by the insurance contract in the first place. Third, insofar as waiver serves the same function as estoppel (that is, to protect the reliance interests of non-waiving parties in situations in which detrimental reliance is difficult or impossible to prove), this function is not limited to minor or technical terms.

j. The rule that waiver cannot expand coverage. Courts often state that waiver by the insurer cannot expand coverage. What this statement appears to mean is that representatives of the insurer cannot create coverage when none would have existed under the policy, assuming all conditions had been met. Under this understanding, the waiver-cannot-expand-coverage rule is not violated if an insurer expressly or impliedly waives a condition, such as a payment deadline for a premium. In such cases, as shown in Illustration 1, waiver can result in the triggering of an

insurer’s obligations with respect to a claim, despite the failure to satisfy a condition. The waiver-cannot-expand-coverage rule, however, would apply to a situation in which an insured contends that its general-liability insurer, owing to the actions or inactions of a representative of the insurer, has waived the policy’s pollution exclusion—or to a situation in which an insured contends that its auto-liability insurer has agreed to provide liability coverage for an automobile not listed in the policy. Permitting waiver to require the insurer to provide coverage in such situations would conflict with this rule of insurance law. To recover in such situations the insured would have to meet the more demanding requirements of estoppel. See § 6, Comment *e*.

Although waiver generally cannot expand coverage, there are other rules of insurance law, with elements common to waiver, that do operate to expand coverage in certain circumstances. For example, in Chapter 2, under § 19, if an insurer breaches the duty to defend, the insurer may have an obligation to provide coverage, despite the existence of an otherwise applicable exclusion. A similar outcome can occur if an insurer defends a legal action brought against an insured without providing the insured with a valid reservation of rights. See § 15.

k. Burden of proof. The non-waiving party has the burden of proving that the waiving party either expressly waived the right in question or engaged in conduct that would reasonably be interpreted as manifesting the intent to waive. Thus, for example, when an insurer refuses to cover an insured’s claim on the ground that the insured failed to satisfy a condition of coverage, it is the insured that bears the burden of proving that the condition was waived.

REPORTERS’ NOTE

a. The function of waiver. The general contract doctrine of waiver is discussed in Restatement Second, Contracts § 84 (AM. LAW INST. 1981) (“[A] promise to perform all or part of a conditional duty under an antecedent contract in spite of the non-occurrence of the condition is binding.”). Waiver allows for contract modification without the typical element of consideration. See 8-40 JOSEPH M. PERILLO, CORBIN ON CONTRACTS § 40.2 (2014-2017) (“Certain kinds of antecedent events called ‘past consideration’ may cause reliance. We need not be surprised, therefore, to find that a promisor can sometimes turn a conditional duty into an unconditional one by a ‘waiver’ of the condition without any consideration.”). For a general overview of what constitutes waiver in insurance contracts, see 1 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 5.07 (Lexis 2012-2017).

b. Agency law applied to waiver. For a statement of the general rule for apparent authority in agency law, see Restatement Third, Agency § 2.03 (AM. LAW INST. 2006) (“Apparent authority is the power held by an agent or other actor to affect a principal’s legal relations with

third parties when a third party reasonably believes the actor has authority to act on behalf of the principal and that belief is traceable to the principal’s manifestations.”); see also 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 31:113 (3d ed. ~~1995~~2017) (“Where it is claimed by the insured that conduct of the insurer’s agent has worked a waiver of the policy’s provisions relating to cancellation, the question of the authority of the insurer’s agent may of course arise.”); 3 *id.* § 48:1 (“In accord with general principles of agency law, the insurer is bound by the actions of his or her agent within the scope of the agent’s authority.”); 5 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 41.04 (Lexis ~~2012~~2017) (“Under [the waiver doctrine], the actions and knowledge of the insurer’s agent, bearing either actual or apparent authority, will typically be imputed to the insurer.”). See generally *Anetsberger v. Metro. Life Ins. Co.*, 14 F.3d 1226, 1234 (7th Cir. 1994) (applying Illinois law) (“A question presented by plaintiffs’ waiver and estoppel arguments . . . is whether [the individual’s] statement bound [the insurer]. To bind the principal, the agent must have either actual authority, apparent authority, or the principal must ratify [the individual’s] actions.”); *Pressley v. Travelers Prop. Cas. Corp.*, 817 A.2d 1131, 1138 (Pa. Super. Ct. 2003) (citation omitted) (“[A]n insurer is liable for the acts of an agent that had authority to bind coverage and had advised the policyholder that he had done so.”).

c. Waiver and estoppel compared. For a general discussion of the similarities and differences between waiver and estoppel, see 17 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 239:96 (3d ed. ~~1995~~2017) (“The most commonly articulated difference [between waiver and estoppel] is that estoppel requires reliance by the insured on the insurer’s actual or implied indications that it will not enforce some right. In contrast, waiver is merely an expression of an intent by words or conduct that the provision in question shall not bind the insured, and no reliance or misleading of the insured is required for waiver.”) (citations omitted); 1 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 5.07 (Lexis ~~2012~~2017) (“Waiver and estoppel are often discussed together because the same conduct may result in the application of either doctrine.”).

d. There is no general rule against post-loss waiver. For the traditional rule of no post-loss waiver in the context of first-party insurance, see, e.g., *Blue Cross and Blue Shield of Alabama, Inc. v. Taylor*, 370 So. 2d 1040, 1043 (Ala. Civ. App. 1979) (In a medical-insurance case the court stated, “a new consideration or estoppel in the alternative is necessary to establish waiver if the waiver is after the loss.”) (citation omitted); *Mary Guest & Son v. Farmers’ Mut. Fire Ins. Co.*, 45 S.W.2d 115, 116 (Mo. Ct. App. 1931) (In a fire-insurance case, stating, “[w]e have examined [cases supporting post-loss waiver] and find that, while some of them indicate that there might be such a waiver after the loss has occurred, a reading of the facts shows that there was an element of estoppel or a consideration present in each instance”); 14 RICHARD A. LORD, WILLISTON ON CONTRACTS § 41:26 (4th ed. ~~1989~~2017) (When the insurer agrees to pay a loss and then, “learns of the insured’s breach of condition after the loss occurs . . . most courts

agree that there can be no waiver established against the insurer.”). For a discussion of the rule that, in the context of liability insurance, defending without a reservation of rights or breaching the duty to defend constitutes a post-loss waiver of conditions and exclusions to coverage, see *Insurance Co. of N. Am. v. Atlantic Nat. Ins. Co.*, 329 F.2d 769, 775-776 (4th Cir. 1964) (applying Virginia law) (“the principles of estoppel and implied waiver do not operate to extend the coverage of an insurance policy after the . . . loss [is] sustained . . . to this well established general rule there appears to be but one, although equally well established, exception[:]. . . the insurer’s unconditional defense of an action brought against its insured constitutes a waiver of the terms of the policy.”) (citations omitted); see also § 15 and accompanying Comments and Reporters’ Note.

e. Use of extrinsic evidence. For the proposition that extrinsic evidence may be used to prove waiver, see 17A ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 253:93 (3d ed. ~~1995~~2017) (“[Prohibitions from the parol evidence rule] do[] not apply to extrinsic evidence regarding the waiver of contractual terms by language or conduct.”); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.08[g] (Lexis ~~2012~~2017) (“[Waiver] may be a legitimate deduction from the acts and conduct of the insurer.”); see also *Gianola v. Continental Cas. Co.*, 817 A.2d 306, 307 (N.H. 2003) (“To establish waiver, the plaintiff must show either explicit language indicating the defendant’s intent to forego a known right, or conduct from which it may be inferred that the defendant abandoned this right.”); *Zahn v. General Ins. Co. of Am.*, 611 P.2d 645, 648-649 (Okla. 1980) (holding insurers waived right to disclaim liability, even though injured parties failed to meet certain conditions, because insurers waited to invoke disclaimer until a few days before rescheduled trial).

f. Express and implied waiver. For the general proposition that manifestations of intent to waive are examined objectively under contract law, see Restatement Second, Contracts § 19(2) (AM. LAW INST. 1981) (A party manifests assent if he intentionally engages in conduct while he “has reason to know that the other party may infer from his conduct that he assents.”); *id.* § 84 (with certain exceptions, a manifestation of intent “to perform all or part of a conditional duty under an antecedent contract in spite of the non-occurrence of the condition is binding”); see also *McKay v. Wilderness Dev., LLC*, 221 P.3d 1184, 1190 (Mont. 2009) (a waiver may “be proven by express declarations or by a course of conduct which induces the belief that the [actor’s] intent and purpose was a waiver.”); 13 RICHARD A. LORD, WILLISTON ON CONTRACTS § 39:14 (4th ed. ~~1989~~2017) (“[T]he term ‘waiver’ has also been defined as . . . conduct that warrants an inference of an intentional relinquishment.”). For the same proposition in the context of insurance law, see *Waller v. Truck Ins. Exch., Inc.*, 900 P.2d 619, 637 (Cal. 1995) (finding waiver “when that party’s acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished”); *Novella v. Hartford Acc. and Indem. Co.*, 316 A.2d 394, 400 (Conn. 1972) (“[W]aiver may be inferred from the circumstances if it is reasonable so to do.”); 17 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL

MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 239:93 (3d ed. ~~1995~~2017) (It is “always open to the insured to show . . . a course of conduct on the part of the insurer which gave the insured just and reasonable ground to infer” a waiver.). For a comparison of express and implied waiver, see, e.g., 13 ~~LEE-R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 194:21 (3d ed. ~~1995~~2017) (“Waiver may result from express statements—spoken or written words In addition, a waiver may be implied from any act or pattern of conduct by the insurer or its authorized agents which reasonably tends to create a belief in the mind of the claimant” that waiver has occurred.).

g. The knowledge requirement. For an example of a case holding that an insurer or an agent of an insurer may waive the insurer’s right without specific knowledge of the legal implications of the waiver, see, e.g., *Jenkins v. Indem. Ins. Co. of N. Am.*, 205 A.2d 780, 784 (Conn. 1964) (holding that insurer need not be certain of legal efficacy of right being waived); *Holt v. Aetna Cas. & Sur. Co.*, 680 So. 2d 117, 129 (La. Ct. App. 1996) (citations omitted) (“Whereupon, the insurer becomes aware of facts which would cause a reasonable person to inquire further, the insurer is then subject to a duty of investigation. Failure to do so, constitutes a waiver of all powers or privileges which a reasonable search would have uncovered”); *Michigan Tp. Participating Plan v. Federal Ins. Co.*, 592 N.W.2d 760, 767 (Mich. Ct. App. 1999) (“Generally, once an insurance company has denied coverage to its insured and stated its defenses, the insurer has waived or is estopped from raising new defenses.”). For the requirement that the waiving party need only have knowledge, or reason to have knowledge, of the essential facts of the transaction, see Restatement Second, Contracts § 93 (AM. LAW INST. 1981) (“A promise within the terms of §§ 82-85 is not binding unless the promisor knew or had reason to know the essential facts of the previous transaction to which the promise relates, but his knowledge of the legal effect of the facts is immaterial.”); see also 2 ~~LEE-R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 31:111 (3d ed. ~~1995~~2017) (“[Waiver does not arise] when the insurer’s failure to act was a result of its ignorance of facts which would entitle it to cancel the policy.”). For a discussion of the historical development and the current status of the contract doctrine imposing an objective- or apparent-intent requirement for a binding waiver, see E. ALLAN FARNSWORTH ET AL., CONTRACTS § ~~3-6 (2004)~~5.5 (7th ed. 2008) (discussing the rise of the objective theory of intent); see also *Intel Corp. v. Hartford Accident & Indem. Co.*, 952 F.2d 1551, 1559 (9th Cir. 1991) (applying California law) (“California courts will find waiver when a party intentionally relinquishes a right, or when that party’s acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished.”). Some commentators have suggested the use of the term “election” to refer to situations in which an objective observer would understand that an insurer had given up a right even though no particular person affiliated with the insurer subjectively intended to do so. See, e.g., ROBERT E. KEETON ~~&~~, ALAN I. WIDISS & JAMES M. FISCHER, INSURANCE LAW § 6.8(c)(3) (~~1988~~2d ed. 2017). Understanding waiver as being subject to an objective standard eliminates the need for the

doctrine of election. TOM BAKER & KYLE D. LOGUE, INSURANCE LAW AND POLICY 75 (3d ed. 2013).

h. Communication and retraction. For an explanation of when retraction is available, see ~~U.C.C.~~UCC § 2-209(5) (AM. LAW INST. & UNIF. LAW COMM'N) (“A party who has made a waiver affecting an executory portion of the contract may retract the waiver by reasonable notification received by the other party that strict performance will be required of any term waived, unless the retraction would be unjust in view of a material change of position in reliance on the waiver.”); Restatement Second, Contracts § 84(2) (AM. LAW INST. 1981) (“If such a promise is made before the time for the occurrence of the condition has expired and the condition is within the control of the promisee or a beneficiary, the promisor can make his duty again subject to the condition by notifying the promisee or beneficiary of his intention to do so if (a) the notification is received while there is still a reasonable time to cause the condition to occur under the antecedent terms or an extension given by the promisor; and (b) reinstatement of the requirement of the condition is not unjust because of a material change of position by the promisee or beneficiary; and (c) the promise is not binding apart from the rule stated in Subsection (1).”); see also 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 199:72 (3d ed. ~~1995~~2017) (“[An] insurer, even if it disclaims liability under the policy before the trial of the original action against the insured, may by its conduct in continuing to act for the insured during the pretrial period waive the insured’s breach of the cooperation clause during this period.”).

i. Waiver of policy terms. For a discussion of the traditional rule that waiver in contract law is limited to “minor” or “technical” provisions, see Restatement Second, Contracts § 84(1)(a) (AM. LAW INST. 1981) (barring application of waiver when “occurrence of the condition was a material part of the agreed exchange”); *id.*, Comment *a* (“a defense not addressed to the merits”); E. ALLAN FARNSWORTH, CONTRACTS § ~~8-5~~8.1, at ~~527~~712 (“the concept of waiver is restricted to conditions that are relatively minor”); David V. Snyder, *The Law of Contract and the Concept of Change: Public and Private Attempts to Regulate Modification, Waiver, and Estoppel*, 1999 WIS. L. REV. 607, 626 (“A waiver does not require agreement, consideration, or reliance, thus explaining the traditional rule that waiver is restricted to conditions that are ‘procedural or technical,’ or at least ‘comparatively minor.’”). For a discussion of how, in the insurance area, waiver doctrine has been applied more broadly, beyond minor or technical provisions, see ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW ~~398~~382 (45th ed. ~~2007~~2012) (“The doctrines of waiver and estoppel have been used to deprive insurers of defenses in virtually every context in which the insurer might deny liability.”). For more information on the scope of waiver in the insurance context, see 1 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 5.07 (Lexis ~~2012~~2017) (“The doctrine[] of waiver . . . ha[s] been applied in a wide variety of insurance situations.”).

j. The rule that waiver cannot expand coverage. For the proposition that the waiver cannot (and should not) expand coverage, see 7 ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN

[PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 101:8 (3d ed. ~~1995~~2017) (“The majority rule is that an insured cannot use the waiver . . . doctrines to broaden coverage under the policy.”); 3 [JEFFREY E. THOMAS](#), NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § ~~16~~16.03 (Lexis ~~2012~~2017) (“~~The reason why waiver generally cannot expand coverage is that expansion of coverage would require a new promise, supported by new consideration, rather than merely waiver of a defense[F]or the insured to extend its coverage to more than it originally bargained, it would have had to enter into a supplemental contract expanding the insuring clause or contracting the exceptions. However, this extension of coverage cannot be attained by waiver, which is a voluntary and intentional relinquishment of a known right.~~”). For a discussion of all the ways in which waiver (and estoppel) in fact has been used in the insurance context to expand coverage, see [ROBERT H. JERRY, II & DOUGLAS R. RICHMOND](#), UNDERSTANDING INSURANCE LAW, at ~~398-401~~382-386; see also *Cugini, Ltd. v. Argonaut Great Cent. Ins. Co.*, 889 So. 2d 1104, ~~1115~~1114 (La. Ct. App. 2004) (insurance coverage can be broadened by waiver when insurer’s conduct was “so inconsistent with the intent to enforce the right as to induce a reasonable belief that it has been relinquished.”) (internal citations omitted); *Lee v. Evergreen Regency Co-op. & Management Sys., Inc.*, 390 N.W.2d 183, 186 (Mich. Ct. App. 1986) (insurance coverage can be created by waiver if the insurer denied coverage and declined to defend an insured in underlying litigation, misrepresented the terms of the policy, or defended the insured without a reservation of rights). The Uniform Commercial Code’s rejection of the consideration requirement for contract modifications can be found at [U.C.C. UCC](#) § 2-209 (AM. LAW INST. & UNIF. LAW COMM’N). Illustration 4 is based on *Jenkins v. Indem. Ins. Co. of N. Am.*, 205 A.2d 780 (Conn. 1964).

k. Burden of proof. For the proposition that the burden of proof in demonstrating waiver falls on the non-waiving party, see *Hartford Fire Ins. Co. v. Enoch*, 96 S.W. 393, 394 (Ark. ~~1903~~1906); *Baysdon v. Nationwide Mut. Fire Ins. Co.*, 130 S.E.2d 311, 317 (N.C. 1963) (citations omitted) (“A party may waive a provision of a contract. A provision in a policy that insurer must give notice to insured as a condition precedent to cancellation is for insured’s benefit and may be waived by him. The burden is on insurer to show a waiver by the insured, and it must appear clearly that the insured expressly or impliedly waived notice if he is to be held bound by such waiver.”); see also ~~16b JOHN ALAN APPLEMAN,~~ [3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW AND PRACTICE](#) § 9084 (“[A]n insured must establish that the insurer had full knowledge of the facts before he can take advantage of a waiver by the insurer’s action in compelling the insured to submit to an examination under a provision of the policy.”); ~~17A LEE R. RUSS & THOMAS F. SEGALLA~~ LIBRARY EDITION § 16.03 (Lexis 2017) (“In particular, ‘no intention to waive rights can be inferred against one . . . ignorant of the existence of such rights.’ However, the insurer will be charged with knowledge of facts which it would have known had it exercised ordinary diligence.”); [17A STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 254:148 (3d ed. ~~1995~~2017) (“The party claiming the benefit of a waiver has the burden of proving its occurrence.”).

§ 6. Estoppel

A party to a ~~liability~~ an insurance policy who makes a promise or representation that can reasonably be expected to induce detrimental reliance by another party to the policy is estopped from denying the promise or representation if the other party does in fact reasonably and detrimentally rely on that promise or representation.

Comment:

a. The function of estoppel. Estoppel is a general contract-law doctrine that permits the enforcement of terms different from those in the original contract, without requiring all of the elements of a new contract, for example, new consideration. Estoppel requires some action or representation on the part of the promisor and reasonable and detrimental reliance on the part of the promisee. Note that conduct other than speech can in some circumstances reasonably be interpreted as a promise or representation, as exemplified by certain cases regarding the loss of grounds for contesting coverage when an insurer exercises the right to defend without reserving the right to contest coverage. See § 15, Comment *a*. Although estoppel and implied waiver are often considered interchangeable in insurance cases, there are important differences between these doctrines that are reflected in this Section and § 5. See § 5, Comments *a*, *b*, *c*, and *f*. The core function of estoppel is to protect the parties' reliance interests. Thus, while waiver requires only proof of an express or implied waiver by a party of a right contained in the policy, estoppel requires the counterparty to also prove his or her reasonable and detrimental reliance on the first party's promise or representation.

b. Equitable and promissory estoppel. Within contract law, a distinction is sometimes drawn between equitable estoppel and promissory estoppel. Equitable estoppel occurs when one party falsely represents certain facts to be true, inducing detrimental reliance by a counterparty. In such situations, it has long been held that the party that made the misrepresentation is "estopped" from denying the fact in question. The doctrine of promissory estoppel involves a promise by one party about some future action that then induces detrimental reliance by a counterparty. In such cases, if the counterparty has relied reasonably to his or her detriment, the promisor is estopped from renegeing on the promise, even in the absence of the normal requirements for a contract, such as consideration and mutual assent. By defining estoppel to include promises and

representations, including conduct that a reasonable person would regard as a promise or representation, this Section captures both equitable and promissory estoppel in one rule.

c. Reasonable and detrimental reliance. If one party either expressly or impliedly, through its actions or inactions, makes a promise or representation to a counterparty that induces reasonable and detrimental reliance by the counterparty, the first party is estopped from denying coverage on the ground that the promise or representation is inconsistent with the terms of the policy. The counterparty's detrimental reliance, however, must be reasonable under the circumstances. In determining whether an insured's reliance on a promise or representation of the insurer was reasonable, a court should take into account the sophistication of the insured and the practical reality that ordinary people do not read, and cannot reasonably be expected to read, their insurance policies. In general, it is reasonable for a policyholder or applicant for insurance to rely on the representations of the insurer's agent with respect to the meaning and significance of questions in the insurance application or renewal process, as well as to what will and will not be covered by the policy. Thus, even if the promise or representation of an insurer's agent contradicts the clear language of the policy, it will generally be reasonable for the policyholder to rely on that promise or representation. The exception to this general rule is when (a) the agent is attempting to invite the policyholder to collude with the agent to defraud the insurer and (b) the policyholder is or should be aware of this collusive intent. In such a situation, reliance by the policyholder on the agent's misrepresentation would be unreasonable. What constitutes detrimental reliance by the insured on a promise or representation by the insurer will depend on the circumstances of each case. Detrimental reliance can include an insured's decision not to seek alternative coverage when the insurer represents that a particular risk will be covered. In some situations, detrimental reliance may include a decision by the insured to engage in a particular activity, and thus to expose itself to the risk of a lawsuit, based on a promise or representation of coverage by the insurer.

d. Use of extrinsic evidence. Proof of the elements of estoppel typically requires the court to admit and consider evidence beyond the insurance policy and the facts of the underlying legal action. Such evidence can include, but is not limited to, testimony on the part of the policyholder and the insurer, or agents of the policyholder and the insurer, with respect to expressed or implied representations that were made by the parties to each other. Evidence of the actions of the parties, which could be considered indicative of objective intent, also is permissible. For a

discussion of the use of extrinsic evidence in connection with the interpretation of insurance-policy terms, see § 3, Comment *fd.*

e. Estoppel can expand coverage. Courts have frequently said that estoppel cannot be used to expand coverage beyond the risks defined in the policy, so much so that it might appear that this is the prevailing rule. However, if the elements of estoppel are satisfied, coverage is necessarily expanded beyond what it would have been in the absence of estoppel, and many courts have used estoppel doctrine to prevent an insurer from raising a ground for contesting coverage. For example, courts regularly have used estoppel to prevent an insurer that has been providing a defense without a reservation of rights from belatedly raising a ground for contesting coverage, so much so that proof of detrimental reliance is no longer required. See § 15.

Illustrations:

1. The policyholder is a small-business owner who purchases a general-liability insurance policy from an insurer to cover risks associated with his business. After the policyholder receives the policy, he calls the agent for the insurer to discuss the policy terms. The policyholder expresses concern that he heard from a business associate that this kind of policy contains an exclusion that excludes a liability risk against which the policyholder wishes to insure. The agent assures the policyholder that an endorsement to the policy contains language that removes the exclusion in question. The endorsement is long and complex, and contains terms that the policyholder would require expert assistance to understand. As it turns out, the agent, whom the policyholder has reason to believe is knowledgeable in these matters, has in fact misinformed the policyholder. The particular endorsement in question does not contain the language promised by the agent, although such an endorsement is available in the insurance market and the policyholder would have purchased that coverage had it been offered to him. A suit is then filed against the policyholder that involves the risk that is expressly excluded by the exclusion. Because the policyholder reasonably relied to his detriment on the agent's representation, the insurer is estopped from enforcing the exclusion in question.

2. Same facts as Illustration 1, except that, in response to the policyholder's inquiry about the exclusion, the agent acknowledges that the policy does contain the

exclusion but, without making any reference to an endorsement, tells the policyholder simply to ignore the exclusion and assume that the risk in question is covered, saying “what the insurer doesn’t know won’t hurt it.” When the suit is filed against the policyholder, the insurer is not estopped from invoking the exclusion, because the policyholder’s detrimental reliance on the agent’s representation was not reasonable.

3. Same facts as Illustration 1, except that an endorsement affording the coverage is not available. Because the endorsement was not available and the policyholder did not otherwise change his behavior as a result of the agent’s conduct (for example by changing a business practice to reduce the risk), the policyholder did not detrimentally rely.

f. Agency law applied to estoppel. The law of agency applies to estoppel as well as waiver. See § 5, Comment *b*. For example, if a person deemed to be an agent of the insurer represents that a particular exclusion or condition has been waived by the insurer or that the exclusion or condition will not be applied to the insured for some reason, and the insured reasonably and detrimentally relies on that representation, the insurer is estopped from asserting the condition or exclusion as a basis for denying coverage. In some cases, an insurer may give the agent actual authority to make such representations on its behalf to vary the terms of the insurance agreement. In other cases, insurers’ agents may have apparent authority. In general, apparent authority requires that the insured reasonably believe that the agent is authorized to make the representation in question on behalf of the insurer and that the insurer have, through a statement or action, done something to create this belief. Whether a person not employed by the insurer is the agent of the insurer and for what purposes he or she is an agent of the insurer depends on the facts and circumstances of each case and does not necessarily depend on the insurance business title used to describe that person. For example, even a broker hired by the policyholder for the purpose of assisting the policyholder in the selection of insurance coverage may be an agent of the insurer for certain purposes.

g. Post-loss statements and conduct can give rise to estoppel. Some courts in the first-party context have held that post-loss statements and conduct by an insurer or its agents cannot give rise to estoppel. Such a rule lacks a coherent justification, as there is no reason to suppose that pre-loss misrepresentations by an insurer are systematically more likely to be misleading or to induce reliance by insureds than post-loss misrepresentations by the insurer. Nor

is there evidence that insureds' reliance on post-loss representations or promises by the insurer's agents is more likely to be unreasonable than their reliance on the agent's pre-loss representations or promises. In both situations, there is the possibility of reasonable and detrimental reliance by the insureds. In any event, post-loss estoppel is clearly available in the context of liability insurance. Therefore, if an insurer's agent, before or after the loss, makes a promise or representation upon which the insured reasonably and detrimentally relies, then the insurer is estopped from denying coverage.

Illustration:

4. A trucking company is sued for bodily injury arising out of a serious trucking accident. The accident is covered under a liability insurance policy, which contains a condition requiring the insured to notify the insurer "in writing" as soon as practicable after a suit is filed against the insured, but no later than 30 days after the suit is filed. An agent of the insured calls an agent of the insurer the day after the suit is filed and, over the course of a long telephone conversation, recounts all of the relevant facts of the accident and answers all of the insurer's questions. The agent of the insured then asks the insurer whether the insured needs to do anything else to trigger coverage under the policy. The agent of the insurer says: "No. You have done everything necessary. The ball is now in our court. We will be in touch if and when we need you to do anything further." The insured relies on this statement by the agent of the insurer and does not send anything to the insurer in writing. The agent for the insurer, however, fails to pass the information along to the relevant department, and the insurer does not follow up on the suit. On the 35th day after the lawsuit was filed, having heard nothing from the insurer, the agent of the insured again calls the insurer for an update on the status of the case. The insurer at that point informs the insured's agent that it will not provide a defense to the suit because it was not notified in writing about the suit, which is a condition of coverage. The insurer is estopped from invoking this notice condition, because the insured reasonably and detrimentally relied on the representations of the agent of the insurer. Estoppel applies even though both the representation by the insurer and reliance by the insured took place after the loss.

h. Burden of proof. The burden of proof rests with the party seeking to invoke estoppel to show that the other party made a promise or representation that would reasonably be expected to induce, and in fact did induce, detrimental reliance.

REPORTERS' NOTE

a. The function of estoppel. The doctrine of estoppel is discussed in Restatement Second, Contracts § 90 (AM. LAW INST. 1981) (“A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise. The remedy granted for breach may be limited as justice requires.”). As with waiver, estoppel results in an enforceable promise without need for consideration. See [3-8 JOSEPH M. PERILLO, CORBIN ON CONTRACTS § 8.7 \(20112017\)](#) (“They should practically always be approved as clearly falling within Restatement of Contracts § 90, stating when a promise without any agreed consideration (agreed equivalent in exchange) is made enforceable by reason of a change of position in reasonable reliance on it.”). For estoppel to apply, one party must show that it relied, to its detriment, on a representation or action of another party; this requirement is not part of a claim of waiver. See [2-ERIC MILLS-HOLMES, HOLMES’3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE § 8 \(2d ed. 2008\); 6-LEE R. RUSS & THOMAS F. SEGALLA LAW LIBRARY EDITION § 16.03 \(Lexis 2017\); 6-STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 85:5 \(3d ed. 19952017\)](#) (“To bind an insurer by an estoppel, there must have been conduct on its part or by its agent which led the insured, erroneously and to his or her detriment, to believe that a condition in the policy would not be relied upon by the insurer. Where the facts are equally known to both parties, there can be no estoppel, for in such case, there is no reliance by one party upon the acts or representations of the other.”); [2 ALLAN WINDT, INSURANCE CLAIMS AND DISPUTES § 6:33 \(56th ed. 20102017\)](#) (“The coverage afforded by an insurance policy should be extended by estoppel whenever the insurer’s actions prior to its final coverage denial are justifiably relied on by the insured to his or her prejudice. . . . For example, an insurer’s admission that coverage exists does not serve to estop the insurer from denying coverage if the insured did not reasonably rely to its detriment on the admission.”). See also *Schoff v. Combined Ins. Co. of Am.*, 604 N.W.2d 43, 48 (Iowa 1999) ([internal quotations omitted](#)) (“[E]stoppel allows individuals to be held liable for their promises despite an absence of the consideration typically found in a contract. Courts have applied the principle of estoppel in effect to form a contract, when the promisee suffered detriment in reliance on a promise.” [-internal quotations omitted](#)); *Verschoor v. Mountain W. Farm Bureau Mut. Ins. Co.*, 907 P.2d 1293, 1298 (Wyo. 1995) ([internal quotations omitted](#)) (“[T]he elements necessary to a claim (or defense) of promissory estoppel [are] (1) a clear and definite agreement; (2) proof that the party urging the doctrine acted to its detriment in reasonable reliance on the agreement; and (3) a finding that the equities support the enforcement of the agreement.” [-internal quotations omitted](#)).

b. Equitable and promissory estoppel. Equitable estoppel was traditionally limited to situations in which one party misrepresented a fact to another party and the latter relied to his or her detriment on that misrepresentation. 4 RICHARD A. LORD, WILLISTON ON CONTRACTS § ~~8.3~~8.6 (4th ed. ~~1989~~2017). Promissory estoppel developed later and encompasses promises with respect to future action made by one party on which another party detrimentally relies. For a general statement of the doctrine of promissory estoppel, see Restatement Second, Contracts § 90(1) (AM. LAW INST. 1981) (“A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise.”); see also 46 C.J.S. *Insurance* § 1146 (2016) (“[S]ome authorities make a distinction between waiver and estoppel and, although recognizing that the coverage of the policy cannot be extended by waiver, hold that the company may be estopped to deny a broader or different coverage than that specified by the terms of the policy. A similar distinction has been drawn between equitable estoppel and promissory estoppel.”). For a thorough discussion of estoppel doctrine, see JOSEPH M. PERILLO, ~~CALAMARI AND PERILLO ON CONTRACTS~~ 253-273~~418-424~~ (~~57~~th ed. ~~2003~~2014).

c. Reasonable and detrimental reliance. For the proposition that reliance must be reasonable and detrimental for estoppel to apply, see *Hous. Gen. Ins. Co. v. Lane Wood Indus., Inc.*, 571 S.W.2d 384, 391 (Tex. Civ. App. 1978) (“The doctrine of estoppel is intended to promote justice and the reliance of the party asserting it must have been in good faith. It is true there is no estoppel where the knowledge of the parties is equal.”); *Harris v. Criterion Ins. Co.*, 281 S.E.2d 878, 881 (Va. 1981) (citations omitted) (“The doctrine of estoppel applies only when the insured can prove he justifiably relied on the insurer’s conduct and was thus misled . . . Unwarranted reliance will not invoke the application of estoppel.”).

e. Estoppel can expand coverage. For examples of courts stating that the doctrine of estoppel cannot be used to expand coverage, see *Deardorff v. Farnsworth*, 343 P.3d 687, 691 (Or. Ct. App. 2015) (“[E]stoppel . . . is not available to avoid an express exclusion; that is, it cannot expand the scope of an insurance contract.”) (citation omitted); *Ulico Cas. Co. v. Allied Pilots Ass’n*, 262 S.W.3d 773, 775 (Tex. 2008) (“[E]stoppel cannot be used to re-write the contract of insurance and provide contractual coverage for risks not insured.”); *Republic Ins. Co. v. Silverton Elevators, Inc.*, 493 S.W.2d 748, 757 (Tex. 1973); *Maxwell v. Hartford Union High Sch. Dist.*, 814 N.W.2d 484, 491 (Wis. 2012) (citations omitted) (“the doctrine of . . . estoppel based upon the conduct or action of the insurer or its agent is not applicable to matters of coverage as distinguished from grounds for forfeiture.”). See generally 1 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 5.07[2] (Lexis ~~2012~~2017) (“[I]t is often said that the doctrines cannot be used to create or expand coverage, so there must be some other basis for the claim of coverage other than merely the application of waiver and estoppel.”).

For rejection of the proposition that estoppel cannot be used to expand coverage, see *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388, 394-395 (Ariz. 1984) (Although “[t]he majority rule is considered to be ‘that the doctrines of waiver and estoppel are

not available to bring within the coverage of an insurance policy risks not covered by its terms, or expressly excluded therefrom, there are strong reasons to recognize a rule which allows an insured to raise the issue of estoppel to establish coverage contrary to the limitations in the boiler-plate insurance policy when the insurer’s agent had represented the coverage as greater than the language found in the printed policy.”) (citations omitted); see also *Harr v. Allstate Ins. Co.*, 255 A.2d 208, 218-219 (N.J. 1969) (“[E]quitable estoppel is available, under appropriate circumstances, to bring within insurance coverage risks or perils which are not provided for in the policy or which are expressly excluded”); *Bill Brown Const. Constr. Co. v. Glens Falls Ins. Co.*, 818 S.W.2d 1, 12 (Tenn. 1991) (“We are persuaded that the effort to distinguish between insuring, exclusionary, and forfeiture clauses is pointless and . . . that the better view is that an insurer may be estopped to deny coverage for any loss by the misrepresentations of its agent upon which the insured reasonably relies.”); *Hunter v. Farmers Ins. Group*, 554 P.2d 1239, 1243 (Wyo. 1976) (“There are some circumstances, if present, where the plaintiff could rely upon an agent’s representations even as against a contrary provision in the insurance policy, based upon not only principles of agency but considerations of equitable estoppel.”). Although there are still cases asserting that the majority rule is that estoppel cannot expand coverage, the proposition is doubtful, given that there are so many widely acknowledged exceptions to the rule. Further, the majority rule is often cited in cases when the necessary elements for estoppel have not been presented. See, e.g., *Sellers v. Allstate Ins. Co.*, 555 P.2d 1113, 1116-1117 (Ariz. 1976) (en banc).

For a discussion of the many contexts in which estoppel in fact has been used in the insurance context to expand coverage, see ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 398-382-401-386 (45th ed. 2007-2012); 3 JEFFREY E. THOMAS, APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.03 (Lexis 2012-2017) (“The substantial body of ~~ease-law~~ caselaw expressly allowing coverage to be expanded by estoppel has developed largely in the context of misrepresentations of the scope of coverage at the time of sale.”).

f. Agency law applied to estoppel. For a statement of the general rule for apparent authority in agency law, see Restatement Third, Agency § 2.03 (AM. LAW INST. 2006) (“Apparent authority is the power held by an agent or other actor to affect a principal’s legal relations with third parties when a third party reasonably believes the actor has authority to act on behalf of the principal and that belief is traceable to the principal’s manifestations.”). For a discussion of these agency-law principles as they relate to insurance, see *Northington v. Dairyland Ins. Co.*, 445 So. 2d 283, 286 (Ala. 1984) (“[I]n order for a principal to be held liable under the doctrine of apparent authority and estoppel, the principal must have engaged in some conduct which led a third party to believe that the agent had authority to act for the principal.”); *Indep. Fire Ins. Co. v. Able Moving & Storage Co.*, ~~Ine.~~ 650 So. 2d 750, 752 (La. 1995) (“Apparent authority is an estoppel principle which operates in favor of third persons seeking to bind a principal for unauthorized acts of an agent. When the apparent scope of an agent’s authority, the indicia of authority, is relied upon by innocent third parties to their detriment, the

principal is liable.”); 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 31:113 (3d ed. ~~1995~~2017) (“[A]n insurer is not estopped . . . by [an] agent who had no authority to act.”); 6 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 61.04 (Lexis ~~2012~~2017) (“Estoppel frequently involves the insured’s interaction with an agent of the insurer. In most cases, insurers are bound by the acts of their agents, either through actual or apparent authority.”).

g. Post-loss statements and conduct can give rise to estoppel. Some courts have held that, in the context of first-party insurance, even if estoppel may be used in some situations to expand coverage, this can only occur if the representation on which the insured reasonably relied takes place prior to the issuance of the policy. On this view, promissory estoppel with respect to insurance policies cannot be applied to representations made by agents of the insurer after the policy has been issued. The leading case in this area is a property-insurance case, *Roseth v. St. Paul Prop. & Liab. Ins. Co.*, 374 N.W.2d 105, 107 (S.D. 1985) (internal citations omitted) (“The requirement that the estopping conduct occur ‘before or at the inception of the policy’ is consistent with the underlying rationale of the minority rule. The minority rule was born out of the inequities which result where an insured relies to his detriment on an insurer’s superior knowledge in purchasing a policy of insurance and consequently is deprived of the opportunity to purchase the desired coverage elsewhere.”). It is worth noting that, while the majority provided a justification for extending the doctrine of estoppel to *precontractual* dealings, it failed to offer any explanation for why *postcontractual* misrepresentations should be precluded from estoppel protections. *Id.* Indeed, it is this absence of reasoning that motivated the dissent. *Id.* at 110-111 (Henderson, J., dissenting) (“For, if you mislead a man into economic ruination or damage, by representations, concealment of material matters, or detrimental reliance prior to an insurance contract, the doctrine of equitable estoppel comes into play; but if the misrepresentation or misleading and detrimental reliance is all ~~postcontract~~ post-contract, estoppel is not activated, a dichotomy or forked reasoning process is established; and the brain, that complicated organ, is swept with fluctuation and oscillation.”). Moreover, the majority in *Roseth* relied heavily on a New Jersey decision, *Harr v. Allstate Ins. Co.*, 255 A.2d 208, 221 (N.J. 1969), which never itself ruled out the applicability of estoppel doctrine in disputes involving postcontractual insurer misrepresentation and insured reliance. For a case permitting post-loss estoppel to expand coverage in the context of liability insurance, see *Mut. Ins. Co. of Arizona v. Bodnar*, 793 P.2d 560, 565 (Ariz. Ct. App. 1990) (insurer estopped from relying on insured’s failure of notice because insurer failed to allow the insured to eliminate the prejudice by using its own funds to buy out the default).

TOPIC 3

MISREPRESENTATION

§ 7. Misrepresentation

(1) Any statement of fact made by a policyholder in an application for an insurance policy is a representation by the policyholder.

(2) Subject to the rules governing defense obligations, an insurer may deny a claim or rescind the applicable—~~liability~~ insurance policy on the basis of an incorrect representation made by a policyholder in an application for an insurance policy (hereinafter referred to as a misrepresentation) only if the following requirements are met:

(a) The misrepresentation was material as defined in § 8; and

(b) The insurer reasonably relied on the misrepresentation in issuing or renewing the policy as specified in § 9.

(3) When the policy is rescinded under subsection (2), the insurer must return all of the premiums paid for the policy.

Comment:

a. The functions of the misrepresentation defense. The functions of misrepresentation doctrine generally are to encourage contracting parties to provide accurate information during the contracting process, to protect those who are misled to their detriment, and to penalize those who mislead. The misrepresentation defense is especially important in the context of insurance contracts. The efficient functioning of insurance markets requires that insurers receive accurate information regarding potentially insured risks so that, among other reasons, insurers can price their policies accurately. The possibility of a claim denial or policy rescission can create incentives for the applicants to provide accurate information during the policy application and renewal process, so long as the contours of the misrepresentation rules match insurance applicants' understanding of what is expected of them. In addition, as a matter of fairness, policyholders who make intentional or reckless misrepresentations on their insurance applications should not be permitted to shift losses to insurance companies that have relied in good faith on the policyholders' answers. Such losses ultimately are shifted to other policyholders who have behaved in good faith in the application and renewal processes.

b. Encouraging insurers' best practices in information gathering. Policyholders are not the only parties to insurance contracts with access to relevant information. Insurers sometimes have the ability to obtain certain types of information regarding an insurance applicant's risk characteristics from sources other than the applicant. Such sources may be as reliable as, or even more reliable than, the information available to the applicant. Misrepresentation doctrine also should encourage insurers to make use of alternative sources of information that are available to them. The reasonableness aspect of the reliance requirement stated in § 9 encourages insurers to make use of that access to information without imposing excessive burdens on insurers. In addition, § 9 states an "inquiry notice" approach that has been adopted by a number of jurisdictions: once an insurer has been put "on notice" that there may be a factual error in the policyholder's representations, the insurer has a duty to make a reasonable investigation. See § 9, Comment *d*.

c. Misrepresentation as a defense and as a basis for rescission. When the requirements of § 7 are met, the insurer may invoke misrepresentation as a valid defense to coverage for a particular claim and as a basis on which to rescind the policy. The burden of proof with respect to each element of misrepresentation lies with the insurer.

d. Relationship to cancellation and rescission. Misrepresentation by a policyholder can provide a basis for either rescinding or cancelling a policy. Rescission voids the policy *ab initio* or "from the beginning." Therefore, if a policy is rescinded, it is as if the policy had never been written; the policy does not provide coverage for any claims; and the premiums are returned. If all of the elements of this Section are met, and the rescission remedy is available to the insurer, the policy is said to be voidable or rescindable at the election of the insurer. By contrast, when an insurance policy is cancelled, it is no longer in force going forward from the date of cancellation. Cancellation prematurely terminates the policy period but otherwise preserves the possibility of coverage of claims arising before the cancellation.

e. Statutory modification. Statutes in some jurisdictions govern the procedure for the cancellation, rescission, and nonrenewal of certain types of insurance. Automobile liability insurance is the most prominent example. With respect to auto liability coverage, the limitations on rescission and cancellation are linked to state laws requiring motor-vehicle owners to carry liability coverage. Such compulsory insurance laws are designed to protect third-party victims in the event of [an](#) accident. That same concern underlies the limitation on insurers' rescission and

cancellation rights. When applicable, those statutes supersede the rule followed in this and the ensuing Sections regarding misrepresentation and concealment.

f. Warranty law. This Section does not endorse the use of warranties as distinct from representations in the application or renewal process for liability insurance. Warranties are reported to have been first used in the 17th century and to have come to prominence in the 18th century, primarily in the area of marine insurance. Policyholders were asked to make warranties (a category of promises) regarding particular facts about the risk being insured. If a warranty proved to be false, the policy was voidable without regard to whether there was reasonable detrimental reliance on the part of the insurer. This strict rule was justified in the marine-insurance context on the grounds that the parties to the contract were of roughly equal sophistication and that evidence necessary to prove the significance of the misrepresentation was often difficult to gather (if the ship had gone down at sea, for example). Warranties are said to remain strictly enforced with respect to marine insurance, for which the most important coverage is a form of property insurance. When policyholders are relatively unsophisticated (as in the case of consumer policyholders), the strict application of warranty provisions is unduly harsh and unfair to insureds, as the law has increasingly recognized. This Section does not follow the few remaining courts that treat warranties as a separate category, outside the special context of [commercial](#) marine-insurance policies. Rather, this Section treats all statements of past or present fact made in connection with the process of applying for or renewing [any](#) liability insurance policy as representations. Promissory warranties, which are descriptions of future facts or promises with respect to future actions, are subject to the requirements of this Section as well.

g. Concealment. Some jurisdictions have adopted a separate doctrine of concealment that requires a showing by the insurer that the policyholder knowingly and intentionally concealed material information from the insurer. Concealment can be difficult for insurers to prove, and it is difficult to find cases decided on the basis of concealment doctrine, in large part because insurers have learned to ask questions about the risk factors that they regard as material. The requirements of the concealment defense are, and should be, particularly difficult for insurers to satisfy in the consumer [insurance](#) context because consumer policyholders ordinarily do not know what information not specifically asked about by the insurer is material to the underwriting process.

h. Misrepresentation in the renewal process. The misrepresentation rules followed in this Section apply not only to an initial application for insurance but also to an application for a renewal of a policy. All the concerns regarding the need to encourage an honest and forthright exchange of information from policyholder to insurer apply to the renewal process as well. In setting premiums for renewal policies, insurers also need to have reliable information regarding the policyholders' risk characteristics. Applying the misrepresentation doctrine to the renewal process helps strengthen the policyholder's incentives to make honest disclosures and ensures that misrepresentations by policyholders at the renewal stage do not go uncorrected. Thus, if at the renewal stage an insurer provides the policyholder with information that the insurer intends to use to compute the renewal premium and asks the policyholder to confirm that the information is accurate, and if the policyholder so confirms, then that confirmation is a representation to which misrepresentation rules apply. A policy renewal does not ordinarily include an affirmation by the policyholder that statements in the original application remain true. If the insurer wants the policyholder to make such an affirmation, it must expressly make that request at the time of renewal and must, prior to the policyholder's affirmation, provide the policyholder with a written copy of the statements from the original application with respect to which affirmation is sought.

i. Representations by a policyholder. Whether and when a person speaks on behalf of a policyholder or an insurer is determined by the law of agency. This is a fact-specific determination that should not be resolved simply on the basis of the job title of the person involved. See § 5, Comment *b*.

j. The problem of innocent misrepresentations. Many common-law courts and legislatures have articulated the doctrine of misrepresentation as one of, in effect, strict liability. Under the common-law or legislative rules in most states and the rule followed in this Section, the misrepresentation defense is available to the insurer whenever there is reasonable and detrimental reliance by the insurer on a material misrepresentation by the policyholder, even if the policyholder's misrepresentation was entirely innocent and unintentional. Although there are strong fairness and efficiency objections to this strict-liability approach, the legislatures in most states have chosen that approach; and among the minority of states without controlling legislation, only about one third have adopted a common-law knowledge requirement. The fairness objection to the majority rule followed in this Section rests on the view that policyholders purchase liability insurance as protection from negligence, and they should

therefore be protected from negligence in applying for insurance. The efficiency objection rests on the similarity between the risk of making an innocent misrepresentation and the risk of making some other mistake that leads to liability, both of which are the kinds of risks that risk-averse policyholders would prefer to shift to insurers and that insurers are able to bear. Because legislation sometimes addresses this issue, however, and because courts sometimes find alternative grounds for reaching the same result, in practice the unfairness that many observers contend results from the absence of a knowledge requirement does not arise as frequently as might be supposed.

REPORTERS' NOTE

a. The functions of the misrepresentation defense. For a general statement of the misrepresentation doctrine in contract law, see Restatement Second, Contracts §§ 159-173 (AM. LAW INST. 1981). In § 164(1), the Restatement states that misrepresentation makes a contract voidable “[i]f a party’s manifestation of assent is induced by either a fraudulent or a material misrepresentation by the other party upon which the recipient is justified in relying.” For a discussion of the necessity of accurate information for insurance markets to operate, see KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 1-8 (6th ed. 2015) (discussing the basic principles of insurance, including how imperfect information hinders the process of risk pooling and accurate insurance pricing).

The misrepresentation defense helps to combat the problem of adverse selection. Adverse selection arises when insurance applicants have better information about the risks that they present than the insurer has. In such situations of asymmetric information, relatively high-risk parties will be disproportionately likely to purchase insurance because insurance companies are unable to identify, and charge different premiums to, applicants within the insurance pool who present different levels of risk. The result is that premiums are driven up for everyone in the pool, inducing relatively low-risk insureds left in the pool to drop out. This process continues until the insurance pool “unravels” completely or an equilibrium is achieved. “In either case, low-risk parties buy less coverage and high-risk parties buy more coverage than they would if insurers could distinguish the risk posed by different policyholders.” ABRAHAM & SCHWARCZ, *INSURANCE LAW AND REGULATION*, at 7. Insurers’ inability to identify accurately the risks posed by individual insureds thus produces both inefficiency and unfairness. The inefficiency results from the fact that insureds who pay premiums that do not reflect accurate risk estimates will tend to make decisions that diverge from the social optimum—for example, engaging in too much of the activity being insured (if their premium is set too low) or too little (if their premium is too high). The unfairness results from the fact that, within a given risk pool, low-risk insureds subsidize high-risk insureds. Such cross-subsidization is inevitable, given the technological limits of risk segregation. Moreover, it is not considered unfair when the insureds are unaware ex

ante whether they present a below- or above-average risk; whether one ends up (ex post) turning out to be a high-risk or a low-risk insured is part of the uncertainty that is shifted from the insureds individually to the pool collectively through the insurance product. The unfairness mainly arises when a subset of insureds are aware ex ante that they are relatively high-risk and choose fraudulently to understate those risks to take advantage of the lower-risk insureds.

For general discussions of the problem of adverse selection and information asymmetry in insurance markets and the resulting inefficiency and unfairness, see generally George Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970) (first paper identifying the problem of adverse selection in certain types of markets); Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371 (2003) (general discussion for a legal audience); Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004) (same); Michael D. Rothschild & Joseph E. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976) (original technical explanation of effects of adverse selection in insurance markets).

b. Encouraging insurers’ best practices in information gathering. See § 9, Comment *e* and accompanying Reporters’ Note.

c. Misrepresentation as a defense and as a basis for rescission. The affirmative defense of misrepresentation, which is a defense at law, is traditionally a distinct claim from the rescission remedy for misrepresentation, which sounds in equity. See generally Donald P. Judges, *Further Thoughts About Insurance Misrepresentation Cases*, 2010 ARK. L. NOTES 39 (reviewing Arkansas misrepresentation cases and noting the murky issue, before law and equity merged in Arkansas, of whether the affirmative defense of misrepresentation also sounded in equity); Ruth K. Kochenderfer, *Misrepresentations and Other Ways to Lose Your Coverage*, 775 PLI/LIT 275 (2008) (discussing rescission and the affirmative defense of misrepresentation as distinct remedies for the insurer under New York law). However, the misrepresentation defense and the rescission remedy are often treated as one in state insurance statutes. For example, a number of insurance statutes say that “[m]isrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery” unless certain elements are met. See, e.g., Ala. Code § 27-14-7 (2011).

In some jurisdictions, insurers can obtain a rescission remedy while pursuing misrepresentation as an affirmative defense; courts may then collapse the two claims into a single “affirmative defense of rescission.” See, e.g., *Caribbean I Owners’ Assoc., Inc. v. Great Am. Ins. Co. of N.Y.*, 600 F. Supp. 2d 1228, 1249 (S.D. Ala. 2009) (applying Alabama law) (determining whether an insurer was entitled to rescind the policy). The distinction between rescission for misrepresentation and misrepresentation as a defense still has relevance, however. For example, an insurer’s rescission remedy may be statutorily limited while the affirmative defense is not. This is the case, for instance, under some mandatory automobile-insurance schemes. See, e.g., *DiDonna v. State Farm Mut. Auto Ins. Co.*, 259 A.D.2d 727, 727-728 (N.Y. App. Div. 1999) (finding that New York’s automobile-insurance statute prohibited canceling “the plaintiff’s

insurance policy ab initio,” but that the insurer may “assert, as affirmative defenses, that the [insured]’s alleged material misrepresentations fraud in obtaining the subject policy precludes her recovery under the policy.”).

d. Relationship to cancellation and rescission. For the basic distinction between cancellation and rescission, see 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 30:3 (3d ed. ~~1995~~2017) (“While courts, insurers, and insureds often use these terms interchangeably, it is important that the party that acts affirmatively choose the right terminology since different terms may invoke entirely different sets of procedures and principles . . . A rescission avoids the contract ab initio whereas a cancellation merely terminates the policy as of the time when the cancellation becomes effective.”); 1 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 3.08[3] (Lexis ~~2012~~2017) (“When a policy is cancelled, it affects only the future obligations of the parties. However, when a policy is rescinded it is treated as void—as if it had never existed—and therefore neither party has any obligations to the other.”). For a statement of the general rule regarding when insurance policies may be canceled, see 3 LEITNER ET AL., LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION § 39:18 (“Where the insurer discovers a material misrepresentation or concealment in the insurance application prior to a loss, most jurisdictions permit the insurer to bring an action for declaratory relief to cancel the policy.”). See 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~, COUCH ON INSURANCE § 30:3 (3d ed. 1995) (footnotes omitted):-

~~A rescission avoids the contract ab initio whereas a cancellation merely terminates the policy as of the time when the cancellation becomes effective. In other words, cancellation of a policy operates prospectively while rescission, in effect, operates retroactively to the very time that the policy came into existence; the distinction is similar to that between divorce and annulment. However, it is important to note that a statute governing grounds and procedures for “cancellation” of insurance contracts, although ambiguous as to whether it encompassed unilateral “rescission,” may be interpreted to regulate both cancellations and rescissions.~~ For cases distinguishing between rescission and cancellation, see, e.g., *Government Employees Ins. Co. v. Allen*, 944 N.Y.S.2d 761, 762 (N.Y. App. Div. 2012) (“Vehicle and Traffic Law § 313(1)(a) supplants an insurer’s common-law right to cancel a contract of insurance retroactively on the grounds of fraud or misrepresentation, and mandates that the cancellation of a contract pursuant to its provisions may only be effected prospectively.” (quoting *Matter of Global Liberty Ins. Co. of N.Y. v. Pelaez*, 922 N.Y.S.2d 510, 511 (N.Y. App. Div. 2011))); *Allstate Ins. Co. v. Boggs*, 271 N.E.2d 855, 857 (Ohio 1971) (holding that Ohio law permits warranties to void a policy ab initio, but a misrepresentation is ground only for prospective cancellation “and may not be used to avoid liability arising under the policy after such liability has been incurred”).

e. Statutory modification. In some jurisdictions, states have statutorily adopted a misrepresentation rule that requires an insurer seeking rescission to show fraud or intent to deceive on the part of the policyholder. 6 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 82:23 (3d ed. ~~1995~~2017) (“Also, on the issue of rescission, the policy or statute may provide that, after a certain period from issuance of a policy, an insurer may void the policy only if misstatements in the application are fraudulent.”); 3-16 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.08[1][e][ii] (Lexis ~~2012~~2017). For authority regarding state statutes creating a fraud or intent-to-deceive requirement for misrepresentation claims, see *Smith v. Republic Nat’l Life Ins. Co.*, 483 P.2d 527, 530 (Ariz. 1971) (interpreting Ariz. Rev. Stat. Ann. § 20-1109 to be read in the conjunctive such that both fraud and materiality requirements must be satisfied); *Foster v. United of Omaha Life Ins. Co.*, 442 F. App’x 922, 926 (5th Cir. 2011) (citing *Johnson v. Occidental Life Ins. Co. of Ca.*, 368 So. 2d 1032, 1036 (La. 1979), for the proposition that both the intent to deceive and materiality elements of La. Rev. Stat. Ann. § 22:860 “must be met in order to rescind policy, notwithstanding the apparently disjunctive language of the statute”); *Liberty Ins. Underwriters, Inc. v. Estate of Faulkner*, 957 A.2d 94, 100-101 (Me. 2008) (interpreting Title 24–A M.R.S. § 2411 to require an insurer to prove both fraud and materiality to rescind a liability insurance policy); *Scottsdale Ins. Co. v. Tolliver*, 127 P.3d 611, 614 (Okla. 2005) (notwithstanding the disjunctive wording in the statute, there must be “a finding of insured’s intent to deceive an insurer before a misrepresentation, an omission or incorrect statement in an application can avoid the policy under § 3609”); Wash. Rev. Code § 48.18.090; *Levy v. North Am. Co. for Life & Health Ins.*, 586 P.2d 845, 848851 (Wash. 1978) (“RCW 48.18.090 denies the right of an insurer to void a policy on the basis of misrepresentation unless the applicant made a false statement which either (1) was made with intent to deceive, or (2) materially affected the acceptance of the risk or the hazard assumed by the insurer.”); *Pum v. Wisconsin Physicians Serv. Ins. Corp.*, 727 N.W.2d 346, 351-352 (Wis. Ct. App. 2006) (citations omitted) (“To be entitled under the statute to rescind an insurance policy, the insurance company must prove: (1) that (a) a misrepresentation was made and (b) the person making it knew, or should have known, that it was false; and (2) either (a)(i) the insurer relied on the misrepresentation, and (ii) that misrepresentation was material, or (iii) it was made with intent to deceive; or (b) the misrepresented fact contributed to the loss.”), review denied, 732 N.W.2d 859 (Wis. 2007). In addition, many statutes place limits on insurers’ ability to cancel a policy. In Texas, for instance, an insurer may only cancel a liability insurance policy after it has been in effect for 60 days for one of the enumerated reasons, which include fraud in obtaining coverage, failure to pay premiums, and an “increase in hazard within the control of the insured that would produce a rate increase.” Tex. Ins. Code Ann. § 551.052 (Vernon 2011); see also Ariz. Rev. Stat. Ann. § 20-1651 (2011) (applying similar limits to all types of non-automobile insurance); Cal. Ins. Code § 660 (West 2011) (similar); Idaho Code Ann. § 41-1842 (2011) (applying similar limits specifically to commercial property, liability, and multi-peril insurance policies). Additionally, the insurer must provide written notice of cancellation or decision not to renew.

Tex. Ins. Code Ann. §§ 551.054-551.055 (West 2011). Other statutes limit cancellation even further, and provide that an insurer may only cancel policies older than 60 days for nonpayment of premiums. See, e.g., Colo. Rev. Stat. § 10-4-110 (2011).

Mandatory insurance schemes, such as those imposed on automobile drivers, often abrogate the common-law or statutory right of insurers to rescind coverage. As of 2011, every state but New Hampshire required drivers to purchase automobile insurance or else demonstrate financial responsibility to cover accident claims. See Wis. Stat. § 344.62 (2011) (making Wisconsin the 49th state to enact a compulsory-insurance scheme); ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW [960936](#) (4th ed. [20072012](#)) (finding that 48 states and the District of Columbia had compulsory-insurance laws). Most courts have found that automobile liability insurers may not retroactively avoid coverage claims from innocent third parties. See, e.g., *Harkrider v. Posey*, 24 P.3d 821, [832831](#) (Okla. 2000) (“Today’s pronouncement is consistent with the approach taken by many other state courts, which have held their various statutory provisions relating to compulsory automobile liability prevent post-loss rescission to defeat the insurer’s liability to an innocent third party.”); *Philadelphia Indem. Ins. Co. v. Montes-Harris*, 146 P.3d 1251, 1254 (Cal. 2006) (“[A]n automobile liability insurer has a nondelegable duty to undertake a reasonable investigation of insurability within a reasonable period of time of the issuance of a policy in order to preserve the ability to rescind the policy based on the insured’s misrepresentations and thereby avoid liability on the policy to a third person whom the insured injures.”) (citing *Barrera v. State Farm Mut. Auto. Ins. Co.*, 456 P.2d 674 (Cal. 1969) and *United Services Auto. Ass’n v. Pegos*, 131 Cal. Rptr. 2d 866 (Cal. Ct. App. 2003)).

Beyond the jurisdictions within the United States, other countries have also adopted rules governing insurance contracts that have some or all of the elements of the *scienter* requirement suggested in [the Reporters’ Note to Comment j](#). Denmark, for example, has special rules for merely negligent misrepresentations. Under the Danish system, if a misrepresentation is negligent, the insurer can choose between a “pro rata rule² or a contribute-to-the-loss rule. Under the pro rata rule, the insured is provided only the coverage he or she would have received had there been no misrepresentation. See Henrik Lando, *Optimal Rules of Negligent Misrepresentation in Insurance Contract Law*, 46 INT’L REV. L. & ECON. 70-77 (June 2016) (citing Danish Insurance Contract Act, Commented (Lovbekendtgørelse 2006-10-05 nr. 999 om forsikringsaftaler), in Karnovs Lovsamling, Karnov Group.). The rule in Germany is that an insurer can only get a reduction in coverage due to policyholder misrepresentation if (a) the misrepresentation was intentional or reckless and (b) the misrepresented fact had a causal impact on the insurance event. See *id.* (citing Helmut Heiss, *Proportionality in the New German Insurance Contract Act 2008*, 5 ERASMUS L. REV. 105 (2012)).

A number of states have statutory definitions of misrepresentation that courts have construed as explicitly permitting the insurer to rescind a policy based on an innocent misrepresentation of a material fact. See Ala. Code § 27-14-7; see also *Alfa Life Ins. Corp. v. Lewis*, 910 So. 2d 757, 762 (Ala. 2005) (“Under § 27-14-7, it is not necessary that the insured

have made the misrepresentation with an intent to deceive; even if innocently made, an incorrect statement that is material to the risk assumed by the insurer or that would have caused the insurer in good faith not to issue the policy in the manner that it did provides a basis for the insurer to avoid the policy.”); Alaska Stat. § 21.42.110; see also *Bennett v. Hedglin*, 995 P.2d 668, 673-674 (Alaska 2000) (“[W]e hold that the insurer may rescind the binder or policy—rendering the contract void ab initio—when the applicant makes a misrepresentation material to the risk.”); Cal. Ins. Code § 359; *Thompson v. Occidental Life Ins. Co. of California*, 513 P.2d 353, 360 (Cal. 1973) (“Material misrepresentation or concealment of such facts are grounds for rescission of the policy, and an actual intent to deceive need not be shown.”); Del. Code Ann. tit. 18 § 2711; see also *United Westlabs, Inc. v. Greenwich Ins. Co.*, 38 A.3d 1255, 1255 (Del. 2012) (affirming lower-court ruling “that title 18, section 2711 of the Delaware Code precluded recovery under the policies because [insured] made misrepresentations in its applications for insurance, which were material.”); D.C. Code § 31-4314; see also *Skinner v. Aetna Life & Cas.*, 804 F.2d 148, 149 (D.C. Cir. 1986) (“The statute sets forth a two-tiered test whereby insurance coverage may be barred. First, the statement must be false. Second, the false statement must have been made with an intent to deceive or must materially affect the acceptance of the risk or hazard assumed by the company.”); Fla. Stat. § 627.409; see also *F.D.I.C. v. Verex Assur., Inc.*, 645 So. 2d 427, 429 (Fla. 1994) (“[Fla. Stat. § 627.409] protects an insurer from material misrepresentations in an application for insurance, even those innocently made by the insured”); Ga. Code Ann. § 33-24-7(b); see also *Pope v. Mercury Indem. Co. of Georgia*, 677 S.E.2d 693, 696 (Ga. Ct. App. 2009) (“To avoid coverage under this statute, ‘the insurer need only show that the representation was false and that it was material.’”) (quoting *White v. Am. Family Life Assurance Co.*, 643 S.E.2d 298, 300 (Ga. Ct. App. 2007)); Haw. Rev. Stat. § 431:10-209; see also *Park v. Government Employees Ins. Co.*, 974 P.2d 34, 39 (Haw. 1999) (discussing statutory rule that “a misrepresentation in an insurance policy application may render the policy voidable”); Idaho Code Ann. § 41-1811; see also *Robinson v. State Farm Mut. Auto. Ins. Co.*, 45 P.3d 829, 837 (Idaho 2002) (“Idaho Code § 41-1811 has codified the common law defense of fraud and misrepresentation in the insurance contract context....”); 215 Ill. Comp. Stat. 5/154; see also *Golden Rule Ins. Co. v. Schwartz*, 786 N.E.2d 1010, 1015 (Ill. 2003) ([citations omitted](#)) (“Under the statute . . . a misrepresentation, even if innocently made, can serve as the basis to void a policy.”); Ky. Rev. Stat. Ann. § 304.14-110; see also *State Farm Mut. Auto. Ins. Co. v. Crouch*, 706 S.W.2d 203, 206 (Ky. Ct. App. 1986) ([citation omitted](#)) (“[O]ur courts have in several instances applied the principles set forth in that statute to invalidate various policies of insurance based upon fraudulent or material misrepresentations.”); Mass. Gen. Laws ch. 175, § 186; *A.W. Chesterton Co. v. Massachusetts Insurers Insolvency Fund*, 838 N.E.2d 1237, 1246 (Mass. 2005) (“Under G.L. c. 175, § 186, a misrepresentation in an application for insurance is material, and, thus, will enable the insurer to avoid the policy, if it is made with actual intent or if it increases the risk of loss.”); Mich. Comp. Laws § 500.2218(1); see also *Wiedmayer v. Midland Mut. Life Ins. Co.*, 324 N.W.2d 752, 754 (Mich. 1982) (“There can be no doubt that insurers are permitted by M.C.L. § 500.2218; M.S.A. § 24.12218 to void a

policy where there has been a material misrepresentation of fact which affected either the acceptance of the risk or the hazard assumed by the insurer.”); Minn. Stat. § 60A.36, subd. 5 (“No insurer may rescind or void a contract of liability or property insurance unless there was material misrepresentation, material omission, or fraud made by or with the knowledge of the insured in obtaining the contract or in pursuing a claim under the policy”); see also *Waseca Mut. Ins. Co. v. Noska*, 331 N.W.2d 917, 924 n.6 (Minn. 1983) (“Previous cases have established that if the material misrepresentation increases the risk of loss, the policy is avoided regardless of the intent with which it was made.”) (citations omitted); Mont. Code Ann. § 33-15-403(2); see also *Williams v. Union Fid. Life Ins. Co.*, 123 P.3d 213, 218 (Mont. 2005) (“§ 33-15-403, MCA, allows an insurer to deny coverage when an applicant fails to provide truthful and accurate information. . . .”); Neb. Rev. Stat. § 44-358; see also *Glockel v. State Farm Mut. Auto. Ins. Co.*, 400 N.W. 2d 250, 255-256 (Neb. 1987) (“Section 44-358, while not expressly using the term rescission, has been interpreted by this court to recognize the right to avoid a policy under certain circumstances in the case of material misrepresentations by an insured. . . . Perhaps it is most accurate to state that in Nebraska there is a common-law right to rescind or avoid insurance policies for material misrepresentations, which is recognized in and limited by § 44-358.”) (citations omitted); Nev. Rev. Stat. § 687B.110; see also *Randono v. CUNA Mut. Ins. Group*, 793 P.2d 1324, 1326 (Nev. 1990) (stating that statute applies regardless of whether inaccuracy in insurance application was fraudulent); N.M. Stat. § 59A-18-11(C); see also *Rael v. Am. Estate Life Ins. Co.*, 444 P.2d 290, 292 (N.M. 1968) (“The general rule, and the rule consistent with principles of contract and the duty of fair dealing, which is the duty imposed upon both the insurer and the insured, is that if misrepresentations be made, or information withheld, and such be material to the contract, then it makes no difference whether the party acted fraudulently, negligently, or innocently.”) (quoting *Modisette v. Found. Reserve Ins. Co.*, 427 P.2d 21, 25 (N.M. 1967)); N.Y. Ins. Law § 3105(b); see also *Penn Mut. Life Ins. Co. v. Remling*, 702 N.Y.S.2d 375, 376 (N.Y. App. Div. 2000) (“Insurance Law § 3105(b) provides that for a misrepresentation to warrant the voiding of an insurance policy, the misrepresentation must be material, meaning that had the insurer known the truth, it would not have issued the policy.”) (citation omitted); N.C. Gen. Stat. § 58-3-10; see also *Ward v. Durham Life Ins. Co.*, 381 S.E.2d 698, 702 (N.C. 1989) (“There is little question that, standing alone, the misrepresentations in the application would be enough to void the policy. ‘A policy of life insurance may be avoided by showing that the insured made representations which were material and false.’”) (citations omitted); N.D. Cent. Code § 26.1-29-24; Or. Rev. Stat. § 742.013; see also *Seidel v. Time Ins. Co.*, 970 P.2d 255, 258 (Or. Ct. App. 1998) (“[T]o prevail on a claim for rescission, an insurer must prove, among other things, that the insured made a misrepresentation or omission and that the misrepresentation or omission was material to the decision to accept the risk of insurance.”); S.D. Codified Laws § 58-11-44; see also *De Smet Farm Mut. Ins. Co. of South Dakota v. Busskohl*, 834 N.W.2d 826, 831-832 (S.D. 2013) (permitting insurer to rescind homeowner’s policy based on material misrepresentation); Tenn. Code Ann. § 56-7-103; *Broyles v. Ford Life Ins. Co.*, 594 S.W.2d 691,

693 (Tenn. 1980) (stating that a misrepresentation may allow rescission either if made fraudulently or if it is material); Utah Code Ann. § 31A-21-105; see also *Doctors’ Co. v. Drezga*, 218 P.3d 598, 604 n.5 (Utah 2009) (“the law permits rescission in cases of misrepresentation”); *Berger v. Minnesota Mut. Life Ins. Co. of St. Paul, Minnesota*, 723 P.2d 388, 390 (Utah 1986) ([citation omitted](#)) (“The statutory alternatives are stated in the disjunctive, not the conjunctive. In order to invalidate a policy because of a misrepresentation by the insured, an insurer need prove applicable only one of the above provisions.”); Vt. Stat. Ann. tit. 8 § 4205; see also *McAllister v. Avemco Ins. Co.*, 528 A.2d 758, 759 (Vt. 1987) (“A material misrepresentation in an application for liability insurance under 8 V.S.A. § 4205 is grounds for declaring the policy void ab initio.”) ([citation omitted](#)); Va. Code Ann. § 38.2-309; see also *Montgomery Mut. Ins. Co. v. Riddle*, 587 S.E.2d 513, 515 (Va. 2003) (“[W]e reiterate that when an insurance carrier seeks to void a policy for alleged material omissions or misrepresentations pursuant to Code § 38.2-309, the insurer must show, by clear proof, two facts: (1) that the statement or omission on the application was untrue; and (2) that the insurance company’s reliance on the false statement or omission was material to the company’s decision to undertake the risk and issue the policy.”); W. Va. Code § 33-6-7; *Massachusetts Mut. Life Ins. Co. v. Thompson*, 460 S.E.2d 719, 724 (W. Va. 1995) (“[N]either West Virginia Code § 33-6-7(b) nor (c) requires that an insurer prove the subjective element that an insured specifically intended to place misrepresentations, omissions, concealments of fact, or incorrect statements on an application in order for the insurer to avoid the policy.”); Wyo. Stat. Ann. § 26-15-109; see also *Harper v. Fid. & Guar. Life Ins. Co.*, 234 P.3d 1211, 1222 (Wyo. 2010) (“[Insurer] rescinded the policy of insurance because it determined, after obtaining an opinion from the chief underwriter, that there were material misrepresentations, omissions, and incorrect statements made on the insurance application which, if they had been known at the time, would have caused the application to have been rejected. There is no question of material fact that § 26-15-109 allows rescission under those circumstances.”).

f. Warranty law. On the historical development of warranties in insurance contracts, see generally Edwin W. Patterson, *Warranties in Insurance Law*, 34 COLUM. L. REV. 595 (1934); see also JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at [780-721](#). Courts and state legislatures have moved away from the common-law warranty doctrine, through either mitigation or outright rejection. Many statutes explicitly state that all statements in an insurance application or contract should be construed as representations instead of warranties and that those misrepresentations make a policy voidable only when they are material or made fraudulently. See, e.g., Ala. Code § 27-14-7 (2011); Ariz. Rev. Stat. Ann. § 20-1109 (2011); Fla. Stat. Ann. § 627.409 (West 2011); Haw. Rev. Stat. Ann. § 431:10-209 (LexisNexis 2011); Idaho Code Ann. § 41-1811 (2011); Ky. Rev. Stat. Ann. § 304.14-110 (West 2011); Me. Rev. Stat. Ann. tit. 24-A § 2411 (2011); Nev. Rev. Stat. Ann. § 687B.110 (West 2011); N.Y. Ins. Law § 3105 (McKinney 2011); Or. Rev. Stat. Ann. § 742.013 (West 2011); S.D. Codified Laws § 58-11-44 (2011). Other states still employ the warranty terminology, but place the same limitations on warranties as they place

on misrepresentations. See, e.g., Cal. Ins. Code §§ 330-361 (West 2011). Finally, a few statutes do not address whether courts may construe statements by insureds as warranties, but instead provide that only material statements, or statements made with intent to deceive, may void coverage. See, e.g., D.C. Code § 31-4314 (2011); Ind. Code Ann. § 27-8-5-5 (West 2011); N.H. Rev. Stat. Ann. § 415:9 (2011); N.J. Stat. Ann. § 17B:24-3 (West 2011); N.M. Stat. Ann. § 59A-18-11 (West 2011); Tex. Ins. Code Ann. § 705.004 (Vernon 2011).

When the warranty doctrine has not been eliminated by state statute, courts have found other methods to avoid the strict application of warranties. Numerous courts have held that a disputed warranty was affirmative, not promissory. In such cases, insureds can satisfy the warranties so long as the statement was true at the time of contract formation; insureds are, therefore, under no obligation to ensure that the statement remains true in the future. See, e.g., *Coppi v. W. Am. Ins. Co.*, 524 N.W.2d 804, 812-813 (Neb. 1994), overruled on other grounds by *D & S Realty, Inc. v. Markel Ins. Co.*, 789 N.W.2d 1 (Neb. 2010) (finding that the Nebraska statute on misrepresentations and warranties did not apply to promissory warranties and did not provide the insurer with grounds for rescission). Even after categorizing a warranty as promissory, however, courts will still generally seek to interpret it as having been satisfied. See, e.g., *Vlastos v. Sumitomo Marine & Fire Ins. Co.*, [707 F.2d 775, 779-780](#) (3d Cir. 1983) (applying Pennsylvania law) (finding that the warranty was ambiguous and that the insured had satisfied at least one reasonable interpretation of the warranty language). Finally, courts may simply classify certain warranty-like promises as representations, thereby preserving the materiality requirement. See, e.g., *Allied Bankers Life Ins. Co. v. De La Cerda*, 584 S.W.2d 529, 532 (Tex. App. ~~1970~~[1979](#)) (“[W]e are persuaded that the good health statement is a representation rather than a warranty.”).

Warranty doctrine appears to survive in marine insurance in at least some states, where courts still uphold claim denials for breach of warranty even in the absence of any showing of materiality or reliance. See, e.g., *Commercial Union Ins. Co. v. Flagship Marine Servs., Inc.*, 190 F.3d 26, 29 (2d Cir. 1999) (applying New York and Florida law) (finding that a marine-insurance contract provision constituted a warranty under either Florida or New York law, and that the insurer therefore had no duty to provide coverage); *Certain Underwriters at Lloyd’s v. Montford*, 52 F.3d 219, 223 (9th Cir. 1995) (applying California law) (enforcing a warranty in a marine-insurance contract even though it was immaterial). Some state misrepresentation statutes explicitly exempt marine and transportation insurance and leave their governance to common law. See, e.g., Fla. Stat. Ann. § 627.409 (West 2011); 215 Ill. Comp. Stat. 5/154 (2011).

g. Concealment. A successful concealment defense must generally demonstrate that the failure to disclose was intentional, fraudulent, and material to the risk. See, e.g., *Cora Pub, Inc. v. Cont’l Cas. Co.*, 619 F.2d 482, 487 (5th Cir. 1980) (applying Florida law) (stating that the insurer “could avoid the policy only by proving that the concealment was intentional, fraudulent, and material to the risk assumed”); *Peninsular Cas. Co. v. McCloud*, 170 S.E. 396, 397 (Ga. Ct. App. 1933) ([citation omitted](#)) (“The mere failure to state material facts in an application for insurance, when not done fraudulently, will not avoid a policy of insurance.”) For a discussion of the

development of the concealment doctrine, see generally JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at ~~789-792~~[757-758](#). In contrast to the misrepresentation defense, courts generally hold that insurers must demonstrate that the insured intentionally concealed a material fact: “While there is authority for the view that the intention is immaterial where the concealment relates to a matter made the subject of specific inquiry, it seems to be the settled rule that, where no inquiry is made, the concealment must be tainted with fraudulent intent.” *Kozlowski v. Pavonia Fire Ins. Co.*, 183 A. 154, 156 (N.J. 1936). See JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at [792-760](#) (“To summarize ~~the American rule~~, intentional concealment of a material fact by an applicant for insurance will provide the insurer unaware of that fact with a defense to coverage.”). Some jurisdictions, however, specify that even unintentional concealment entitles the insurer to withdraw coverage. See, e.g., Cal. Ins. Code § 333 (West 2011). Despite a general requirement that concealment be intentional, the line between misrepresentation analysis and concealment analysis is not always clear. Many statutes do not distinguish between misrepresentation and concealment in this regard. See, e.g., Ala. Code § 27-14-7 (2011) (“[m]isrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery” unless certain elements are met); Ariz. Rev. Stat. Ann. § 20-1109 (2011) (same).

h. Misrepresentation in the renewal process. An insurer may deny coverage or rescind a policy when an insured makes a material misrepresentation in ~~a~~ response to a question on the renewal application, just as it could for a material misrepresentation on the initial application. See, e.g., *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F. Supp. 2d 988, 997-998 (W.D. Wash. 2004) (applying Washington law) (allowing the insurer to rescind the policy based on the insured’s misrepresentations in documents the insurer requested as part of the renewal application when the application specifically provided “the information contained in and submitted with this application is on file and along with the application . . . is considered physically attached to the policy and will become a part of it. The insurer will have relied upon this application and attachments in issuing any policy”), judgment aff’d, 144 F. App’x 600 (9th Cir. 2005); *Chicago Ins. Co. v. Halcond*, 49 F. Supp. 2d 312, 314-317 (S.D.N.Y. 1999) (applying New York law) (engaging in ordinary misrepresentation analysis to determine if the insurer could avoid coverage for statements by the insured in response to a question on its renewal application); *Mt. Airy Ins. Co. v. Thomas*, 954 F. Supp. 1073, 1080 (W.D. Pa. 1997) (similar), aff’d without opinion, 149 F.3d 1165 (3d Cir. 1998) (applying Pennsylvania law). Unless the insurer specifically requests confirmation that the statements on the original application remain true, however, “an insured who is merely renewing a policy, with no new application to be completed, has no duty to inform the insurer of new developments concerning matters that had affected, or might be deemed to have affected, the risk to the insurer.” 21 AM. JUR. PROOF OF FACTS, 3D 565 § 4 (~~2012~~[2017](#)). See, e.g., *Zurich General Acc. & Liability Ins. Co. v. Flickinger*, 33 F.2d 853, 856 (4th Cir. 1929) (“[I]t is well settled that statements in an application for a policy which is renewed relate to the time when the original policy was issued; and, if they were true at that time, it is no defense that they may not have been true later or at the time of

renewal.”); *Nat’l Union Fire Ins. Co. of Pittsburgh v. Cont’l Illinois Corp.*, 643 F. Supp. 1434, 1441-1442 (N.D. Ill. 1986) (applying Illinois law) (holding that the insured had not made any misrepresentation because the insurers had not “asked for a new representation of the same kind” at the renewal stage in 1981 that information provided in the original applications in 1969 and 1976 was still true); see also 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), *COUCH ON INSURANCE* § 29:32 (3d ed. ~~1995~~2017) (“[S]ince the insured normally is a lay individual and not particularly knowledgeable in the field of insurance risks, it is unreasonable to impose on the insured a continuing duty to notify the insurer of any change which would materially affect the continuation of the risk.”).

i. Representations by a policyholder. For the proposition that representations made by agents of the policyholder are generally binding on the policyholder, see 6 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), *COUCH ON INSURANCE* § 81:101 (3d ed. ~~1995~~2017) (“Assuming that the agent [of the policyholder] has the authority to speak in such matters for the principal,” representations made by the agent to the insurer have the same effect “as though the representations were made by the insured, and the actual innocence or good faith of the insured is immaterial.”). Misrepresentations by an officer authorized to act on behalf of a corporation, for instance, may void a policy secured for the corporation. See, e.g., *Pioneer Industries, Inc. v. Hartford Fire Ins. Co.*, 639 F.3d 461, 467 (8th Cir. 2011) (applying Minnesota law) (holding that the insured company’s CFO “was specifically authorized to purchase Pioneer’s insurance, and thus any misrepresentations he made were attributable to Pioneer”); *In re Payroll Express Corp.*, 186 F.3d 196, 210 (2d Cir. 1999) (applying New Jersey law) (“Under New Jersey law the corporate principal is responsible for the consequences of its agent’s material misrepresentations on an insurance application, even when the principal could have no knowledge of the agent’s deceptions.”). Similarly, an insured may be held accountable for misrepresentations relayed on his or her behalf from an insurance agent to the insurer. John Dwight Ingram, *Misrepresentations in Applications for Insurance*, 14 U. MIAMI BUS. L. REV. 103, 108 & n.23 (2005) (discussing the rule adopted by some states that imputes the agent’s answers on the application to the insured, and collecting cases). See, e.g., *Prudential Ins. Co. of America* ~~Am.~~ v. Perry, 174 S.E.2d 570, 574 (Ga. Ct. App. 1970) (“[T]he applicant is bound by the answers recorded on the application, whether written by him or by the agent, absent any fraud on the part of the agent in deceiving him as to what was in fact written down as answers, or in preventing him from reading and ascertaining what was written down.”).

j. The problem of innocent misrepresentations. For courts applying a common-law knowledge requirement as an element of misrepresentation doctrine, see *Hollinger v. Mut. Benefit Life Ins. Co.*, 560 P.2d 824, 827 (Colo. 1977) (“[W]e hold that in order to avoid a life insurance policy on the basis of misrepresentations in the application, the insurer must prove that (1) the applicant made a false statement of fact or concealed a fact in his application for insurance; (2) the applicant knowingly made the false statement or knowingly concealed the fact; (3) the false statement of fact or the concealed fact materially affected either the acceptance of

the risk or the hazard assumed by the insurer; (4) the insurer was ignorant of the false statement of fact or concealment of fact and is not chargeable with knowledge of the fact; (5) the insurer relied, to its detriment, on the false statement of fact or concealment of fact in issuing the policy.”); *Silver v. Colorado Cas. Ins. Co.*, 219 P.3d 324, 328 (Colo. App. [2009](#)) (applying rule to property insurance), cert. denied, 2009 WL 3534579 (Colo. Nov. 2, 2009); *Middlesex Mut. Assurance Co. v. Walsh*, 590 A.2d 957, 963-964 (Conn. 1991) (“[I]n order to constitute a misrepresentation sufficient to defeat recovery on an automobile insurance policy, a material representation on an application for such a policy must be known by the insured to be false when made.”); *Mt. Airy Ins. Co. v. Millstein*, 928 F. Supp. 171, 175-176 (D. Conn. 1996) (applying Connecticut rule to professional-liability insurance); *Ranger Ins. Co. v. Kovach*, 63 F. Supp. 2d 174, 185 (D. Conn. 1999) (applying Connecticut rule to aviation-liability policy); *Am. States Ins. Co. v. Ehrlich*, 701 P.2d 676, 678-679 (Kan. 1985) (Under Kansas law, insurance policies can be rescinded only for “fraudulent misrepresentations”; “actionable fraud includes an untrue statement of fact, known to be untrue by the party making it, made with the intent to deceive or recklessly made with disregard for the truth, where another party justifiably relies on the statement and acts to his injury and damage. Fraud is never presumed and must be shown by clear and convincing evidence.”); *Matinchek v. John Alden Life Ins. Co.*, 93 F.3d 96, 102 (3d Cir. 1996) (“Under Pennsylvania law, an insurance contract is void if (1) the representation was false; (2) the insured knew it to be false when made or acted in bad faith; and (3) the representation was material to the risk being insured.”); see *Allstate Ins. Co. v. Stinger*, 163 A.2d 74, 78 (Pa. 1960) (applying [PA Pa.](#) rule to auto policy); *A.G. Allebach, Inc. v. Hurley*, 540 A.2d 289, 294-295 (Pa. Super. Ct. 1988) (applying [PA Pa.](#) rule [to errors and omissions](#) policy); *Strickland v. Prudential Ins. Co. of Am.*, 292 S.E.2d 301, 304 (S.C. 1982) (South Carolina common law similarly requires “that the insurer show not only the falsity of the statement challenged, but also that the falsity was known to the applicant” and was “made with the intent to defraud the insurer.”); *Evanston Ins. Co. v. Watts*, 52 F. Supp. 3d 761, 766-767 (D.S.C. 2014) (applying the test from *Strickland* to a professional-liability policy); *Mayes v. Mass. Mut. Life Ins. Co.*, 608 S.W.2d 612, [646615](#) (Tex. 1980) (“[an \[A\]n](#) insurer cannot avoid liability on the ground of misrepresentation by the insured unless there is a finding that the insured intended to procure issuance of the policy by representations known to be false.”); *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 282 (Tex. 1994) (“[in \[I\]n](#) Texas, an insured’s intent to deceive must be shown in order for an insurance company to successfully raise a defense of misrepresentation on the basis of a false statement made by the insured in the application for *any type of insurance*.”) (emphasis added); *Essex Ins. Co. v. Redtail Prods., Inc.*, No. Civ. A3:97cv2120D, 1999 WL 627379, at *5-6 (N.D. Tex. Aug. 17, 1999) (denying misrepresentation defense to a CGL claim because the insurer could not provide the proof of intent required under Texas common law).

For cases applying a common-law rule that even an innocent misrepresentation may void coverage, see, e.g., *Allied Prop. & Cas. Ins. Co. v. Good*, 938 N.E.2d 227, 232 (Ind. Ct. App. 2010) (“A material misrepresentation or omission of fact in an insurance application, relied on by the insurer in issuing the policy, renders the coverage voidable at the insurance company’s

option.”); Hofmann v. John Hancock Mut. Life Ins. Co., 400 F. Supp. 827, 829 (D. Md. 1975) (applying Maryland law) (citations omitted) (“The general law in the insurance area is clear: a material misrepresentation in the form of an incorrect statement in an application invalidates a policy issued on the basis of such application. This is true without inquiry into the presence of a conscious design to defraud.”); Mooney v. Nationwide Mut. Ins. Co., 822 A.2d 567, 569 (N.H. 2003) (affirming insurer’s policy rescission based on insured’s material misrepresentation). For a listing of legislation regarding misrepresentation requirements and cases construing that legislation, see the Reporters’ Note to Comment *e*.

§ 8. Materiality Requirement

A misrepresentation by ~~or on behalf of~~ an insured during the application for, or renewal of, an insurance policy is material only if, ~~in the absence of~~ but for the misrepresentation, a reasonable insurer in this insurer’s position would not have issued the policy or would have issued the policy only under substantially different terms.

Comment:

a. The function of the materiality requirement. The misrepresentation defense encourages the sharing of truthful and relevant information. The materiality requirement addresses the objective relevance of that information and encourages efficient underwriting practices on the part of insurers. A material misrepresentation is one that so significantly understates the risk presented by the policyholder’s application or renewal that the misrepresentation would induce an objectively reasonable insurer in this insurer’s position either to (a) issue a policy when it would not otherwise have done so or (b) issue a policy on substantially different terms than it would otherwise have done. This definition of materiality is sometimes referred to as the “material to the risk” or “increased risk” test of materiality, in the sense that the falsity of the misrepresented fact would lead a reasonable insurer in this insurer’s position to bear a substantially greater risk than it believed it was insuring.

b. In this insurer’s position. This Section states a tailored objective understanding of materiality that considers the relevance of the misrepresented information from the perspective of a reasonable insurer in the position of the actual insurer. This tailored objective understanding may in some cases differ from that of an average or ordinary insurer. The question is not what an average or ordinary insurer would have done, but rather what a reasonable insurer in the position of this insurer would have done. Evaluating materiality from the perspective of an average or

ordinary insurer could have the undesirable effect of inhibiting insurers from developing innovative underwriting categories or other underwriting practices that differ from the norm.

c. Distinguishing materiality from reliance. In some jurisdictions the materiality test is stated in a way that either expressly adopts or could be interpreted as adopting a subjective standard. In those states the materiality requirement asks, in effect, whether the particular insurer in the case would have issued the policy under the same terms had it known of the true facts. This is a subjective causation test that is indistinguishable from the subjective element of the detrimental-reliance requirement. In this Section, materiality is a purely objective inquiry. The materiality requirement requires the insurer to demonstrate that there is an objectively reasonable basis for the judgment embodied in its regular underwriting practices.

d. An objectively reasonable basis for the underwriting judgment. Perhaps the most common way to demonstrate that an insurer had an objectively reasonable basis for the judgment embodied in its underwriting practices is to demonstrate that a reasonable insurer—with “reasonable” understood here as ordinary or average—would regard the misrepresented information as very important. Because most misrepresentation cases concern misstatements that almost any insurer would regard as important, courts rarely confront situations in which an innovative insurer asks questions that most other insurers do not. In such an unusual case, the proper inquiry is not whether the information would be sufficiently important to an average or ordinary insurer. If that were the proper inquiry, the materiality element would make it impossible for insurers to insist upon honest answers to innovative questions. Rather, the proper inquiry is whether the information would be sufficiently important to a reasonable insurer in this insurer’s position.

It is important to emphasize that the materiality analysis focuses on a “reasonable insurer in this insurer’s position,” not on “this insurer.” The work that the reasonableness requirement is doing in this context is to require that there be some evidence supporting the actual insurer’s judgment that the information is important, so that there is a basis for the trier of fact to evaluate whether a reasonable insurer in this insurer’s position would agree with that judgment. This evidence can consist of an actuarial opinion, an empirical study, testimony regarding custom and practice, or any other evidence that a reasonable insurer would use to decide whether a category of information is sufficiently important for the purpose of deciding whether to insure an applicant and, if so, at what price.

e. Substantiality. For the materiality standard to be met, the insurer must demonstrate that, knowing the correct facts *ex ante*, a reasonable insurer in its position would have offered the policy, if at all, only with substantially different terms, such as a substantially higher premium. The misrepresentation defense is not available in circumstances in which a reasonable insurer in this insurer’s position would regard the misrepresentation in question as trivial or inconsequential.

Illustrations:

1. On an application for a standard homeowner’s insurance policy, the policyholder is asked whether in the past 10 years he has been a defendant in a civil lawsuit. The policyholder who has in fact been sued three times during that period nevertheless checks the “no” box on the application. The insurer issues the policy. Had the insurer known the truth with respect to this question, it would not have issued the policy. The insurer can demonstrate that other insurers also decline to issue homeowner’s insurance policies to applicants who have been sued three times in the past 10 years. Accordingly, the policyholder’s misrepresentation was material.

2. On an application for a standard automobile-insurance policy, the policyholder is asked how far she commutes to work each day. The policyholder answers “two miles,” when the correct answer is “five miles.” The insurer issues the policy with a premium of \$1000 for six months. Had the insurer known the truth with respect to this question, it would have charged \$25 more for a policy. The policyholder’s misrepresentation was not material.

3. An insurer conducts research that demonstrates to its reasonable satisfaction that people who frequently play a certain kind of online video game are more likely to suffer a substantial loss under their automobile-insurance policy. The insurer adds a question asking whether the applicant plays this kind of video game to its application for auto insurance. A policyholder who regularly plays the game more than 10 hours a week provides the false answer “no” to the question, “Have you played [this kind of video game] within the last 60 days?” Had the policyholder answered yes to this question, the insurer would not have issued the policy. The policyholder’s misrepresentation was material.

4. An insurer adds a question regarding history of sexually transmitted disease to its application for homeowner's insurance based on the belief of a senior executive that people with a history of sexually transmitted disease are likely to pose a higher liability risk. A policyholder who does have a history of sexually transmitted disease provides a false answer "no" to the question, "Have you ever been diagnosed with a sexually transmitted disease?" Had the policyholder answered yes to this question, the insurer would have charged the policyholder 50 percent more for the liability coverage. At trial in a case in which the insurer raises this false answer as the basis for a rescission, the insurer is unable to present any evidence supporting the senior executive's belief that it considered before adopting the policy, nor is it able to present any evidence from its claims records supporting the association between sexually transmitted disease and liability risk. The policyholder's misrepresentation was not material.

REPORTERS' NOTE

a. The function of the materiality requirement. For examples of states that have adopted the material-to-the-risk or increased-risk standard of materiality, see Ala. Code § 27-14-7 (2011); Fla. Stat. § 627.409; Okla. Stat. Ann. tit. 36, § 3609 (West 2011); *Fabric v. Provident Life & Accident Ins. Co.*, 115 F.3d 908, 912 (11th Cir. 1997) (applying Fla. Stat. § 627.409); *Burgess v. Farmers New World Life Ins. Co.*, 12 F.3d 992, 993 (10th Cir. 1993) (applying Okla. Stat. Ann. tit. 36, § 3609); *Alfa Life Ins. Co. v. Lewis*, 910 So. 2d 757, 762 (Ala. 2005) (applying Ala. Code § 27-14-7). A number of states have explicitly adopted an objective, reasonable-insurer definition of materiality for purposes of the misrepresentation doctrine. See, e.g., *Penn Mut. Life Ins. Co. v. Mechanics' Savings Bank & Trust Co.*, 72 F. 413, 429 (6th Cir. 1896) (applying Pennsylvania law) (adopting the objective-insurer standard in a life-insurance-policy context); *Cox v. Am. Pioneer Life Ins. Co.*, 626 So. 2d 243, 246 (Fla. Dist. Ct. App. 1993); *New York Life Ins. Co. v. Kuhlenschmidt*, 33 N.E.2d 340, 347 (Ind. 1941) ("The test of materiality is not that the company was influenced but that the facts if truly stated might reasonably have influenced the company in deciding whether it should reject or accept the risk."); *York Mut. Ins. Co. v. Bowman*, 746 A.2d 906, 909 (Me. 2000) (auto insurance); *Palisades Safety & Ins. Assoc. v. Bastien*, 814 A.2d 619, 622 (N.J. 2003) (adopting the objective-insurer standard for materiality in an automobile-insurance context). See generally STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* § 5A:11 (2d ed. 2011-2017) (discussing states that have adopted an objective definition of materiality); ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 776-760 (45th ed. 2007-2012) (same).

b. In this insurer's position. Jerry and Richmond discuss the objective and subjective tests for materiality:

In most jurisdictions, the test for materiality is objective: the inquiry is whether *a reasonable insurer* under the circumstances would have been so induced. In contrast, some formulations of the materiality doctrine use a subjective test: whether *this particular insurer*, had it known the truth about the misrepresented fact, would have charged a higher premium or refused the insurance. As between the two tests, the objective test is more consistent with general contract law, the rules of which are generally premised on what a reasonable person in the shoes of the contracting party would believe the other party's manifestations mean in the context presented.

JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at 746-745; see also Francis C. Amendola et al., *Materiality*, 45 C.J.S. *Insurance* § 862 (2012-2017) (“A material fact, measured by an objective standard, is one which would naturally influence the judgment of an underwriter in making the contract at all, or in estimating the degree and character of the risk, or in fixing the rate of the premium.”); Ashley, *Bad Faith Actions* § 5A:11 (“A majority of jurisdictions base the materiality test on an objective standard: would the misrepresentation induce a reasonable insurer to issue a policy or charge a lower premium?”); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 3-16.08[1][d] (Lexis 2012-2017) (“The generally accepted test for determining the materiality of a misrepresentation to the insurer is whether reasonably careful and intelligent underwriters would have regarded the misrepresentation . . . as substantially increasing the chances of loss insured against so as to bring about a rejection of the risk or the charging of an increased premium.”). For additional cases articulating the objective-materiality standard, see, e.g., ~~New York Life Ins. Co. v. Kuhlenschmidt, 33 N.E.2d 340, 347 (Ind. 1941) (“The test of materiality is not that the company was influenced but that the facts if truly stated might reasonably have influenced the company in deciding whether it should reject or accept the risk.”); York Mut. Ins. Co. v. Bowman, 746 A.2d 906, 909 (Me. 2000) (construing Maine’s misrepresentation statute to “impose an objective test of materiality. The relevant inquiry . . . is whether the facts, if truly stated, would have influenced a reasonable insurer in deciding whether to accept or reject the risk of entering into a contract, in fixing the premium rate, in fixing the amount of coverage, or in providing coverage with respect to the hazard resulting in the loss”); Haynes v. Missouri Property Ins. Placement Facility, 641 S.W.2d 497, 499 (Mo. Ct. App. 1982) (“The materiality of a misrepresentation in an insurance application is determined by whether the fact, if stated truthfully, might reasonably influence an insurance company to accept or reject a risk or to charge a different premium and not whether the insurer in question was actually influenced.”); Spellmeyer v. Tennessee Farmers Mut. Ins. Co., 879 S.W.2d 843, 846 (Tenn. Ct. App. 1993) (citations omitted) (“The misrepresentation must increase the risk of loss to the insurer. Otherwise stated, the matter misrepresented must ‘naturally and reasonably’ influence the judgment of the insurer in making a contract.”).~~

One potential criticism of the objective standard is that, if the test is merely what an average or ordinary insurer would do, an insurer with different or “stricter underwriting standards than most other insurers” might reasonably find the misrepresentation material and nevertheless

fail to meet the objective standard of materiality. JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at [747746](#) (noting that this is a situation in which “[t]he subjective test of materiality can make a difference”). In response to this concern, this Section focuses the inquiry on whether a similarly situated insurer, acting reasonably, would have issued a different policy or no policy at all—which some courts adopting an objective standard appear to consider in practice. See, e.g., *Federal Ins. Co. v. HPSC, Inc.*, 480 F.3d 26, 33 (1st Cir. 2007) (applying Massachusetts law) (adopting an objective standard to determine the materiality of a misrepresentation, but allowing the insured to introduce evidence of the insurer’s past underwriting practices as evidence of what a reasonable insurer would do in the situation at hand); *Pinette v. Assurance Co. of America*, 52 F.3d 407, 411 (2d Cir. 1995) (applying Connecticut law) (considering Connecticut case law, common sense, and the evidence of the insurer’s underwriting practices to determine that “an applicant’s prior loss history is material to a reasonable insurance company’s decision whether to insure that applicant or determination of the premium”); *Utica Mut. Ins. Co. v. National Nat’l Indem. Co.*, 173 S.E.2d 855, 858 (Va. 1970) (“The record discloses that [the insurer] was principally engaged in writing so-called ‘substandard’ risks at increased rates and that its underwriting standards were extremely liberal when judged by industry standards. The fact that the representation was material to the risk when assumed is fully established by the uncontroverted evidence that [the insured] would not have met even [the insurer’s] liberal standards had there been disclosure of his epileptic condition.”); *Mutual of Omaha Ins. Co. v. Echols*, 154 S.E.2d 169, 172 (Va. 1967) (in Virginia, “[a] fact is material to the risk to be assumed by an insurance company if that fact would reasonably influence the company’s decisions whether or not to issue a policy.”).

c. Distinguishing materiality from reliance. Most jurisdictions adopt both a materiality and a reliance requirement in their misrepresentation defenses in the insurance context. See KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 16-[17](#) (6th ed. 2015); JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at [769749](#); see also Or. Rev. Stat. Ann. § 742.013 (West 2011) (listing both elements); Wis. Stat. Ann. § 631.11 (West 2011) (listing both elements); *Allied Prop. and Cas. Ins. Co. v. Good*, 938 N.E.2d 227, 236 (Ind. Ct. App. 2010) (holding that an insurance company’s reliance on a misrepresentation was not enough, but the omission also “must have been material to the risk insured”). See *Montgomery Mut. Ins. Co. v. Riddle*, 587 S.E.2d 513, 515 (Va. 2003) (“[W]e recognize the intimate conceptual relationship between reliance and materiality . . . [I]f there is no reliance upon a statement or omission, it could not have affected the decision-making process; consequently, it could not be material.”); see also ABRAHAM & SCHWARCZ, INSURANCE LAW AND REGULATION, at 17 (“[I]f a subjective test is adopted, there may not be much left of the distinction between materiality and reliance.”); JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW, at [776745](#) n.[115128](#) (“To some extent, the subjective test of materiality duplicates the reliance element of misrepresentation, under which the insurer must prove it was induced to underwrite the risk in reliance upon the misrepresentation.”). Some states adopt a subjective-standard-of-materiality test. Some use a

more objective standard of materiality. See generally ASHLEY, *BAD FAITH ACTIONS* § 5A:11 (2d ed. ~~2011~~2017); JERRY & RICHMOND, *UNDERSTANDING INSURANCE LAW*, at ~~776-745~~.

d. An objectively reasonable basis for the underwriting judgment. In *Federal Ins. Co. v. HPSC, Inc.*, the First Circuit listed the different types of evidence that an insurer may use to show that a misrepresentation would be material to a reasonable insurer:

[T]he materiality of a misrepresentation depends on what a reasonable underwriter would have done differently had she known the truth behind the misrepresentation. There are, as a matter of common sense, a variety of ways to objectively prove what an underwriter would do in a given situation. The parties could offer the testimony of various underwriter or other risk management experts as to what they would have done in the same situation . . . Or the parties could provide evidence of what underwriters have in fact done in the past in similar situations. Similarly, it makes sense that an insurer might wish to establish what it would do in a particular situation by presenting evidence of its own policies and past practices.

480 F.3d 26, 33-34 (1st Cir. 2007) (applying Massachusetts law). As the First Circuit stated, industry custom and standards can be an important source of evidence. See, e.g., *Meeker v. Shelter Mut. Ins. Co.*, 766 S.W.2d 733, 740 (Mo. Ct. App. 1989) (“Industry custom and practice is relevant to the issue of whether misrepresentations in an application for insurance are material.”); see also *Golden Rule Ins. Co. v. Hughes*, 784 F. Supp. 817, 822 (D. Utah 1992) (denying summary judgment to the insurer because it had offered “no evidence of the industry standards regarding the insurability of conditions like the Defendants [sic]” and so the court could not determine what “those engaged in the insurance industry, acting reasonably and naturally in accordance with the usual practice among insurance companies in such circumstances, would have done had they known the truth”); 6 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 82:14 (3d ed. ~~1995~~2017) (“Whether or not a misstatement is material to the risk depends . . . upon what those engaged in the same insurance business, acting reasonably and naturally, in accordance with the practice usual among such companies under such circumstances, would have done had they known the truth.”).

In addition, the practices of a particular insurer may also be helpful, but only to the extent they demonstrate that the insurer’s own underwriting practices are reasonable:

The questions an insurance company asks on its application to determine the types of conditions or circumstances that the insurance company considers relevant to its risk of loss, may be used for the purposes of determining if the insured made misrepresentations that increased the insurer’s risk of loss. Materiality of insured’s misrepresentation may be established by testimony as to underwriting practices or by an employee of the company. However, the trier of facts is not required to

believe “post mortem” [[sic] post-loss] testimony of the company’s agents that the insurance policy would have been refused if the true facts had been made known.

Amendola et al., *Materiality*, 45 C.J.S. *Insurance* § 862 (20122017).

e. Substantiality. For cases applying a substantiality requirement, see, e.g., *Pinette v. Assurance Co. of America Am.*, 52 F.3d 407, 411 (2d Cir. 1995) (applying Connecticut law) (“Under Connecticut law, a misrepresentation is material ‘when, in the judgment of reasonably careful and intelligent persons, it would so increase the degree or character of the risk of the insurance as to substantially influence its issuance, or substantially affect the rate of premium.’” (quoting *Davis Scofield Co. v. Agricultural Ins. Co.*, 145 A. 38, 40 (1929))); *Axis Ins. Co. v. Innovation Ventures, LLC*, 737 F. Supp. 2d 685, 689 (E.D. Mich. 2010) (applying Michigan law) (“The Michigan Supreme Court has held that a misrepresentation is a false statement of fact, and that a fact is material if ‘communication of it would have had the effect of substantially increasing the chances of loss insured against so as to bring about a rejection of the risk or the charging of an increased premium.’” (quoting *Oade v. Jackson Nat’l Life Ins. Co. of Mich.*, 632 N.W.2d 126 (Mich. 2001))); *Buckeye Union Cas. Co. v. Robertson*, 147 S.E.2d 94, 96 (Va. 1966) (similar analysis under Virginia law); see also *JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW*, at 748760 (listing the types of misrepresentations courts have generally found important enough to be material). Illustration 2 is drafted so that the difference in the premium is obviously insubstantial. There is no further significance to the \$25 amount. A larger amount could be insubstantial, depending on the situation.

§ 9. Reasonable-Reliance Requirement

The reliance requirement of § 7(2)(b) is met only if:

(1) ~~Absent~~ **But for** the misrepresentation, the insurer would not have issued the policy or would have issued the policy only with substantially different terms; and

(2) Such actions would have been reasonable under the circumstances.

Comment:

a. The function of the detrimental-reliance requirement. Misrepresentation doctrine includes both subjective and objective aspects. The reliance element, especially in § 9(1), primarily addresses the subjective aspect: the impact of the misrepresentation on the particular insurer. This element requires an insurer to demonstrate that the misrepresentation caused it significant harm. If the insurer would have issued the policy on substantially the same terms even if it had received the correct information, then the insurer did not rely to its detriment on the misrepresentation. Thus, a misrepresentation by a policyholder will not render a policy voidable

when the insurer has actual knowledge of the true facts or of the falsity of the policyholder's representation. This reliance requirement is similar to the inducement requirement in the common law of contract, which is, in turn, similar to the causation doctrine in tort.

b. The contribute-to-the-loss approach. To demonstrate detrimental reliance it is sufficient that the insurer demonstrate that it would have charged a significantly higher premium had it received the correct information, even if that information had nothing to do with the risk that produced the loss in question. It is sometimes suggested that insurance law should limit the insurer's misrepresentation defense to situations in which the misrepresentation by the policyholder actually materialized in ("contributed to") the loss that occurred and for which the insured filed a claim. This is often referred to as the "contribute-to-the-loss" or "causal relation" approach. The proponents of this approach argue that requiring such a close causal connection between the policyholder's misrepresentation and the actual loss suffered by the insurer protects insureds from arbitrary outcomes. The classic example comes from life insurance: when the insurance applicant falsely represents him- or herself to be a nonsmoker but then dies from a cause unrelated to smoking, the contribute-to-the-loss approach would not permit the insurer to deny coverage based on misrepresentation. The same principle could apply in the liability insurance context as well. (See Illustration 4 below.)

This Section does not follow the contribute-to-the-loss approach for four reasons. First, the contribute-to-the-loss rule does not address the primary concern to which the doctrine of misrepresentation is a response: the problem of high-risk policyholders intentionally and dishonestly understating their risks in order to obtain coverage at a price that is subsidized by honest members of the same risk pool. Such adverse selection is unfair and inefficient (as discussed in Comment *a* to § 7) and should be discouraged even if the policyholder's misrepresentation did not give rise to the loss under the policy. The contribute-to-the-loss approach would penalize only those misrepresentations that happen to contribute to the particular loss for which the insured files a claim. By contrast, the standard followed in this Section appropriately penalizes all misrepresentations that meet the requirements of § 7. Second, the contribute-to-the-loss rule can be unreasonably difficult for an insurer to satisfy, because of the absence of proof of the precise connection between the misrepresentation in question and the cause of the loss for which a claim is being filed. The rule therefore results in unfair cross-subsidies, as relatively high-risk policyholders who have misrepresented their risks under

circumstances in which the causal connection is present but impossible to prove are subsidized by relatively low-risk policyholders who have made no such misrepresentations. Third, no court has adopted the contribute-to-the-loss rule as part of the common law of liability insurance. Finally, if a court were willing to adopt a common-law innovation to address the unfairness of the strict-liability misrepresentation rule, the arbitrary outcomes that the contribute-to-the-loss approach is intended to avoid are better addressed by limiting the insurer's misrepresentation defense to situations in which the policyholder acted intentionally or recklessly.

c. The role of agents in establishing reliance. Insurance organizations act through people. The law of agency determines which people act for an insurer and in which circumstances, as well as the circumstances under which an insurance broker is in fact an agent of the policyholder rather than the insurer. Agency law can also affect what constitutes detrimental reliance on the part of an insurer. Ordinarily, if an agent of an insurer knows that a misrepresented fact is untrue at the time of the application, there can be no detrimental reliance on the part of the insurer, as the agent's knowledge is imputed to the insurer. Similarly, if the agent is aware of the misrepresentation and assures the policyholder that the insurer will not rely upon the false information in question in deciding whether to issue the policy or in determining the policy terms, and if it is reasonable under the circumstances for the policyholder to rely on those assurances, the insurer may be estopped from invoking the misrepresentation defense. See § 6 on estoppel. These rules have the beneficial effect of placing the burden on insurers to monitor their agents and adopt practices and procedures that ensure that agents will convey all relevant information to the insurer and not engage in behavior that detrimentally misleads policyholders. The difficulty with these rules, however, is that they also create the risk of collusion between policyholder and agent to defraud the insurer. To some extent, insurers can reduce this risk by taking precautions in selecting and monitoring their agents. In addition, however, courts can be made aware of this problem and take it into account when applying the misrepresentation rules.

Illustrations:

1. The insurer asks on the application for a standard homeowner's insurance policy whether the applicant "serves on the board of any organization, whether for profit or not for profit, and, if so, whether the applicant is an insured under a Directors' and Officers' Liability Insurance Policy issued to the organization." The policyholder, who is

an active board member for two nonprofit organizations, nevertheless checks the “no” box in the space next to this question and submits the application. The insurer’s agent, who takes the application for the insurer, reasonably believes that this answer is correct. The insurer issues a standard homeowner’s policy for a preferred low-risk premium of \$775/year. The policyholder subsequently is sued and tenders the suit to the insurer for a defense. At this point, the insurer investigates the policyholder’s activities, and learns that the policyholder had in fact been a member on the board and that the board did not have Directors’ and Officers’ Liability Insurance policies. Had the policyholder answered truthfully about her service on the nonprofit boards, the insurer would not have issued a homeowner’s policy to her. The insurer reasonably and detrimentally relied on the policyholder’s misrepresentation. Because there is no contribute-to-the-loss requirement, it does not matter whether the suit arose out of the insured’s activities as a board member.

2. Same facts as Illustration 1, except that, had the insurer received the correct information, it would have issued the same policy with a premium of \$800/year. Here the insurer has not shown detrimental reliance, because the terms of the policy that would have been issued absent the misrepresentation are not substantially different from the terms of the policy that was issued.

3. Same facts as Illustration 1, with the following exceptions: The agent who reads the application is aware of the policyholder’s volunteer activities and notices the incorrect answer, but nevertheless, without disclosing this knowledge to the policyholder or the insurer, forwards the uncorrected application to the insurer, which later issues the policyholder a standard homeowner’s policy for a preferred low-risk premium. Because the agent knew the correct facts about the information that was misrepresented, the agent’s knowledge is imputed to the insurer, which therefore is deemed not to have relied on the misrepresentation.

4. On an application for auto liability insurance the policyholder is asked who will be the primary driver of the car. The policyholder, knowing that his teenage daughter will be the primary driver, nevertheless answers that he will be the primary driver. The insurer issues a policy for a preferred low-risk premium of \$750/year. If the policyholder had answered truthfully, the insurer would have issued the same policy, but only for a premium of \$1500/year. An accident occurs while the policyholder (rather than his

daughter) happens to be driving the car, and the accident gives rise to a lawsuit against the policyholder. The insurer is entitled to the misrepresentation defense even though the misrepresentation in question did not contribute to the loss that occurred. The impact of any state auto-insurance-policy cancellation statute is beyond the scope of this Illustration.

d. Inquiry notice and the objective-reasonableness element of the reliance requirement.

Under this Section, the insurer must not only show that it relied on the misrepresentation, but also that this reliance was reasonable under the circumstances. This reasonableness requirement has a different objective than the reasonableness requirement of the materiality element of the misrepresentation defense. In the materiality element, the reasonableness requirement focuses on whether the insurer reasonably regarded the information as important. In the reliance element, the reasonableness requirement focuses on whether the insurer reasonably failed to discover or act upon the truth. Accordingly, under § 9(2), the insurer must show that an objectively reasonable insurer in this insurer's position would not have discovered the misrepresentation in question before the claim arose. See § 8, Comment *d*, for further discussion of the reasonable insurer in this insurer's position. This objective element of the reliance requirement provides an incentive for insurers to undertake a reasonable amount of investigation and analysis before issuing a policy and, in some cases, even after the policy is issued (for example, if there was insufficient time to complete a reasonable investigation before issuing the policy). Thus, for example, if there is something suspicious in an application that would cause an objectively reasonable insurer to undertake further investigation, the reasonable-reliance requirement would impose such a duty on the insurer. This objective requirement makes systematic what is sometimes referred to as the "inquiry notice" doctrine, which holds that, when a contracting party has been put "on notice" that there might be a factual error in the counterparty's representations, the contracting party has a duty to make a reasonable investigation. What constitutes a reasonable investigation at the underwriting stage of a liability insurance transaction will depend on the circumstances of each case and may vary depending on the type of policy, the nature of the risks, and the type of insured.

Illustration:

5. On an application for auto liability insurance, the policyholder is asked whether she has received any speeding tickets in the past five years. The policyholder, knowing that she has had five speeding tickets during that time, nevertheless checks the “no” box. Had the insurer known the truth about the policyholder’s speeding tickets, it would not have issued the policy. The insurer accepts the policyholder’s “no” answer as true without checking her prior driving record, even though the insurer is aware that the policyholder’s previous auto policy, issued by a different insurer, had been cancelled on misrepresentation grounds. The insurer’s actual reliance on the policyholder’s misrepresentation was not reasonable, because the insurer failed to make the reasonably straightforward investigation that an objectively reasonable insurer would have made into the truthfulness of the policyholder’s answers on her application under the circumstances.

e. Evidence of reliance. In determining whether the insurer detrimentally relied on the policyholder’s misrepresentation, the court may consider the insurer’s past practices with respect to accepting or rejecting similar risks. Relevant evidence may include documents such as contemporaneous underwriting manuals, written guidelines, or the underwriting files of other similarly situated policyholders in the same general time period.

f. Requiring reliance even for fraudulent misrepresentations. Sections 9 and 11 of the Restatement Third, Torts: Liability for Economic Harm (Tentative Draft No. 2, 2014, approved in May 2014), require justifiable reliance even in the case of fraud. Justifiable reliance is a somewhat less demanding requirement than reasonable reliance, requiring only freedom from recklessness. The rationale for a less demanding requirement seems to be that the protection afforded by the reasonable-reliance requirement is unnecessary when the misrepresenting party has committed fraud. Both standards promote what may be the most important objective of the reliance requirement: avoiding an incentive for insurers to include in insurance applications irrelevant or unimportant questions to which applicants can be expected to provide knowingly false information. This Section follows the reasonable-reliance requirement for two reasons. First, the difference between justifiable and reasonable reliance is unlikely to have much significance in the insurance context, so the additional burden associated with maintaining separate standards is unlikely to provide much benefit to the insurance pool. Second, and more importantly, there are externalities in the liability insurance context that are not present in the

usual fraud context. In many if not most cases the main beneficiary of the fraud is not the policyholder, but rather a tort claimant who was harmed by the policyholder. Therefore, § 7 imposes a reliance requirement even for intentional misrepresentations. This does not require proof that the policyholder had knowledge of, or was willfully indifferent to, the fact that the misrepresentation in question was likely to be relied upon by the insurer. It is enough that the insurer reasonably relied on that material misrepresentation to its detriment.

REPORTERS' NOTE

a. The function of the detrimental-reliance requirement. The reliance requirement is a well-settled part of the doctrine of misrepresentation in insurance law. 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.08[1][c] (Lexis ~~2012~~2017). The contractual concept of inducement can be found in the Sections on misrepresentation in the Restatement Second, Contracts. Section 164, for example, defines the misrepresentation that renders a contract voidable as being when “a party’s manifestation of assent is induced by either a fraudulent or a material misrepresentation by the other party upon which the recipient is justified in relying.” Restatement Second, Contracts § 164 (AM. LAW INST. 1981). Further, § 167, entitled “When a Misrepresentation Is an Inducing Cause,” defines the inducement in terms of causation: “A misrepresentation induces a party’s manifestation of assent if it substantially contributes to his decision to manifest his assent.” *Id.* § 167.

b. The contribute-to-the-loss approach. To date, no state appears to have applied the causal-relation or contribute-to-the-loss requirement to the liability insurance context. At least one state has adopted a contribute-to-the-loss requirement for warranties. Neb. Rev. Stat. § 44-358 (“The breach of a warranty or condition in any contract or policy of insurance shall not avoid the policy nor avail the insurer to avoid liability, unless such breach shall exist at the time of the loss and contribute to the loss, anything in the policy or contract of insurance to the contrary notwithstanding.”). At least five states have adopted statutes that require some form of causal relationship between a misrepresentation and the actual loss in the context of life, health, or accident insurance. Ark. Code Ann. § 23-79-107 (“In any action to rescind any policy or contract or to recover thereon, a misrepresentation is material if there is a causal relationship between the misrepresentation and the hazard resulting in a loss under the policy or contract.”); Kan. Stat. Ann. §§ 40-418, 40-2205 (2011) (providing that no misrepresentation on an application for certain types of insurance would bar recovery unless the false statement “actually contributed to the contingency or event on which the policy is to become due or payable”); Mo. Ann. Stat. § 376.580 (West 2011) (providing that, in policies for life, health, and accident insurance, “[n]o misrepresentation made in obtaining or securing a policy of insurance . . . shall be deemed material, or render the policy void, unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due and payable, and whether it so contributed in any case shall be a question for the jury”); Okla. Stat.

Ann. tit. 36, § 2515 (West 2011) (providing under the article governing limited stock life, accident, and health insurance that “[n]o representation made in obtaining or securing a policy of insurance on the life or lives of any person, or persons, shall be deemed material, or render the policy void, unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due or payable”); R.I. Gen. Laws § 27-4-10 (2011) (requiring that misrepresentation made in procuring a policy of life insurance contribute to “the contingency or event on which the policy is to become due or payable” in order to be deemed material). A number of other states include the contribute-to-the-loss requirement as an alternative to the increased-risk element in the showing of materiality. See, e.g., Wis. Stat. Ann. § 631.11 (West) (“No misrepresentation . . . constitutes grounds for rescission of, or affects the insurer’s obligations under, the policy unless, if a misrepresentation, the person knew or should have known that the representation was false, and unless any of the following applies: 1. The insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive. 2. The fact misrepresented or falsely warranted *contributes to the loss.*”) (emphasis added). See generally Kathryn H. Vratil & Stacy M. Andreas, *The Misrepresentation Defense in Causal Relation States: A Primer*, 26 TORT & INS. L.J. 832, 835-838 (1991). For an argument, consistent with the position taken in this Section, that the increased-risk standard should generally be used instead of the contribute-to-the-loss standard, see [E. EDWIN W. PATTERSON](#), *ESSENTIALS OF INSURANCE LAW* § 72, at 356-357 (1957); and R. KEETON, *BASIC TEXT ON INSURANCE LAW* § 6.5, at 382 (1971).

c. The role of agents in establishing reliance. It is a standard principle of agency law that knowledge of a material fact by an agent is generally imputed to the principal. Restatement Third, Agency § 5.03 (AM. LAW INST. 2006) (“[N]otice of a fact that an agent knows or has reason to know is imputed to the principal if knowledge of the fact is material to the agent’s duties to the principal”). The primary exception to this rule is when the agent is acting adversely to the principal, although this exception does not apply “when necessary to protect the rights of a third party [such as an insured] who dealt with the principal [the insurer] in good faith.” *Id.* § 5.04. In the insurance context, it has long been held that false information entered into an insurance application by an agent of the insurer will be imputed to the insurer unless the insured has reason to know that the agent is attempting to defraud the insurer. See B.H. Glenn, Annotation, *Insured’s Responsibility for False Answers Inserted by Insurer’s Agent in Application Following Correct Answers by Insured, or Incorrect Answers Suggested by Agent*, 26 A.L.R.3d 6, 33-45 (1969 & Supp. 2000) (collecting cases holding that knowledge of an insurance agent will be imputed to insurer, despite fraud of agent, unless the applicant has notice of the fraud). For the proposition that an insured party can defeat claims of actual reliance by demonstrating that the insurer, or its agents, knew the truth despite the misrepresentation, see *Royal Indem. Co. v. Kaiser Aluminum & Chem. Corp.*, 516 F.2d 1067, 1070 (9th Cir. 1975) (applying California law) (explaining that the insurer’s reliance on the insured’s statements was not justifiable in light of its “total dependence on slight information known to be incomplete”); 3

JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.08[1][c] (Lexis ~~2012~~2017).

The function of this rule imputing knowledge of an agent to the principal is to give the principal—here, the insurer—the appropriate incentive to monitor its agents and to install systems efficiently and accurately conveying information from the agents to the insurer. Restatement Third, Agency § 5.03, Comment *b* (AM. LAW INST. 2006) (“Imputation creates incentives for a principal to choose agents carefully and to use care in delegating functions to them. Additionally, imputation encourages a principal to develop effective procedures for the transmission of material facts, while discouraging practices that isolate the principal or coagents from facts known to an agent.”). Illustration 2 is drafted so that the difference in the premium is obviously insubstantial. There is no further significance to the \$25 amount. A larger amount could be insubstantial, depending on the situation.

d. Inquiry notice and the objective-reasonableness element of the reliance requirement. The objective element of the reliance requirement stated in this Section is similar to the objective element in the “notice inquiry” doctrine, which provides that a party will be deemed to be “on notice” of another party’s misrepresentation if a reasonable person under the circumstances would have investigated further and acquired actual knowledge of the misrepresentation. See, e.g., *Union Ins. Exchange, Inc. v. Gaul*, 393 F.2d 151, 155 (7th Cir. 1968) (applying Indiana law) (applying inquiry-notice doctrine to auto liability policy), citing, among other cases, *Columbian National Nat'l Life Insurance Ins. Co. of Boston, Mass. v. Rodgers*, 116 F.2d 705, 707 (10th Cir. 1940) (applying Kansas law) (“Knowledge which is sufficient to lead a prudent person to inquire about the matter, when it could have been ascertained conveniently, constitutes notice of whatever the inquiry would have disclosed, and will be regarded as knowledge of the facts.”); *Travelers Insurance Ins. Co. v. Eviston*, 37 N.E.2d 310, 316 (Ind. App. 1941) (“The rule that whatever puts a person on inquiry amounts, in law, to notice of such facts as an inquiry pursued with ordinary diligence and understanding would have disclosed, is applicable to charge an insurer with notice. This is in line with the general rule . . . that the principal is charged with the knowledge of that which his agent, by ordinary care, could have known, where the agent has received sufficient information to awaken inquiry.”); *Supreme Lodge Knights of Pythias of the Work v. Kalinski*, 163 U.S. 289, 298 (1896) (“If the company ought to have known of the facts, or with proper attention to its business, would have been apprised of them, it has no right to set up its ignorance as an excuse [in order to secure forfeiture.]”); see also *Allied Prop. & Cas. Ins. Co. v. Good*, 938 N.E.2d 227, 232 (Ind. Ct. App. 2010) (“An insurance company has no right to rescind a policy ‘where it had knowledge of the facts notwithstanding the material misrepresentations, or where a reasonable person would have investigated further.’” (quoting *Colonial Penn Ins. Co. v. Guzorek*, 690 N.E.2d 664, 674 (Ind. 1997))). The courts often hold that, although there is no general duty for the insurer to “look beneath the surface” of the insured’s application, there is such a duty when there are facts that put the insurer “on notice” of a possible factual inaccuracy. *Allied Prop. & Cas. Ins. Co. v. Good*, 938 N.E.2d at 232; see also *id.* sources cited at n.5. For further discussion on reasonable reliance, see KENNETH S. ABRAHAM

& DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 25 (6th ed. 2015) (“The ‘inquiry notice’ rule provides that, if the insured furnishes reasonably complete answers that ~~could~~would lead an objectively reasonable insurer to the information it seeks through diligent follow-up search, then there has been no misrepresentation or concealment.”). For an expansive discussion of the problem of insurers relying excessively on post-claim factfinding and insufficiently on factfinding at the application stage, see generally Thomas C. Cady & Georgia L. Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000). Illustration 5 is based on *Union Ins. Exchange, Inc. v. Gaul*, 393 F.2d 151 (7th Cir. 1968) (applying Indiana law).

e. Evidence of reliance. When the court is examining whether a particular insurer would have issued the disputed policy—regardless of whether the court frames the inquiry in terms of reliance or materiality to the risk—the documented practice of the insurer at the time it issued the policy is important evidence. See, e.g., *Curanovic v. N.Y. Cent. Mut. Fire Ins. Co.*, 307 A.D.2d 435, 437 (N.Y. App. Div. 2003) (“To establish materiality of misrepresentations as a matter of law, the insurer must present documentation concerning its underwriting practices, such as underwriting manuals, bulletins or rules pertaining to similar risks, to establish that it would not have issued the same policy if the correct information had been disclosed in the application.”). Standing alone, post-loss testimony by the underwriter about what the underwriter would have done differently has not carried much weight with courts. See, e.g., *id.* (“Conclusory statements by insurance company employees, unsupported by documentary evidence, are insufficient to establish materiality as a matter of law.”); *Capitol Life & Health Accident Ins. Co. v. Phelps*, 66 S.W.3d 678, 681 (Ark. Ct. App. 2002) (declaring the testimony of the insurer’s vice president insufficient to demonstrate the materiality of the misrepresentations when he “offered no proof of any underwriting practices either in his own company or within the industry with regard to applicants with the type of health conditions reflected in [the insured]’s records”). See generally ~~6 LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 82:15 (3d ed. ~~1995~~2017) (“[A]lthough admissible, the testimony of officers or underwriters of an insurer that they would have not accepted a risk if they had known of certain conditions which a true statement by the insured in his or her application would have revealed, is not, of course, conclusive as to the materiality of the misrepresentation in the application; such testimony would constitute only evidence on the issue of materiality.”).

f. Requiring reliance even for fraudulent misrepresentations. See Restatement Third, Torts: Liability for Economic Harm §§ 9 and 11 (AM. LAW INST., Tentative Draft No. 2, 2014, approved in May 2014). Several states now specifically require reliance for all types of misrepresentations, whether fraudulent or material, in order for the insurer to avoid coverage. See, e.g., N.Y. Ins. Law § 3105(b)(1) (McKinney 2011) (“No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.”); Or. Rev. Stat. Ann. § 742.013(1) (West 2011) (“Misrepresentations . . . shall not prevent recovery under the

policy unless the misrepresentations . . . (b) Are shown by the insurer to be material, and the insurer also shows reliance thereon; and (c) Are either: (A) Fraudulent; or (B) Material either to the acceptance of the risk or to the hazard assumed by the insurer.”); see also Utah Code Ann. § 31A-21-105(2) (West 2011) (“[N]o misrepresentation or breach of an affirmative warranty affects the insurer’s obligations under the policy unless (a) the insurer relies on it and it is either material or is made with intent to deceive; or (b) the fact misrepresented or falsely warranted contributes to the loss.”); Wis. Stat. Ann. § 631.11 (West 2011) (similarly requiring either reliance or actual contribution to the loss, even when the misrepresentation was knowingly made). Others have enacted similar statutes requiring that the insurer relied on the misrepresentation or else that the misrepresentation was material to the risk assumed, even if it was intentionally or recklessly made. See, e.g., Miss. Code Ann. § 83-9-11(3) (West 2011) (“The falsity of any statement in the application for any policy . . . may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.”); Neb. Rev. Stat. Ann. § 44-358 (2011) (“No oral or written misrepresentation or warranty made in the negotiation for a contract or policy of insurance by the insured, or in his behalf, shall be deemed material or defeat or avoid the policy, or prevent its attaching, unless such misrepresentation or warranty deceived the company to its injury.”); N.M. Stat. Ann. § 59-A-18-11(3) (West 2011) (“The falsity of any statement in the application for any policy covered by this Code may not bar the right to recover thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurance company.”); and Va. Code Ann. § 38.2-309 (2011) (“No statement in an application or in any affidavit made before or after loss under the policy shall bar a recovery upon a policy of insurance unless it is clearly proved that such answer or statement was material to the risk when assumed and was untrue.”).

Nevertheless, the most common language in misrepresentation statutes provides that “[m]isrepresentations . . . shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (3) The insurer in good faith . . . would not have issued the policy or contract . . .” Ala. Code § 27-14-7(a) (2011). This means that reliance is required only if the misrepresentation was not fraudulent. See, e.g., Alaska Stat. § 21.42.110 (2011); Ariz. Rev. Stat. Ann. § 20-1109 (2011); Del. Code Ann. Tit. 18, § 2711 (West 2011); Fla. Stat. Ann. § 627.409 (West 2011). For a discussion of fraudulent misrepresentation, see generally 6 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 82:27 (3d ed. ~~1995~~2017) (“To make a misrepresentation fraudulent, it is variously stated that it must have been made willfully with the intent to deceive the insurer, willfully with fraudulent intent, with a fraudulent intent, with intent to deceive and defraud, and that it was intentionally made.”). But although “some” statutes tend to provide that even immaterial fraud makes a policy voidable~~—~~, cases in which this actually occurs are difficult to find²² because of the “occasional judicial tendency to interpret the provisions of the relevant warranty/misrepresentation statute in a manner that favors coverage” in order to avoid

disproportionate forfeiture. [KENNETH S. ABRAHAM & DANIEL SCHWARCZ](#), *INSURANCE LAW AND REGULATION* ~~16~~[17-18](#) (~~5~~[6](#)th ed. ~~2010~~[2015](#)). Another commentator describes the current state of the law similarly:

Although one can find judicial pronouncements that an immaterial but fraudulent misrepresentation will void a policy, these pronouncements are rare. More importantly, no court appears to have voided an insurance policy because an insured fraudulently misrepresented an immaterial fact. Some courts purporting to adhere to the rule that a fraudulent misrepresentation will void the policy irrespective of the representation's materiality have reintroduced what is in effect a materiality requirement by demanding that the misrepresentation affect the risk or influence the insurer's judgment.

[ROBERT H. JERRY, II & DOUGLAS R. RICHMOND](#), *UNDERSTANDING INSURANCE LAW* ~~§ 102~~[§ 749](#) (5th ed. 2012) (arguing further that “[i]mmaterial representations, even if intentional, should not provide the insurer with a basis for voiding [the] policy”). But see 6 ~~LEE R. RUSS & THOMAS F. SEGALLA~~[STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), *COUCH ON INSURANCE* § 82:25 (3d ed. ~~1995~~[2017](#)) (“Where the misrepresentation is made by the insured with the fraudulent intent of deceiving the insurer, however, there is authority that the misrepresentation is made material by such fraudulent purpose. ~~Other~~[Some older](#) courts ~~face~~[faced](#) the issue more directly and ~~hold~~[held](#) that when a misrepresentation is fraudulent, it is not necessary to determine whether it is material.”).

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CHAPTER 2
MANAGEMENT OF POTENTIALLY INSURED LIABILITY CLAIMS
TOPIC 1
DEFENSE

§ 10. Scope of the Right to Defend

When ~~an~~ liability insurance policy grants the insurer the right to defend a legal action, that right includes, unless otherwise stated in the policy or limited by applicable law:

(1) The authority to direct all the activities of the defense of any legal action that the insurer has a duty~~right~~ to defend, including the selection and oversight of defense counsel; and

(2) The right to receive from defense counsel all information relevant to the defense or settlement of the action, subject to the exception for confidential information stated in § 11(2).

Comment:

a. Relationship to duty to defend. Traditionally, personal liability insurance policies, such as the liability-coverage parts of ~~homeowners'~~homeowner's and automobile-insurance policies, and many commercial liability insurance policies assign to the insurer the right and duty to defend any potentially covered suit brought against an insured. This Section addresses the right to direct or manage the defense of a covered suit or other legal action. The insurer's duty to defend a covered legal action is addressed in § 13.

b. The right to defend in the full-coverage case. The right to defend gives the insurer control over the defense of a legal action for which the insured seeks coverage, including the activities of the defense lawyer. The right to defend creates a relationship among the insurer, defense counsel, and the insured that is unproblematic and routine in the case of an ordinary liability action in which there is adequate insurance for the potential damages. In that full-coverage case, the insurer faces substantially all of the important legal risks posed by the action. As a result, the insurer has an incentive to provide a defense that is commensurate with the legal risks presented by the legal action. Indeed, precisely because the insured has shifted those legal risks to the insurer, liability insurance law and practice developed the duty to

cooperate, which discourages insureds from abandoning their critical role in the defense of the action. An additional reason for assigning control over the defense to the insurer is that insurers have greater capacity to direct the defense of a legal action than all but the most sophisticated insureds. In the vast majority of cases insurance companies manage legal actions brought against their policyholders, and the insurer's right and duty to defend do not present any problems. This Chapter addresses rules that are needed primarily in the minority of cases in which there is a potential for uninsured liability.

c. The right to defend when there is a substantial potential for uninsured liability. When the insurer does not bear all the risks presented by a suit or other legal action that it has the duty to defend, an unlimited right to defend can become problematic. Insureds bear the risks presented by a legal action for three possible reasons: (1) the plaintiff seeks damages in excess of the applicable limits of the insurance policy, (2) there is a possibility that some or all of the damages may be excluded from coverage, or (3) the insured faces some other kind of risk that is not covered by the liability insurance policy, such as damage to reputation or criminal liability. In such cases, the interests of the insured and insurer may diverge. In some cases, as addressed in § 16, the divergence may lead to a conflict of interest that is sufficiently acute that the insurer no longer has the right to defend, but rather must provide the insured an independent defense. In most cases, however, the insurer retains the right to defend, and liability insurance law manages the divergence of interests through the rules governing the insurer's duty to defend, the duty of good faith and fair dealing, and the rule that obligates insurers to retain counsel on terms that comply with the law governing lawyers. See generally Restatement Third, The Law Governing Lawyers.

d. Except as limited by law. Limits on the insurer's right to receive information from defense counsel include the rule stated in § 11, pursuant to which an insurer does not have the right to receive any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to advantage the insurer at the expense of the insured.

e. Legal action. The term “legal action” is used in this Section and elsewhere in this Chapter as a general term that refers to a demand for redress of the kind that fits within the usual framework of insured liabilities. Which legal actions are insured under any particular liability

insurance policy and when an insurer’s obligation to defend that legal action begins are defined by that policy. See § 13, Comment *f* (regarding the “suit” requirement).

REPORTERS’ NOTE

a. Relationship to duty to defend. The majority of courts agree that the duty to defend provides the insurer with the right to direct all activities of the defense. 1 ROBERT P. REDEMANN & MICHAEL F. SMITH, LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION § 4.9 (West ~~2013~~2017) (“~~[T]he~~The duty to defend gives the insurer the right to control the conduct of the litigation.”). See also *Cont’l Cas. Co. v. City of Jacksonville*, 550 F. Supp. 2d 1312, 1342 (M.D. Fla. 2007) (applying Florida law) (citation omitted) (“[N]ot only does an insurer have a contractual duty to defend an insured, but as a corollary, the insurer has a contractual right to defend.”); *Long v. Century Indem. Co.*, 163 Cal. App. 4th 1460, 1468 (2d Dist. 2008) (internal citations omitted) (“Generally, an insurer owing a duty to defend to the insured . . . has the right to control defense and settlement of the third party action against its insured-...”); *Safeco Ins. Co. of Am. v. Butler*, 823 P.2d 499, 504 (Wash. 1992) (“The insurer’s duty to defend the insured is one of the main benefits of the insurance contract.”) (citing R. Long, 1A *The Law of Liability Insurance* § 5B.15 at 5B-143 (1990)). Scholarship also suggests that this is the majority rule. See Robert H. Jerry II, *Consent, Contract, and the Responsibilities of Insurance Defense Counsel*, 4 CONN. INS. L.J. 153, 174-175 (1997-1998) (noting that the principle that insurance companies are entitled to control the defense of the insured “appears to have near-universal acceptance”). Insureds often purchase insurance for defense coverage as well as indemnity coverage. 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.01[1][a] (Lexis ~~2011~~2017) (“Many insureds purchase liability insurance for the peace of mind that comes with knowing that their insurer will defend them if they are sued in an action that comes within the scope of protection provided by their policy.”). See also *Montrose Chemical Corp. v. Superior Court*, 861 P.2d 1153, 1157 (Cal. 1993) (“The insured’s desire to secure the right to call on the insurer’s superior resources for the defense of third party claims is, in all likelihood, typically as significant a motive for purchase of insurance as is the wish to obtain indemnity for possible liability.”). In addition to having greater financial resources, “[i]nsurers have more expertise than most insureds in managing litigation.” William T. Barker, *Insurer Control of Defense: Reservations of Rights and Right to Independent Counsel*, 71 DEF. COUNS. J. 16, 16 (2004).

b. The right to defend in the full-coverage case. In a full-coverage case, “[e]xercise of virtually complete control of the defense for an insured has been viewed as an appropriate approach because of the insurer’s financial interest in the resolution of the claims.” Alan I. Widiss, *Abrogating the Right and Duty of Liability Insurers to Defend their Insureds: The Case for Separating the Obligation to Indemnify from the Defense of Insureds*, 51 OHIO ST. L.J. 917, 918 (1990). See, e.g., *Ottaviano v. Genex Coop., Inc.*, 15 A.D.3d 924, 924 (N.Y. App. Div. 2005) (“As a general rule, a liability insurer has a right to control the defense of underlying litigation against its insured based on the right of the insurer to protect its financial interests.”).

See William T. Barker, *Insurer Control of the Defense: Reservations of Rights and the Right to Independent Counsel*, 71 DEF. COUNS. J. 16, 16 (“[Insurers] have stronger, more immediate incentives to manage litigation efficiently than would insureds who expect their insurers to pay defense counsel’s bills.”); James M. Fischer, *Insurer or Policyholder Control of the Defense and the Duty to Fund Settlements*, 2 NEV. L.J. 1, 1 (2002) (“Control by the insurer is so pervasive that for claims that are likely to be resolved within the policy limits of the insurance contract the policyholder is often treated as a mere bystander to the resolution of the underlying claim.”). For a discussion of the uncomplicated insurer–insured relationship arising from the “ordinary case,” see Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255, 293-296 (1996). The insurer’s right to control the defense “entitles the insurer to select and direct defense counsel.” James M. Fischer, *Insurer or Policyholder Control of the Defense and the Duty to Fund Settlements*, 2 NEV. L.J. 1, 1 (2002). Because the “vast bulk of cases defended by insurers are fully covered,” allowing insurers plenary control of the defense “works well for insureds. Typically they have no interest in how a suit is defended, so long as the insurer pays any resulting judgment or settlement.” William T. Barker, *Insurer Control of Defense: Reservations of Rights and Right to Independent Counsel*, 71 DEF. COUNS. J. 16, 17 (2004).

c. The right to defend when there is a substantial potential for uninsured liability. For a discussion of the ways in which the possibility of uninsured liability affects incentives and alters the relationship between insurer and insured, see Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101, 107-109 (1997-1998). Conflicts of interest typically complicate the insurer’s duty to defend in three circumstances. See generally Douglas R. Richmond, *Lost in the Eternal Triangle of Insurance Defense Ethics*, 9 GEO. J. LEGAL ETHICS 475 (1996) (discussing the common situations in which conflicts of interest may arise). First, “situations where the complaint contains certain claims that fall within the policy’s coverage and others that fall outside the scope of coverage . . . can lead to a conflict of interest between the insured and the insurer.” 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 200:1 (3d ed. 2017). See, e.g., *Maryland Cas. Co. v. Peppers*, 355 N.E.2d 24, 30 (Ill. 1976) (discussing the conflicting incentives for the insurer and the insured when the underlying complaint alleged both negligence, which would be covered, and intentional injury, which would not). See also Todd R. Smyth, Annotation, *Duty of Insurer to Pay for Independent Counsel When Conflict of Interest Exists Between Insured and Insurer*, 50 A.L.R.4th 932 § 2[a] (Originally published in 1986) (“Many conflict of interests cases arise in the situation where the complaint filed against the insured contains allegations which are potentially within and outside policy coverage.”). Second, “a conflict of interest between the insured and the insurer may arise . . . where the complaint seeks damages in excess of the policy limits.” *Id.* See, e.g., *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, 20 Cal. App. 4th 1372, 1394 (Cal. Ct. App. 1993) (finding the insurer had created a conflict of interest by “pursuing a settlement . . . in excess of the insurers’ alleged policy limits.”). Finally, litigation may impose

risks on insureds entirely unrelated to their liability policy, such as reputation damage or criminal exposure. See Douglas R. Richmond, 9 GEO. J. LEGAL ETHICS at 510 (“A professional’s reputation may be damaged by malpractice allegations. A professional’s reputation also exists wholly independent of any insurance coverage.”).

§ 11. Confidentiality

(1) ~~The provision of~~ An insurer or insured does not waive rights of confidentiality with respect to third parties by providing to the insured or the insurer, within the context of the investigation and defense of a legal action, information protected by attorney–client privilege, work-product immunity, or other confidentiality protections ~~to an insurer or an insured within the context of the investigation and defense of a legal action does not waive any rights of the insured or the insurer to the confidentiality of that information with respect to third parties.~~

(2) An insurer does not have the right to receive any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer’s duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured.

Comment:

a. Confidentiality of information. An effective defense of an insured or potentially insured legal action requires the insurer, the insured, the defense lawyer, and their agents to share information on a confidential basis in a manner that is protected from disclosure to the claimant and other parties outside of the insurer–intermediary–insured relationship. All these parties share a common interest in protecting the insured from the action. Moreover, insurance policies should properly be regarded as appointing insurers, including non-defending insurers, as the insured’s agents for purposes of defending or considering whether to settle the legal action. With regard to parties outside of that liability insurance relationship, the confidentiality protection for information disclosed within that relationship should be as strong as if the parties to that relationship were a single entity. The scope of the information so protected is very broad. It includes information protected by attorney–client privilege, work-product immunity, and defense lawyers’ duty of confidentiality under rules of professional conduct. The non-waiver rule stated in subsection (1) applies whenever the information is provided to the insured or the insurer, including but not limited to the provision of information pursuant to the right to defend, the duty to defend, the right to associate, and the duty to cooperate. The non-waiver rule also applies

when the insured or the insurer provides the information to an intermediary such as a broker or claims administrator.

Illustrations:

1. Insured is sued in a slip-and-fall case in which the insured's knowledge of a dangerous condition is an important fact in dispute. Insurer hires a defense lawyer to defend the insured. In a private meeting, the insured informs the defense lawyer that the insured had been aware of the dangerous condition. The defense lawyer provides that information to the insurer. The provision of that information to the insurer does not waive the confidentiality of that information with respect to the plaintiff in the underlying tort action.

2. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. Insurer hires a defense lawyer to defend the insured. During a private meeting with the child and the child's parents, the attorney obtains information indicating that the child may have intentionally set the fire for the purpose of damaging the school. The defense lawyer provides this information to the insurer without the consent of the child or the parents. That information is relevant to a potential coverage dispute between the insured and insurer and should not have been disclosed to the insurer under the circumstances. Nevertheless, the provision of that information to the insurer does not waive the confidentiality of that information with respect to the plaintiff in the underlying tort action.

b. Information shared with non-defending insurers. An insurer providing a defense should come within the scope of the insured's confidentiality protections as an agent of the insured. An insurer that is not providing a defense should also be regarded as an agent of the insured for purposes of receiving confidential information related to the legal action, because the insurer may subsequently be called upon to pay a settlement or a judgment on behalf of the insured or, in some cases, even to take over the defense on behalf of the insured. A non-defending insurer should also come within the scope of the common-interest rule, pursuant

to which disclosure of privileged information by parties with a common interest is protected as against third persons, with the caveat that some authorities require that both parties be represented by counsel with respect to the matter.

c. A note of caution. The rule stated in this Section is not universally followed. There are courts that have required the use of certain documentary formalities, such as the express appointment of the insurer as the insured's communicating agent for purposes of managing the dispute or as the insured's co-client under a common-interest arrangement in which the parties are represented by counsel. Such formalities may be particularly important in the case of a non-defending insurer. Even when such formalities are observed, there may be some risk that disclosure will waive a privilege or immunity, and that risk is greater when an insurer has not unequivocally accepted coverage for the claim.

d. No right to confidential information that could benefit the insurer at the expense of the insured. The rule stated in subsection (2) is an insurance-law rule that is complementary to the rules stated in the Restatement Third, The Law Governing Lawyers, which expressly declines to address the law governing the relationship between insurer and insured. See Restatement Third, The Law Governing Lawyers § 134, Comment *a*. Rules governing lawyers' professional obligations are outside the scope of this Restatement. Under the rule stated in subsection (2), the insurer's right to defend does not include the right to receive confidential information from the defense lawyer that could harm the insured with regard to a matter that is in dispute, or potentially in dispute, between the insurer and insured. See Restatement Third, The Law Governing Lawyers § 59 (defining confidential client information). This rule reduces the likelihood that a defense lawyer will be placed in a situation in which the lawyer has conflicting obligations to the insured and the insurer, and it reduces the concern that an insurer can use its control over the defense to further its own interests at the expense of the insured.

Section 14(1)(b) places a corresponding obligation on the insurer to require defense counsel to protect from disclosure to the insurer any information of the insured that is protected by attorney-client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured. In practice, the application of this rule places a burden on defense counsel to use judgment in determining when to obtain the insured's consent before

providing information to the insurer. This burden extends only to information that counsel knows or should know may benefit the insurer at the expense of the insured. If a reservation-of-rights letter provided pursuant to § 15 is also provided to defense counsel, that letter will inform counsel of known grounds for contesting coverage, and thus identify matters in which the insurer and the insured's interests are in conflict. It is also possible, however, that the defense lawyer may learn of facts that are relevant to different potential grounds for contesting coverage. Counsel may always provide confidential information to the insurer with the informed consent of the insured. See Restatement Third, The Law Governing Lawyers § 134, Comment *e* (noting that the consent must meet the requirements of § 62 of that Restatement). Thus, if there is confidential information that counsel believes, on balance, would be in the interests of the insured to provide to the insurer, even though there is some risk that it may be used to benefit the insurer at the expense of the insured, counsel may provide it to the insurer as long as the insured provides informed consent.

Illustrations:

3. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. Insurer hires a defense lawyer to defend the insured. During a private meeting with the child and the child's parents, the attorney obtains information indicating that the child may have intentionally set the fire for the purpose of damaging the school. Because such information could lead the insurer to refuse to pay the claim based on an exclusion for intentional harm in the liability insurance policy and because the information is protected by attorney–client privilege, the insurer does not have the right to this information from the defense lawyer.

4. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. Insurer hires a defense lawyer to defend the insured. During a deposition, the child provides testimony indicating that the child may have intentionally set the fire for the purpose of damaging the school. Upon request, the insurer has the right to a copy of the transcript of the deposition, even though the testimony could lead the insurer to refuse to cover the suit, because deposition testimony is not confidential.

REPORTERS' NOTE

a. Confidentiality of information. The usual case—in which the insurer bears all the judgment risk, accepts coverage, appoints defense counsel, and directs the defense—should not present the kinds of confidentiality problems addressed in the cautionary note to this Section, because there is no basis for disputing the status of the insurer as the insured's agent for managing the claim nor the common interest of the insurer and insured with respect to the information. See Restatement Third, The Law Governing Lawyers § 70, Comment *f* (AM. LAW INST. 2000):

The privilege applies to communications to and from the client disclosed to persons who hire the lawyer as an incident of the lawyer's engagement. Thus, the privilege covers communications by a client-insured to an insurance-company investigator who is to convey the facts to the client's lawyer designated by the insurer, as well as communications from the lawyer for the insured to the insurer in providing a progress report or discussing litigation strategy or settlement (see § 134, Comment *f*). Such situations must be distinguished from communications by an insured to an insurance investigator who will report to the company, to which the privilege does not apply.

The problems primarily arise, like almost all problems relating to the defense and settlement of legal actions, when the insurer does not bear all of the judgment risk. This Section states that the same non-waiver rules should apply in all such cases and, under existing law the same rules probably would apply in such cases in most jurisdictions, but, as reported in the Note to Comment *c* below, there is some authority to the contrary. For a recent case finding non-waiver in the context of information provided by an insurer to an insured, see *State ex rel. Montpelier U.S. Insurance Co. v. Bloom*, 757 S.E.2d 788, 798 (W. Va. 2014) (~~applying West Virginia law~~) (finding no waiver when the insurer provided a copy of a coverage opinion letter to its insured).

b. Information shared with non-defending insurers. See, e.g., *Exxon Corp. v. St. Paul Fire & Marine Ins.*, 903 F. Supp. 1007, 1010 (E.D. La. 1995) (applying Louisiana law) (“Because of the nature of the relationship between an insured and an insurer, including excess insurers, the Court refuses to hold that ~~A&A~~[excess insurer's] communication of a clearly privileged document to an excess insurer on behalf of the insured constitutes a waiver of the attorney–client privilege. Excess insurers are not disinterested third parties but entities who have a contractual relationship with the insured and whose interests—in most cases—are the same.”). For authority limiting the common-interest rule to information provided to attorneys, see, e.g., *In re Teleglobe Communications Corp.*, 493 F.3d 345, 363-364 (3d Cir. 2007) (applying Delaware law) (holding under Delaware law that the common-interest exception applies only to attorneys sharing privileged information, not clients); *In re XL Specialty Ins. Co.*, 373 S.W.3d 46, 55 (Tex. 2012) (holding that the attorney–client privilege was lost when the information was provided directly to an unrepresented employer in the situation of a non-defending insurer). Because insurers

commonly use non-lawyer personnel to track the developments of cases in which they have an interest but are not defending, this approach to the common-interest exception would not provide the necessary confidentiality protection in such cases. For that reason, the Comment also grounds the confidentiality protection in the (limited) agency relationship, not exclusively in the common-interest exception. As reflected in the Reporter’s Note to Restatement Third, The Law Governing Lawyers § 70, Comment *f* (AM. LAW INST. 2000), there is significantly greater risk when providing the information to a non-lawyer employee. Accordingly, many insurers have a practice of employing monitoring counsel for this purpose.

c. A note of caution. See, e.g., *Cont’l Cas. Co. v. St. Paul Surplus Lines Ins. Co.*, 265 F.R.D. 510, 525 (E.D. Cal. 2010) (applying California law) (declining to protect communications between insured’s defense lawyer and a non-defending insurer that had issued a reservation of rights); *In re Imperial Corp. of America*, 167 F.R.D. 447 (S.D. Cal. 1995), *aff’d* on other grounds, 92 F.3d 1503 (9th Cir. 1996) (applying California law) (letters sent by defense attorney to D&O insurer that had reserved rights were a waiver of the work-product immunity). See generally John P. Ludington, Annotation, *Insured-Insurer Communications as Privileged*, 55 A.L.R.4th 336 1[a] (Originally published in 1987) (collecting and discussing cases); John Buchanan & Wendy Feng, *Protecting Privilege While Preserving Coverage*, A.B.A. SEC. LITIGATION: INSURANCE COVERAGE, Mar. 8, 2012, available at <http://apps.americanbar.org/litigation/committees/insurance/articles/janfeb2012-protecting-privilege.html> (last visited Mar. 14, 2017) (discussing the preservation of privilege when the insured retains independent counsel).

d. No right to confidential information that could benefit the insurer at the expense of the insured. Numerous jurisdictions have held that “the cooperation clause in the insurance policies does not operate to override . . . the attorney client privilege,” and that insurers are therefore not entitled to protected information shared by the insured with counsel. *Eastern Airlines, Inc. v. U.S. Aviation Underwriters, Inc.*, 716 So. 2d 340, 343 (Fla. Dist. Ct. App. 1998). See, e.g., *Remington Arms Co. v. Liberty Mut. Ins. Co.*, 142 F.R.D. 408, 419-420 (D. Del. 1992) (applying Connecticut law) (holding that the insurer could not compel discovery of certain documents because they were protected by attorney–client privilege and likewise not discoverable under work-product doctrine); *Rockwell Inter. Corp. v. Superior Court*, 32 Cal. Rptr. 2d 153, 159 (Cal. Ct. App. 1994) (“[W]e refuse to read into the cooperation clause an unintended implied waiver of the attorney client privilege.”). See also John Buchanan & Wendy Feng, *Protecting Privilege While Preserving Coverage*, A.B.A. SEC. LITIGATION: INSURANCE COVERAGE, Mar. 8, 2012, available at <http://apps.americanbar.org/litigation/committees/insurance/articles/janfeb2012-protecting-privilege.html> (last visited Mar. 14, 2017) (discussing disclosure obligations of insurance defense counsel). Nevertheless, courts and commentators have reached divergent conclusions on the insurer’s right to protected information. Compare *Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 654 F. Supp. 1334, 1365 (D.D.C. 1986) on reconsideration, 672 F. Supp. 1 (D.D.C. 1986), *aff’d*, 944 F.2d 940 (D.C. Cir. 1991) (applying Missouri law) (observing that

“communications between an insured and its attorney connected with the defense of underlying litigation are normally not privileged vis-à-vis the insured’s carriers in subsequent litigation”) and Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255, 343-348 (1996) (stating that the insurer has the right to information but not obligating the lawyer to provide it) with *Trau-Med of Am., Inc. v. Allstate Ins. Co.*, 71 S.W.3d 691, 697 (Tenn. 2002) (stating that “the employment of the attorney by the insurer does not impose upon that attorney any duty or [sic] loyalty to the insurer that could impair the attorney-client relationship between the attorney and the insured”). Illustrations 2, 3, and 4 are modeled on *Parsons v. Cont’l Nat’l Am. Group*, 550 P.2d 94 (Ariz. 1976). For further discussion of the responsibilities of insurance defense counsel when a conflict of interest exists, see KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION* 658-587 (56th ed. 2010) (collecting articles 2015).

§ 12. Liability of Insurer for Conduct of Defense

(1) If an insurer undertakes to select counsel to defend a legal action against the insured and fails to take reasonable care in so doing, the insurer is subject to liability for the harm ~~such failure causes to the insured~~ caused by any subsequent negligent act or omission of the selected counsel that is within the scope of the risk that made the selection of counsel unreasonable.

(2) An insurer is subject to liability for the harm caused by the negligent act or omission of counsel provided by the insurer to defend a legal action when the insurer ~~acts to override the duty of the counsel to exercise independent professional judgment and~~ directs the conduct of the counsel with respect to the negligent act or omission in a manner that overrides the duty of the counsel to exercise independent professional judgment.

Comment:

a. Insurer liability for the conduct of defense. When a defense counsel selected by an insurer to represent an insured commits professional malpractice, the insured may recover from that attorney for any harm that results, subject to meeting the standard elements of a tort claim for professional malpractice. Under the rule stated in this Section, an insured may also seek recovery

in tort for harms caused by that malpractice from the liability insurer in two limited sets of circumstances.

b. Insurer liability for negligent selection of defense counsel. Under subsection (1), a liability insurer can become subject to liability for the negligence of defense counsel if the insurer fails to exercise reasonable care in selecting defense counsel. An insurer has a duty to select defense counsel when the insurance policy obligates it to do so, provided that the insurer has not been relieved of that duty because of a conflict of interest addressed in § 16. The insurer breaches that duty when it fails to take reasonable care in selecting the attorney who will provide the insured with a defense. What constitutes negligence in the selection of defense counsel is a fact-specific question that ~~ordinarily~~ turns on the insurer's efforts to assure that the lawyer has adequate skill and experience in relation to the claim in question, as well as adequate professional liability insurance. See Comment c. The insurer is not subject to liability for all wrongful acts of the selected counsel, but rather only for acts or omissions within the scope of the risk that made the selection of counsel unreasonable.

Illustrations:

1. A tort action arising out of an auto accident is brought against Jane; the claims asserted in the action are covered under a duty-to-defend liability insurance policy issued by Insurer. Insurer selects defense counsel to represent Jane. Insurer's claims personnel are aware that defense counsel has regular, substantial periods of unreliability related to substance abuse. The substance abuse causes defense lawyer to commit malpractice at trial, leading to a verdict in excess of the insurance policy limit. Insurer is subject to liability for the amount by which Jane proves that the damages award was increased by the substance-abuse-related malpractice.

2. A tort action arising out of an auto accident is brought against Jane; the claims asserted in the action are covered under a duty-to-defend liability insurance policy issued by Insurer. Insurer selects defense counsel to represent Jane. Insurer's claims personnel are aware that defense counsel has regular, substantial periods of unreliability related to substance abuse. Despite defense lawyer's reasonable efforts, which meet the standards of

the legal profession, there is a plaintiff's verdict in the case in an amount in excess of the policy limits. Insurer is not subject to liability under the rules stated in this Section because defense counsel did not breach the standard of care. Whether the insurer may be subject to liability because of a breach of the duty to make reasonable settlement decisions is beyond the scope of this Illustration.

3. A tort action arising out of an auto accident is brought against Jane; the claims asserted in the action are covered under a duty-to-defend liability insurance policy issued by Insurer. Insurer selects defense counsel to represent Jane. Insurer's claims personnel are aware that defense counsel has had regular, substantial periods of unreliability related to substance abuse. Although the claims personnel are not aware of this development, defense counsel has stopped engaging in substance abuse. For reasons that are unrelated to the former substance abuse, defense counsel commits malpractice that leads to a verdict in excess of the policy limit. Insurer is not subject to liability for the amount that the damages award was increased by the malpractice, because malpractice that is unrelated to substance abuse is not within the scope of the risks that made the insurer's conduct unreasonable. Whether the insurer may be subject to liability because of a breach of the duty to make reasonable settlement decisions is beyond the scope of this Illustration.

c. Failure to retain defense counsel with adequate professional liability insurance. One important example of negligence in the selection of counsel is the failure to ~~ensure that~~select defense counsel ~~has adequate professional liability~~with reasonable insurance. See Comment *e* (explaining that the ability of insurers to protect policyholders by ensuring the defense counsel has adequate liability insurance is the most important policy reason for rejecting the special insurance-law vicarious-liability rule recognized in some jurisdictions). It is foreseeable that the insured could be harmed by defense counsel's lack of adequate professional-liability insurance, and it is not unduly burdensome for the insurer to arrange its defense-counsel-retention procedures in a manner that ensures that defense counsel has adequate liability insurance. Indeed, liability insurers commonly include professional-liability-insurance requirements in their guidelines for outside lawyers whom they appoint as defense counsel. What constitutes adequate liability insurance coverage is a question of fact that turns on factors such as the availability of

liability insurance coverage, customary liability insurance purchasing patterns for defense lawyers handling matters of the sort for which the defense is provided, the potential liability of the insured in relation to that legal action, and the policy limits of the liability insurance policy pursuant to which the insurer is providing a defense. Whether the insurer has a continuing duty to monitor that adequate coverage remains in force throughout the term of the defense counsel's representation of the insured, or whether it is sufficient to assess the adequacy of coverage only at the time that counsel is initially retained, is likewise a factual question of what constitutes reasonable behavior of a liability insurer under the circumstances.

d. Insurer liability when overriding the duty of the defense counsel to exercise independent judgment. Under subsection (2), the insurer is subject to liability for harm caused by the negligence of defense counsel if the insurer has acted to override the defense counsel's independent professional judgment and directed defense counsel to act, or fail to act, in a manner that breached the professional standard of care and caused harm to the insured. In general, a defense counsel who is retained by a liability insurer to defend a legal action brought against an insured owes a duty to that insured to take reasonable care in representing the insured's interests as well as a duty to exercise independent professional judgment in that representation. See Restatement Third, The Law Governing Lawyers § 134. Because of this professional obligation, most courts have not applied general principles of agency and tort law—such as the doctrines of actual or apparent authority or the related doctrine of *respondeat superior*—to impose vicarious or direct liability on insurers for the professional malpractice of defense counsel. If an insurer takes steps to overrule the professional judgment of defense counsel, however, substituting its own judgment for that of defense counsel, then the insurer can be subject to liability if the result is a breach of defense counsel's duty of reasonable care owed to the insured.

e. The special insurance-law vicarious-liability rule rejected. Some jurisdictions have adopted a special vicarious-liability rule making an insurer liable for the actions of defense counsel. The reasons provided for that special vicarious-liability rule include the loss-prevention and loss-spreading justifications for tort liability more generally: insurers are in a better position than insureds to select and monitor the actions of defense lawyers and thereby prevent losses and to shift or spread the risk of those losses that do occur. While those reasons are ~~good ones, valid~~ as between insurers and ~~defense counsel~~insureds, defense counsel ordinarily is in a better position than an insurer to prevent losses from counsel's own negligence. In addition, if defense

counsel maintains adequate liability insurance, defense counsel is in just as good a position as the insurer to spread the risk of those losses that do occur. Thus, if liability insurers ensure that their chosen defense counsel have adequate liability insurance to cover the consequences of malpractice, there is no need for that special vicarious-liability rule. This Section declines to follow ~~this~~the special vicarious-liability rule because the liability insurer's obligation to retain counsel with adequate liability insurance, discussed in Comment *c*, adequately addresses the loss-spreading objectives of that rule.

Illustrations:

~~1.4.~~ A tort action arising out of an auto accident is brought against Jane; the claims asserted in the action are covered under a duty-to-defend liability insurance policy issued by Insurer. Insurer selects defense counsel to represent Jane. In preparation of the case for trial, it is counsel's professional opinion that ~~depositions should be taken of not only the plaintiff in the underlying action but also three other people who claim to have been at the scene of the auto accident. Insurer insists that counsel take a deposition only of the plaintiff himself; no other depositions are to be taken. Defense counsel, fearing the~~defense should demand an independent medical examination and retain expert witnesses to challenge the plaintiff's damages claim. Insurer refuses to authorize these expenses. Defense counsel informs the insurer that, in her professional judgment, both measures are standard practice in a case such as this and particularly necessary in this case. Insurer directs counsel not to incur these expenses. Fearing the loss of future business from Insurer, ~~agrees to the deposition limitation imposed by Insurer, even though it is contrary to both the lawyer's own professional judgment and the standards within the legal profession for a case such as this~~counsel agrees not to incur these expenses. The trial results in a verdict for the plaintiff in excess of the limits of the policy. ~~If Insured can demonstrate that defense counsel breached its professional duty owed to Insured, that the breach was a cause of the excess verdict, and that Insurer's exercise of undue control over defense counsel's trial strategy was a cause of the excess verdict, Insurer~~Assuming that the failure to conduct the independent medical examination and to retain expert witnesses on damages was negligence in this case, insurer is subject to liability ~~to the insured for the excess judgment and any other harms proximately caused by Insurer's actions.~~for the

amount by which Jane proves that the damages award was increased as a result, to the extent that amount exceeds the policy limits.

5. Same facts as Illustration 4, except that the defense counsel independently chose not to conduct an independent medical examination or to retain the damages experts without consulting with the insurance company. The insurer is not subject to liability.

~~2.6.~~ Same facts as Illustration ~~1,5,~~ except that ~~Insurer does not override defense counsel’s professional judgment. Instead,~~ at the time Insurer hires counsel, Insurer does not inquire as to whether counsel has any ~~malpractice~~professional liability insurance. Counsel has not had liability insurance coverage for over a year; counsel’s prior policy had been canceled for ~~breach of various conditions in the policy~~non-payment; and, because of poor prior-claims experience, counsel had not been able to secure coverage at a reasonable price. If ~~counsel commits malpractice in the course of representing Jane, and~~ Jane is not able to recover from counsel because of ~~his~~the lack of liability insurance coverage, Insurer ~~may be held directly liable for negligent selection of counsel if all elements of the tort are satisfied~~is subject to liability for the amount by which the damages award exceeds the limit of Jane’s policy and the amount that Jane is able to collect from counsel, with such liability not to exceed the limit of the professional liability insurance policy that a reasonable insurer would have required defense counsel to obtain.

REPORTERS’ NOTE

a. Insurer liability for the conduct of defense. For a statement of the basic rule that lawyers are liable for the economic harms that they negligently cause their clients in the performance of their professional obligations to those clients, see generally Restatement Third, Torts: Liability for Economic Harm § 4 (AM. LAW INST., Tentative Draft No. 1, 2012) (“A professional is subject to liability in tort for economic loss caused by the negligent performance of an undertaking to serve a client.”).

b. Insurer liability for negligent selection of defense counsel. Despite the existence of a clear and general tort-law obligation to take reasonable care in selecting defense counsel, there is a dearth of reported cases holding liability insurers directly liable for negligent selection. Restatement Third, Torts: Liability for Physical and Emotional Harm § 55 (AM. LAW INST. 2012). See also Restatement Third, Agency § 7.05(1) (AM. LAW INST. 2006) (“A principal who

conducts an activity through an agent is subject to liability for harm to a third party caused by the agent's conduct if the harm was caused by the principal's negligence in selecting, training, retaining, supervising, or otherwise controlling the agent.”). The courts that have addressed the question, however, have clearly supported the rule of this Section. See, e.g., *Evans v. Steinberg*, 699 P.2d 797, 799 (Wash. Ct. App. 1985) (recognizing potential negligence action in selecting counsel); *Kapral v. Geico Indemnity Co.*, D.C. Docket No. 8:13-cv-02967-CEH-AAS, 11th Cir., January 23, 2018 (unpublished opinion) (“Under Florida law, an insurer is not vicariously liable for the negligence of the attorney it retains to defend the insured, *so long as the attorney is competent and qualified.*”) (emphasis added); *Brown v. Lumbermens Mut. Cas. Co.*, 369 S.E.2d 367 (N.C. Ct. App. 1988) (rejecting vicarious insurer liability for negligence of appointed attorney but implying the possibility of negligent-selection cause of action); and *C. Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 881 (1973) (rejecting vicarious liability of insurer but implicitly endorsing idea that insurer is expected to select competent counsel). The likely explanation for the dearth of cases is that insureds tend to frame any potential negligent-selection claims as claims for breach of the duty to make reasonable settlement decisions or breach of the duty to defend. For a general discussion of the circumstances in which liability insurers may be held directly liable for negligently selecting an attorney chosen to represent an insured, see George M. Cohen, *Liability of Insurers for Defense Counsel Malpractice*, 68 RUTGERS U. L. REV. 119, 129-135 (2015). [Regarding the ordinary tort- law rules in economic-loss cases, see Restatement Third, Torts: Liability for Economic Harm §§ 4 and 5 \(Am. Law Inst., Tentative Draft No. 1, 2012\) \(stating standards for liability for professional negligence and negligent misrepresentation, respectively\) and id. § 6 \(Am. Law Inst., Tentative Draft No. 2, 2014\) \(stating standard for liability for negligent performance of services\).](#)

c. Failure to retain defense counsel with adequate professional liability insurance. Although there are no published cases expressly dealing with a situation in which the liability insurer hires counsel who turns out to have insufficient liability insurance coverage, and as a result is unable to pay a malpractice claim brought by insured against counsel, there is little doubt that hiring counsel with no or inadequate liability insurance would be inconsistent with what is considered reasonable behavior by insurers within the industry and could therefore constitute a type of negligent retention. The balance of the costs and benefits supports this same conclusion: the benefits to the insured are high because of the importance of having a financially responsible defense lawyer, while the costs to the insurer are low of establishing a procedure for ensuring that defense counsel have adequate liability insurance.

d. Insurer liability when overriding the duty of the defense counsel to exercise independent judgment. It is a longstanding rule of both tort and agency law that an employer is vicariously liable for the torts committed by its employees while acting within the scope of their employment. Restatement Third, Agency § 2.04 and § 7.07 (AM. LAW INST. 2006) (“An employer is subject to liability for torts committed by employees while acting within the scope of their employment”). Likewise, it is a well-accepted proposition of tort and agency law that one

who hires an agent that is not an employee can nevertheless be held vicariously liable for the torts committed by that agent if the agent is acting within his or her apparent authority. Restatement Third, Agency § 7.08 (AM. LAW. INST. 2006) (“A principal is subject to vicarious liability for a tort committed by an agent in dealing or communicating with a third party on or purportedly on behalf of the principal when actions taken by the agent with apparent authority constitute the tort or enable the agent to conceal its commission.”); and Restatement Third, Torts: Liability for Physical and Emotional Harm § 65, Comment *b* (AM. LAW. INST. 2012). Finally, general principles of tort and agency law provide that a principal can be held liable for the torts of its agent if the principal is negligent in the manner in which it supervises the agent. Restatement Third, Agency § 7.05 (AM. LAW. INST. 2006).

If these general rules of tort and agency law were applied straightforwardly to the liability insurance context, the negligence of an attorney hired by an insurer to represent an insured might be expected to be attributed to the insurer in many cases, either under a theory of respondeat superior or under a theory of apparent authority. Moreover, one might expect to find cases involving direct insurer liability for negligent supervision of counsel representing the insured. In fact, however, a thorough research of the case law reveals that insurers are rarely held liable in this way. In fact, with the exception of a few jurisdictions that have adopted a version of vicarious insurer liability (discussed in Comment *e*), very few cases can be found even hinting at insurer liability for the misconduct of counsel retained on behalf of an insured. See, e.g., *Lloyd v. State Farm Mut. Auto. Ins. Co.*, 860 P.2d 1300, 1301 (Ariz. Ct. App. 1992) (holding “that an insurer’s voluntary assumption of the duty to defend may give rise to a cause of action for derelictions in that defense even when there is no actual coverage.”). Indeed, no cases were found holding a liability insurer liable for the torts of counsel on a theory of apparent authority or negligent supervision.

The reason for this dearth of cases likely has to do with the special professional obligations owed by attorneys to their clients. Lawyers hired by insurers to represent insureds are not understood to be agents of the insurers. Lawyers in such situations have professional and ethical obligations to represent the interests of the insured whom they are hired to defend, and not the interests of the insurer; and such lawyers are expected, indeed required, to exercise their own independent judgment, even when—perhaps especially when—it is the insurer who pays their bills. This special relationship can be seen, for example, in the Restatement rules forbidding defense counsel from sharing certain information with the insurer, if that information might be used to contest the coverage owed by the insurer to the insured. Because defense counsel are not generally agents of the insurer, vicarious, apparent-authority, and negligent-supervision liability claims would not make sense. If, however, an insurer were to take steps to override the normal professional independence of defense counsel, this prevailing presumption against vicarious and direct liability of the insurer would be overcome.

e. The special insurance-law vicarious-liability rule rejected. A minority of jurisdictions have held that insurers may be held vicariously liable for the wrongful acts of the defense counsel they retain, see *Smoot v. State Farm Mut. Auto. Ins. Co.*, 299 F.2d 525, 530 (5th Cir. 1962)

(applying Georgia law) (“Those whom the Insurer selects to execute its promises, whether attorneys, physicians, no less than company-employed adjusters, are its agents for whom it has the customary legal liability.”). See also *Boyd Bros. Transp. Co., Inc. v. Fireman’s Fund Ins. Cos.*, 729 F.2d 1407, 1409 (11th Cir. 1984) (applying Alabama law) (rejecting “the independent contractor theory”); *Pac. Employers Ins. Co. v. P.B. Hoidale Co., Inc.*, 789 F. Supp. 1117, 1122 (D. Kan. 1992) (applying Kansas law) (holding that “[a]lthough [the counsel] may have been acting as the agent of [the insured], [he] also represented the interests of [the insurer], the principal who hired him” and thus the counsel’s negligence is attributable to the insurer); *Cont’l Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 294 (Alaska 1980) (following vicarious-liability theory, in part, because the retained counsel’s “first loyalty was to” the insurer); *Stumpf v. Cont’l Cas. Co.*, 794 P.2d 1228, 1229 (Or. Ct. App. 1990).

The majority of jurisdictions, however, have rejected insurer vicarious liability for the torts of defense counsel. See, e.g., *Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 881-882 (Cal. Ct. App. 1973) (“Having chosen competent independent counsel to represent the insured in litigation, the carrier may rely upon the trial counsel to conduct the litigation, and the carrier does not become liable for trial counsel’s legal malpractice. If trial counsel negligently conducts the litigation, [the insured’s] remedy for this negligence is found in an action against counsel for malpractice and not in a suit against the counsel’s employer to impose vicarious liability.”); *Aetna Cas. & Sur. Co. v. Protective Nat-l Ins. Co. of Omaha*, 631 So. 2d 305, 306 (Fla. Dist. Ct. App. 1993) (recognizing that jurisdictions are split on vicarious liability and siding with cases holding that an insurance company is not vicariously liable for malpractice of its defense attorney); *Kapral v. Geico Indemnity Co.*, D.C. Docket No. 8:13-cv-02967-CEH-AAS, 11th Cir., January 23, 2018 (unpublished opinion) (applying Florida law to hold that insurer is not vicariously liable for the negligence of the attorney it retains to defend the insured, even if counsel is employee of insurer); *Feliberty v. Damon*, 527 N.E.2d 261, 265 (N.Y. 1988) (“given the insurer’s inability to provide or control the legal services in issue, and the existence of a remedy for incompetence against counsel, we conclude that the imposition of vicarious liability in the circumstances is unwarranted”); *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998) (“A defense attorney, as an independent contractor, has discretion regarding the day-to-day details of conducting the defense, and is not subject to the client’s control regarding those details.”). Cf. Restatement Third, Agency § 7.06 (AM. LAW INST. 2006) (stating that the independent-contractor defense does not apply if the defendant owes a direct duty of care to the injured person).

For a summary of the case law on this issue, see George M. Cohen, *Liability of Insurers for Defense Counsel Malpractice*, 68 RUTGERS U. L. REV. 119, 125-126 (2015) (stating that a majority of courts have rejected vicarious liability and the “clear trend” is in that direction, reporting the count at the time of writing as seven states in favor of vicarious liability and 12 states against).

— [Illustrations: For examples of legal-malpractice cases involving defense counsel’s failure to undertake adequate efforts to challenge a plaintiff’s damages claim, see *Transcraft, Inc.*](#)

v. Galvin, Stalmack, Kirshner & Clark, 39 F.3d 812, 817 (7th Cir. 1994); Carbis Sales, Inc. v. Eisenberg, 935 A.2d 1236, 1250 (N.J. Super. Ct. App. Div. 2007).

§ 13. Conditions Under Which the Insurer Must Defend

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

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

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

(b) Any additional allegation known to the insurer, not contained in the complaint or comparable document stating the legal action, that a reasonable insurer would regard as an actual or potential basis for all or part of the action.

(3) ~~The~~An insurer that has the duty to defend under subsections (1) and (2) must defend until its duty to defend is terminated under § 18 by declaratory judgment or otherwise, unless facts not at issue in the legal action for which coverage is sought and as to which there is no genuine dispute establish that:

(a) The defendant in the action is not an insured under the insurance policy pursuant to which the duty to defend is asserted;

(b) The vehicle or other property involved in the accident is not covered property under a liability insurance policy pursuant to which the duty to defend is asserted and the defendant is not otherwise entitled to a defense;

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer's performance is excused under the rule stated in § 35(2);

(d) The action is subject to a prior and pending litigation exclusion or a related claim exclusion in a claims-made policy; ~~or~~

(e) There is no duty to defend because the insurance policy has been properly cancelled; or

(f) There is no duty to defend under a similar, narrowly defined exception to the complaint-allegation rule recognized by the courts in the applicable jurisdiction.

Comment:

a. The duty to defend and the complaint-allegation rule. When evaluating whether to defend a legal action that is brought against an insured, the insurer must take as true all the facts alleged in the complaint or comparable document that favor coverage. An allegation in a complaint that, if proven, would subject the insured to a covered liability conclusively establishes that the insurer has a duty to defend, subject only to the exceptions permitted by subsection (3), which allows an insurer to avoid the duty to defend without filing a declaratory-judgment action in narrowly defined circumstances. (As stated in Comment *c*, it is anticipated that courts will consider additional exceptions through a common-law process of reasoning by analogy.)

This widely accepted rule is variously known as the “four corners,” “eight corners,” or “complaint allegation” rule. The “four corners” label refers to the four corners of the complaint, reflecting that the insurer must defend based on the allegations in the complaint even if facts outside the complaint would demonstrate that those allegations are false. The “eight corners” label refers to the four corners of the complaint plus the four corners of the insurance policy, reflecting that, as long as the complaint contains an allegation that would be covered by the policy, parties and judges can make the duty-to-defend determination simply by reference to the complaint and the policy.

In determining whether to undertake the defense of an insured, an insurer must resolve any factual uncertainty in favor of the duty to defend. For example, any factual assertion in the complaint or comparable document favoring coverage is to be treated as if true, except to the extent that there are inconsistencies between or among assertions, in which case the assertions favoring coverage are to be treated as if true. If there is evidence outside of the complaint that favors coverage, that evidence should be treated as true for purposes of resolving factual uncertainty with respect to whether coverage exists. Similarly, subsection (3) requires that all factual uncertainty regarding matters not at issue in the underlying claim must also be resolved in favor of the duty to defend.

When an insurer has the duty to defend, it must do so until that duty terminates in one of the ways enumerated in § 18. Typically, this means the insurer must defend the legal action all the way through final adjudication of the action, unless the action is settled or the insurer prevails in a declaratory-judgment action establishing that the action is not covered by the liability insurance policy.

b. The potential for coverage. If the insurer knows of an allegation that, under existing pleading rules, could reasonably be expected in the circumstances to be added as an allegation in the legal action, and that, if so added, would require the insurer to defend the action, then the insurer has a duty to defend that action. The courts have not considered whether an insurer that should know of such an allegation, but because of an inadequate investigation does not in fact know of that allegation, must provide a defense. Accordingly, this Section limits the rule stated in subsection (32)(b) to facts known to the insurer. In an appropriate circumstance, an inadequate investigation could provide the basis for liability insurance bad faith, provided that the requirements of § 49 are met. If the circumstances indicate that the underlying claimant (a) is aware of facts that could serve as the basis for a potentially covered allegation and (b) has made a choice not to pursue a potentially covered cause of action, then the insurer does not have a duty to defend the action because a reasonable insurer would not regard the allegation as an actual or potential basis for all or part of the action. But the duty will arise if the claimant later decides to make the allegation.

Except as provided in subsection (3) and discussed in Comment *c*, the consideration of facts outside the complaint works in one direction only: facts or circumstances not alleged in the complaint or comparable document generally may not be used to justify a refusal or failure to defend. Such information may be used, however, in a declaratory-judgment action brought by the insurer seeking to terminate its duty to defend an action that it is defending under a reservation of rights. See § 18, Comment *j*. This is the majority rule.

Illustrations:

1. Insured is sued for assault arising out of an altercation following an auto accident. Insured's automobile liability insurer denies coverage on the grounds that the complaint alleges that the insured intentionally assaulted the plaintiff and, thus, the suit is

excluded under a provision stating that the insurance policy does not apply to “bodily injury . . . caused intentionally by or at the direction of the insured.” Insured acknowledges striking the plaintiff, but alleges that he acted in self-defense. According to Insured, he reasonably feared for his personal safety, because the plaintiff approached the insured’s car in a menacing manner and jerked open the door. On these facts, the plaintiff has the potential to recover from Insured on a negligent self-defense theory that would be covered. Thus, the insurer has the duty to defend.

2. Insured is sued for bodily injury sustained during a fight in a bar. The complaint contains two counts. In the first count, the plaintiff alleges that Insured intentionally assaulted the plaintiff. In the second count, the plaintiff alleges that Insured negligently struck the plaintiff on the head. Insured’s homeowner’s insurer investigates the claim and determines, based on reliable witnesses, that Insured attacked the plaintiff with a wooden club. Nevertheless, the insurer has a duty to defend because count two in the complaint sets forth a covered legal theory.

3. Same facts as Illustration 2, except that Insured tenders the legal action to an automobile liability insurer for a defense. The insurer investigates. Because the facts alleged in the complaint do not contain any allegation that provides a basis for concluding that the injuries arose out of the operation of an automobile, and there is no additional information to that effect not contained in the complaint, the insurer has no duty to defend the action.

c. Coverage questions that turn on facts not at issue in the legal action against the insured. The general rule is that insurers may not use facts outside the complaint as the basis for refusing to defend, with the result that even an insurer with a strong factual basis for contesting coverage must defend under a reservation of rights and then file a declaratory-judgment action to terminate the duty to defend. Only in a declaratory-judgment action filed while the insurer is defending, or in a coverage action that takes place after the insurer has fulfilled the duty to defend, may the insurer use facts outside the complaint as the basis for avoiding coverage. Courts that follow this general rule have identified the five specific exceptions to this rule stated in subsection (3). In these circumstances, courts have allowed insurers to refuse to defend even when the elements of the complaint-allegation rule are otherwise met.

Courts in a few states have recognized a broader, general exception to the complaint-allegation rule that allows insurers to refuse to defend based on their unilateral assessment of any facts that are not at issue in the legal action for which coverage is sought. Although this Section does not recognize this broader exception, a court following this Section could recognize other narrow exceptions on a case-by-case basis, reasoning by analogy to the exceptions stated in subsection (3). Each such case requires striking a balance between the benefits of judicial supervision of the decision to refuse to provide a defense and the benefits of avoiding the need for declaratory-judgment actions in cases in which undisputed facts, not at issue in the liability action for which coverage is sought, establish that a legal action is not covered.

Illustrations:

4. Homeowner is sued by Guest alleging injuries from a slip and fall. Homeowner's liability insurer refuses to defend on the grounds that it has the right to rescind the policy because the Homeowner falsely answered "no" to a question regarding prior convictions on the application for the applicable insurance policy. The insurer has breached the duty to defend because the complaint alleges a covered cause of action and a misrepresentation defense is not one of the exceptions to the complaint-allegation rule listed in § 13(3).

5. Same facts as Illustration 4, except the insurer defends under reservation of rights and files a declaratory-judgment action seeking to terminate the duty to defend. In that declaratory-judgment action, the insurer's duty to defend is determined based upon all the facts and circumstances including any information not included in the complaint that might show that the insurer is entitled to rescind the policy for misrepresentation.

6. Driver is sued by pedestrian alleging injuries from an automobile accident involving Sedan, which is owned by Driver's friend. Driver requests a defense from Insurer solely on the grounds that Insurer issued a policy pursuant to which Sedan is a covered vehicle. Insurer denies coverage on the grounds that Sedan is not a covered vehicle. Sedan is, in fact, not a covered vehicle under the policy. Accordingly, the insurer has not breached the duty to defend.

7. Law firm is sued by ~~client~~Client for malpractice. The law firm does not provide notice of the suit to the insurer on the risk until six months after the end of the applicable claims-made-and-reported insurance policy. The policy contains a condition in the insuring agreement that requires the law firm to report the claim to the insurer no later than 120 days after the conclusion of the policy period. The insurer refuses to defend based on breach of the claim-reporting condition. The insurer did not breach the duty to defend because these are circumstances that qualify under the rule stated in § 35(2), pursuant to which the insurer need not prove prejudice in order to avoid coverage based on the insured's failure to meet the claim-reporting condition.

d. The all-the-facts-and-circumstances approach distinguished. Some commentators have argued in favor of an approach that would permit a liability insurer, without resorting to a declaratory-judgment action, to decline to provide a defense based on all the facts and circumstances available to the insurer at that time. Such an all-the-facts-and-circumstances approach would go well beyond the kinds of exceptions recognized in subsection (3). Under this approach, when deciding whether to defend a legal action filed against the insured, the insurer would be able to consider any and all circumstances that bear on whether the action is covered. There would be no requirement that the insurer first defend under a reservation of rights and then seek declaratory judgment. Instead, the insurer would be able to refuse to defend based on its unilateral assessment of the coverage-relevant facts. Under this approach, the insurer could even refuse to defend based on facts that were at issue in the legal action for which the insured sought a defense. Thus, even if a complaint alleged facts that, if proven, would give rise to a covered claim, the insurer could decline to defend the case, without resort to a declaratory-judgment action, if the insurer decided that facts outside of the complaint would demonstrate that the claim was not covered. The insurer would have breached the duty to defend only if it were subsequently determined that the insurer's assessment of all the facts and circumstances was wrong.

The problem with this approach, which has not found favor in the courts, is the uncertainty it would create for insureds, who would in a wider range of situations be put in a position of having to finance their own defense and then to bring a separate breach-of-contract action against their insurers to recoup those costs. The possibility of such an after-the-fact

remedy would be of little comfort to insureds, who would find such litigation expensive and daunting. By contrast, under the rule followed in this Section, which is the clear majority rule, there is substantially less uncertainty borne by insureds regarding when they can expect to receive a defense from their insurer. As long as the complaint contains allegations that, if proven, would form the basis of a covered action, or the insurer obtains evidence outside of the complaint that supports coverage, the insured can be confident of receiving a defense, except in the limited circumstances permitted by subsection (3).

e. Duty to defend is independent of the merits of the legal action. The insurer’s duty to defend does not depend on the likelihood of the claimant’s success in the legal action. In almost every case in which an insured is named as a defendant in a lawsuit, the insured will need a lawyer to provide a defense—to investigate the plaintiff’s factual assertions, to determine the credibility of the evidence, and to evaluate the legal theory on which the legal claim is based. Only in a subset of cases will payment of a judgment be required. In the absence of a defense from the insurer, the insured could be forced by a nonmeritorious lawsuit either to pay an out-of-pocket settlement or to incur large legal bills to defend against the suit.

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

REPORTERS’ NOTE

a. The duty to defend and the complaint-allegation rule. See, e.g., *Stevens v. United Gen. Title Ins. Co.*, 801 A.2d 61, 66 n.4 (D.C. 2002) (reporting that “the majority of jurisdictions

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follow “[the] ‘eight corners rule’ (that is, a comparison of the ‘four corners’ of the complaint with the ‘four corners’ of the policy).”). As one commentator has explained,

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

3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.01[2][a] (Lexis 2012). ~~See also *Pancakes of Haw. v. Pomare Props. Corp.*, 944 P.2d 83, 89-91 (Haw. Ct. App. 1997) (applying Hawai‘i law) (holding that under the complaint-allegation rule, the duty to defend is construed broadly and is triggered when “any of the allegations in the complaint potentially include conduct that is covered by the indemnity contract.”);~~ 2017). ~~See also~~ *Montrose Chemical Corp. of Cal. v. Superior Court*, 861 P.2d 1153, 1160 (Cal. 1993) (“Any doubt as to whether the facts establish the existence of the defense duty must be resolved in the insured’s favor.”); *Frontier Ins. Co. v. State*, 662 N.E.2d 251, 253 (N.Y. 1995) (citation omitted) (holding that an insurer may demonstrate no duty to defend “only if it can be concluded as a matter of law that there is no possible factual or legal basis on which the insurer will be obligated to indemnify the insured”).

The rule that “the insurer must defend any suit whose allegations would fall within coverage if the allegations were proved to be true” has become “hornbook law.” KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 631584 (56th ed. 20102015). See also C. T. Drechsler, Annotation, *Allegations in third person’s action against insured as determining liability insurer’s duty to defend*, 50 A.L.R.2d 458 § 4 (originally published in 1956) (“It appears to be well settled that, generally speaking, the obligation of a liability insurance company under a policy provision requiring it to defend an action brought against the insured by a third party is to be determined by the allegations of the complaint in such action.”); Ellen S. Pryor, *The Tort Liability Regime and the Duty to Defend*, 58 MD. L. REV. 1, 23 (1999) (“The almost universally-used approach is the eight-corners rule: one takes the allegations in the plaintiff’s complaint, assumes the truth of those allegations without resorting to evidence extrinsic to the complaint, and then asks whether these allegations, if true, would establish a liability covered under the policy.”).

b. The potential for coverage. The law is “almost equally clear that the insurer must defend even when the complaint does not allege facts within coverage, if the insurer possesses extrinsic information that the claim ~~probably~~ does fall within coverage.” KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 631584 (56th ed. 20102015). For courts holding that facts outside of the complaint can trigger a duty to defend, see, e.g., *Great Divide Ins. Co. v. Carpenter*, 79 P.3d 599, 616 (Alaska 2003) (internal citations omitted) (“If the complaint does not contain allegations indicating coverage, there is nonetheless a duty to defend

if facts underlying the complaint are within, or potentially within, the policy coverage and are known *or reasonably ascertainable* by the insurer.”) (emphasis added); *Hyundai Motor America Am. v. National Nat’l Union Fire Ins. Co.*, 600 F.3d 1092, 1097-1098 (9th Cir. 2010) (applying California law) (“Determination of the duty to defend depends, in the first instance, on a comparison between the allegations of the complaint and the terms of the policy. But the duty also exists where extrinsic facts known to the insurer suggest that the claim may be covered.”) (quoting *Scottsdale Ins. Co. v. MV Transp.*, 115 P.3d 460, 466 (Cal. 2005)); *Pennzoil Co. v. U.S. Fidelity and Guar. Co.*, 50 F.3d 580, 583 (8th Cir. 1995) (applying North Dakota law) (“[T]he rule that has evolved in most jurisdictions is that, if the insurer acquires actual knowledge of additional facts [beyond the complaint] that establish a reasonable possibility of coverage, the duty to defend is triggered, even if the insurer made an appropriate initial decision not to defend”). See also *Fitzpatrick v. American Am. Honda Motor Co.*, 575 N.E.2d 90, 93-94 (N.Y. 1991):

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

For a 50-state survey of court decisions regarding the use of extrinsic evidence in determining the insurer’s duty to defend, see [1-5](#) RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~111 et seq.~~ [§ 5](#) (3d ed. 2015). Maniloff and Stempel point out that “[w]hile many states adhere to the ‘four corners’ rule, about twice as many do not and have concluded that extrinsic evidence can be considered by a court in its duty to defend determination.” *Id.* at ~~112~~ (referring in that discussion to use of extrinsic evidence to expand the insurer’s duty to defend, not to narrow it). For authority that the court may consider all the facts and circumstances in a declaratory-judgment action brought while the insurer is defending under a reservation of rights, see, e.g., *Estate of Sustache v. Am. Family Mut. Ins. Co.*, 751 N.W.2d 845, 852 (Wis. 2008). Illustration 1 is based on *Gray v. Zurich Ins. Co.*, 419 P.2d 168 (Cal. 1966). Illustration 2 is based on *Thornton v. Paul*, 384 N.E.2d 335 (Ill. 1978).

c. Coverage questions that turn on facts not at issue in the legal action against the insured. For authority regarding the general rule that insurers may not consider facts outside the complaint to avoid the duty to defend, see, e.g., *Woo v. Fireman’s Fund Ins. Co.*, 164 P.3d 454, 459 (Wash. 2007) (“The insurer may not rely on facts extrinsic to the complaint to deny the duty to defend—it may do so only to trigger the duty.”). See also *Capital Environmental Services, Inc. v. North River Ins. Co.*, 536 F. Supp. 2d 633, 642 (E.D. Va. 2008):

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

~~Accord~~ *York Ins. Group of Maine v. Lambert*, 740 A.2d 984, 985-986 (Me. 1999) (holding that the court could not consider extrinsic evidence to allow the insurer to avoid its duty to defend); *Fitzpatrick v. Am. Honda Motor Co., Inc.*, 575 N.E.2d 90, 92 (1991) (“the courts of this State have refused to permit insurers to look beyond the complaint’s allegations to avoid their obligation to defend”). See also ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW [834801](#) (45th ed. [20072012](#)) (“Insurers are not allowed to refuse to defend when the complaint makes allegations within coverage simply because the insurer has knowledge of extrinsic evidence showing that the complaint’s allegations are incorrect or untrue”); ~~DAVID L. LEITNER ET AL.~~; [ROBERT P. REDEMANN & MICHAEL F. SMITH](#), LAW AND PRAC. OF INS. COVERAGE LITIG. § 4:14 (July [20122017](#)) (“For an insurer to avoid the obligation to defend, it must be concluded *as a matter of law* that there is no possible factual or legal basis on which the insurer might eventually be held obligated to indemnify the insured under any provision of the insurance policy. . . . The insurer is not obligated to defend a suit only when there is no potential for coverage.”) (emphasis added); 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 200:11 (3d ed. [20112017](#)) (“When coverage under the duty to defend depends on an outstanding factual dispute, the disputes must be resolved in favor of coverage until the insurer conclusively establishes that there is ~~not~~no potential for coverage.”).

For authority regarding the specific exceptions to this rule listed in subsection (3), see, e.g., *Edwards v. Lexington Ins. Co.*, 507 F.3d 35, 40-41 (1st Cir. 2007) (permitting the insurer to refuse to defend based on incontestable extrinsic evidence regarding late reporting of a claim under a claims-made policy); *Weingarten Realty Mgmt. Co. v. Liberty Mut. Fire Ins. Co.*, 343 S.W.3d 859, 864 (Tex. ~~Ct.~~ App. 2011) (permitting the insurer to refuse to defend based on incontestable extrinsic evidence to the effect that the defendant was not an insured under the policy); *Rowell v. Hodges*, 434 F.2d 926, 929-930 (5th Cir. 1970) (applying Florida law) (permitting insurer to refuse to defend based on incontestable evidence that the defendant was not driving a covered automobile); *HR Acquisition I Corp. v. Twin City Fire Ins. Co.*, 547 F.3d

1309, 1315 (11th Cir. 2008) (applying Alabama law) (permitting consideration of extrinsic evidence regarding application of the pending-litigation exclusion in a claims-made policy); *Worthington Federal Bank v. Everest Nat'l Ins. Co.*, 110 F. Supp. 3d 1211, 1235 (N.D. Ala. 2015) (permitting consideration of extrinsic evidence regarding relationship between the current action and a prior action for purposes of determining coverage under a claims-made policy). See also *Navajo Freight Lines, Inc. v. Liberty Mut. Ins. Co.*, 471 P.2d 309, 315 (Ariz. Ct. App. 1970):

[C]ontractual provisions generally impose an obligation to defend against any suit alleging the occurrence of risks ~~against the insured~~ against even if the suit is groundless, false, or fraudulent However, these contractual provisions do not purport to obligate the insurer to defend a complete stranger to the contract. A *Sine qua non* to the existence of any obligation to defend, or pay, whether the suit be groundless or otherwise, is the pre-existing relationship of the insurer-insured.

There is some authority in favor of a broader exception. See *Pompa v. American Am. Family Mutual Insurance Co.*, 520 F.3d 1139, 1147 (10th Cir. 2008) (applying Colorado law) (permitting insurer to refuse to defend based on “an indisputable fact that is not an element of either the cause of action or a defense in the underlying litigation”); *Blake v. Nationwide Ins. Co.*, 904 A.2d ~~1071~~1071, 1076 (Vt. 2006) (permitting insurer to consider extrinsic evidence regarding undisputed “actual/factual questions not covered in the complaint, namely, whether the accident occurred in the scope of employment,” which was not at issue in the underlying litigation); *Farm Family Mut. Ins. Co. v. Whelpley*, 767 N.E.2d ~~1101~~1101, 1104 (Mass. App. Ct. 2002) (“this case falls within one of the rare exceptions to the rule that an insurer has a duty to defend as long as the complaint states or adumbrates a claim within the coverage [citation omitted], that exception being the existence of an undisputed extrinsic fact that takes the case outside of the coverage and that will not be litigated at the trial of the underlying action”); *Nationwide Mutual Fire Insurance Ins. Co. v. Keen*, 658 So. 2d 1101, 1103 (Fla. Dist. Ct. App. 1995) (“if uncontroverted evidence places the claim outside of coverage, and the claimant makes no attempt to plead the fact creating coverage or suggest the existence of evidence establishing coverage, we think the carrier is relieved of defending”). In addition, there are a small number of published opinions from courts in jurisdictions outside of Vermont and Massachusetts that permit the insurer to refuse to defend based on extrinsic evidence regarding facts not at issue in the underlying litigation in circumstances that do not fit within the exceptions noted in subsection (3), but the opinions do not express the view that there should be a broader exception to the complaint-allegation rule. Indeed, the opinions generally do not indicate an awareness that the court is acting contrary to the complaint-allegation rule. See, e.g., *Bilyeu v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 184 So. 3d 69 (La. Ct. App. 2015) (permitting insurer to consider extrinsic evidence regarding the date of the wrongful act for purposes of the application of a prior-act exclusion in a claims-made policy); *Acosta, Inc. v. Nat'l Union Fire Ins. Co.*, 39 So. 3d 565 (Fla. Dist. Ct. App. 2010) (examining complaint in prior case to evaluate whether a prior-litigation exclusion applies).

Ch. 2. Management of Potentially Insured Liability Claims

§ 12

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

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

e. Duty to defend is independent of the merits of the legal action. See, e.g., *Miller v. Westport Ins. Corp.*, 200 P.3d 419, 423 (Kan. 2009) (in contracts that provide a duty to defend, the insurer “is contractually obligated to defend even meritless suits that fall within the coverage.”) (quoting *JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW*, § 111[a] at 826-827 (4th ed. 2007)); *Abouzaid v. Mansard Gardens Associates, LLC*, 23 A.3d 338, 347 (N.J. 2011) (“Notably, the potential merit of the claim is immaterial: the duty to defend ‘is not abrogated by the fact that the cause of action stated cannot be maintained against the insured either in law or in fact—in other words, because the cause is groundless, false or fraudulent’.”) (quoting *Danek v. Hommer*, 100 A.2d 198 (N.J. Super. Ct. App. Div. 1953)); see also *Scottsdale Ins. Co. v. Subscription Plus, Inc.*, 299 F.3d 618, 622-623 (7th Cir. 2002):

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

f. The “suit” requirement. See ~~Mark Bradford, *What Constitutes a Suit*, in DRI~~Tanya T. Austin, *INSURER’S DUTY TO DEFEND: A COMPENDIUM OF STATE LAW* ~~59 (2005)~~, 2016 DRI-INSDD 96 (2016), which provides a useful explanation of the different understandings of suit. Compare, e.g., *Foster-Gardner, Inc. v. National Nat’l. Union & Fire Ins. Co. of Pittsburgh*, 959 P.2d 265, 282 (Cal. 1998) (declining to require insurer to defend based on a governmental demand letter); *Lapham-Hickey Steel Corp. v. Protection Mutual Ins. Co.*, 655 N.E.2d 842, 847-848 (Ill. 1995) (same) with *Compass Ins. Co. v. City of Littleton*, 984 P.2d 606, 622 (Colo. 1999) (holding that coercive actions begun by government demand letters are “suits”); *Hazen Paper Co. v. USF&G Co.*, 555 N.E.2d 576, 579-580 (Mass. ~~1998~~1990) (same). See also STEVEN

PLITT & JORDAN ROSS PLITT, 1 PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 2:8 (~~2012~~2017) (stating that the broader interpretation of suit is the significant majority view).

§ 14. Duty to Defend: Basic Obligations

When an insurance policy obligates an insurer to defend a legal action:

(1) Subject to the insurer’s right to terminate the defense under § 18, the insurer has a duty ~~to defend the action includes the obligation~~ to provide a defense of the action that:

(a) Makes reasonable efforts to defend the insured from all of the causes of action and remedies sought in the action, including those not covered by the liability insurance policy; and

(b) Requires defense counsel to protect from disclosure to the insurer any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer’s duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured;

(2) The insurer may fulfill the duty to defend using its own employees, except when an independent defense is required; and

(3) Unless otherwise stated in the policy, the costs of the defense of the action are borne by the insurer in addition to the policy limits.

Comment:

a. Importance of the duty to defend. Liability insurance not only provides financial protection against judgments; it also protects insureds against the liability action itself. Some liability insurance policies highlight this protection by stating that the insurer will defend a suit even if it is “groundless, false or fraudulent.” The insurer’s promise to defend a legal action provides litigation insurance that is at least as important as the insurer’s promise to pay a judgment or settlement.

b. The duty to defend the whole action. It is often said that the insurer has a duty to defend the “whole claim.” This Section states that rule more precisely: the insurer’s duty is to defend the insured from all of the causes of action and remedies sought in a suit or other proceeding that the

insurer has the duty to defend. This way of stating the duty distinguishes between judgment risks and non-judgment risks. Judgment risks are the potential direct legal consequences of the legal action to the insured: the entry of judgment and the associated obligation to pay damages or provide other remedies. Those risks are sometimes not fully insured because the damages may exceed the policy limits, some of the remedies sought may be of a type that is not insured by the policy, or the insurer may have a ground for contesting coverage. The insurer's duty to defend includes the obligation to provide a defense of the legal action that makes reasonable efforts to defend the insured from all of the judgment risks, whether they are insured or not, as long as there is one actual or potential cause of action that is covered. Non-judgment risks are the other possible consequences of the legal action, such as loss of reputation or goodwill. Such risks typically are not insured. In defending the insured against judgment risks, insurers as a practical matter do protect insureds against non-judgment risks, but courts have not identified specific obligations regarding non-judgment risks. Thus, the insurer's duties with regard to non-judgment risks are subject only to the obligations it agrees to assume as well as the general duty of good faith and fair dealing.

Illustrations:

1. An individual insured with a \$100,000 limit liability insurance policy with the duty to defend cut off a stranger's foot with a lawn mower. The stranger files suit for negligence seeking \$1 million in damages. The insurer must defend the suit as if it faced liability for the full extent of the claimed damages.

2. Insured Company supplies a piping system to a manufacturer for use in a manufacturing plant. Due to defects in the pipe, the piping system leaks, causing some damage to a part of the plant other than the piping system and requiring the plant to be shut down while the piping system is replaced. Manufacturer sues Company for the damage to the plant, the costs of replacing the piping system, and lost profits and consequential damages from the shutdown. Company is insured under a general-liability insurance policy with the duty to defend. Notwithstanding the fact that the policy excludes coverage for property damage to Company's product arising out of that product, and, thus, a significant portion of the potential damages is unlikely to be insured, the

insurer must defend the suit as if it faced liability for the full extent of the claimed damages.

3. Insured Company is sued by a former business partner for breach of contract, intentional interference with contractual relations, and defamation. Under Company’s general-liability policy, which includes the duty to defend a covered suit, a suit seeking damages solely because of breach of contract or intentional interference with contractual relations would not be covered. The policy provides coverage, however, for suits seeking damages because of “personal injury,” which is defined in a manner that includes the allegations of defamation in the suit, and there are no exclusions in the policy that would apply to the defamation allegations in this suit. Because the suit includes allegations of defamation that, if proven, would be covered by the policy, the insurer must defend the suit as if it faced liability for the full extent of the claimed damages.

c. Benefits to insurers and insureds. The rule that the duty to defend a legal action requires the insurer to make a reasonable effort to protect the insured against all causes of action and remedies sought in that legal action addresses a potential conflict of interest between insurers and their insureds that could otherwise arise when only a portion of an action being defended by the insurer is covered. The rule provides a benefit to both parties. The reasonable-effort requirement benefits insurers by allowing them to scale the defense effort to the judgment risk at stake in a legal action: what is reasonable will generally depend on the expected value of the potential damages or other remedies, taking into account the probability of the plaintiff’s success. The requirement that the defense protect the insured against all of the causes of action and remedies sought in the legal action benefits insureds by reducing the insurer’s incentive to underinvest in the defense of a legal action that poses a mix of insured and uninsured causes of action or remedies.

d. Relationship to the law of lawyering. The rules stated in this Section are insurance-law rules. When the law of lawyering provides additional protection for the insured, that protection is incorporated in the insurer’s duty to defend through the general obligation to appoint a defense lawyer under conditions that comply with the law governing lawyers. See, e.g., Restatement Third, The Law Governing Lawyers § 134 (regarding compensation or direction of a lawyer by a third person).

e. Protecting the insured's confidential information. Because of the potential for uninsured risks, there are circumstances in which confidential information of the insured could be used to benefit the insurer at the expense of the insured—for example, confidential information that would assist the insurer to avoid coverage for a legal action. In such circumstances, as stated in § 11, the insurer does not have the right to receive that confidential information from defense counsel, notwithstanding that such information may be relevant to the defense or settlement of the claim. This Section states the corollary rule that the insurer's duty to defend includes the obligation to arrange the defense so that the lawyer retained by the insurer does not have an obligation to the insurer to reveal such confidential information, directly or indirectly, including through withdrawal from the representation of the insured.

This rule is consistent with the Restatement Third, The Law Governing Lawyers, which expressly declined to address the relationship between insurer and insured. See Restatement Third, The Law Governing Lawyers § 134, Comment *a*. Indeed, Comment *f* to § 134 of the Restatement Third, The Law Governing Lawyers, which states that a lawyer may be obligated to withdraw from the representation in certain circumstances, illustrates the need for an insurance-law rule requiring the insurer to arrange the representation to avoid those circumstances, so that the lawyer does not have an obligation to the insurer that would obligate the lawyer to withdraw in a manner that may alert the insurer to the potential availability of a ground for contesting coverage. The rule in subsection (1)(b) does not restrict the lawyer's ability to withdraw from the representation for other reasons that are required or permitted under the law governing lawyers, such as when a client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent. See § 11, Comment *d* (regarding management of the burden placed on defense counsel).

Illustration:

4. Insured child is sued for property damage arising out of a fire allegedly started by the child at school. Insurer hires a defense lawyer to defend the insured. During a private meeting with the child and the child's parents, the attorney obtains information indicating that the child may have intentionally set the fire for the purpose of damaging the school. Because this information could be used by the insurer to avoid coverage for the suit, the defense lawyer may not provide this information to the insurer without the

consent of the parents. The parents instruct the lawyer not to provide the information to the insurer. The insurer has retained the defense lawyer on terms that obligate the lawyer to withdraw from the representation in the event that such a conflict of interest materializes. The withdrawal of the lawyer from the defense is a breach of the insurer's duty to defend because it signals to the insurer that the defense lawyer has come into possession of confidential information that may be useful to the insurer in avoiding coverage for the claim.

f. The insurer's own employees as defense counsel. Liability insurance law permits insurers to fulfill the duty to defend using lawyers who are employees of the insurer, as well as lawyers employed by law firms. These are the kinds of decisions that, subject to adherence to professional and contractual obligations, are appropriately committed to the insurance market and, if necessary, regulatory authorities.

g. The costs of defense. The stated default rule regarding the costs of defense under a duty-to-defend policy is the longstanding approach in the personal liability insurance market. The rule also reflects what was and to some extent remains the prevailing approach in the commercial liability insurance market. (Commercial liability insurance policies became more varied in this regard beginning in the 1970s.) Most purchasers of liability insurance are unlikely to have a sound basis for predicting the costs of defense when deciding how much insurance to purchase. The default rule provides coverage that more closely comports with the expectations of most insureds than the alternative approach in which the costs of defense erode the limits of coverage. See § 22 (on defense-cost-indemnification policies).

REPORTERS' NOTE

a. Importance of the duty to defend. In insurance policies containing a duty to defend, the duty "is a valuable service paid for by the insured and one of the principal benefits of the liability insurance policy." *Woo v. Fireman's Fund Ins. Co.*, 164 P.3d 454, 459-460 (Wash. 2007). Because the duty to defend is a distinct benefit of the policy that protects the insured against the threat of liability:

[I]t is well-recognized that the duty to defend is broader than the duty to indemnify [sic] inasmuch as the duty to defend turns on a complaint's allegations whereas the duty to indemnify requires established or litigated facts. A duty to defend limited to and coextensive with the duty to indemnify would be essentially

meaningless; insureds pay a premium for what is partly ‘litigation insurance’ designed to ‘protect the insured from the expense of defending suits brought against him’.

Capital Environmental Services, Inc. v. North River Ins. Co., 536 F. Supp. 2d 633, 640 (E.D. Va. 2008) (applying Virginia law), quoting *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 448 F.3d 252, 258 (4th Cir. 2006). See also *Beckwith Machinery Co. v. Travelers Indem. Co.*, 638 F. Supp. 1179, 1186 (W.D. Pa. 1986) (applying Pennsylvania law) (“[The insurer’s duty to defend] is separate and distinct from its duty to indemnify; the insurer’s duty to defend is broader than its obligation to indemnify the insured.”). In order to effectively protect the insured from the burden of litigation, the obligation to defend “arises whenever allegations against the insured state a claim which is *potentially* within the scope of the policy’s coverage, even if such allegations are ‘groundless, false or fraudulent.’” *Id.*, quoting *Gedeon v. State Farm Mut. Auto. Ins. Co.*, 188 A.2d 320, 321 (Pa. 1963); [KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 624577 \(56th ed. 20102015\)](#) (noting that older policies specified that the duty to defend extended even to suits that are “groundless, false, or fraudulent,” and although this language has since dropped out “[i]n the drive for plain language,” courts will likely “continue to interpret policies as though they contained this clarification.”).

b. The duty to defend the whole action. “In the majority of jurisdictions, an insurer’s duty to defend extends to the entire action, which includes covered, potentially covered, and uncovered allegations within the claim.” 14 [LEE R. RUSS & THOMAS F. SEGALLA STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 200:25 \(3d ed. 20112017\)](#). See also 3 [JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 3-1717.01\[3\]\[a\] \(Lexis 20112017\)](#) (“Virtually all courts agree that if an action contains both potentially covered and noncovered claims—a so-called ‘mixed’ action—the insurer must defend the entire action.”). As explained by one court,

[We](#)[\[W\]](#)[e](#) can, and do, justify the insurer’s duty to defend the entire ‘mixed’ action prophylactically, as an obligation imposed by law in support of the policy. To defend meaningfully, the insurer must defend immediately. To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not. To do so would be time consuming. It might also be futile: The plasticity of modern pleading allows the transformation of claims that are at least potentially covered into claims that are not, and vice versa.

Buss v. Superior Court, 939 P.2d 766, 775 (Cal. 1997) (internal citations and quotation marks omitted). See also *Travelers Cas. & Sur. Co. v. American InternAm. Int’l Surplus Lines Ins. Co.*, 465 F. Supp. 2d 1005, 1013 (S.D. Cal. 2006) (applying California law) (“Even if only a single claim in a multi-count complaint is potentially covered, the insurer normally must defend the entire action.”); *Reinsurance Ass’n of Minnesota v. Timmer*, 641 N.W.2d 302, 307 (Minn. Ct.

App. 2002) (“If a complaint alleges several claims, and *any one* of them would require the insurer to indemnify, the insurer must provide a defense against all claims.”).

c. Benefits to insurers and insureds. Many courts and commentators have recognized that a cause of action exists for a negligently or inadequately handled defense proffered by an insurer pursuant to the duty to defend. See *Lloyd v. State Farm Mut. Auto. Ins. Co.*, 860 P.2d 1300, 1301 (Ariz. Ct. App. 1992) (holding “that an insurer’s voluntary assumption of the duty to defend may give rise to a cause of action for derelictions in that defense even when there is no actual coverage.”); *BellSouth Telecommunications, Inc. v. Church & Tower of Florida, Inc.*, 930 So. 2d 668, 673 (Fla. Dist. Ct. App. 2006) (labeling “meritless” an insurer’s attempted distinction that a case relied on by the insured “involved a failure to provide an adequate defense, rather than a refusal to provide a defense at all”); *Aaron v. Allstate Ins. Co.*, 559 So. 2d 275, 277 (Fla. Dist. Ct. App. 1990) (holding not only that an insured has “a cause of action for inadequate defense” stemming from the insurer’s “duty to adequately defend,” but also that the insured can assign its rights under a suit for breach of that duty to the plaintiff); *Carrousel Concessions, Inc. v. Florida Ins. Guar. Ass’n*, 483 So. 2d 513, 518 (Fla. Dist. Ct. App. 1986) (holding that the “principles” surrounding a breach of the duty to defend “are equally applicable here where it is alleged that the insurer breached its duty to defend because it provided an inadequate defense”); *O’Keefe v. Safeco Ins. Co. of Am.*, 639 P.2d 1312 (Or. Ct. App. 1981) (finding a jury question as to whether the insurer breached the duty to defend by defending a \$2,000,000 action as if it were a \$20,000 action).

e. Protecting the insured’s confidential information. The principle stated in this Section addresses the issue underlying the debate between differing approaches to the tripartite relationship between the defense lawyer, the insured, and the insurer, such as the “primary client” and “equal weighting” approaches. Compare Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101, 146-147 (1998) (explaining why the equal-weighting rule is impracticable) with Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255, 343-348 (1996) (urging an equal co-client approach that would require the defense lawyer to disclose the existence of a conflict of interest and withdraw). See generally ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 892-860 (45th ed. 2007-2012) (discussing what happens when dual representation is not possible). This Section does not take any position on the question of whether the insurer is a client of the defense lawyer, as such matters are properly addressed by the law governing lawyers. Although the law governing lawyers is beyond the scope of this project, it is worth noting that ABA Formal Opinion 08-450 concludes that, even when the insurer is a co-client, the defense lawyer is not obligated to withdraw “if the substantive law precludes the lawyer from acting contrary to the interests of the insured.” As ABA Formal Opinion 08-450 notes, the majority of states require the defense lawyer to treat the insured as either the sole or primary client in the event of a conflict. *Id.* at note 19. Illustration 4 is loosely based on the facts in *Parsons v. Continental National Nat’l Am. Group*, 550 P.2d 94, 96 (Ariz. 1976).

f. The insurer’s own employees as defense counsel. A majority of jurisdictions adhere to the principle set forth in subsection (2). See WILLIAM T. BARKER & CHARLES SILVER, PROFESSIONAL RESPONSIBILITIES OF INSURANCE DEFENSE COUNSEL § 7.02; Denise Purpura, *Should Insurers in Texas Be Prohibited From Using Staff Attorneys to Defend Third Party Claims Brought Against Insureds?: A Closer Look at American Home Assurance*, 13 CONN. INS. L.J. 177, 179 (2006-2007) (“[T]he majority of states have held that the use of staff attorneys by insurance companies neither constitutes the unauthorized practice of law nor violates the professional rules of responsibility.”); ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW ~~§ 114(b)(6) at 903–4868~~ (5th ed. ~~2007~~2012) (“The vast majority of courts and state ethics authorities that have considered the validity of the arrangements [permitting insurer’s use of its own employees to defend] have approved them . . .”). Nonetheless, at least three jurisdictions have held that there is a per se prohibition on an insurer’s use of staff attorneys to defend third-party actions brought against insureds. See *Brown v. Kelton*, 380 S.W.3d 361, 365 (Ark. 2011); *Am. Ins. Ass’n v. Ky. Bar Ass’n*, 917 S.W.2d 568, 570 (Ky. 1996); *Gardner v. North Carolina State Bar*, 341 S.E.2d 517, 520 (N.C. 1986).

g. The costs of defense. In most insurance policies, “the sums paid by the insurer pursuant to its duty to defend are owed in addition to the full policy limit.” 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES, ~~56TH~~ § 4:12 (~~2012~~2017). See, e.g., *DPC Industries, Inc. v. AmericanAm. Specialty Lines Ins.*, 615 F.3d 609, 615 n.3 (5th Cir. 2010) (applying Texas law) (noting that most commercial general-liability policies exclude defense costs from the policy limits); *O’Keefe v. Safeco Ins. Co. of AmericaAm.*, 639 P.2d 1312, 1315 (Or. Ct. App. 1982) (“[The insurer’s] duty to defendant includes the duty to investigate properly and to prepare the case for trial or settlement. This duty is owed to the insured over and beyond the policy limits of coverage and is without limitation.”). “It is well established that the insurer may be obligated to pay the cost of defending a suit against the insured, although these expenses may bring the total amount paid beyond the coverage limits set out in the policy.” 1 ROBERT P. REDEMANN & MICHAEL F. SMITH, LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION § 4:19 (Database Updated ~~June 2013~~July 2017). Nevertheless, policies may provide that defense costs will be capped by policy limits.

[A] policy that provides for a duty to defend subject to an overall limit of liability is ‘cost inclusive.’ Under a cost-inclusive policy, the maximum liability of the insurer is capped by the limit of liability expressed in the policy, and both indemnity payments for claimants and the costs of defending against such claims will be charged against the limit of liability. After the cap is reached, the insurer bears no further obligation under the policy.

Aetna Cas. & Sur. Co. v. Home Ins. Co., 882 F. Supp. 1328, 1335 (S.D.N.Y. 1995). See also *DPC Industries, Inc.*, 615 F.3d at 615 n.3 (contrasting “the typical comprehensive general liability policy where defense costs are excluded from the calculation of the policy limits” with “an eroding policy under which defense costs ‘count’ against and ‘erode’ the policy limits.”); 1

STEVEN PLITT & JORDAN R. PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 2:19 (~~May 2012~~July 2017) (“Where the policy is an eroding policy, the duty to defend terminates once the expenditure of defense costs exceeds the policy limits.”).

§ 15. Reserving the Right to Contest Coverage

(1) An insurer ~~that undertakes the defense of a legal action may later~~may reserve the right to contest coverage for ~~that~~an action ~~only before undertaking the defense of the action~~ if it ~~provides~~gives timely notice to the insured, ~~before undertaking the defense,~~ of any ground for contesting coverage of which it knows or should know.

(2) If an insurer already defending a legal action learns of information, which it did not have constructive notice of under subsection (1), that provides a ground for contesting coverage for that action, the insurer must give notice of that ground to the insured within a reasonable time ~~in order~~ to reserve the right to contest coverage for the action on that ground.

(3) Notice to the insured of a ground for contesting coverage must include a written explanation of the ground, including the specific insurance- policy terms and facts upon which the potential ground for contesting coverage is based, in language that is understandable by a reasonable person in the position of the insured.

(4) When an insurer reasonably cannot complete its investigation before undertaking the defense of a legal action, the insurer may temporarily reserve its right to contest coverage for the action by providing to the insured an initial, general notice of reservation of rights, in language that is understandable by a reasonable person in the position of the insured, but to preserve that reservation of rights the insurer must pursue that investigation with reasonable diligence and must provide the detailed notice stated in subsection (3) within a reasonable time.

Comment:

a. The basis for the reservation-of-rights requirement. The rule requiring insurers to provide timely notice in order to preserve the right to contest coverage was originally grounded in estoppel. The underlying idea is that insureds’ expectations about their liability insurance protection are formed in relation to a full-coverage case. In a full-coverage case, the insurer faces substantially all the risk, and a rational insured not only can safely concede full control over the

defense to the insurer, but also can choose to engage with the defense at the minimal level required to satisfy the duty to cooperate. Once there is the possibility that the insurer may refuse to pay a judgment, however, the insured faces a very different calculus. Now the insurer asserts that it does not face substantially all the risk. That leads to potential conflicts of interest regarding the scope and direction of the defense and settlement strategy. If insureds do not receive notice of the possibility that the insurer may later deny coverage, they are deprived of the opportunity to engage with the defense at a level appropriate to the risk, and they may not realize, for example, that they have the right to independent counsel.

This situation may meet the requirements of estoppel in many cases. For example, the insurer's provision of a defense of an action without providing notice of the potential ground for contesting coverage can be understood as a promise to pay the settlement or judgment that may result. The insured's passive acceptance of, rather than active engagement in, the defense can be treated as reasonable and detrimental reliance on the insurer's promise. There are two problems with grounding this rule entirely in estoppel, however. First, the rule is now so well established that an insurer that does not raise a ground for contesting coverage should be understood to have waived its right to contest coverage in nearly all cases. Second, there are situations in which it would be very difficult for the insured to demonstrate detrimental reliance, particularly in the consumer context. For these reasons, among others, courts in practice have dispensed with the need to explicitly satisfy the requirements of estoppel in the reservation-of-rights context. This Section recognizes that practical reality by stating a simple-to-apply, straightforward rule that requires an insurer to inform the insured about the insurer's possible defenses to coverage at the outset of the defense of a claim, or, pursuant to subsection (4), within a reasonable time thereafter. Insurers that do not timely reserve their rights to contest coverage lose those rights.

b. A ground for contesting coverage. The rules stated in this Section apply to any ground for contesting coverage, without regard to such distinctions as those between conditions and coverage provisions or between policy and coverage defenses. (For purposes other than the reservation-of-rights requirement, some courts distinguish between "coverage defenses," which are based on the insurance- policy terms setting forth the scope of coverage, and "policy defenses," which are based on other rules or requirements such as misrepresentation, non-cooperation, or breach of a condition in the policy. Other courts use these terms

interchangeably.) An insurer that undertakes to provide a defense without providing timely notice to the insured of any ground of any kind for contesting coverage of which it knows or should know loses the opportunity to contest coverage on that basis.

c. Which the insurer knows or should know. What an insurer knows or reasonably should know is a question of fact. In many cases, the relevant facts are amenable to summary resolution by the court. The insurer knows of any information contained in its own records. The insurer also knows of any information obtained by its agents. (Importantly, the defense lawyer is not an agent of the insurer in relation to information germane to any grounds for contesting coverage.) An insurer should know within a reasonable time any allegation contained in any pleading and in any other filing or transcript that a reasonable insurer managing the defense of a case would have reviewed. In addition, the insurer should know of any information that would be obtained through a reasonable investigation. Whether the new information identified in any specific case is something that the insurer should already have known may be readily ascertainable in many cases, particularly by a judge with civil-litigation experience. To the extent that it is difficult to determine whether the insurer should have known this information earlier, however, the insured bears the burden of proof, as is appropriate given the harsh consequences for an insurer that has not adequately reserved its rights.

d. Timing. Insurers are entitled to a reasonable time to investigate in order to identify potential grounds for contesting coverage. If circumstances require an insurer to begin defending a legal action before it has a reasonable time to conclude its investigation, the insurer may preserve the right to contest coverage by providing the insured with a general notice that the insurer is not yet able to make a determination about whether the action is covered. Thereafter, the insurer must timely provide the specific notice required by this Section in order to avoid losing a potential ground for contesting coverage. In some cases, an insurer may be required to provide multiple notices. For example, depending on the circumstances, an insurer may be obligated to provide a general notice at the outset of undertaking a defense, a specific notice once it has completed its initial investigation, and yet another notice when it later learns of additional facts that provide a basis for another ground for contesting coverage.

e. No right to reject the defense. This Section does not follow a minority rule that gives an insured the option to “reject the defense” under a reservation of rights issued pursuant to a liability insurance policy that does not explicitly grant the insured this option. Under this “reject the defense” rule, an insurer, in effect, gives up the right to defend whenever it provides notice to the insured of a potential ground for contesting coverage: the insured may choose to allow the insurer to continue defending under a reservation of rights, but it has the option of hiring and paying the lawyer directly and later seeking reimbursement from the insurer. This rule has been justified on the grounds of protecting insureds from conflicts of interest. Yet, managing conflicts of interest does not require the insurer to relinquish the right to defend in every case in which the insurer reserves the right to contest coverage. A reservation of rights undeniably reduces the alignment of interest between insurer and insured from that of a full-coverage case, but other rules governing the duty to defend and the duty to make reasonable settlement decisions better protect the insured than a rule that gives the insured the option of self-funding its own defense and then seeking reimbursement.

In some cases, the independent-defense requirement of § 16 provides better protection to insureds than the “reject-the-defense” rule, because the insurer is required to pay for an independent defense on an ongoing basis. In other cases, insureds are protected by the rule stated in § 14 requiring the insurer to provide a defense that makes reasonable efforts to protect them from all the judgment risks posed by the legal action and the rule stated in § 25(3) authorizing them to settle without the insurer’s consent unless the insurer waives any grounds for coverage. Moreover, a reject-the-defense approach would be meaningless in many, if not most, cases involving consumer insureds, as such insureds are unlikely to have the resources to self-fund the defense of a legal action.

Nevertheless, the rules stated in this Section do not prohibit parties from entering into insurance contracts that provide the insured the right to reject the defense. In addition, insureds that wish to have the option to reject the defense may also contract for that right through a claims-handling agreement, which is a common form of contract entered into as part of a liability insurance program assembled by commercial policyholders.

REPORTERS' NOTE

a. The basis for the reservation-of-rights requirement. In most jurisdictions, “if an insurer conducts an insured’s defense without timely reserving its right to deny coverage, it cannot later disclaim based on any policy defense as to which it was on notice at the time it assumed the insured’s defense.” 1 ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 2:7 (6th ed. ~~2013~~2017). See also *Gibson v. Preferred Risk Mut. Ins. Co.*, 456 S.E.2d 248, 250 (Ga. Ct. App. 1995) (“[I]f a liability insurer, with knowledge of a ground of forfeiture or noncoverage under the policy, assumes and conducts the defense of an action brought against the insured, without disclaiming liability and giving notice of its reservation of rights, it is thereafter precluded in an action upon the policy from setting up such ground of forfeiture or noncoverage.”), quoting *Jones v. Ga. Cas., etc., Co.*, 78 S.E.2d 861, 864 (Ga. Ct. App. 1953); 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 202:64 (3d ed. ~~2011~~2017) (“Where an insurer defends its insured in an underlying action but neither defends under a reservation of rights nor files a declaratory judgment proceeding, an insurer may be estopped from denying its own liability under the policy”); 3 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 16.03[3][a] (Lexis ~~2012~~2017) (stating the general rule that “[i]f ~~an~~the insurer provides a defense without indicating that it reserves the right to deny coverage, it will typically be deemed to have acknowledged coverage and may be estopped to later deny coverage.”).

Although the requirement that the insurer must reserve its rights was originally grounded in estoppel, “a review of the case law reveals it has since developed into a distinct doctrine that stands on its own.” *Employers Ins. Of Wausau v. Ehlco Liquidating Trust*, 708 N.E.2d 1122, 1135 (Ill. 1999). See also *Pendleton v. Pan Am. Fire & Cas. Co.*, 317 F.2d 96, 99 (10th Cir. 1963) (applying New Mexico law) (citation omitted) (“[T]his case is controlled by the long established rule that a liability insurance carrier, which assumes and conducts the defense of an action brought against its insured with knowledge of a ground of forfeiture or noncoverage under the policy, and without disclaiming liability or giving notice of a reservation of its right to deny coverage, is thereafter precluded in an action upon the policy from setting up the ground of forfeiture or noncoverage as a defense. In other words, the insurer’s unconditional defense of an action brought against its insured constitutes a waiver of the terms of the policy and an estoppel of the insurer to assert the defense of noncoverage.”); *Collins v. Orange Mut. Cas. Co.*, 706 N.E.2d 856, 859 (Ohio Ct. App. 1997) (“Generally, ‘the doctrine of waiver cannot be employed to expand the coverage of a policy.’ [citation omitted] An exception to that general rule may occur, however, when the insurer provides a defense to the insured without reserving its rights under the policy.”). Treating the doctrine as distinct from estoppel relieves the insured of the “impossible burden of proving that he or she is demonstrably worse off because of having been denied the opportunity to assert his or her rights.” 1 WINDT § 2:10. Many courts have therefore either adopted a non-rebuttable presumption of prejudice or else determined that prejudice occurs as a matter of law when the insurer defends without reserving its rights. See *Knox-Tenn Rental*

Co. v. Home Ins. Co., 2 F.3d 678, 684 (6th Cir. 1993) (applying Tennessee law) (“The rule regarding an insurer’s failure to inform an insured that it was defending pursuant to a reservation of rights by its very language establishes the presumption of prejudice. Otherwise, there would be no necessity for its promulgation.”), quoting [American Am. Home Assur. Co. v. Ozburn-Hessey Storage Co.](#), 817 S.W.2d 672, 675 (Tenn. 1991); [Transcontinental Ins. Co. v. J.L. Manta, Inc.](#), 714 N.E.2d 1277, 1282 (Ind. Ct. App. 1999) (“[A]n insured suffers prejudice as a matter of law where an insurer, without reserving its rights and giving the insured an opportunity to determine whether to accept the tender of defense, assumes a complete defense of the underlying suit against the insured and controls the litigation for an extended period of time after becoming aware of a coverage defense.”).

b. A ground for contesting coverage. [Cozzens v. Bazzani Bldg. Co.](#), 456 F. Supp. 192, 200 (E.D. Mich. 1978) (applying Michigan law) (holding the sufficiency of a reservation “doubtful,” even though it set out the language of the pertinent exclusions verbatim, on grounds that the notice was directed at a layman and yet was “silent as to the meaning of the specific exclusions and as to how and why [the exclusions] would apply”); [Harleysville Group Ins. v. Heritage Communities, Inc.](#), ~~2017 WL 105021~~[Inc.](#), ~~803 S.E.2d 288, 297-299~~ (S.C. ~~2016~~2017) (holding that a general reservation-of-rights letter that contained a cut and paste of the insurance policy was insufficient to reserve the insurer’s right to contest coverage based on an exclusion in the liability insurance policy); [World Harvest Church, Inc. v. GuideOne Mut. Ins. Co.](#), 695 S.E.2d 6, 10 (Ga. 2010) (oral reservation of rights is insufficient); [Bogle v. Conway](#), 433 P.2d 407, 412 (Kan. 1967) (finding inadequate a reservation notice that made “no mention of any exclusionary clause in the policy or of any purported factual basis upon which a denial of coverage might be predicated”); [Mobil Oil Corp. v. Maryland Cas. Co.](#), 681 N.E.2d 552, 560 (Ill. App. Ct. 1997) (“A notice of a reservation of rights must make specific reference to the policy defense to be asserted by the insurer and to the potential conflict of interest.”); [Richards Mfg. Co. v. Great Am. Ins. Co.](#), 773 S.W.2d 916, 919 (Tenn. Ct. App. 1988) (“notice will be held sufficient only if it fairly informs the insured of the insurer’s position”); [Weber v. Biddle](#), 483 P.2d 155, 159 (Wash. Ct. App. 1971), quoting [Meirthew v. Last](#), 135 N.W.2d 353, 355 (Mich. 1965) (suggesting that a reservation-of-rights letter “smacks of bad faith” if it is in “for want of specific reference to that clause of the policy the garnishee has pleaded”). See generally 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~[STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 202:64 (3d ed. ~~2011~~2017) (discussing the sufficiency of a reservation of rights).

c. Which the insurer knows or should know. An insurer’s undertaking of a defense will only preclude it from disputing coverage if it failed to reserve its rights “after having received information sufficient to put it upon inquiry as to the ground of nonliability which it later seeks to assert against the insured.” 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~[STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 202:59 (3d ed. ~~2011~~2017). See also [First United Bank of Bellevue v. First Am. Title Ins. Co.](#), 496 N.W.2d 474, 480 (Neb. 1993) (identifying a “widely recognized” exception to the typical estoppel rule

that holds “when an insurance company assumes the defense of an action against its insured, without reservation of rights, and with knowledge, actual or presumed, of facts which would have permitted it to deny coverage, it may be estopped from subsequently raising the defense of non-coverage.”); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.03[3][d][i] (Lexis ~~2012~~2017) (“If an insurer, having notice of possible grounds to deny indemnification, assumes control of an insured’s defense without reserving its right to deny coverage on such grounds, it may later be estopped to deny.”). Any possible basis for contesting coverage arising from information in the complaint or within the insurer’s actual possession must, therefore, be specified in a reservation of rights. See, e.g., *Founders Ins. Co. v. Olivares*, 894 N.E.2d 586, 593 (Ind. Ct. App. 2008) (finding the insurer was estopped to deny coverage when the allegations clearly named a driver explicitly excluded under the policy, and the insurer failed to prove that it notified the insureds of its “excluded driver” defense before assuming their defense).

An insurer will also be deemed to know or be on notice of any information that would have been uncovered in a reasonable investigation of the action. See, e.g., *City of Carter Lake v. Aetna Cas. and Sur. Co.*, 604 F.2d 1052, 1062 (8th Cir. 1979) (applying Nebraska law) (finding that the insurer could not dispute coverage when it failed to conduct “an early initial investigation and [consider] all possible lines of defense.”); *Beckwith Machinery Co. v. Travelers Indem. Co.*, 638 F. Supp. 1179, 1187 (W.D. Pa. 1986) (applying Pennsylvania law) (holding that the insurer, which had defended the insured for 13 months unconditionally and had failed to conduct a proper investigation, was estopped to deny coverage). See generally 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 202:59 (3d ed. ~~2011~~2017) (“[I]t is the insurer’s duty to investigate all the facts in connection with the supposed loss, as well as any possible defense upon the policy, before undertaking the defense of the case against the insured.”).

d. Timing. See generally 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 202:3 (3d ed. ~~2011~~2017) (discussing procedural rules surrounding the declaratory-judgment action, including timing, issues of joinder and stay, and justiciability). Although insurers are on notice of facts that would have been uncovered in a reasonable investigation, courts have generally allowed them a “reasonable time to investigate the facts to determine [their] acceptance of liability.” *Diamond Serv. Co., Inc. v. Utica Mut. Ins. Co.*, 476 A.2d 648, 656 (D.C. 1984). See, e.g., *Capoferri v. Allstate Ins. Co.*, 322 So. 2d 625, 627 (Fla. Dist. Ct. App. 1975) (holding that initial appearance by insurer’s attorneys did not preclude the insurer from later disputing coverage because the insurer “is entitled to a reasonable time in which to investigate and determine whether it desires to avail itself of any defense that may be found to exist.”). See also 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 202:50 (3d ed. ~~2011~~2017) (“Courts generally allow an insurer the right to reasonably investigate the facts and circumstances underlying the action against the insured, and will not find such actions to be a subsequent waiver” and “[t]he bulk of authority is to the

effect that, assuming that the reservation of rights is sufficiently specific, the insurer will not be estopped or otherwise prevented from asserting, or found to have waived, the defense that the insured’s loss was not covered by the insurance policy”). Therefore, “[a]s long as the insurer conducts any such investigation and analysis with reasonable diligence and promptly notifies the insured of its position once the process is complete, that is generally sufficient.” 3 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 16.03[3][d][i] (Lexis ~~2012~~2017).

While the investigation is underway, however, an insurer must provide a general reservation of rights to put the insured on notice “that the insurer reserves the right to disclaim coverage based on further factual development.” ~~Arthur J. Liederman, *Reservation of Rights/Denial of Coverage Waiver/Estoppel*, 598 PLI/Lit 115(A)(4)(c)(i) (1990)~~ Barry R. Ostrager & Thomas R. Newman, *HANDBOOK ON INSURANCE COVERAGE Disputes* § 2.02(b) (18th ed. 2016). See, e.g., *Standard Fire Ins. Co. v. Donnelly*, 689 F. Supp. 2d 696, 704 (D. Vt. 2010) (“If further investigation is required to ascertain whether coverage is available, the reservation of rights letter (or non-waiver agreement) should state that the insurer reserves the right to disclaim coverage based on further factual development.”), quoting *In re Lynch*, 226 B.R. 813, 816 n.7 (Bankr. D. Vt. 1998). See also 1 ALLAN D. WINDT, *INSURANCE CLAIMS AND DISPUTES*, 56TH § 2:14 (~~2012~~2017) (“The only circumstance, therefore, in which an insurer can properly send a reservation of rights letter in which it merely reserves all of its rights is when it assumes the insured’s defense without having had a reasonable opportunity to analyze the existence of coverage.”).

But once the insurer’s investigation directs it to “information concerning the possible absence of coverage, the insurer must promptly serve upon the insured a reservation of rights.” *AIG Hawaii* Hawai’i Ins. Co. Inc. v. Smith, 891 P.2d 261, 264 (Haw. 1995). See also 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 202:46 (3d ed. ~~2011~~2017) (“When an insurer obtains knowledge . . . which may raise the possibility of conflict between the insurer’s duty to represent and defend the insured and its duty to assume liabilities under the policy, the insurer must promptly provide notice of its reservation of rights on peril of estoppel to assert such policy defenses.”).

e. No right to reject the defense. “[A] reservation of rights does not alter the insurer’s duty to defend; the insurer remains obligated to defend the insured reasonably, responsibly, and in good faith.” Douglas R. Richmond, *Reconsidering the Rejection of Reservation of Rights*, 34 No. 1 Ins. Litig. Rep. 5 § II.C (2012). Numerous courts have therefore held that insurers may defend under a reservation of rights without the insured’s consent. See, e.g., *Draft Systems, Inc. v. Alspach*, 756 F.2d 293, 296 & n.2 (3d Cir. 1985) (applying Pennsylvania law) (“[R]eservations of rights’ letters do not require assent of the insured” to be “valid and effective in Pennsylvania.”); *Walbrook Ins. Co. Ltd. v. Goshgarian & Goshgarian*, 726 F. Supp. 777, 783 (C.D. Cal. 1989) (applying California law) (“[A] survey of the limited number of cases on refusals to consent to reservations of rights from other jurisdictions shows that the modern trend

is to find a unilateral reservation to be effective without the insured’s consent.”); *McGouch v. Ins. Co. of North America*, 691 P.2d 738, 744-745 (Ariz. Ct. App. 1984) (holding that an insurer may defend under a reservation of rights, and “an insured may not condition the insurer’s right to defend upon an agreement by the insurer to waive its right to later litigate the question of coverage.”).

Only a minority of jurisdictions allow insureds to reject a defense under a reservation of rights. Douglas R. Richmond, *Reconsidering the Rejection of Reservation of Rights*, 34 No. 1 Ins. Litig. Rep. 5 § I (2012) (“A defense under a reservation of rights is enormously beneficial to the insured. . . In a few jurisdictions, however, insureds may reject a defense under a reservation.”). See also William T. Barker, *Insurer Control of Defense: Reservations of Rights and Right to Independent Counsel*, 71 DEF. COUNS. J. 16, 17-18 (2004) (“A few states authorize the insured to reject the insurer’s defense whenever there is a reservation of the right to deny indemnification. . . [This doctrine] is not generally accepted.”). For cases adopting the minority rule, see, e.g., *Mid-Continent Cas. Co. v. American Pride Bldg. Co. LLC*, 601 F.3d 1143, 1149 (11th Cir. 2010) (applying Florida law) (“While an insurer must defend its insured, and may tender its defense subject to a reservation of rights, Florida law does not require an insured to accept such a defense.”); *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 120 (5th Cir. 1983) (applying Texas law) (“When a reservation of rights is made, however, the insured may properly refuse the tender of defense and pursue his own defense.”).

The minority rule is sometimes justified as protecting the insureds from a conflict of interest. See, e.g., *Rhodes v. Chicago Ins. Co.*, 719 F.2d at 120 & n.6 (noting that the “reservation of rights serves as notice to the insured of the potential conflict of interest” and enables the insured to “properly refuse the tender of defense and pursue his own defense.”). But “[t]he fact that a case is defended under a reservation of rights . . . does not necessarily mean that there is a conflict of interest” Douglas R. Richmond, *Reconsidering the Rejection of Reservation of Rights*, 34 No. 1 Ins. Litig. Rep. 5 § II.C (2012). See, e.g., *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co.*, 433 F.3d 365, 372 (4th Cir. 2005) (applying South Carolina law) (“[W]e . . . reject the notion that the reservation of rights letter issued in this case creates a per se conflict of interest”); *Rx.com Inc. v. Hartford Fire Ins. Co.*, 426 F. Supp. 2d 546, 559 (S.D. Tex. 2006) (applying Texas law) (“Not every reservation of rights creates a conflict of interest Rather, the existence of a conflict depends on the nature of the coverage issue as it relates to the underlying case.”). See also William T. Barker, *Insurer Control of Defense: Reservations of Rights and Right to Independent Counsel*, 71 DEF. COUNS. J. 16, 18 (2004) (“[M]ost jurisdictions that have addressed the issue consider questions of the right to control the defense in terms of whether there is a conflict of interest, implying that a reservation of rights alone is not enough to deprive the insurer of this right.”). Finally, “if a reservation of rights presents a conflict of interest between the insurer and the insured, a preferable solution would be to require the insurer to provide the insured with independent counsel at the insurer’s expense. This approach assures the insured of an adequate defense without forcing unreasonable

choices on the insurer.” Douglas R. Richmond, *Reconsidering the Rejection of Reservation of Rights*, 34 No. 1 Ins. Litig. Rep. 5 § II.C (2012).

§ 16. The Obligation to Provide an Independent Defense

When an insurer with the duty to defend provides the insured notice of a ground for contesting coverage under § 15 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.

Comment:

a. Common facts at issue in the legal action and the coverage dispute. When there are facts that are common to the claimant’s allegations in the legal action for which a defense is sought and to the insurer’s asserted ground for contesting coverage, there is the risk that the defense of the action may be handled in a manner that advantages the insurer in contesting coverage. This risk exists even if facts adjudicated in the coverage proceeding are not binding in the underlying legal action brought against the insured, because the knowledge gained in the underlying proceeding could be used in the coverage proceeding. Leaving the management of this conflict of interest to the professional judgment of the defense lawyer selected by the insurer may in fact be adequate to protect insureds in most situations, but there are enough examples of mistakes having been made at the insured’s expense to justify a structural, rather than a disciplinary and malpractice-liability, solution. The structural solution stated in this Section—requiring an independent defense—provides better protection to insureds and also increases the legitimacy of liability insurance and defense lawyers within the civil-justice system. This approach is consistent with Restatement Third, The Law Governing Lawyers, which recognizes the potential for conflicts of interest whenever there is a question about insurance coverage for a legal action. See § 134 (Compensation or Direction of a Lawyer by a Third Person), Comment *f* (representing an insured).

Illustrations:

1. When investigating a serious but otherwise routine “slip and fall” involving a repairman at the home of an insured with adequate liability insurance for the resulting suit, the insurer discovers information indicating that the insured has been conducting business at the home, despite having answered “no” to a question in the policy application regarding business at the home. The insurer reserves the right to contest coverage for the suit on the grounds of misrepresentation. Because the facts that will determine the outcome of the misrepresentation defense are different than the facts that will determine the outcome of the slip-and-fall claim, the insurer is not obligated to provide an independent defense.

2. Insured is sued for bodily injury sustained during a fight in a bar. The complaint contains two counts. In the first count, the plaintiff alleges that Insured intentionally assaulted the plaintiff. In the second count, the plaintiff alleges that Insured negligently struck the plaintiff on the head. The insurer reserves the right to contest coverage for the suit based on the “expected or intended” exclusion in the policy. The insurer must provide an independent defense because the intent of the insured is a fact that may affect liability and damages in the suit against the insured as well as the potential coverage contest, thereby creating a risk that the defense of the suit may be handled in a manner that increases the likelihood that the insurer will be able to avoid coverage through the application of the intentional-harm exclusion.

b. Benefit the insurer in contesting coverage. Any reservation of rights creates a divergence between the interests of the insured and the insurer. As long as there is a possibility that the insurer will be able to avoid coverage for the legal action, the insurer has less incentive to defeat that action and, thus, more reason to underinvest in the defense of the action. Liability insurance law protects insureds from insurer underinvestment through the ordinary duty-to-defend requirements (including liability for failure to provide an adequate defense), the ability of insureds to settle without consent under § 25(3), and the potential for bad-faith liability. This independent-counsel requirement is directed at a problem that is qualitatively different than the more routine underinvestment incentive. The independent-counsel requirement addresses the possibility that an insurer may actively manage the defense to avoid coverage for the legal action.

While labels, alone, are not sufficient to convey the distinction, the independent-counsel requirement addresses the risk of sabotage, not underinvestment.

c. Demand for damages in excess of the applicable limits of coverage. A demand for damages in excess of the applicable policy limits creates a potential conflict of interest between the insurer and the insured. Insurance law addresses this conflict through the duty to make reasonable settlement decisions, however, so independent counsel is not ordinarily required. See § 24.

d. Demand for punitive damages. When punitive damages are not insured, a demand for punitive damages exposes the insured to a risk that is analogous in some respects to a demand for damages in excess of the applicable limits of coverage. Because the duty to make reasonable settlement decisions does not require the insurer to take the insured's exposure to an uninsured punitive-damages award into account in making a settlement decision, however, the duty to make reasonable settlement decisions does not address this conflict of interest. Thus, there is the potential for the insurer to “gamble with the insured's money” in those situations in the manner described in § 24, Comment *a*. While troubling, this potential should lead to an independent-counsel requirement only if the defense could be conducted in a manner that benefits the insurer at the expense of the insured. The presence of a punitive-damages claim does not ordinarily lead to this kind of conflict of interest. As long as there is no reservation of rights to deny coverage more broadly, there is not the concern about confidentiality of coverage-related information that would more typically lead to the need for independent counsel. Moreover, efforts to reduce the insured's exposure to covered compensatory damages typically also reduce the insured's exposure to the noncovered punitive damages.

Nevertheless it is possible that a punitive-damages claim could lead to a serious conflict in the defense: for example, if the compensatory damages claimed are so small in relation to the potential punitive damages that the defense of the legal action might otherwise be handled in a hard-edged manner that disproportionately risks exacerbating the punitive-damages exposure or if there was a realistic possibility that the manner of presentation at trial could affect the jury's allocation between pain-and-suffering damages and punitive damages. Accordingly, a bright-line rule is not appropriate. Rather, the question whether an uninsured punitive-damages claim

requires independent counsel is to be determined according to the general rules stated in this Section, together with the law governing lawyers. If the controlling law permits the insured to obtain indemnification for any punitive damages that result from (a) an insurer's mishandling of a case or (b) an insurer's breach of the duty to make reasonable settlement decisions, however, then the presence of an uninsured punitive-damages claim would be unlikely to create the kind of potential conflict of interest that provides the justification for the independent-counsel requirement.

Illustrations:

3. Insured shopkeeper is sued for \$1,000,000 in compensatory damages. The shopkeeper is insured under a business owners' package policy with an applicable liability limit of \$100,000. The insurance company agrees to defend the suit but reserves the right to rescind the policy based on an alleged misrepresentation in the application for the policy. No independent counsel is required. Because there are no facts at issue in the suit that are also at issue in relation to the alleged misrepresentation, and because the insurance law in the jurisdiction obligates the insurer to make reasonable settlement decisions, the insurer is not obligated to provide an independent defense.

4. Insured shopkeeper is sued for \$5000 in compensatory damages and \$100,000 in punitive damages in an action arising out of an altercation in the store in which there is some indication that a store employee acted in a manner that was affected by racial animus. The insurance policy excludes coverage of punitive damages. The insurer agrees to defend, reserving the right to refuse to pay for any punitive damages. Because the extent of the punitive damages sought so greatly exceeds the nominal compensatory damages sought and because there is a realistic potential that the suit could be defended in a manner that would increase the insured's exposure to punitive damages—for example, by failing to adequately attend to the allegations of racial animus—there is a potential conflict of interest. Provided that governing law would permit the insured to obtain indemnification for punitive damages that can be proven to result from either the insurance defense lawyer's mishandling of the defense or from the insurer's breach of the duty to make reasonable settlement decisions, however, the potential conflict is not sufficiently severe to require the insurer to appoint independent counsel. If the governing

law does not clearly permit such indemnification and if the insurer is unwilling to waive any public policy or other defense to a claim for such indemnification, then the insurer must provide independent counsel.

5. Insured individual is sued for compensatory and punitive damages arising out of an automobile accident in which the insured allegedly was intoxicated and the plaintiff suffered disabling injuries. The complaint seeks \$2,000,000 in compensatory damages and unspecified punitive damages. The punitive damages are not insurable in the jurisdiction. The applicable bodily injury limit of the automobile liability insurance policy is \$100,000. The insured does not have other substantial assets that would be available to pay a civil judgment. The insurer agrees to defend, reserving the right to refuse to pay for any punitive damages. Because the allegations involving intoxication could also influence the amount of pain-and-suffering damages that a jury awards and because the amount at risk significantly exceeds the policy limits even in the absence of punitive damages, the insurer's and insured's interests are sufficiently aligned that the claim for punitive damages does not create a conflict of interest sufficient to require the appointment of an independent counsel.

e. Relationship to the law of lawyering. Because the duty to defend includes the obligation to appoint a defense lawyer under conditions that comply with the law governing lawyers, the duty to defend includes the obligation to provide at least as much protection to insureds as required by the law of lawyering. Accordingly, if the law of lawyering requires an independent counsel in circumstances beyond those stated in this Section, or separate counsel when there are multiple insureds, an insurer with the duty to defend must provide such independent or separate counsel, as the case may be. See, e.g., Restatement Third, The Law Governing Lawyers § 134 (regarding compensation or direction of a lawyer by a third person).

REPORTERS' NOTE

a. Common facts at issue in the legal action and the coverage dispute. This Section states a principle that is followed in the majority of jurisdictions. See 4 RONALD E. MALLEN-~~& JEFFREY M. SMITH WITH ALLISON D. RHODES~~, LEGAL MALPRACTICE § 30:2162 (2013~~2017~~ ed.) (“The prevailing rule [for whether an insurer–insured conflict exists] is that the coverage issue must also bear upon a material liability issue, so that the manner of defense can influence

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coverage.”). See, e.g., *Employers Fire Ins. v. Beals*, 240 A.2d 397, 403 (R.I. 1968) (“[A]n insured, when faced with the quandary posited by the facts of the instant case, [in which whether the insured intentionally injured the claimant was a common fact at issue in both the underlying suit and in the determination of coverage], has a legitimate right to refuse to accept the offer of a defense counsel appointed by the insurance company[.]”²¹) (~~abrogated by *Peerless Ins. Co. v. Viegas*, 667 A.2d 785 (R.I. 1995)~~); *Prashker v. U.S. Guarantee Co.*, 136 N.E.2d 871, 875-876 (N.Y. 1956) (holding that, because the defending attorney has a concurrent duty to the insureds to defeat recovery on any ground and a duty to the insurer to defeat recovery only on such grounds as might render the insurer liable, a conflict of interest may arise that should be resolved by allowing the insured to select the attorney to defend the underlying suit and requiring the reasonable value of the professional services rendered to be paid by the insurer). See generally Ellen S. Pryor, *The Tort Liability Regime and the Duty to Defend*, 58 MD. L. REV. 1 (1999) (discussing the circumstances under which an insurer must provide an independent defense); William T. Barker & Charles Silver, *Professional Responsibilities of Insurance Defense Counsel* § 6.04. California has codified this rule in Cal. Civ. Code § 2860. Illustration 2 is modeled on *State Farm Fire and Casualty Co. v. Wicka*, 474 N.W.2d 324 (Minn. 1991).

c. Demand for damages in excess of the applicable limits of coverage. The rule stated in this Section is followed in the majority of jurisdictions. See 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 202:30 (3d ed. ~~2011~~2017) (“The fact that the damages requested by the plaintiff in the underlying tort action exceed the limits of the insurance policy does not generally amount to a conflict of interest sufficient to require the appointment of independent counsel.”). See *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, 20 Cal. App. 4th 1372, 1394 (Cal. Ct. App. 1993) (holding that the insured is not entitled to independent counsel at the insurer’s expense merely because the complaint seeks damages in excess of policy limits, as the duty to appoint independent counsel because of a conflict of interest is not based on insurance law but on the ethical duty of an attorney to avoid representing conflicting interests); ~~*Roussos v. Allstate Ins. Co.*, 655 A.2d 40, 44 (Md. Ct. Spec. App. 1995) (holding that the fact that the potential liability was several times greater than the policy limit did not constitute a conflict of interest and the insurer’s duty to defend thus did not include a duty to pay for independent counsel of the insured’s choosing)~~; Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101, 114-118 (1997-1998) (discussing conflicts of interests arising from a demand for damages in excess of applicable limits of coverage).

d. Demand for punitive damages. For cases involving independent counsel granted as a result of a punitive-damages action, see *Nandorf, Inc. v. CNA Ins. Cos.*, 479 N.E.2d 988, 993 (Ill. App. Ct. 1985) (requiring independent counsel because of the extent of the punitive-damages exposure relative to the compensatory-damages exposure); *Illinois Mun. League Risk Management Ass’n v. Siebert*, 585 N.E.2d 1130, 1139 (Ill. App. Ct. 1992) (holding that a conflict of interest between the insurer and the insureds requires outside counsel paid for by the insurer when allegations against the insured include noncovered, punitive damages); *Parker v.*

Agricultural Ins. Co., 440 N.Y.S.2d ~~964~~964, 968 (N.Y. Sup. Ct., ~~N.Y. Cty.~~ 1981) (“Indisputedly, the great bulk of litigation involving insureds, wherein punitive damages may be routinely tacked onto the ad damnum clause, may be predictably, regularly and properly defended and controlled by the insurer, thus adhering to the general rule. If punitive damages were a negligible or co-equal portion of the total damages sought, defendants’ disclaimers therefor might not be of great significance. But in five actions discussed at the outset punitive damages totaling 169 million dollars exceed compensatory damages more than sixfold.”). Cf. WILLIAM BARKER & CHARLES SILVER, PROFESSIONAL RESPONSIBILITIES OF INSURANCE DEFENSE COUNSEL § 6.04[11] (~~2013~~2017) (discussing the *Nandorf* case and noting that “the separation of compensatory from punitive damages, while sharp in theory, is very indistinct in practice” and that “it is not difficult to imagine that there might be ways of shaping the defense . . . to affect the allocation between the two categories”); Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101, 132-134 (1997-1998) (explaining the conflict of interest). But see Cal. Civil Code § 2860 (West 1987) (“No conflict of interest shall be deemed to exist as to allegations of punitive damages. . .”); Alaska Stat. § 21.96.100(b) (West 2008) (stating that an action for punitive damages does not constitute a conflict of interest).

§ 17. The Conduct of an Independent Defense

When an independent defense is required under § 16:

- (1) The insurer does not have the right to defend the legal action;**
- (2) The insured may select defense counsel and related service providers;**
- (3) The insurer is obligated to pay the reasonable fees of the defense counsel and related service providers on an ongoing basis in a timely manner;**
- (4) The insurer has the right to associate in the defense of the legal action under the rules stated in § 23; and**
- (5) The rules stated in § 11 govern the insured’s provision of information to the insurer ~~does not waive the confidentiality of the information with respect to third parties.~~**

Comment:

a. Insured’s selection of defense counsel. The rule giving the insured the right to select the independent defense counsel is the majority rule. While there are some good arguments in favor of requiring the insured to obtain the insurer’s consent to the chosen counsel, there is no good way to ensure that all insurers act reasonably in withholding consent. There are few

insureds that would be willing to take the risk of using counsel to which the insurer withheld consent or to undertake the effort and expense of bringing a declaratory-judgment action seeking to establish that the insurer was unreasonably withholding consent. If the insured makes an unreasonable choice in the selection of counsel, the insurer has at least three means of recourse. The insurer can explain to the insured the reasons for objecting to the counsel selected and provide alternative sources of independent advice. The insurer can object to the reasonableness of the fees (including the hourly rate and the number of hours or other basis for the fees). In addition, the insurer can, as a condition of the payment of any fees, insist that counsel maintain professional-liability insurance that is adequate to protect the insured (and indirectly the insurer) from the financial consequences of incompetence.

b. Reasonable fees. The reasonableness of defense fees in relation to the complexity of the legal action and the risks at stake is a fact question. What the insurer usually pays lawyers to defend similar actions is relevant, but not dispositive. Law firms regularly retained by an insurer to defend suits commonly accept reduced rates in return for a good supply of business. A lawyer providing an independent defense should not be required to accept the rates paid to the insurer's regular defense lawyers, unless the lawyer so regularly accepts other business at those rates that they represent the reasonable value of his or her services. On the other hand, the rates that the lawyer regularly is paid for other matters or the amount of time spent on the matter in question may be excessive in relation to the complexity of the claim or the amount at stake in the matter. In such cases, the insured should have the option of paying the difference between a reasonable fee and the independent defense counsel's regular fees in order to obtain a defense from that counsel. In the event of a dispute during the course of the defense about the reasonableness of fees, either party should have the option of paying counsel under protest the difference between what the parties contend to be a reasonable fee, and counsel should have the option of receiving under protest what it regards as only a partial payment, and thereby defer the resolution of the reasonableness of the fees until after the duty to defend has ended and any coverage contest has been adjudicated or settled, so as not to invade the attorney-client privilege or work-product immunity.

c. Right to associate. The right to associate is addressed in § 23.

d. Confidentiality of information. The grounds for protecting confidentiality in the independent-counsel context are at least as strong as those in the ordinary duty-to-defend context. See § 11, Comment *a*. The conflict of interest that lies behind the independent-counsel requirement does not eliminate the common interest of insurer and insured in defeating the third-party claim; it does not change the fact that the insurer serves as the insured’s agent for purposes of settling; and it does not eliminate the need for the insurer and insured to share confidential information in a manner that is protected from disclosure to third parties. Moreover, because the insured may in the end be obligated to pay a settlement or judgment that is not covered, the risks to the insured from the potential loss of confidentiality are even greater.

There is a risk in sharing information in a jurisdiction in which courts have not previously agreed with the rule stated in this Section. There are courts that have required the use of certain documentary formalities, such as the appointment of the insurer as the insured’s communicating agent for purposes of managing the dispute or as the insured’s co-client under a common-interest arrangement. Even when such formalities are observed, there may be some risk that disclosure will waive a privilege or immunity, and that risk is greater when an insurer has not unequivocally accepted coverage for the claim.

REPORTERS’ NOTE

a. Insured’s selection of defense counsel. Courts and commentators have differed as to whether the insurer has any control over selection of defense counsel. Under the majority approach, see *CHI of Alaska, Inc. v. Employers Reinsurance Corp.*, 844 P.2d 1113, 1120 (Alaska 1993) and Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857 (2011), the insured has an exclusive right to select independent counsel. The rationale underlying this approach, notes one commentator is that:

a lawyer whom an insurer regularly engages to defend its insureds . . . will either consciously or subconsciously favor the insurer over the insured in any given matter, including one in which coverage may be shaded in favor of the insurer. This incentive is perceived to exist because the lawyer’s relationship with the insurer is continual, supported by a strong financial interest in future assignments, and sometimes characterized by genuine friendships between the lawyer and members of the insurer’s claims or legal staff. Conversely, the lawyer’s relationship with an insured “usually is transitory”, seldom extending beyond a single case or claim. Few insureds are potential sources of future engagements for a defense lawyer.

Richmond, at 862. See also *Union Ins. Co. v. Knife Co., Inc.*, 902 F. Supp. 877, 881 (W.D. Ark. 1995) (interpreting Arkansas law) ([internal citation omitted](#)) (“The law of various states, which appears to be the ‘majority rule’ also supports giving the choice of counsel to the insured in a conflict situation.”). “Even the most optimistic view of human nature,” the Eighth Circuit observed, “requires us to realize that an attorney employed by an insurance company will slant his efforts, perhaps unconsciously, in the interest of his real client—the one who is paying his fee and from whom he hopes to receive future business—the insurance company.” *United States Fid. & Guar. Co. v. Lewis A. Roser Co.*, 585 F.2d 932, 938 n.5 (8th Cir. 1978) (applying Minnesota law). For [other](#) cases holding that the insured has a unilateral right to select independent counsel of its choice, see *Previews Inc. v. California Union Ins. Co.*, 640 F.2d ~~1026~~[1026, 1028](#) (9th Cir. 1981) (applying California law) (interpreting California law to hold that “the insurer’s obligation to defend extends to paying the reasonable value of the legal services and costs performed by independent counsel selected by the insured.”); *CHI of Alaska, Inc.*, 844 P.2d at 1120 (“[T]he insured should have the unilateral right to select independent counsel”); *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc’y*, 208 Cal. Rptr. 494, 501-502 (Cal. Ct. App. 1984) (“[T]he insurer must pay the reasonable cost for hiring independent counsel by the insured—~~—~~.”) [\(superseded by statute as stated in *United Enterprises, Inc. v. Super. Ct.*, 108 Cal. Rptr. 3d 25 \(Cal. Ct. App. 2010\)](#); *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24, 31 (Ill. 1976) (holding that the insured “has the right to be defended . . . by an attorney of his own choice who shall have the right to control the conduct of the case”); [Illinois](#) *Masonic Medical Ctr. v. Turegum Ins. Co.*, 522 N.E.2d 611, 613 (Ill. App. Ct. 1988) (“[W]here a conflict of interest exists the insured, rather than the insurer, is entitled to assume control of the defense of the underlying action; . . . the insurer must underwrite the reasonable costs incurred by the insured in defending the action with counsel of his own choosing.”); *Prashker v. United States Guar. Co.*, 136 N.E.2d 871, 876 (N.Y. 1956) (“[T]he selection of the attorneys to represent the assureds should be made by them rather than by the insurance company, which should remain liable for the reasonable value of the services . . .”). When the insured has the exclusive right to select independent counsel, this right may be affected by the implied covenant of good faith and fair dealing. See, e.g., *CHI of Alaska, Inc.*, 844 P.2d at 1121 (“[T]he covenant of good faith and fair dealing in [the context of selecting independent counsel] requires that the insured select an attorney who is, by experience and training, reasonably thought to be competent to conduct the defense of the insured.”). This restraint “fairly balances the interest of the insured—being defended by competent counsel of undivided loyalty—with the interests of the insurer—having the defense of the insured conducted by competent counsel.” *Id.* Moreover, since the insurer is “only required to pay the reasonable cost of the defense[,]” the insurer is protected “against overbilling—and overlitigating—by independent counsel.” *Id.*

Another set of courts and commentators argues that the right of an insurer to defend its insureds must include “some prerogative . . . beyond simply paying defense costs” and that the insurer cannot, accordingly, “contemplate anything less than its participation in the selection of [defense] counsel.” Federal [Insurance](#) *Ins. Co. v. X-Rite, Inc.*, 748 F. Supp. 1223, 1229 (W.D.

Mich. 1990) (applying Michigan law). Under this approach, the insurer should appoint a lawyer—either from a firm with which it regularly deals or from a preselected list of firms with which it does not regularly deal but which the insurer reasonably believes is competent to represent the insured—with the instruction that the selected lawyers are to “(1) represent the insured alone, (2) consider the insured their sole client, (3) act exclusively in the insured’s best interests at all times and be guided by the insured’s best interests when making all strategic or tactical decisions, and (4) have absolutely no role in coverage issues insofar as the insurer is concerned.” Richmond, at 875 (citing *X-Rite, Inc.*, 748 F. Supp. at 1228 n.1). Dismissing concerns over the potential for misconduct by “allegedly conflicted defense counsel,” *id.* at 869, these courts and commentators are “convinced that the rules governing [state bars] and the attendant threat of malpractice liability provide sufficient assurance that counsel appointed by an insurer would not continue to represent an insured in the event that a conflict of interest interfered with counsel’s ability to make independent professional judgments on behalf of his client.” *Travelers Indem. Co. of Illinois III v. Royal Oak Enterprises, Inc.*, 344 F. Supp. 2d ~~1358~~1358, 1375 (M.D. Fla. 2004) (applying Florida law). See also Richmond, at 876 (“State ethics rules prohibiting conflicts of interest and mandating confidentiality and independence of professional judgment, and potential liability for breach of fiduciary duty and legal malpractice, are powerful incentives for insurer-selected independent counsel to faithfully serve the insureds they are hired to represent.”). For cases following this approach, see *HK Systems, Inc. v. Admiral Ins. Co.*, 2005 WL 1563340, at *16 (E.D. Wis. 2005) (applying Wisconsin law) (predicting that the Supreme Court of Wisconsin would hold that the insurer retains the right either to choose independent counsel or to allow the insured to choose counsel at the insurer’s expense); *United States v. Daniels*, 163 F. Supp. 2d 1288, 1290 (D. Kan. 2001) (applying Kansas law) (noting that, under Kansas insurance-law principles, insurers may hire independent counsel to represent the insured); *Central Michigan Bd. of Trustees v. Employers Reinsurance Corp.*, 117 F. Supp. 2d 627 (E.D. Mich. 2000) (construing Michigan law to hold that the insurer discharged its duty to defend by assigning an attorney and her law firm to defend the insured and was not obligated to honor the insured’s selection of defense counsel at the insured’s own expense).

b. Reasonable fees. Minding the need to protect insurers against “runaway legal fees,” *MetLife Capital Corp. v. Water Quality Ins. Co-Syndicate*, 100 F. Supp. 2d 90, 96 (D.P.R. 2000) (applying Puerto Rico law), an insurer is obligated to pay only reasonable defense costs for independent counsel. See also *Cont’l Cas. Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 940 F. Supp. 2d 898, 928 (D. Minn. 2013) (applying Minnesota law) (citing *Prahm v. Rupp Constr. Co.*, 277 N.W.2d 389, 391 (Minn. 1979)) (“In [the presence of a conflict of interest between an insurer and its insured], an insurer is only required to reimburse its insured for ‘reasonable’ attorneys’ fees.”); *United Pac. Ins. Co. v. Hall*, 245 Cal. Rptr. 99, 102 (Cal. Ct. App. 1988) (holding that the obligation of the insurer to pay for independent counsel “does not delegate to [independent] counsel a meal ticket immunized from judicial review for reasonableness.”). While no single factor controls whether the cost of independent counsel is reasonable, Richmond, at

882, Model Rule of Professional Conduct 1.5(a) suggests a list of eight factors to consider including:

- (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
- (2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
- (3) the fee customarily charged in the locality for similar services;
- (4) the amount involved and the results obtained;
- (5) the time limitations imposed by the client or by the circumstances;
- (6) the nature and length of the professional relationship with the client;
- (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
- (8) whether the fee is fixed or contingent.

A “recurring source of controversy” in obliging insurers to pay for independent counsel is that lawyers selected by the insureds often charge higher rates than the lawyers and firms insurers regularly engage. Richmond, at 881. This, in turn, stems from the fact that insurers, “as frequent and sophisticated purchasers of legal services[,] . . . tend to supply [these] firms with respectable volumes of business” and can “negotiate steep discounts” with their counsel. Id. at 883. Thus, the fact that an insurer’s counsel is compensated at a lower rate “does not compel the conclusion that higher rates proposed by independent counsel are unreasonable.” Id. (citing *N. Sec. Ins. Co. v. R.H. Realty Trust*, 941 N.E.2d 688, 691-693 & n.13 (Mass. App. Ct. 2011) (suggesting that rates typically paid by the insurer to defense counsel are not dispositive as to the reasonableness of legal fees)). But see *Aquino v. State Farm Ins. Cos.*, 793 A.2d 824, 832 (N.J. Super. Ct. App. Div. 2002) (noting that the discounted rates normally paid by insurers to defense counsel may require independent counsel to accept less than its standard rate).

d. Confidentiality of information. See Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857, 892-893 (2011):

Except for information relating to coverage, independent counsel cannot invoke work product immunity or the attorney-client privilege to deny the insurer information it needs to analyze or evaluate the insured’s defense. Independent counsel should not be concerned that sharing information with the insurer will be discoverable by the plaintiff because even though the insurer is not a client, communications between them are immune from discovery under the work product doctrine. . . . Depending on the facts and the jurisdiction, the communications may also be shielded from discovery by the plaintiff by the attorney-client privilege and any insurer-insured privilege. If nothing else, the attorney-client privilege certainly should extend to independent counsel’s communications with the insurer under the ‘common interest’ doctrine.

See also Cal. Civ. Code § 2860(d) (“Any information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.”).

§ 18. Terminating the Duty to Defend a Legal Action

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

- (1) An explicit waiver by the insured of its right to a defense of the action;
- (2) Final adjudication of the action;
- (3) Final adjudication or dismissal of ~~part~~parts of the action that eliminates any basis for coverage of any remaining ~~components~~parts of the action;
- (4) Settlement of the action that fully and finally resolves the entire action;
- (5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining ~~components~~parts of the action;
- (6) If so stated in the insurance policy, exhaustion of the applicable policy ~~limit~~limits;
- (7) A correct determination by the insurer that ~~there is no duty to defend under § 13(3) or other judicially recognized exception to the complaint-allegation rule stated in § 13(1)~~it does not have a duty to defend the legal action under the rules stated in § 13; or
- (8) Final adjudication that the insurer does not have a duty to defend the action.

Comment:

a. Only upon the occurrence of the enumerated events. Because of the importance of the insurer’s duty to defend and the possibility of irreparable harm if an insurer prematurely withdraws from the defense of a legal action, insurance law requires judicial supervision over withdrawals except in the situations enumerated in subsections (1) to (7). In all other cases in which the insurer ~~has~~continues to have a duty to defend under the rules stated in § 13, the insurer must ~~continue to~~ defend the action until relieved of that duty by adjudication.

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

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

d. Final adjudication of part of the action. Partial adjudication of an action may end the duty to defend in circumstances in which an action is based on covered and noncovered causes of action. Adjudication eliminating the covered cause from the action, so that the only remaining cause of action is not covered, ends the insurer’s duty to defend the action, provided that the time for taking an appeal from that adjudication has expired, any appeals have been resolved, or the claimant has relinquished its appeal rights. It is expected that because of the rules governing the professional responsibilities of defense lawyers and the ordinary status of the insurer as a nonparty to the litigation, any motion seeking such partial adjudication would require the consent of the insured. To the extent that it is possible for the insurer to seek such partial adjudication without the consent of the insured, the insurer’s actions will be subject to the duty of good faith and fair dealing.

Illustration:

1. Insured homeowner is sued for defamation and negligent infliction of emotional distress. Insurer agrees to defend the suit under the “personal injury” coverage part, which provides coverage for claims of defamation, but reserves the right to contest coverage for the negligent-emotional-distress claim on the grounds that the suit does not allege any bodily injury. The policy provides coverage for negligent-infliction-of-emotional-distress

claims only if such claims allege bodily injury. With the consent of the insured, the defense lawyer moves to dismiss the defamation count. The motion to dismiss is granted with prejudice. Provided that the plaintiff agrees to relinquish any appeal rights, the insurer may withdraw from the defense. Neither the complaint nor the results of the insurer's reasonable investigation reveal any allegations of bodily injury. Thus, after the dismissal of the defamation count, the suit no longer satisfies the conditions under which the insurer must provide a defense under § 13.

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

f. Settlement. A settlement that fully and finally establishes the insured's responsibilities with regard to an action terminates the duty to defend. Just as a partial adjudication may fully resolve all of the insured portions of the action, a partial settlement that resolves all of the components of the action that are covered by the liability insurance policy may also terminate the duty to defend. Such a partial settlement requires the consent of the insured after being informed of the consequences thereof. Otherwise, insurers would have an incentive to avoid their obligation to defend the whole legal action by settling the covered portions of the action in a manner that would disadvantage the insured.

Illustration:

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

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

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

i. Withdrawal pursuant to a ~~§ 13(3) or similar~~ correct determination: that the insurer does not have a duty to defend under the rules stated in § 13. Subsection (7) to this Section is a corollary to ~~the § 13(3) exceptions to the complaint allegation rule.~~ § 13. Subsection (7) clarifies that an insurer has a continuing opportunity to reevaluate whether it has a duty to defend under the rules in § 13. An insurer that starts to defend an action is permitted to withdraw from the defense if it subsequently determines, correctly, that it does not have a duty to defend under ~~a § 13(3) exception~~ the rules in § 13, for example because (a) the insurer has learned of facts to which there is no genuine dispute establishing that one of the § 13(3) exceptions to the

complaint-allegation rule ~~or under another judicially recognized exception to the complaint allegation rule stated in § 13(1)~~ applies, (b) there has been a legal development in the jurisdiction resolving a previously undecided question of law, (c) the insurer determines for some other reason that it incorrectly applied the complaint-allegation rule in the first instance, or (d) the circumstances have clarified that there is no obligation to defend under the potentiality rule. Note that the insurer's determination regarding the duty to defend must be correct. An incorrect determination and withdrawal of a defense is a breach of the duty to defend.

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

Illustrations:

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

amount within the limits of the homeowner’s policy, and brings a breach-of-contract action against the insurer. At trial in the breach-of-contract action, the insurer’s liability is determined solely on the basis of whether the insurer had the duty to defend. Because the complaint alleged that the child negligently caused the fire, the insurer had the duty to defend regardless of the child’s mental state. Therefore, the insurer is obligated to pay damages for breach of the duty to defend.

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

REPORTERS’ NOTE

a. Only upon the occurrence of the enumerated events. See *Lee v. Aetna Casualty & Surety Company Co.*, 178 F.2d 750, 753 (2d Cir. 1949) (applying New York law) (“[I]f the plaintiff’s complaint against the insured alleged facts which would have supported a recovery covered by the policy, it was the duty of the defendant [insurer] to undertake the defense until it could confine the claim to a recovery that the policy did not cover.”); *Montrose Chemical Corp. of Cal. v. Superior Court*, 861 P.2d 1153, 1157 (Cal. 1993) (internal citations omitted) (“The defense duty is a continuing one, arising on tender of defense and lasting until the underlying lawsuit is concluded or until it has been shown that there is no potential for coverage”); *United Enterprises, Inc. v. Superior Court*, 183 Cal. App. 4th 1004, 1011 (Cal. Ct. App. 2010) (“Normally, an insurer must defend until the underlying action is resolved by settlement or judgment. However, ~~but~~ circumstances may change such that there is no longer a potential for coverage by, for example, (1) the discovery of new or additional evidence, (2) a narrowing or partial resolution of claims in the underlying action, or (3) the exhaustion of the policy. When any such circumstances exist, an insurer may bring a

declaratory relief action, in order to conclusively establish that there is no longer a duty to defend.”) (internal citations omitted).

This rule is supported by a public policy of protecting the insureds’ expectation of a meaningful defense. See, e.g., *Montrose*, 861 P.2d at 1157-1158 (“The insured’s desire to secure the right to call on the insurer’s superior resources for the defense of third party claims is, in all likelihood, typically as significant a motive for the purchase of insurance as is the wish to obtain indemnity for possible liability. As a consequence, California courts have been consistently solicitous of insureds’ expectations on this score.”); *Continental Ins. Co. v. Burr*, 706 A.2d 499, 502 (Del. 1998) (“A reasonable policy holder would expect to be defended until claims arising under the policy are resolved, either by settlement or judgment. To read the policy otherwise would be to nullify the duty to defend in those situations where the insured most needs that protection.”).

b. Explicit waiver by the insured. See *Cincinnati Companies Cos. v. West American Am. Ins. Co.*, 701 N.E.2d 499, 503-504 (Ill. 1998) (“[A]n insured may knowingly forgo the insurer’s assistance by instructing the insurer not to involve itself in the litigation. The insurer would then be relieved of its obligation to the insured with regard to that claim.”); *Richard Marker Associates Assocs. v. Pekin Ins. Co.*, 743 N.E.2d 1078, 1082-1083 (Ill. App. Ct. 2001) (holding that the “right to forgo coverage” with insurer “included an ability to deactivate the coverage” even after settlement of the underlying dispute).

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

d. Final adjudication of part of the action. See, e.g., *City of Sandusky, Ohio v. Coregis Ins. Co.*, 192 F. App’x 355, 362 (6th Cir. 2006) (applying Ohio law) (holding that the duty to defend remained when the covered claims had been dismissed in nonfinal order of summary judgment); *C.A. Fielland, Inc. v. Fidelity & Casualty Co. of New York*, 297 So. 2d 122, 127 (Fla. Dist. Ct. App. 2d Dist. 1974) (“Even though only a portion of a claim made against an insured is within the liability coverage, the insurance carrier has the duty to defend the entire action, at least until such time as the covered portions of the claim have been eliminated from the suit.”); *Commerce & Industry Ins. Co. v. Bank of Hawaii Hawaii*, 832 P.2d 733, 737 (Haw. 1992) (holding that the insurer could not withdraw from its duty to defend after a partial summary judgment until either a “Rule 54(b) certification was granted and the appeal period had expired or a final judgment had disposed of the entire case.”); *Frankenmuth Mut. Ins. Co. v. Beyer*, 395 N.W.2d 36, 38 (Mich. Ct. App. 1986) (holding that the insurer was not required to defend the

insured after negligence count against the insured was dropped, with prejudice, and all that remained was a tortious assault-and-battery charge for which coverage was not provided under the insurance policy); *City of Niagara Falls v. Merchants Ins. Group*, 34 A.D.3d 1263, 1263-1264 (N.Y. App. Div. 2006) (an insurer that initially “failed to establish . . . that it had no duty to defend” the insured because one of the allegations fell within the scope of the policy could later terminate its defense when the insured was absolved of liability for that claim).

e. Final full or partial dismissal. See, e.g., *Baron Oil Co. v. Nationwide Mut. Fire Ins. Co.*, 470 So. 2d 810, 815 (Fla. Dist. Ct. App. 1st Dist. 1985) (an original complaint that “has been superseded by an amended complaint [that no longer contains potentially covered allegations] . . . can no longer furnish a basis for determining the insurer’s duty to defend.”) (citing *Alabama Farm Bureau Mutual Casualty Insurance Co. v. Harris*, 279 Ala. 326 (1966)); *National Nat’l Union Fire Ins. Co. of Pittsburgh Pennsylvania v. Starplex Corp.*, 188 P.3d 332, 336 n.1 (Or. Ct. App. 2008) (holding that the duty to defend may be extinguished by the filing of a subsequent amended complaint).

f. Settlement. See, e.g., *Great American Am. Ins. Co. v. Superior Court*, 100 Cal. Rptr. 3d 258, 269 (Cal. Ct. App. 2009) (“Normally, the insurer must defend until the underlying action is resolved by settlement or judgment.”); *Koese v. Liberty Mut. Ins. Co.*, 387 A.2d 1259, 1262 (N.J. Super. Ct. Law Div. 1978) (“Certainly, if [the insurer] could have effected settlement of the claim and it saw fit to dispose of it in that fashion, there would be no duty to defend the action.”); see also 1 STEVEN PLITT & JORDAN R. PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 2:19 (20122017) (When “the potential for covered liability has ended by settlement,” the duty to defend expires.); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.06[2][a] (Lexis 20122017) (“Courts . . . have held an insurer cannot extinguish its duty to defend by tendering the amount of its policy limits without obtaining a complete release for its insured in the underlying action . . .”). But, “payment of policy limits pursuant to a partial settlement of claims brought against the insured may not terminate the duty to defend.” 1 STEVEN PLITT & JORDAN R. PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 2:19 (20122017). In *Levenfeld v. Clinton*, for instance, the insurer attempted to settle only the covered claims in order to avoid the cost of defending the remaining noncovered claims. 674 F. Supp. 255, 258 (N.D. Ill. 1987). Holding that the settlement was unenforceable because the insurer had acted in bad faith, the court noted that

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

Id. at 258. But see *Meadowbrook, Inc. v. Tower Ins. Co., Inc.*, 559 N.W.2d 411, 417 (Minn. 1997) (“Even though the insurer agreed to defend the entire claim against the insured, its duty

extended only to those claims arguably covered by the policy. Once the insurer settled and paid those claims, it had completely performed its contractual duty. . . . Regardless of the insurer’s motivation in settling the defamation claims, the fact remains that the insurer’s action relieved the insured of any liability resulting from those arguably coverable claims”).

g. Exhaustion of the policy limit. See *Commercial Union Ins. Co. v. Pittsburgh Corning Corp.*, 789 F.2d 214, 219 (3d Cir. 1986) (applying Pennsylvania law) (“Although a few such cases do appear to hold that the insurer is required to defend the insured even after exhaustion of coverage through settlement or judgment . . . the predominant weight of authority is to the contrary.”); *Zurich Ins. Co. v. Raymark Industries, Inc.*, 514 N.E.2d 150, 163 (Ill. 1987) (“Where the insurer has exhausted its indemnity limits, . . . the insurer cannot ultimately be obligated to indemnify the insured. . . . [W]hen . . . the insurer has no potential obligation to indemnify, it has no duty to defend.”); *Zurich Ins. Co. v. Northbrook Excess and Surplus Ins. Co.*, 494 N.E.2d 634, 645 (Ill. App. Ct. 1986) (holding that policy language—limiting the insurer’s duty to the limits of liability—clearly evinced the intent of the parties to extinguish the insurer’s duty to defend upon exhaustion by judgment or settlement); *American Am. States Ins. Co. of Texas v. Arnold*, 930 S.W.2d 196, 200-201 (Tex. App. 1996) (holding that policy language—providing that the insurer’s “duty to settle or defend ends when [its] limit of liability for [the] coverage has been exhausted”—is unambiguous and terminates the insurer’s duty to defend when the policy limits are exhausted). Provisions that are ambiguous are construed in favor of the insured so as to require the insurer to continue defending the insured until settlement or judgment, despite having paid the policy limit. See, e.g., *Brown v. Lumbermens Mut. Cas. Co.*, 390 S.E.2d 150, 154 (N.C. 1990) (“Given the ambiguity, the provision relating to the insurer’s duty to defend must be interpreted favorably to the insured. So interpreted, it means that the insurer’s duty to defend continues until its coverage limits have been exhausted in the settlement of a claim or claims against the insured or until judgment against the insured is reached.”); *St. John’s Home of Milwaukee v. Continental Cont’l Cas. Co.*, 435434 N.W.2d 112, 121-122 (Wis. Ct. App. 1988) (construing policy language continuing the duty to defend to the “maximum potential liability” to require the insurer to continue to defend up to the insured’s maximum potential liability even though the insurer had tendered its maximum policy limit).

See also *Anderson v. United States U.S. Fidelity & Guar. Co.*, 339 S.E.2d 660, 661 (Ga. Ct. App. 1986):

There is no intimation in ~~an insurance~~the policy that its duty to defend may be satisfied by merely paying into court the applicable policy limits. To read the policy otherwise would render a near nullity a most significant protection afforded by the policy;— that of defense. ~~The~~We do not agree with appellee that the term “exhaust” encompasses, ~~not~~ the paying into court of the policy limits, but interpret that term to mean the payment either of a settlement or of a judgment wholly depleting the policy amount.

Accord [ContinentalCont'l](#) Ins. Co. v. Burr, 706 A.2d 499, 502 (Del. 1998). See also *Samplly v. Integrity Ins. Co.*, 476 So. 2d 79, 83-84 (Ala. 1985) (holding that an insurer, when it obligated itself to defend, could not avoid its duty to defend against an insured's contingent liability by tendering its policy limits into court without effectuating a settlement or obtaining consent of insured); *Continental Cas. Co. v. Farmers Ins. Co. of Arizona*, 883 P.2d 473, 476 (Ariz. Ct. App. 1994) (holding that the policy—which read in relevant part: “[w]e will not defend any suit or make additional payments after we have paid the limit of liability for the coverage”—terminated the insurer's duty to defend once the insurer had paid its policy limits and obtained a covenant not to execute that protected the insured); *Conway v. Country Cas. Ins. Co.*, 442 N.E.2d 245, 247 (Ill. 1982) (holding that an insurer is not discharged from its duty to defend the insured by the payment of the policy limits); *Maguire v. Ohio Cas. Ins. Co.*, 602 A.2d 893, 896 (Pa. Super. Ct. 1992) (holding that an insurer may not tender its policy limit into the court pending a determination of liability in order to avoid its duty to defend because such actions are not taken in good faith as is required to be excused from the duty to defend once it has paid its policy limits); *Weimer v. Ypparila*, 504 N.W.2d 333, 335 (S.D. 1993) (holding that the duty to defend continued, even though the insurer had offered its policy limits, until it had obtained a judgment or settlement and a release in favor of the insured, in order to protect the insured from prejudice).

When a dispute arises over whether an insurer has exhausted its policy limits, the insurer has a continuing duty to defend until adjudication determines that it has exhausted its policy limits. *Hartford Accident & Indemnity Co. v. Superior Court*, 23 Cal. App. 4th 1774, 1779 (Cal. Ct. App. 1994).

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

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

coverage issue in favor of the insurer”) (citing *Elliott v. Donahue*, 485 N.W.2d 403, 406 (Wis. 1992)).

§ 19. Consequences of Breach of the Duty to Defend

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

Comment:

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

b. Material breach of the duty to defend. The remedies stated in this Section are available only in the case of a material breach of the duty to defend, not a technical or inconsequential breach. A material breach includes a refusal to defend when required, a provision of a materially inadequate defense, a failure to provide an independent defense when required, and a withdrawal of a defense when the duty to defend has not terminated.

c. Damages for breach of the duty to defend. Damages for breach of the duty to defend are addressed in § 48. In general, the damages for breach of the insurance policy include the foreseeable consequences of a breach of the insurer’s contractual obligations. When an insurer breaches the duty to defend, those consequences include the reasonable costs of defense, any amount by which a noncovered settlement or judgment entered in the case is larger than it otherwise would have been as a result of the breach of the duty to defend, ~~the attorneys’ fees in the action establishing the breach of the duty to defend,~~ and any other damages recoverable for breach of a liability insurance contract (e.g., in many jurisdictions, the attorneys’ fees in the action establishing the breach of the duty to defend). The insurer is also obligated to pay any covered judgment or the reasonable amount of any covered settlement, subject to the policy limits, but that obligation is part of the insurer’s ordinary duty to pay covered claims, not part of the damages for breach of the duty to defend. A breach of the duty to defend does not ordinarily

obligate the insurer to indemnify the insured for amounts in excess of the policy limit, unless the insured can demonstrate that the breach caused that excess verdict. Otherwise, an insurer that breaches the duty to defend may become obligated to pay amounts in excess of the policy limit only because of the breach of some other obligation, such as the duty to make reasonable settlement decisions. Similarly, an insurer that breaches the duty to defend may lose its coverage defenses only if the breach was in bad faith (recognizing that a respectable minority of jurisdictions hold that an insurer that breaches the duty to defend loses its coverage defenses without regard to whether the breach was in bad faith). See § 50, Comment *c*.

REPORTERS' NOTE

a. Loss of control over defense and settlement. See, e.g., *Burgett, Inc. v. AmericanAm. Zurich Ins. Co.*, 830 F. Supp. 2d 953, 965 (E.D. Cal. 2011) (applying California law); *Willcox v. AmericanAm. Home Assur. Co.*, 900 F. Supp. 850, 855 (S.D. Tex. 1995) (applying Texas law) (“[O]nce an insurer has breached its duty to defend, as in the instant case, the insured is free to proceed as he sees fit; he may engage his own counsel and either settle or litigate, at his option.”); *MCO EnvironmentalEnvtl, Inc. v. Agricultural Excess & Surplus Ins. Co.*, 689 So. 2d 1114, 1116 (Fla. Dist. Ct. App. 1997) (“If an insurance company breaches its contractual duty to defend, the insured can take control of the case, settle it, and then sue the insurance company for damages it incurred in settling the action.”); *Krenitsky v. Ludlow Motor Co. Inc.*, 276 A.D. 511, 513 (N.Y. App. Div. 1950) (“By refusing to defend, it has forfeited to the defendant the right to control its defense of the actions.”).

Following a breach of the duty to defend, an insurer is bound by the judgment or settlement of the underlying case in terms of both liability and damages and can only reopen or re-litigate the underlying liability or damages on limited grounds, such as the reasonableness of the settlement or the existence of fraud or collusion. See, e.g., *Garamendi v. Golden Eagle Ins. Co.*, 116 Cal. App. 4th 694, 718-719 (Cal. Ct. App. 2004) ([citations omitted](#)) (noting that an insurer who breaches the duty to defend “is bound by a judgment in the action, in the absence of fraud or collusion, as to all material findings of fact essential to the judgment of liability of the insured. The insurer is not bound, however, as to issues not necessarily adjudicated in the prior action and can still present any defenses not inconsistent with the judgment against the insured.”); *Matychak v. Security Mut. Ins. Co.*, 181 A.D.2d 957, 959 (N.Y. App. Div. 1992) (holding the same for default judgments). With respect to settlements, see, e.g., *Risely v. Interinsurance ExchangeExch. of Auto. Club*, 107 Cal. Rptr. 3d 343, ~~350~~351 (Cal. Ct. App. 2010) (noting that an insured who has been abandoned by his or her insurer and elects to settle “is entitled to an evidentiary presumption, in a subsequent action against the insurer” to enforce the underlying liability and damages); *Guillen ex rel. Guillen v. Potomac Ins. Co. of Illinois*, 751 N.E.2d 104, 115 (Ill. App. Ct. 2001), *aff’d as modified and remanded*, 785 N.E.2d 1 (Ill. 2003)

(“[A]n insurer that has breached its duty to defend may *only* attack a settlement agreement by demonstrating that a settlement agreement is *unreasonable* (i.e., the settlement was made in anticipation of liability and the settlement amount is unreasonable), or that the settlement agreement contains otherwise *uninsurable items*.”); (emphasis in original); Isadore Rosen & Sons, Inc. v. Sec. Mut. Ins. Co. of New York, 291 N.E.2d 380, 382 (N.Y. 1972) (“[W]here an insurer ‘unjustifiably refuses to defend a suit, the insured may make a reasonable settlement or compromise of the injured party’s claim, and is then entitled to reimbursements from the insurer, even though the policy purports to avoid liability for settlements made without the insurer’s consent’”), quoting Matter of Empire State Sur. Co., 108 N.E. 825 (N.Y. 1915). See generally 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.07[2] (Lexis 2017) (“If an insurer breaches its duty to defend, however, the insured may enter into a reasonable, non-collusive settlement without the consent of the insurer and without forfeiting coverage.”).

b. Material breach of the duty to defend. An insurer can breach its duty to defend in multiple ways. An insurer breaches simply by refusing to defend when it has a duty to do so. See, e.g., Francis C. Amendola et al., *Insurer’s Liability for Wrongful Failure or Refusal to Defend*, 46 C.J.S. *Insurance* § 1641 (~~2012~~2017) (“When an insurance company wrongfully refuses to defend on the ground that the claim is not within policy coverage, the company is guilty of breach of contract, rendering it liable to the insured for all damages resulting to him or her because of such breach.”). Similarly, an insurer breaches if it initially defends, but withdraws its defense before the duty to defend has terminated. See, e.g., *City of Sandusky v. Coregis Ins. Co.*, 192 F. App’x 355, 361 (6th Cir. 2006) (applying Ohio law) (insurer “breached its duty to defend by withdrawing its defense . . . before a final order was entered or an appeal pursued.”); *Arceneaux v. Amstar Corp.*, 66 So. 3d 438, 450 (La. 2011) (citations omitted) (“The insurer’s duty to defend suits brought against its insured is determined by the allegations of the injured plaintiff’s petition, with the insurer being obligated to furnish a defense unless the petition unambiguously excludes coverage”). An insurer also breaches if it defends, but fails to provide an adequate defense. See, e.g., *Carrousel Concessions, Inc. v. Florida Ins. Guar. Ass’n*, 483 So. 2d 513, 517 (Fla. Dist. Ct. App. 1986) (“If [the insured] is able to establish that the defense supplied by [the insurer] was inadequate,” the insurer has breached its duty to defend and the insured could recover “all reasonable costs and attorney’s fees incurred at the trial level.”); 2 CALIFORNIA INS. LAW DICTIONARY & DESK REF. § I14:3 (~~2011~~2017 ed.) (“inadequate or perfunctory defense is tantamount to an insurer’s refusal to defend.”). Finally, an insurer may breach its duty to defend if it fails to provide adequate independent counsel when obligated to do so. See, e.g., *Great Divide Ins. Co. v. Carpenter ex rel. Reed*, 79 P.3d 599, 609-610 (Alaska 2003) (holding that failure to notify the insured of his right to have independent counsel paid for by the insurer constituted a breach of the insurer’s duty to defend).

c. Damages for breach of the duty to defend. See §§ 48 and 50, Reporters’ Notes.

§ 20. When Multiple Insurers Have a Duty to Defend

When more than one insurer has the duty to defend a legal action brought against an insured:

(1) The insured may select any of these insurers to provide a defense of the action;

(2) If that insurer refuses to defend or otherwise breaches the duty to defend, the insured may select any of the other insurers ~~with a defense obligation~~ that has a duty to defend the action; and

(3) The selected insurer must provide a full defense until the duty to defend is terminated pursuant to § 18 or until another insurer assumes the defense pursuant to subsection (4)(a).

(4) If the policies establish an order of priority of defense obligations among them, or if there is a regular practice in the relevant insurance market that establishes such a priority, that priority will be given effect as follows:

(a) An insurer selected pursuant to subsection (1) or (2) may ask any insurer whose duty to defend is earlier in the order of priority to assume the defense; and

(b) An insurer that incurs defense costs has a right of contribution or indemnity for those costs against any other insurer whose duty to defend is in the same position or earlier in the order of priority.

(5) If neither the policies nor the insurance-market practice establish an order of priority:

(a) The duty to defend is independently and concurrently owed to the insured by each of the insurers;

(b) Any nonselected insurer has the obligation to pay its pro rata share of the reasonable costs of defense of the action and the noncollectible shares of other insurers; and

(c) A selected insurer may seek contribution from any of the other insurers for the costs of defense.

Comment:

a. The “other insurance” problem in liability insurance. It is frequently the case that a legal action is covered, or potentially covered, by liability insurance policies issued by more than one insurer. Many liability insurance policies attempt to address the resulting problem of overlapping coverage through the use of “other insurance” clauses that purport to establish an order of priority of coverage. Because the extent of overlap of insurance coverage is not always predictable and because individuals and entities can be covered by liability insurance policies that they did not purchase, among other reasons, the liability insurance market cannot always be expected to produce a workable solution to this problem, even if policyholders understood their insurance policies and carefully selected among the competing options. While most courts have endeavored to discern the order of priority of coverage, it is not always possible to do so, and some courts have declared “other insurance” clauses mutually repugnant even when it is possible to discern an order of priority because of the burden that carefully parsing the clauses places on an insured who needs an immediate defense.

The rules stated in this Section provide a practical approach to the “other insurance” problem that (a) gives effect to the order of priority of defense obligations when it is possible to do so, (b) provides a clear rule that governs when it is not possible to determine all or part of the order of priority, (c) protects insureds from having to hire an insurance-coverage expert to determine which insurer to ask for a defense, and (d) provides a mechanism for an insurer that provides the defense to obtain contribution or indemnification from others. The precise articulation of these rules may be an innovation, but the rules are consistent with the spirit of all of the well-reasoned cases and with the holdings of most cases.

b. An order of priority of defense. Whether the insurance policies or the practice within the insurance industry establish an order of priority for the obligation to defend the insured is, in the first instance, for the insurers themselves to work out. That is, if an insured selects Insurer A, and according to the order of priority established in the policies or in the industry practice Insurer B should have the primary defense obligation, Insurer A should immediately transfer the case to Insurer B for a defense. At that point Insurer B should promptly take up the defense, and the insured should be informed of the switch. Whether insurers will agree to accept a transfer will inevitably be affected by established practices within the relevant insurance market. In resolving disputes among insurers regarding the order of defense priority, courts should defer to such

established industry practices, in part to encourage the formation of such practices and in part to discourage unnecessary litigation. This deference to industry practices, however, should not leave the insured caught in the middle and left worse off by virtue of having two applicable insurance policies rather than just one. Hence, this Section permits the insured to select any of the insurers to defend the action, without regard to the presence of any “other insurance” provisions in any of the policies or practices in the insurance market, and leaves it to that insurer to work out whether there is another insurer that properly should provide the defense and, if so, to make sure that the proper insurer in fact provides the defense. In addition, this Section recognizes that when neither the policies nor the practice establishes an order of priority the insurers owe an independent and concurrent obligation, analogous for some purposes to joint and several liability in tort law. Therefore, the order of priority addressed in this Section is primarily a concern to insurers and not the insured, since the insured is entitled to ask any of the insurers to provide a defense whether the policies establish a coherent order or not. Insurers can establish any order of priority that they wish. What they cannot do is require the insured to request a defense in the first instance from the insurer that is first in the order of priority. Such a practice would require the insured to develop expertise or hire experts in analyzing insurance policies and it would place on the insured the risk of disputes over the order of priority, making an insured who has access to multiple policies potentially worse off than an insured who has access to only one policy.

c. When there is an established order of priority for some policies but not others. When there is an established order of priority for some policies but not others, a selected insurer may transfer the defense of the legal action to an insurer whose duty to defend is prior in the order of priority, and the insurers’ contribution and indemnity rights and obligations will reflect the order of priority as it can be established. Those insurers with equal priorities will be treated as independently and concurrently liable for their aggregate share of the defense costs as compared to insurers with other priorities. These rules preserve the allocation of risk reflected in the insurance policies’ provisions and market practices that establish the order of priority.

Illustrations:

1. Contractor is the named insured under a general-liability insurance policy it purchased from Insurer A and an additional insured under a general-liability insurance policy purchased by Subcontractor from Insurer B. The contractor is sued for bodily

injury arising out of activities that are covered by both insurance policies. The contractor may choose to be defended by Insurer A or B without regard to any “other insurance” clauses in either liability insurance policy. The selected insurer may transfer the defense to the other insurer if the insurance policies or market practices establish an order of priority to that effect.

2. Contractor is the named insured under a general-liability insurance policy it purchased from Insurer A and an additional insured under a general-liability insurance policy purchased by Subcontractor from Insurer B. The contractor is sued for bodily injury arising out of activities that are covered by both insurance policies. Insurer A’s policy contains an “excess” “other insurance” provision and Insurer B’s policy contains a “pro rata” “other insurance” provision. Under established practices in the relevant insurance market, the defense obligations under an insurance policy with a “pro rata” provision come before the defense obligations of an insurance policy with an “excess” provision. The contractor selects Insurer A to defend. Insurer A must agree to provide a defense but it may transfer the defense to Insurer B. Insurer B must accept the transfer; but if Insurer B does not do so, Insurer A must defend.

3. Contractor is the named insured under a general-liability insurance policy it purchased from Insurer A and it is an additional insured under two other policies, a general-liability insurance policy purchased by Subcontractor 1 from Insurer B and a general-liability insurance policy purchased by Subcontractor 2 from Insurer C. The contractor is sued for bodily injury arising out of activities that are covered by all three insurance policies. Insurer A’s policy contains an “excess” “other insurance” provision and Insurer B’s and Insurer C’s policies each contain the identical “pro rata” “other insurance” provisions. Under established practices in the relevant insurance market, the defense obligations under an insurance policy with a “pro rata” provision come before the defense obligations of an insurance policy with an “excess” provision. The contractor selects Insurer A to defend. Insurer A accepts the defense and requests Insurer B to assume the defense. Insurer B refuses. Insurer A then requests Insurer C to assume the defense. Insurer C assumes the defense. Insurer C may obtain contribution for the costs of defense from Insurer B on a pro rata basis.

4. Driver gets into an accident while driving a rental car and injures Pedestrian. Pedestrian sues Driver. Driver is covered by a liability insurance policy purchased from Rental Car Insurer through the rental-car agency and also by Driver's personal automobile policy purchased from Personal Auto Insurer. Pedestrian sues Driver. Under established practices in the relevant insurance market, an insurer that issued a liability insurance policy to a rental-car customer has a duty to defend the customer that comes earlier in the order of priority than that of the customer's personal automobile liability insurer. Driver selects Personal Auto Insurer to defend the claim. Personal Auto Insurer accepts the defense and then requests Rental Car Insurer to assume the defense. Rental Car Insurer must assume the defense. If Rental Car Insurer does not assume the defense, Personal Auto Insurer must defend Driver but Personal Auto Insurer has a right of indemnification for the costs of the defense from Rental Car Insurer.

d. An insurer that in good faith transfers or assumes the defense has not breached the duty to defend. It is possible that one or more insurers will respond to a claim and arrange for the insured to receive a defense based on an understanding or belief about an established order of priority that is different from what a court subsequently determines the order of priority to be. If such a mismatch between insurer action and court ruling were to occur, an insured might attempt to argue that one or more insurers breached the duty to defend despite following what the insurers in good faith determined to be an established order of priority. This argument should fail. As long as the insured in fact received a defense in this situation, there would be no breach of the duty to defend by any of the insurers involved in transferring or assuming the defense.

e. Independent, concurrent obligation. This Section states the insurers' independent, concurrent obligation for a defense as the default rule, consistent with the rule stated in the Restatement Third, Restitution and Unjust Enrichment. See § 24, Comment *e*, of the Restatement Third, Restitution and Unjust Enrichment, especially Illustration 17 (treating insurers with overlapping defense obligations as "joint obligors"). This rule is analogous to joint and several liability in tort law, which is a common, easily administrable solution to a problem of overlapping obligations that ensures that none of the overlapping obligations of the insurers fall on the insured. Recognizing the insurers' independent, concurrent obligation to defend helps to secure the insured's right to an immediate defense of a potentially covered legal action by

reducing the jousting for advantage among the insurers that can delay the provision of a defense. The insurers are in a better position than the insured to understand how the responsibility for the costs of the defense will ultimately be divided. They can arrange for payment of those costs on that basis early in the defense of the action. Moreover, if there is an established market practice that leads the insurers to conclude that the insurer selected by the policyholder is not the proper insurer to control the defense, they can transfer the defense to the proper insurer.

f. Relationship to “selective tender” rule. The insured’s right to select the insurer to defend the legal action stated in this Section is similar in some ways to the “selective-tender” rule (sometimes called the “targeted-tender” rule) developed by the courts in Illinois. The selective-tender rule permits the insured to select the insurer to defend the action. That insurer is obligated to defend and, if appropriate, pay the judgment or settlement of the action. There are two important differences between insurers’ defense-cost obligations under the rules stated in this Section and the selective-tender rule, however. First, this Section permits the selected insurer to transfer the defense to another insurer when there is an established order of priority of defense obligations that is consistent with that transfer. Second, this Section permits insurers to seek contribution or indemnity for the costs of defense from other insurers that have also covered the risk in question. By contrast, the selective-tender rule prevents the selected insurer from transferring the defense or seeking contribution from other insurers in many situations. As a result, the selective-tender rule may create an unfortunate incentive for insurers to avoid being selected. This incentive conflicts with the primary objective of the rules governing the duty to defend, which is to encourage insurers to immediately undertake the defense of the insured when asked. In effect, the selective-tender rule penalizes the selected insurer, by making it bear the full costs of defense (and possibly even indemnity), and rewards a nonselected insurer, by relieving it of any responsibility for the costs of defense (and possibly even indemnity), discouraging insurers from standing ready to quickly fulfill the obligation to defend.

g. Contribution. See § 42 (contribution) and § 43 (settlement credits). For purposes of contribution under § 42, the insurer’s share is determined with reference to the rules stated in this Section, in addition to the principles of restitution and unjust enrichment.

REPORTERS’ NOTE

a. The “other insurance” problem in liability insurance. The rule followed in this Section is the majority rule, pursuant to which courts attempt to give effect to an established order of priority among “other insurance” clauses, while providing similar protection to insureds as the minority rule, pursuant to which “other insurance” clauses are treated as mutually repugnant. See *W9/PHC Real Estate LP v. Farm Family Cas. Ins. Co.*, 970 A.2d 382, 397 (N.J. Super. Ct. App. Div. 2009) ([internal citations omitted](#)) (“Cases generally fall into two types. In the first type, the pro-rata clause in one policy and the excess clause in the other are not held mutually repugnant and the policy containing the pro-rata provision must be exhausted first up to ~~its~~the policy limits. This is the majority rule. In the second type, commonly referred to as the *Lamb-Weston* rule . . . all other-insurance clauses are treated the same. Thus, any conflict between such clauses is considered to be mutually repugnant and the loss is apportioned according to the limits of each policy. This approach has been deemed the minority view.”). See also David P. Van Knapp, Annotation, *Resolution of Conflicts, in Non-Automobile Liability Insurance Policies, Between Excess or Pro-Rata “Other Insurance” Clauses*, 12 A.L.R.4th 993 (Originally published in 1982) (stating that “most jurisdictions” reject *Lamb-Weston* and hold that in a conflict between an excess clause and a pro rata clause, the terms of the excess clause prevail). For cases adopting the *Lamb-Weston* rule, see, e.g., *Harbor Ins. Co. v. United Services Auto. Ass’n*, 559 P.2d 178, ~~182~~183 (Ariz. Ct. App. 1976) (“We believe ~~that~~ the better rule is that where two policies cover the same occurrence and both contain ‘other insurance’ clauses, the excess insurance provisions are mutually repugnant and must be disregarded.”); *Illinois Nat’l Ins. Co. v. Farm Bur. Mut. Ins. Co.*, 578 N.W.2d 670, 671 (Iowa 1998); *Carriers Ins. Co. v. American Am. Policyholders’ Ins. Co.*, 404 A.2d 216, 219 (Me. 1979) (noting that reliance on “other insurance” clauses “encourages the continuing draftsmanship battle by which insurers seek still more specific policy terms, and the end is not in sight” and that “[f]airly read, each insurer, through its excess clause, seeks to place the initial loss on any other applicable insurance, saving for itself a role as secondary insurer.”); *Lamb-Weston, Inc. v. Oregon Automobile Ins. Co.*, 341 P.2d 110, 135 (Or. 1959), modified & reh’g denied, 346 P.2d 643 (Or. 1959). “Escape” clauses are disfavored by courts and often are not enforceable. *CSE Ins. Group v. Northbrook Prop. & Cas. Co.*, 29 Cal. Rptr. 2d 120, 124 (Cal. Ct. App. 1994) ([citation omitted](#)) (“[P]ublic policy disfavors ‘escape’ clauses whereby coverage purports to evaporate in the presence of other insurance.”); Douglas R. Richmond, *Issues and Problems in “Other Insurance,” Multiple Insurance, and Self-Insurance*, 22 PEPP. L. REV. 1373, 1387 (1995) (“No matter how they are classified, escape clauses are disfavored . . . [and] are frequently viewed as being contrary to public policy”). For general discussion of different “other insurance” clauses and how courts have interpreted them, see generally Douglas R. Richmond, *Issues and Problems in “Other Insurance,” Multiple Insurance, and Self-Insurance*, 22 PEPP. L. REV. 1373 (1995) (reviewing the different clauses and discussing their effect on indemnity and defense duties).

The original reason for “other insurance” clauses was to prevent over insurance and double recovery under property- and fire-insurance policies. *Jones v. Medox, Inc.*, 413 A.2d 1288, 1290 (D.C. 1980), vacated on other grounds, 430 A.2d 488, 490 (D.C. 1981) (recognizing

“the confusion that pervades the entire realm of ‘other insurance’ clauses.”). In third-party-liability cases, the fear of over insurance is greatly diminished because recovery does not inure to the benefit of the policyholder, but, rather, to the benefit of the injured third party. “Other insurance” clauses are placed in the insurance contracts between policyholders and their insurers because they have no other place to go, as there are no contracts between or among the various insurers that issue insurance policies to a particular policyholder. See generally Susan Randall, *Coordinating Liability Insurance*, 1995 WIS. L. REV. 1339, 1353 n.48 (1995) (explaining that “other insurance” clauses do not apply to policyholders and are included in insurance policies only because there is no other contractual vehicle in which to define how to apportion liability among insurance companies). See also Douglas R. Richmond, *Issues and Problems in “Other Insurance,” Multiple Insurance, and Self-Insurance*, 22 PEPP. L. REV. 1373, 1380-1381 (1995):

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

e. Independent, concurrent obligation. See, e.g., [American Am. States Ins. Co. v. National Nat'l Fire Ins. Co. of Hartford](#), 135 Cal. Rptr. 3d 177, 183 (Cal. Ct. App. 2011) (internal quotation omitted) (“In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others.”); *Mutual of Enumclaw Ins. Co. v. USF Ins. Co.*, 191 P.3d 866, 873-874 (Wash. 2008) (same). Note that some courts have held that defense costs are subject to a pro rata allocation in the case of long-tail claims under occurrence policies. See Reporters’ Note to § 41, Comment *l*. This Restatement does not follow that rule.

f. Relationship to “selective tender” rule. For cases articulating the “selective tender” rule, see *Employers Ins. v. James McHugh Constr. Co.*, 144 F.3d 1097, 1105-1107 (7th Cir. 1998) (applying Illinois law); *Chicago Hosp. Risk Pooling Program v. Ill. State Med. Inter-Ins. Exch.*, 758 N.E.2d 353, 357 (Ill. [App. Ct.](#) 2001); *John Burns Constr. Co. v. Indiana Ins. Co.*, 727 N.E.2d 211, 217 (Ill. 2000); *Alcan United, Inc. v. W. Bend Mut. Ins. Co.*, 707 N.E.2d 687, 694 (Ill. [App. Ct.](#) 1999); *Cincinnati Cos. v. W. Am. Ins. Co.*, 701 N.E.2d 499, 503 (Ill. 1998); Cf. *Illinois School District Agency v. The St. Charles Community Cmty. Unit School District 303*, ~~2012 Ill. App. LEXIS 242971 N.E.2d 1099~~ (Ill. App. Ct. ~~Mar. 30,~~ 2012) (holding that the prohibition on contribution does not apply to policies covering different time periods in a toxic-tort action). See also [13 JEFFREY E. THOMAS, THE NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.03\[9\]\[e\]166.06](#) (Lexis ~~2012~~2017).

§ 21. Insurer Recoupment of the Costs of Defense

Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not seek recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs.

Comment:

a. The default rule is no recoupment of defense costs. Insurers sometimes provide a defense of a legal action in situations in which it is later determined that they had no legal obligation to do so. If an insurer provides a defense under a reservation of rights, and the coverage dispute is subsequently decided in the insurer’s favor, the insurer may have provided a defense of an action that was outside the scope of its duty to defend, as measured by the rules of § 13 and § 14.

Because § 14 provides that the duty to defend includes the obligation “to defend the insured from all of the causes of action and remedies sought in the action, including those not covered by the liability insurance policy,” the insurer has a contractual duty to defend the entire action whenever the action includes a potentially covered cause of action. Similarly, any time an insurer is defending under a reservation of rights because of a *factual* uncertainty related to a ground for contesting coverage, courts generally agree the insurer has a contractual duty to defend until that duty is terminated in the manner specified in § 18 of this Restatement. When an insurer is defending because of *legal* uncertainty regarding its duty to defend the action, however, some courts may later determine that the insurer did not have the duty to defend. Only in such cases will the insurer have incurred costs that it was not legally obligated to incur. Some insurers in this position have sought recoupment for their defense costs; and some insurers have even sought recoupment for the portions of the defense costs attributable to noncovered claims incurred in defending legal actions that they did have a duty to defend. (Analogous recoupment claims have been asserted in cases in which insurers paid to settle legal actions that were subsequently determined to be outside the scope of the duty to indemnify (see § 25, Comments *c* and *d*.)

When an insurer’s claim to recoupment is based on a contractual right to reimbursement—whether because of a provision of the insurance policy or a subsequent agreement with the insured—it presents no legal difficulty. When neither the policy nor a

subsequent agreement of the parties provides the insured with a right of reimbursement, however, the viability of such a claim has been intensely controversial, and there is a split among the courts on this issue.

This Section follows the emerging state-court majority rule that the insurer does not have a right of recoupment of defense costs unless this right is stated in the insurance policy or otherwise agreed to by the parties. About half of the state courts that have considered this issue, and a majority of the federal courts making Erie predictions, have held to the contrary, based on a theory of unjust enrichment. State courts that have decided this issue for the first time in more recent years, however, have rejected the insurer's claim to recoupment in the absence of a provision in the policy or other agreement permitting reimbursement. This Section follows this emerging state-court majority rule as the more appropriate one in the context of coverage disputes arising under liability insurance policies.

It is sometimes said that, in choosing the most desirable default rule in a contractual setting, the task of the court is to identify the rule that the majority of parties in that contractual setting would agree to, if transaction costs were minimal and the parties had the time and inclination to reach a bargain. With that framing of the question, there are several reasons why the default rule followed in this Section is the more sensible of the two in this context. First, the default rule followed in this Section would likely result in lower overall litigation costs than would the alternative rule of recoupment. For example, in cases involving covered and noncovered causes of action, under a recoupment rule there would often have to be subsequent litigation over the question whether, or to what extent, the defense costs were incurred by the insurer in connection with noncovered causes of action. The rule followed in this Section entails no such secondary litigation. Second, because this rule is merely a default, if it turns out that the recoupment rule would be relatively easy to administer or that the costs justify the expense, insurers can incorporate an express right to recoupment in their policies. Third, situating the right to recoupment in the insurance policy carries significant advantages; it puts the legal basis of the insurer's entitlement beyond dispute, and it specifies the contours of that entitlement in advance of a dispute, making it easier to evaluate for all parties concerned. Fourth, a default rule of no recoupment places the burden of contracting around the rule on the party best able to do so.

Against this background, an insurer's choice not to insert a recoupment provision in the policy acquires contractual significance. At a minimum, it suggests that the hardship created by

the lack of a right of recoupment is not as substantial as might appear in retrospect, when an insurer has defended a specific legal action that it was not obligated to defend. Moreover, recognizing that the insurer is making the choice not to insert a recoupment provision in the policy brings the default rule followed in this Section within the principle disfavoring the use of unjust enrichment when the parties are in a position to address the issues by contract. See Restatement Third, Restitution and Unjust Enrichment § 2, Comment *c*. The issue of the right to recoup the costs of defending a noncovered legal action is a known uncertainty that the insurer can address in the liability insurance contract, as is frequently the case in Directors' and Officers' Liability Insurance policies. In addition, a default no-recoupment rule better informs insurance regulators of the coverage that the insurer intends to provide under the policy form, facilitating informed administrative review of insurers' intent to seek recoupment, and, once the form permitting recoupment is approved, better informs insurance purchasers of the more limited defense coverage provided by the policy.

b. Relationship to the Restatement Third, Restitution and Unjust Enrichment. The Restatement Third, Restitution and Unjust Enrichment (R3RUE), expresses a general view with respect to recoupment that differs from, but can be reconciled with, the special case of the default rule followed in this Restatement as a matter of insurance law. Under that general approach, an insurer that defends or settles a wholly noncovered legal action could be understood to confer benefits beyond the scope of its obligation, because, if decisions must be made before a coverage dispute can be adjudicated, an insurer may feel compelled to defend or settle what it believes in good faith (and in fact correctly) to be a noncovered action, in view of the risk of enhanced liability that could attend an adverse decision on coverage. See § 27 (for breach of duty to make reasonable settlement decisions, there is liability to indemnify without regard to policy limits). The R3RUE solution to this problem is to permit an obligor acting in good faith to render the performance demanded under a unilateral reservation of the right to seek restitution.

This Restatement does not question the R3RUE's analysis of a general pattern of unjust enrichment outside of the liability insurance context, but there are substantial reasons to conclude that recognition of such a claim by a liability insurer is inappropriate because of special considerations of insurance law. In addition to those reasons stated in Comment *a*, an insurer that chooses to defend under a reservation of rights receives substantial benefits from exercising that choice, beyond avoiding the risk of enhanced liability. These benefits include maintaining control

over the cost, quality, and direction of the defense, obtaining access to privileged defense-related materials, and participating in settlement discussions. All of these benefit the insurer in the event that the legal action is later determined to be within the scope of coverage.

The apparent conflict between R3RUE § 35's general approach to unjust enrichment and the special case addressed by this Restatement can be resolved by observing that R3RUE § 35 starts from a different assumption about what it refers to as "local insurance law." Both the R3RUE's premise (about extra-contractual performance) and its conclusion (about unjust enrichment) disappear once insurance law is understood to include a no-recoupment default rule. In that case, an insurer that defends under a reservation of rights, without an explicit agreement regarding the right to recoupment, is not performing beyond its contractual obligation, because that obligation incorporates the default no-recoupment rule implied by insurance law. Most restitution claims between insurers and policyholders arise in contexts unrelated to coverage disputes; they more typically involve problems of mistake or subrogation. See Restatement Third, Restitution and Unjust Enrichment §§ 6, 24. The rule stated in this Section has no bearing on the insurer's entitlement to restitution in these fundamentally different liability insurance settings. See, e.g., § 20, Comment *e* (following R3RUE § 24 in the context of overlapping defense obligations) and § 28, Comment *a* (following R3RUE § 24 in the context of equitable subrogation).

c. Managing the risk that the default rule may discourage insurers from defending. There is a legitimate concern that the no-recoupment default rule may discourage insurers from undertaking a defense in some cases in which there is legal uncertainty regarding the insurer's duty to defend. All other things being equal, an insurer that has some probability of recouping the costs of defense will be more likely to undertake the defense than an insurer that cannot recoup the costs of defense. The no-recoupment default rule permits parties to address this concern in two ways. First, parties may include a provision in the insurance policy that grants the insurer a right to recoupment. Second, even if the insurance contract does not grant the insurer a right to recoupment, the parties may contract for such a right at the time of claim. An insurer that in good faith would otherwise refuse to defend a legal action could agree to undertake the defense of the action upon the condition that the insured agree to reimburse the insurer's costs if it is subsequently determined that the insurer did not have a duty to defend. Such an agreement could benefit the insured by providing access to a quality defense at a lower cost and benefit the insurer

by reducing the potential liability in the event that the action is later determined to be within coverage. A statement in a reservation-of-rights letter informing the insured that the insurer will be seeking reimbursement does not create a right of reimbursement, however, unless the insured affirmatively agrees to accept a defense under that condition.

d. Application to defense-cost-indemnification policies. The justifications for this default rule are the same for a defense-cost-indemnification policy as a duty-to-defend policy: the default rule better matches policyholder expectations regarding defense coverage; requiring the insurer to explicitly state the recoupment right better informs regulators and policyholders of the more limited defense coverage provided by a policy with such a provision; and the default rule preserves the parties' ability after a legal action has been made to agree to permit recoupment in order to encourage the insurer to provide or pay for a defense in a close case. The courts that have considered this issue in the defense-cost-indemnification context generally reach the same result as they reached in the duty-to-defend context.

e. Allocation and timing when recoupment is permitted. When recoupment is permitted, courts have agreed that recoupment is limited to costs of defense of components of legal actions that were not even potentially covered by the policy (i.e., components for which any uncertainty regarding coverage was legal as opposed to factual; see § 13, Comments *e* and *f*). Moreover, any action to recoup the costs of defense should be postponed until after the duty to defend has terminated so that disputes over the amount of recoupment will not interfere in the defense of the claim or lead to impermissible disclosure of confidential information of the insured.

REPORTERS' NOTE

a. The default rule is no recoupment of defense costs. While some courts have characterized the default rule in favor of recoupment as the majority rule, see, e.g., [General Gen. Agents Insurance Ins. Co. of America Am. v. Midwest Sporting Goods Co.](#), 828 N.E.2d 1092, 1104 (Ill. 2005) (“We choose, however, to follow the minority rule and refuse to permit an insurer to recover defense costs pursuant to a reservation of rights absent an express provision to that effect in the insurance contract between the parties.”), commentators have stated that the trend is toward adopting the rule as stated in this Section. [1-7 RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE 195 § 7 \(3d ed. 2015\)](#) (“[L]itigation surrounding an insurer’s right to reimbursement of defense costs has been active for the past fifteen years, with a significant spike in the last five. In general, insurers have won a few more of these cases than they’ve lost. But the score is close. And the minority view is gaining ground.”); Angela R. Elbert & Stanley C. Nardoni, *Buss Stop: A Policy*

Language Based Analysis, 13 CONN. INS. L.J. 61, 92 (2007). See also [National Nat'l Sur. Corp. v. Immunex Corp.](#), 297 P.3d 688, 693 (Wash. 2013) (“more recently . . . courts deciding in the first instance whether insurers can recover defense costs have generally concluded that they cannot.”).

For state courts adopting the rule followed in this Section, see *Med. Liab. Mut. Ins. Co. v. Alan Curtis Enters. Inc.*, 285 S.W.3d ~~233~~, ~~235~~ [233](#) (Ark. 2008); *Gen. Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1097 (Ill. 2005) (“[insurer’s] reservation of rights letter could only reserve the rights contained within the insurance policy and could not create new rights.”); *Holyoke Mut. Ins. Co. in Salem v. Vibram USA, Inc.*, 2017 WL 1311937, at *6 (Mass. Super. Ct. [Mar. 21](#), 2017) (discussing law nationwide and concluding “the Pennsylvania Supreme Court’s decision in *Jerry’s* comports with Massachusetts law”); *Am. & Foreign Ins. Co. v. Jerry’s Sport Ctr., Inc.*, 2 A.3d 526, 546 (Pa. 2010) (“We therefore hold that an insurer may not obtain reimbursement of defense costs for a claim for which a court later determines there was no duty to defend, even where the insurer attempted to claim a right to reimbursement in a series of reservation of rights letters.”); ~~*National Surety Nat'l Sur. Corp. v. Immunex Corp.*~~, 297 P.3d 688 (Wash. 2013). See also *Attorneys Liab. Protection Soc’y, Inc. v. Ingaldson Fitzgerald*, [P.C.](#), [370](#) P.3d 1101 (Alaska 2016) (holding that the Alaska independent-counsel statute means that an insurer cannot obtain recoupment for defense costs even if the insurance policy contains a recoupment provision). Cf. *Texas Ass’n of Counties County Gov’t Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128, 131 (Tex. 2000) (refusing to permit recoupment of settlement costs, stating that “a unilateral reservation-of-rights letter cannot create rights not contained in the insurance policy”).

For federal courts making an Erie prediction that a state would adopt the rule followed in this Section, see, e.g., *Westchester Fire Ins. Co. v. Wallerich*, 563 F.3d 707, 719 (8th Cir. 2009) (applying Minnesota law) (“Here, [insurer] could have included in the policy an express provision for such reimbursement. [Insurer] cannot now unilaterally amend the policy by including the right to reimbursement in its reservation-of-rights letter.”); *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 448 F.3d 252, 259 (4th Cir. 2006) (applying Maryland law) (noting that “[a] partial right to reimbursement of defense costs would . . . undermine the bargain that Maryland courts describe insurers reaching with their insureds . . . [and] would significantly tip the scales in favor of the insurer”); *James River Ins. Co. v. Arlington Pebble Creek, LLC*, 188 F. Supp. 3d ~~1246~~, ~~1264~~ [1246](#) (N.D. Fla. 2016) (predicting Alabama law); *Great Am. Assurance Co. v. PCR Venture of Phoenix LLC*, 161 F. Supp. 3d 778, 788 (D. Ariz. 2015) (predicting Arizona law, not acknowledging contrary prediction made in *Phillips & Assocs, P.C. v. Navigators Ins. Co.*, 764 F. Supp. 2d 1174, 1178 (D. Ariz. 2011)); *Evanston Ins. Co. v. Bosski, Inc.*, 2017 WL 1158245 (D. Idaho [Mar. 28](#), 2017) (following Idaho-law prediction of three prior district-court opinions); *Pekin Ins. Co. v. Tysa, Inc.*, 2006 WL 3827232, at *19 (S.D. Iowa [Dec. 27](#), 2006) (predicting Iowa law); ~~*General Gen. Star Indem. Co. v. Driven Sports, Inc.*~~, 80 F. Supp. 3d 442, 460 (E.D.N.Y. 2015) (predicting New York law, acknowledging earlier, contrary predictions and a contrary decision by intermediate appellate court in New York and explaining why they are unpersuasive).

For state courts adopting a rule contrary to that followed in this Section, see *Scottsdale Ins. Co. v. MV Transp.*, 115 P.3d 460, 462 (Cal. 2005) (applying the rule in *Buss v. Superior Court*, 939 P.2d 766, 776 (Cal. 1997) to actions in which insurer had no duty to defend); *Hecla Mining Co. v. New Hampshire Ins. Co.*, 811 P.2d 1083, 1089 (Colo. 1991) (dicta stating, “The appropriate course of action for an insurer who believes that it is under no obligation to defend, is to provide a defense to the insured under a reservation of its rights to seek reimbursement should the facts at trial prove that the incident resulting in liability was not covered by the policy, or to file a declaratory judgment action after the underlying case has been adjudicated.”); *Nationwide Mut. Ins. Co. v. Flagg*, 789 A.2d 586, 597 (Del. Super. Ct. 2001) (“Nationwide has a duty to defend on all claims, but it may seek reimbursement from Flagg of those expenses, costs or fees incurred by providing his defense on those claims which may be proven later to fall outside the policy coverage.”); *Colony Ins. Co. v. G&E Tires & Serv., Inc.*, 777 So. 2d 1034 (Fla. Dist. Ct. App. 2000) (holding that insurer’s reservation of right to be reimbursed for defense costs was sufficient to establish such a right); *Certain Underwriters at Lloyd’s London Subscribing to Policy Number SYN-10000263 v. Lacher & Lovell-Taylor*, P.C., 975 N.Y.S.2d 870 (N.Y. App. Div. 2013) (summary decision permitting insurer to obtain reimbursement of defense costs, with no analysis and relying solely on a citation to an earlier intermediate appellate court decision from the same department that similarly lacks analysis). Note that the Arizona intermediate appellate court permitted an insurer to recoup nine percent of the costs incurred in defending a matter in a non-published, non-citable opinion that relied solely on *Buss* and did not conduct any analysis. *Nucor Corp. v. Employers Ins. Co. of Wausau*, 2012 WL 6117029, at *4 (Ariz. Ct. App. Nov. 23, 2012). Cf. *Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co.*, 826 A. 2d 107, 125 (Conn. 2003) (addressing a different issue from that addressed in this Section: permitting insurer to recoup defense costs on a pro rata basis for a long-tail claim in which the policyholder was self-insured for part of the triggered period); ~~*Montana*~~, *Travelers Cas. & Sur. Co. v. Ribi Immunochem Research, Inc.*, 108 P.3d 469, 480 (Mont. 2005) (permitting insurer to recoup costs incurred defending a claim that it had no duty to defend because insured failed to object to a recoupment right asserted in the reservation-of-rights letter); *Evanston Ins. Co. v. Midwest Language Banc, Inc.*, 2012 WL 3638998 (Minn. Dist. Ct. Mar. 6, 2012) (permitting recoupment on the grounds that the insured’s failure to object to insurer’s assertion of a right of recoupment in a reservation-of-rights letter constituted an acceptance of a defense on that basis); *Chiquita Brands Int’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 57 N.E.3d 97, 101 (Ohio Ct. App. 2015) (permitting insurer to recoup defense costs on an equitable theory, citing R3RUE, in narrow circumstances in which an insurer provided a defense pursuant to a trial-court decision that was later reversed, not addressing the broader circumstances addressed in this Section). In addition, there are some earlier state-court decisions permitting an insurer to allocate defense costs to covered and noncovered counts in circumstances in which the insurer breached the duty to defend that are inconsistent with the rule in this Section. See, e.g., *Loewenthal v. Sec. Ins. Co. of Hartford*, 436 A.2d ~~493, 499 & n.5~~493 (Md. Ct. Spec. App. 1981); *SL Industries, Inc. v. Am. Motorists Ins. Co.*, 607 A.2d ~~1266, 1280~~1266 (N.J. 1992).

For federal courts making an Erie prediction that is contrary to the rule followed in this Section, see, e.g., *United Nat'l Ins. Co. v. SST Fitness Corp.*, 309 F.3d 914, 922 (6th Cir. 2002) (predicting Ohio law); *Illinois Union Ins. Co. v. NRI Constr. Inc.*, 846 F. Supp. 2d 1366, 1377 (N.D. Ga. 2012) (predicting Georgia law); *Scottsdale Ins. Co. v. Sullivan Props. Inc.*, 2006 WL 505170, at *2 n.3, *12 (D. Haw. Feb. 28, 2006) (predicting Hawai'i law); *Emp'rs Reins. Corp. v. Mut. Ins. Co.*, 2006 WL 2724437, at *4 (W.D. Ky. 2006) (predicting Kentucky law by following 6th Circuit's prediction of Ohio law in *SST Fitness*); *Probuilders Speciality Ins. Co. v. Double M. Constr.*, 116 F. Supp. 3d 1173, 1182 (D. Nev. 2015) (predicting Nevada law without discussing any of the extensive national case law on this issue); *Resure, Inc. v. Chem. Distribs., Inc.*, 927 F. Supp. 190, 194 (M.D. La. 1996) (predicting New Mexico law); *Cincinnati Ins. Co. v. Grand Pointe, LLC*, 501 F. Supp. 2d 1145, 1152 (E.D. Tenn. 2007) (predicting Tennessee law); *Krueger Int'l, Inc. v. Fed. Ins. Co.*, 647 F. Supp. 2d 1024, 1043-1045 (E.D. Wis. 2009) (predicting Wisconsin law). Cf. *Cont'l Cas. Co. v. Indian Head Indus., Inc.*, 666 F. App'x 456, 468 (6th Cir. 2016) (predicting Michigan law and addressing a different issue from that addressed in this Section: permitting insurer to recoup defense costs on a pro rata basis for a long-tail claim in which the policyholder was self-insured for part of the triggered period). See generally 1 WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION* § 2.11[7] (2d ed. 2014, 2017) (surveying case law).

While some courts and commentators do not distinguish between a circumstance in which an insurer is held not to have had a duty to defend and a circumstance in which the insurer defended an action that included both covered and noncovered counts (a “mixed” case), the strength of the claim for recoupment on equitable grounds is very different in the two circumstances. In a mixed case, the insurer is legally obligated to defend the entire action. Thus, the insurer does not incur any costs that it had the legal right to avoid. By contrast, when the insurer never had the legal duty to defend, the insurer incurred costs without any legal obligation to do so. Because of this distinction, a state-court ruling that an insurer may not recoup the costs of defending the uncovered portion of a “mixed” case does not rule out the possibility that the liability insurance law of the state would permit the insurer to recoup the costs of defending a legal action that it did not have the legal obligation to defend at all. See, e.g., *Shoshone First Bank v. Pac. Employers Ins. Co.*, 2 P.3d 510, 514 (Wyo. 2000) (ruling that an insurer may not recoup the costs of defending the uncovered portions of the action unless there is an insurance-policy provision to that effect but not reaching the question whether an insurer may recoup the costs of defending an action that it had no legal duty to defend).

Some might contend that the default rule followed in this Section is unjust to insurers, because it results in policyholders receiving coverage that they did not contract for. That argument, however, assumes its own conclusion. The reason we need a default rule is that the contract does not say expressly whether recoupment will be provided to the insurer or not. Therefore, it is wrong to conclude that the policyholder did not purchase the right not to face a recoupment action. That is in fact the question at issue. That is the gap in the policies for which a default rule must be selected. There is a large amount of academic literature on default rules in

contract law. See generally Richard Craswell, *Contract Law: General Theories*, in ENCYCLOPEDIA OF LAW & ECONOMICS, vol. 3, 1-24 (Boudwewijn Bouckaert & Gerrit DeGeest eds.) (Cheltenham, U.K.: Edward Elgar Publishing 2000). For a discussion of when the optimal default rule is the rule that the majority of parties in that contractual setting would agree to, if transaction costs were minimal and the parties had the time and inclination to reach a bargain, see generally Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 1 (1989).

b. Relationship to the Restatement Third, Restitution and Unjust Enrichment. It is important to note that applying the restitution rule stated in R3RUE § 35 to the liability insurance context would support a recoupment claim only when the claim is wholly uncovered, because it is only in that circumstance that an insurer has provided a defense that it was not legally obligated to provide. Thus, for example, the R3RUE § 35 rules do not support the result in *Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997). For a discussion of the benefits to the insurer of defending a suit rather than taking its chances on whether its coverage position is correct, see KENNETH S. ABRAHAM, & DANIEL SCHWARCZ, ~~INSURANCE LAW AND REGULATION: CASES AND MATERIALS 649-650 (5 584-586 (6th ed. 20102015). Professor~~Professors Abraham ~~identifies~~and Schwarcz identify the following benefits:

- a) the insurer can defer its determination of coverage issues, thus avoiding being estopped to deny its indemnity obligation if it later turns out that it did have a duty to defend;
- b) the insurer can control defense expenditures;
- c) the insurer can ensure that the claim is effectively defended, thus minimizing its potential indemnity exposure;
- d) the insurer can participate in, and perhaps control, settlement negotiations; and
- e) the insurer can gain access to otherwise-privileged communications.

d. Application to defense-cost-indemnification policies. D&O policies frequently contain provisions entitling the insurer to obtain reimbursement of noncovered defense costs. See, e.g., *Vigilant Ins. Co. v. Credit Suisse First Boston Corp.*, 10 A.D.3d 528, ~~528~~529 (N.Y. 2004) (internal citations omitted) (“While, under certain circumstances, the insurers must advance defense costs incurred by the insured in connection with a claim, the insured is obligated to repay such advance payments upon a finding that it is not entitled ‘to payment of such Loss.’ Thus, defense costs are only recoverable [by the insured] for covered claims.”). Such provisions are enforceable. Cf. *Commercial Capital Bankcorp. Inc. v. St. Paul Mercury Ins. Co.*, 419 F. Supp. 2d 1173, 1184 (C.D. Cal. 2006) (applying California law) (holding that public policy does not proscribe policy provisions which permit the insurer to advance only defense costs on actions “it believes to be covered, until a different allocation is reached later by negotiation, arbitration, or judicial decision.”).

e. Allocation and timing when recoupment is permitted. When recoupment is available, it is limited to costs of defense of causes of action that were not even potentially covered by the

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policy. See 1 ROBERT P. REDEMANN & MICHAEL F. SMITH, LAW AND PRAC. OF INS. COVERAGE LITIG. § 4:21 (Database updated ~~2013~~2017) (stating that regardless of the view on reimbursement in the jurisdiction, “jurisdictions agree . . . that the insurer must cover the costs of any claim having the remotest possibility of being covered by the policy.”). See, e.g., *Buss v. Superior Court*, 939 P.2d 766, 768-769, 775 (Cal. 1997) (“[F]or what specific costs may the insurer obtain reimbursement? Those that can be allocated solely to claims that are not even potentially covered. . . . As to the claims that are at least potentially covered, the insurer may not seek reimbursement for defense costs.”); *Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co.*, 826 A.2d 107, 125 (Conn. 2003) (“Where the insurer defends the insured against an action that includes claims not even potentially covered by the insurance policy, a court will order reimbursement for the cost of defending the uncovered claims in order to prevent the insured from receiving a windfall.”). The insurer may not receive recoupment for actions potentially covered by the policy. See, e.g., *Travelers Prop. Cas. Co. v. R.L. Polk & Co.*, No. 06-12895, 2008 WL 786678, at *1 (E.D. Mich. Mar. 24, 2008) (applying Michigan law) (“[Insurer] is only entitled to reimbursement of defense costs for those claims which were clearly not potentially or arguably covered by the policy. That is, where [insurer] has a duty to defend [insured], [insurer] has no duty [sic] to reimbursement.”); *Med. Protective Co. v. McMillan*, CIV. A. 501CV00073, 2002 WL 31990490, at *7 (W.D. Va. Dec. 16, 2002) (applying Virginia law) (“In summation, not only does MedPro have no right under its insurance contract to seek reimbursement from its insureds, there is no case law supporting the plaintiff’s theory of reimbursement. To the contrary, all of the decisional authority suggests that MedPro is not entitled to reimbursement from its insureds for choosing to defend a claim at least potentially covered under its policy.”).

The insurer generally has the burden of proving by a preponderance of the evidence that it is entitled to recoupment of defense costs. *Buss v. Superior Court*, 939 P.2d 766, 778 (“In a ‘mixed’ action, when the insurer seeks reimbursement for defense costs from the insured . . . [i]t is the insurer that must carry the burden of proof.”). Courts that allow recoupment pursuant to a unilateral reservation of rights require that the insurer may only seek recoupment after the duty to defend has been terminated. See *Knapp v. Commonwealth Land Title Ins. Co., Inc.*, 932 F. Supp. 1169, 1172 (D. Minn. 1996) (applying Minnesota law) (“The courts should be consistent in encouraging insurance companies to properly meet their duty to defend its insured against third party claims and minimize unnecessary claims to enforce policy coverage. However, where an insurer has properly met its duty and subsequently successfully challenges policy coverage, it should be entitled to the full benefit of such a challenge and be reimbursed for the benefits it bestowed, in good faith, to its insured.”); *Frank & Freedus v. Allstate Ins. Co.*, 52 Cal. Rptr. 2d 678, 686 (Cal. Ct. App. 1996) (“The law permits an insurance company to condition an acceptance of defense on a *later* right to contest coverage or to seek reimbursement of defense costs.” (emphasis added)); *Hecla Min. Co. v. New Hampshire Ins. Co.*, 811 P.2d 1083, 1089 (Colo. 1991) (“The appropriate course of action for an insurer who believes that it is under no obligation to defend, is to provide a defense to the insured under a reservation of its rights to seek reimbursement should the facts at trial prove that the incident resulting in liability was not

covered by the policy, or to file a declaratory judgment action after the underlying case has been adjudicated.”).

§ 22. Defense-Cost-Indemnification Policies

(1) A defense-cost-indemnification policy is an insurance policy in which the insurer agrees to pay the costs of defense of a covered legal action and does not undertake the duty to defend. Typically, such policies also cover settlements and judgments.

(2) When a defense-cost-indemnification policy obligates an insurer to pay the costs of defense on an ongoing basis:

(a) The scope of the insurer’s defense-cost obligation is determined using the rules governing the duty to defend stated in § 13, § 18, and § 20;

(b) To preserve the right to contest coverage for a legal action, the insurer must follow the reservation-of-rights procedure stated in § 15; and

(c) An insurer that breaches this defense-cost obligation loses the right to associate in the defense of the action under § 23 and the right to exercise any control in the settlement of the action.

(3) When a defense-cost-indemnification policy does not obligate an insurer to pay the costs of defense of a covered legal action on an ongoing basis, the insurer’s obligation to pay defense costs is determined based on all the facts and circumstances, unless otherwise provided in the policy.

Comment:

a. Scope of the defense obligation when the insurer must pay the costs of defense on an ongoing basis. Most courts that have considered the issues addressed in this Section treat defense-cost-indemnification policies the same as duty-to-defend policies, as long as the defense-cost-indemnification policies obligate the insurer to pay the defense costs on an ongoing basis. By contracting to pay defense costs on an ongoing basis, an insurer promises to provide the policyholder access to a timely, insurer-funded defense. This promise implicates the same access-to-justice justifications that undergird the duty-to-defend rules incorporated by reference in this Section. Accordingly, the insurer has an obligation to pay all of the costs of the defense, including costs that are incurred solely to defend components of the legal action that are not covered; the insurer must provide the insured with a proper notice under § 15 in order to preserve

a ground for contesting coverage; the insurer may terminate the duty to pay defense costs exclusively in the manner stated in § 18; when there are multiple insurers with an obligation to pay defense costs on an ongoing basis, the insured may select which insurer has the primary obligation to pay defense costs under the procedure stated in § 20 for duty-to-defend policies; and the insurer may obtain recoupment of noncovered defense costs only if that right is stated in the insurance policy; and, finally, an insurer that breaches the duty to pay defense costs on an ongoing basis loses the right to associate in the defense and to assert any control in the settlement of the underlying legal action. Courts have not had occasion to address all these issues in the context of defense-cost-indemnification policies, but courts have consistently treated the two types of “real time” defense coverage identically.

b. Notice of grounds for contesting coverage. Because the insured controls its own defense under a defense-cost-indemnification policy, the justifications for the reservation-of-rights requirement under such a policy are not as strong as the justifications for the reservation-of-rights requirement under a duty-to-defend policy. Cf. § 15, Comment *a*. Nevertheless, there is a similar potential for the insured’s reasonable expectations to be frustrated when an insurer pays the costs of defense without reserving the right to contest coverage. A rule that requires insurers to provide notice of grounds for contesting coverage protects those expectations and permits insureds to organize their affairs in light of their insurers’ defenses. While there is little authority that directly engages with these rules, the current practice among insurers that issue defense-cost-indemnification policies, such as Directors’ and Officers’ Liability Insurance, is to provide reservation-of-rights letters that identify all of the potential grounds for denial of insurance coverage and for insurers to update those letters when they obtain information indicating other potential grounds for denial of coverage.

c. When the duty to pay defense costs is not on an ongoing basis. A retrospective defense-cost-reimbursement policy does not raise the same access-to-justice concerns as a defense-cost-indemnification policy in which the insurer agrees to pay defense costs on an ongoing basis. A retrospective reimbursement policy does not promise to provide access to an insurer-funded defense. Rather, it promises to reimburse the insured, at the end of the process, for the costs of defending a covered legal action. Whether the action is covered is to be evaluated based on all of the information available at the time that reimbursement, if any, is owed. At that point the opportunity to defend the action is over and, thus, none of the special rules that are

designed to encourage the insurer to undertake the defense, or to pay the costs of defense on an ongoing basis, have any application.

REPORTERS' NOTE

a. Scope of the defense obligation when the insurer must pay the costs of defense on an ongoing basis. Insurers “may assume a duty to reimburse for defense costs without assuming a duty to defend.” *Save Mart Supermarkets v. Underwriters at Lloyd’s London*, 843 F. Supp. 597, 603 (N.D. Cal. 1994) (applying California law). Directors’ and Officers’ insurance policies, for instance, are “commonly written as indemnity-only, with no duty to defend and with a total indemnity limit that is applicable to both the costs of defense and costs of settlement or judgment.” Ellen S. Pryor, *The Stories We Tell: Intentional Harm and the Quest for Insurance Funding*, 75 TEX. L. REV. 1721, ~~1751~~1750 n.91 (1997). See also Wayne E. Borgeest et al., *Current Issues in Directors and Officers Liability Insurance*, [Order No. H4-5184](#), 495 PLI/Lit 379, 382 (1994) (“D&O policies do not provide for a right or a duty to defend as do general liability policies. . . [T]he liability limits of D&O policies are inclusive of, and depleted by, the incurring of defense costs.”).

When there is a duty to pay the ongoing costs of defense, the majority of courts that have engaged the issue have held that the initial determination of the scope of the duty is controlled by the [complaint-allegation rule \(sometimes also called the “pleadings test”\)](#) and the “one claim-all claims” principle as it would be in a duty-to-defend case. *Am. Chem. Soc. v. Leadscope, Inc.*, No. 04AP-305, 2005 WL 1220746, at *2 (Ohio Ct. App. May 24, 2005). Thus, the test of the duty of an insurer to advance defense costs is:

the scope of the allegations of the complaint in the action against the insured, and where the complaint brings the action within the coverage of the policy the insurer is required to make defense, regardless of the ultimate outcome of the action or its liability to the insured.

Id. at *2 (citing *Motorists Mutual v. Trainor*, 294 N.E.2d 874, 875 (Ohio 1973)), and:

where the insurer’s duty to [advance defense costs] is not apparent from the pleadings in the action against the insured, but the allegations do state a claim which is potentially or arguably within the policy coverage, or there is some doubt as to whether a theory of recovery within the policy coverage has been pleaded, the insurer must accept the [defense costs] of the claim.

Id. (citing *Willoughby Hills v. Cincinnati Ins. Co.*, 459 N.E.2d 555, 558 (Ohio 1984)). See also *Julio & Sons Co. v. Travelers Cas. & Sur. Co.* [of Am.](#), 591 F. Supp. 2d 651, 659 (S.D.N.Y. 2008) (applying Texas law) [\(internal citations omitted\)](#) (“[T]he ~~court~~Court holds that the eight corners rule applies to the [coverage](#) dispute here at issue. While there appears to be no dispute that the defendant has no duty to defend any claim against plaintiff,--- the Court has found no decisions by the Texas courts concerning a different standard for a duty to advance costs, and the

reasons for applying the eight corners rule to duty to defend [disputes](#) appear to apply equally to the duty to advance described in the [policy](#) [Policy](#).”); *Federal Ins. Co. v. Kozlowski*, 18 A.D.3d 33, 40 (N.Y. App. Div. 2005) (“The rule is well settled that the duty to defend is broader than the duty to indemnify. The duty to defend arises whenever the underlying complaint alleges facts that fall within the scope of coverage. ‘The same allegations that trigger a duty to defend trigger an obligation to pay defense costs.’ . . . The ultimate validity of the underlying complaint’s allegations is irrelevant.” (quoting *Travelers Prop. Cas. Corp. v. Winterthur Ins. Int’l*, No. 02 Civ. 2406(SAS), 2002 WL 1391920, at *6 (S.D.N.Y. June 25, 2002))). Moreover, “when a complaint against an insured states several claims based on the same occurrence, and the insured [sic] is contractually obligated to the insured for one claim, it has the duty to [advance defense costs of] the insured against all claims, regardless of the ultimate outcome of the action or the insurer’s ultimate liability to the insured . . .” *Am. Chem. Soc. v. Leadscope, Inc.*, No. 04AP-305, 2005 WL 1220746, at *3 (Ohio Ct. App. May 24, 2005) (citing *Preferred Mut. Ins. Co. v. Thompson*, 491 N.E.2d 688 (Ohio 1968)). See also *Fed. Ins. Co. v. Sammons Fin. Grp., Inc.*, 595 F. Supp. 2d 962, 976 (S.D. Iowa 2009) (applying Iowa law) (“[S]tate courts generally have viewed an insurer’s duty to advance defense costs as an obligation congruent to the insurer’s duty to defend . . .”) (citing *Acacia Research Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, No. 05-501, 2008 WL 4179206, at *11 (C.D. Cal. Feb. 8, 2008)); *Hurley v. Columbia Cas. Co.*, 976 F. Supp. 268, 275 (D. Del. 1997) (applying [Delaware](#) [Michigan](#) law); *Am. Chem. Soc. v. Leadscope, Inc.*, No. 04AP-305, 2005 WL 1220746, at *4-8 (Ohio Ct. App. May 24, 2005).

This Section does not adopt a default rule as to whether the insurers’ duty to pay defense costs is on an ongoing basis. Many insurers now include “specific language dealing with contemporaneous reimbursement”; some agree to “contemporaneously reimburse for defense costs as they are incurred,” while others “have altered the policy terms to make it clear that the insurer has no duty to defend and will not pay or reimburse for any defense costs until the case is finally resolved.” Borgeest et al., *Current Issues*, 495 PLI/Lit at 385. See also [4BC](#) ROBERT L. HAIG, N.Y. PRAC., COM. LITIG. IN NEW YORK STATE COURTS [8394](#):71 ([3d4th](#) ed. [2011](#)[2017](#)) (“Whether or not an insurer has an obligation to advance expenses as they are incurred or whether it is simply required to reimburse expenses at the conclusion of litigation typically depends upon the language of the insurance policy at issue.”). In the absence of clear policy language, courts have split as to whether defense costs must be paid contemporaneously. See Borgeest et al., *Current Issues*, 495 PLI/Lit at 383 (“One issue which has received considerable attention is whether a D&O insurer is obligated . . . to pay defense costs as they are incurred and prior to the final disposition of the action. The courts remain split . . .”); 2 STEVEN PLITT & JORDAN R. PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 14:15 ([2012](#)[2017](#)) (same); William B. Pollard, *Conflicting Views on Requiring Advancement of Defense Cost Under D&O Policies in the Absence of an Advancement Provision*, 79 PLI/Lit 43 (2009).

In *Okada v. MGIC Indemnity Corp.*, 608 F. Supp. 383 (D. Haw. 1985) (applying Hawai‘i law), *aff’d in part, rev’d in part*, 795 F.2d 1450 (9th Cir. 1986), amended and corrected, 823 F.2d 276 (9th Cir. 1987), a D&O policy was held to require contemporaneous payment of defense

costs. The policy at issue in *Okada* provided that a “loss occurs” whenever the insureds are “legally obligated to pay” on a covered action and that a loss includes legal-defense costs. 823 F.2d at 280. The Ninth Circuit, upon rehearing, affirmed the disposition of the district court, holding that such language, “in the absence of other provisions,” requires the insurer, as a general rule, to pay defense costs as they are due, i.e., contemporaneously. *Id.* For similar holdings, see *McCuen v. American Casualty Am. Cas.*, 946 F.2d 1401, 1407 (8th Cir. 1991) (applying Iowa law) (holding, in the absence of contrary policy language, that the insured’s defense costs constituted a “loss” which the insurer was obligated by the policy to pay as the costs were legally incurred); *Commercial Capital Bankcorp. Inc. v. St. Paul Mercury Ins. Co.*, 419 F. Supp. 2d 1173, 1180-1181 (S.D. Cal. 2006) (applying California law) (holding that the default rule requires the insurer to make contemporaneous payment of defense costs incurred by the insured); *Fight Against Coercive Tactics Network, Inc. v. Coregis Ins. Co.*, 926 F. Supp. 1426, 1434 (D. Colo. 1996) (applying Colorado law) (holding that the policy language must be clear in order to modify the general duty of contemporaneous payment of legal costs of defense).

b. Notice of grounds for contesting coverage. See *Welch Foods, Inc. v. Nat’l Union Fire Ins. Co.*, [No. 09-12087-RWZ](#), 2011 [U.S. Dist. LEXIS 17134](#), [WL 576600](#), at *9 (D. Mass. Feb. 9, 2011) (applying Massachusetts law) (“[T]he insurer bears the responsibility for making this determination [to forward defense costs even if the claim may be uncovered], and the concomitant risk if its decision to advance fees is wrong.”). One commentator discusses the difference between a reservation-of-rights letter issued under a policy with a duty to defend, and a letter issued when the insurer only has a duty to pay defense costs:

If a reservation of rights letter is issued with respect to a general liability policy, which includes a duty to defend, the insured has notice that a potential conflict exists. This conflict arises over the fact that by reserving its rights to contest coverage, the carrier is alerting the insured that it will not defend claims for which it believes no coverage exists. In D&O insurance, however, which generally provides only for a duty to pay, any comparable conflict disclosed by a reservation of rights letter is theoretically not [as](#) significant because the insured chooses its own counsel. . . . Carriers advance defense costs subject to an express reservation of rights, or even an agreement, that the carrier may deny coverage under the policy at the conclusion of the litigation, if there turns out to be no coverage, the insured is liable to repay the funds that have been advanced.

JOHN K. VILLA, *BANK DIRECTORS’, OFFICERS’, AND LAWYERS’ CIVIL LIABILITIES* § 4.11[B] ([2012](#) [2d ed.](#) [2018](#)). As in liability policies containing a duty to defend, an insured has no right to refuse an advancement of defense costs made contingent on a proper reservation of rights:

[The insurer] may, of course, in payment of costs on covered claims as those costs come due, reserve its rights pursuant to the contract should the claims ultimately prove uncovered. For example, [the insurer], while advancing costs, may reserve its rights under section 3(a)(5) should the directors’ acts ultimately prove

intentional rather than negligent. The directors have a right to the contemporary payment of costs. They have no right, however, to the unconditional payment of costs, when those conditions were clearly and unequivocally expressed.

Okada v. MGIC Indem. Corp., 823 F.2d 276, 282 (9th Cir. 1986) (applying Hawai‘i law). See Old Republic Ins. Co. v. FSR Brokerage, Inc., 95 Cal. Rptr. 2d 583, 591 (Cal. Ct. App. 2000) (an insurer with a potential right to reimbursement of defense costs forfeits that right if it does not specifically reserve it in a communication to the policyholder before advancing the defense costs). In Haley v. ~~Continental Casualty Company~~ Cont’l Cas. Co., for example, the court first held that the doctrine of waiver did apply to a “duty to reimburse” (as opposed to a duty-to-defend) policy, and further that “the notice of claim letters constituted a demand for reimbursement and triggered [the insurer’s] duty to raise any void *ab initio* defense it might have had to indemnification of the insureds.” 749 F. Supp. 560, 567-568 (D. Vt. 1990) (applying Vermont law). Thus, the insurer “as a matter of law waived the right to assert a void *ab initio* defense.” Id. at 570.

c. When the duty to pay defense costs is not on an ongoing basis. Breach of retroactive defense-reimbursement policies is treated differently from ongoing defense-reimbursement policies because of the lesser risk of harm to the insured. A retroactive defense-reimbursement policy requires the insured to bear the costs of defense in the first instance, so breach of the contract does not interfere with the provision of an adequate defense. See, e.g., Nat’l Union Fire Ins. Co. v. Greenwich Ins. Co., ~~2009 U.S. Dist. LEXIS 53085, No. C07-2065-JCC, WL 1794041~~, at *15 (W.D. Wash. June 22, 2009) (applying Washington law) (insurer does not lose coverage defenses for breach of a retroactive reimbursement policy because the insured received appropriate counsel); Safeco Ins. Co. of Am. v. Butler, 118 Wash. 2d 383, 389 (Wash. 1992) (same).

§ 23. The Right to Associate in the Defense

(1) When an insurer has the right to associate in the defense of a legal action, that right includes, unless otherwise stated in the insurance policy:

(a) The right to receive from defense counsel and the insured, upon request, information that is reasonably necessary to assess the insured’s potential liability and to determine whether the defense is being conducted in a manner that is commensurate with that potential liability, with the exception of information protected by attorney–client privilege, work-product immunity, or a defense lawyer’s duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured; and

(b) A reasonable opportunity to be consulted regarding major decisions in the defense of the action that is consistent with the insurer’s level of engagement with the defense of the action.

(2) The provision of information to an insurer pursuant to the right to associate does not waive any confidentiality rights of the insured with respect to third parties.

Comment:

a. Reasonable opportunity to be consulted. Defense-cost-indemnification policies and excess-liability insurance policies commonly contain provisions granting the insurer the right to associate in the defense. An insurance company providing an independent defense under a duty-to-defend policy also has a right to associate in the defense. The right to associate allows an insurer to manage its exposure by giving the insurer the opportunity to exercise a voice in the defense of the legal action. The right to associate is not the right to direct the defense of the action. It is the right to be heard in the course of the defense and to obtain information reasonably necessary to be heard. The information that must be provided and the situations in which consultation is required are subject to a reasonableness rule that is context dependent. If an insurer with the right to associate would like to receive specific types of information and to be consulted on specific types of decisions, it would be prudent for the insurer to make those expectations known to the insured. Such expectations need be honored only to the extent that they are reasonable. In most cases and especially in cases involving large commercial policyholders with high-quality defense counsel, the insurer does not need an explicit right to associate. This is because a prudent insured will keep the insurer well informed in order to prepare the case for eventual settlement or trial, and the insurer will be unlikely to exercise the right to associate to any significant extent. The right to associate primarily protects the insurer and the risk pool in the unusual situation in which the insured or the insured’s defense counsel is seriously mishandling the defense. The right to associate provides the insurer access to the information needed to determine whether such a situation is arising and, if so, to attempt to influence counsel and the insured to put the defense on a better course.

b. Major decisions in the defense of the claim. What constitutes a major decision will vary according to the nature of the legal action. In cases involving excess insurance, the obligation to consult with excess insurers will depend on the likelihood that the decision affects the exposure of the insurer. For example, the insured and a primary insurer would not ordinarily

be required to consult with an excess insurer regarding an opportunity to settle for an amount that is below the attachment point of the excess insurer.

c. Consistent with the insurer's level of engagement. Insurers choose to be more or less involved in the defense of an action for many reasons. It would not be efficient to require insureds to consult to the same degree with all insurers in all cases. A one-size-fits-all rule would lead to excessive consultations in some situations and insufficient consultations in others. Some insurers take a “hands off” approach, while others are more actively engaged. The insured's corresponding duty to cooperate is commensurate with that choice. See § 30. Accordingly, one part of the rule of reason that is the guide to all aspects of the right to associate is the consideration of the insurer's level of engagement with the legal action. If an insurer that has taken a hands-off approach to the action would like to become more actively involved, it is the insurer's obligation to so inform the insured and the defense team. On the other hand, if the course of the defense of an action changes such that a high-level excess insurer now appears to be much more exposed to potential loss than it had been led to believe in the past, it is the insured's obligation to so inform that excess insurer.

d. Exceptions for confidential information. Consistent with the rules governing the right to defend, an insurer with the right to associate does not have the right to certain confidential information. See § 11, Comment *d*.

e. A note of caution. Subsection (2) clarifies that information shared with an insurer pursuant to a right to associate should be subject to the same level of protection from third parties as information shared with an insurer exercising the right to defend. See § 11, Comment *a*. As described in Comment *c* to § 11, however, there is a risk in sharing information in a jurisdiction in which courts have not previously agreed with this position. There are courts that have required the use of certain documentary formalities, such as the appointment of the insurer as the insured's communicating agent for purposes of managing the dispute or as the insured's co-client under a common-interest arrangement. Such formalities may be particularly important in the case of a non-defending insurer, which will generally be the situation for an insurer with only the right to associate in the defense. Even when such formalities are observed, there may be some risk that disclosure will waive a privilege or immunity, and that risk is greater when an insurer has not unequivocally accepted coverage for the claim.

REPORTERS' NOTE

a. Reasonable opportunity to be consulted. There is little law on any aspect of the right to associate. The relatively few reported opinions that exist are not inconsistent with the rules stated in this Section, with the exception of some authority that provides less confidentiality protection for communications than that provided by subsection (2). See Reporters' Note to Comment *d* for this authority. In policies or reinsurance agreements in which the insurer does not retain the duty to defend, the right to associate gives the insurer “adequate means by which to keep informed of events that may give rise to coverage under its agreement, and also provides sufficient means to protect its own interests.” *North River Ins. Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363, 370 (D.N.J. 1992) (applying New Jersey law). The right to associate is therefore typical in reinsurance and excess-insurance contracts, as well as policies under which the insured controls the defense. See 7 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION*

§ 72.02[5][g] (Lexis ~~2012~~2017) (“Reinsurance contracts often provide the reinsurer with a right to associate with the cedant in the investigation and defense of the underlying claim.”); Michael A. Knoerzer, *Introduction to Excess Insurance and Reinsurance*, 652 *PLI/Lit* 115, 134 (2001) (outlining the right to associate in excess-insurance contracts); James A. Fanto, *Insurance Policies*, *PLIREF-DIRLIAB* § 8:4.4[E][1] (2011) (“A typical D&O policy will also provide the insurer the right to associate with the company, directors and officers in defense and settlement of the claims.”).

In excess-insurance policies, a typical clause detailing the rights and obligations of the excess insurer provides:

The company shall NOT be obligated under this policy to assume responsibility for the defense, investigation, settlement, or management of any suit or claim instituted against the named insured. The Company shall have, at its option and at its expense, the right and opportunity to associate or participate with the named insured in the defense, investigation, settlement, management and control of any suit or claim which appears reasonably likely to involve this excess insurance policy.

Knoerzer, *Introduction*, 652 *PLI/Lit* at 134. Similar language appears in policies where the insured retains primary control of its own defense. See, e.g., *MBIA Inc. v. Federal Ins. Co.*, 652 F.3d 152, 167 (2d Cir. 2011) (applying New York law) (quoting a right-to-associate clause from a D&O policy). Finally, reinsurance policies typically include the following language:

While the reinsurer does not undertake to investigate or defend claims or suits, the reinsurer shall have the right and shall be given the opportunity with full cooperation of the reinsured, to associate counsel at its own expense in the defense and control of any claim involving this reinsurance.

3 ~~DAVID L. LEITNER~~ MITCHELL A. ORPETT ET AL., LAW AND PRAC. OF INS. COVERAGE LITIG. § 41:26 (July 20122017). See also 7 Jeffrey E. Thomas, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 72.02[5][g] (Lexis 20122017) (quoting similar language).

Unlike the duty to defend, the right to associate only allows an insurer to participate in the claim-management process; the insured or another insurer “remains responsible for providing a defense, for investigating the claim or for attempting to get control of the claim in order to effect an early settlement.” 7 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 72.02[5][g] (Lexis 20122017). See also *MBIA Inc. v. Federal Ins. Co.*, 652 F.3d 152, 167 (2d Cir. 2011) (applying New York law) (collecting cases holding that “right to associate” clauses provide only an option or opportunity to intervene); *Christiania Gen. Ins. Corp. of N.Y. v. Great Am. Ins. Co.*, 979 F.2d 268, 277 (2d Cir. 1992) (applying New York law) (describing right to associate as “opportunity”); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 536 F.2d 730, 736 (7th Cir. 1976) (applying Illinois law) (“The reservation of the option to ‘associate’ in the defense imposes no duties when that option is not exercised.”); Knoerzer, *Introduction*, 652 PLI/Lit at 134 (noting that excess insurers typically have no duty to defend, but reserve the right to associate). Similarly, the right to associate by itself does not usually allow an insurer to veto an insured or primary insurer’s decision in the handling of an action, or allow the insurer to later deny coverage on the ground that a decision was unreasonable. See, e.g., *Utah Power & Light Co. v. Federal Ins. Co.*, 983 F.2d 1549, 1558 (10th Cir. 1993) (applying Utah law) (holding that the insured, by consistently updating the insurer on the action and settlement negotiations, had fulfilled its duty under the right-to-associate clause and the insurer was “barred from contesting the reasonableness of the settlement amount”).

Instead, the right to associate affords the insurer “the right to consult with and advise” the insured or primary insurer in the handling of the action. *Unigard Sec. Ins. Co., Inc. v. North River Ins. Co.*, 594 N.E.2d 571, 575 (N.Y. 1992). Meaningful participation in the action in turn requires that the insurer has notice of the action and access to the relevant information. See, e.g., *MBIA Inc.*, 652 F.3d at 167 (holding that an insured who “provided sufficient notice” and “gives the insurer an invitation to associate with adequate information about the claim under consideration” had discharged its duty to the insurer under the “right to associate” clause). See also 7 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 73.03[1] (Lexis 20122017) (“A cedant’s notice of an impending claim is the first opportunity the reinsurer has to exercise its ‘right to associate.’”). In reinsurance policies, the right to associate “often appears in the same clause as the notice provision and operates in tandem with notice to afford the reinsurer an opportunity to form an intelligent estimate of its liabilities.” *Id.*, § 72.02[5][g].

b. Major decisions in the defense of the claim. Many excess-insurance policies explicitly provide that the right to associate is limited to “any suit or claim which appears reasonably likely to involve this excess insurance policy.” Knoerzer, *Introduction*, 652 PLI/Lit at 134. See, e.g., *Tucker v. American InternAm. Int’l Group, Inc.*, No. 3:09-CV-1499, 2012 WL 314866, at *12 (D. Conn. Jan. 31, 2012) (applying Connecticut law) (“The Insurer shall have the right to effectively associate with the Company . . . in the defense of any Claim that appears reasonably

likely to involve the insurer[.]”). See also Scott M. Seaman & Charlene Kittredge, *Excess Liability Insurance: Law and Litigation*, 32 TORT & INS. L.J. 653, 663 (1997) (“These provisions [are intended to](#) allow the excess insurer . . . to become involved in actively defending lawsuits that could involve its layer of coverage.”). Reinsurance policies may include similar language. See, e.g., *Unigard Sec. Ins. Co., Inc.*, 594 N.E.2d at 579 (reinsurer reserved the opportunity to associate in “any claim, suit, or proceeding which may involve this reinsurance”).

In cases potentially implicating an insurer or reinsurer, what constitutes a major decision will vary depending on the nature of the case. When a policyholder incurred enormous legal fees defending a long suit without keeping its excess insurer properly informed of the proceedings, for instance, the court found the excess insurer had been deprived of its right to associate because it had been prevented from participating in “decisions such as choice of law firms, choice of forum, and how to weigh the cost of ongoing litigation versus the cost of settlement—all factors that affect legal fees.” *Lexington Ins. Co. v. United Health Group Inc.*, No. 09cv10504-NG, 2011 WL 1467939, at *10 & n.12 (D. Mass. Apr. 18, 2011) (applying Minnesota law). In cases that reach settlement discussions, the right [to associate](#) [clause in some insurance policies](#) may include [a right to receive](#) notice of settlement offers and [participation](#) [participate](#) in negotiations. See, e.g., *Tucker v. American Intern. Am. Int’l Group, Inc.*, No. 3:09-CV-1499, 2012 WL 314866, at *12 (D. Conn. Jan. 31, 2012) (applying Connecticut law).

c. Consistent with the insurer’s level of engagement. In *MBIA Inc. v. Fed. Ins. Co.*, 652 F.3d 152, 168 (2d Cir. 2011), the court held that informing the insurer at the outset of negotiations satisfied the “opportunity” or “option” for a right to associate, and when the other insurer declined to participate, the insured was entitled to “take the insurer’s RSVP at face value.” “This is not to say that the right to associate is a one-shot opportunity, but it is not the insured’s duty to return to the nonparticipating insurer each time negotiations about the same claim take a new twist and ask if the insurer still wants to opt out” especially when the insurer had been notified of the action long before settlement and the disputed component of the settlement was not unforeseeable. *Id.* at 167-168. See also *Federal Insurance Fed. Ins. Co. v. Hawaiian Electric Industries Indus.*, No. 84CV771, 1995 WL 1913089, at *16 (D. Haw. Dec. 15, 1995) (applying Hawai’i law) (holding that multiple notices by the insured inviting the insurer to participate in the defense discharged the insured’s duty to cooperate further with the insurer).

d. Exceptions for confidential information. “Virtually all cases addressing the attorney-client privilege in the insurer-insured context have arisen where the insurer possessed an express duty to defend.” Melvin R. Goldman et al., *Directors’ and Officers’ Insurance: An Analysis of Current Issues*, 443 PLI/Lit 411, 472 (1992). As explained by one commentary however,

[W]here an attorney is retained by the insurer to defend an insured, the attorney’s work product and the attorney’s communications with the insured are protected from disclosure so that the parties can freely communicate regarding common defense of the action. . . [T]he distinction between the D&O type of policy and the duty to defend type of policy lies in which party actually retains defense counsel

and which party controls the course of the litigation. It does not appear that these differences should affect issues of attorney-client privilege and attorney work product.

W. Borgeest & E. Boyle, *Duties of the Insured to the Directors' and Officers' Insurer*, 535 PLI/Comm 147, 202-203 (1990). In theory, this limitation on the insurer's right to information should not change merely because the insured controls selection of counsel and the control of the defense. *Id.* at 203-206 (noting that there is no precedent precisely on point in the context of D&O policies). The same rationale for protecting information shared between the insurer and the insured when the insurer controls the defense—allowing a “free flow of information” in a common defense—applies to policies under which the insured or another insurer controls the defense. *Id.* at 200, 203 (noting also that although “there is no apparent precedent for [this] precise issue . . . it appears that an analogous situation arises in connection with ‘duty to defend’ type policies where, due to potential conflicts between the insured and the insurer, the insured actually retains defense counsel with the consent of the insurer.”). See, e.g., *Lectrolarm Custom Systems Sys., Inc. v. Pelco Sales, Inc.*, 212 F.R.D. 567, 572-573 (E.D. Cal. 2002) (applying California law) (holding that California law does not recognize an automatic attorney–client privilege for information shared with the insurer when a conflict of interest entitles the insured to independent counsel, but “communications relating to that common interest” in defending covered actions do not waive the insured’s privilege); *United States Fidelity & Guar. Co. v. Superior Ct.*, 252 Cal. Rptr. 320, 328 (Cal. Ct. App. 1988) (“[B]oth the counsel provided by the insurer and the independent counsel are entitled to participate in all aspects of the litigation and they are required to cooperate fully in the exchange of information The insured is not relieved of the duty to cooperate with the insurer under the terms of the policy. Moreover, independent counsel and the insured have a duty to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes.”). But see *Fidelity Nat'l Financial, Inc. v. National Nat'l Union Fire Ins. Co. of Pittsburgh*, No. 09cv140-AJBGPC-KSC, 20122014 WL 4443993, 1393743, at *54 (S.D. Cal. Sept. 25, May 30, 2012) (applying California law) (disagreeing with *Lectrolarm* and finding that “where a reservation of rights has been made, there is no ‘common interest’ and as such, the production of privileged information to the insurer constitutes a waiver of privilege”). Two federal courts in California have reached diverging conclusions regarding whether information remains privileged when shared with an insurer that has neither an obligation to defend nor an explicit right to associate. Compare *Great American Am. Surplus Lines Insurance Ins. Co. v. Ace Oil Co.*, 120 F.R.D. 533, 535, 537-538 (E.D. Cal. 1988) (applying California law) (holding that information given by the liability insurer to its reinsurer in order to keep the reinsurer “notified of progress on the claims” was privileged under a theory of reasonable necessity), with *In re Imperial Corp. of America Am.*, 167 F.R.D. 447, 452-456 (S.D. Cal. 1995) (applying California law) (declining to extend attorney–client privilege to policies under which the insurer has no duty to defend, even though the D&O policy at issue still obligated the insured to cooperate with the insurer). For further discussion of protection of information shared between the insurer and the insured when

the insured conducts the defense, see generally Lindsay Fisher, Comment, *D&O Insurance: The Tension Between Cooperating with the Insurance Company and Protecting Privileged Information from Third Party Plaintiffs*, 32 SEATTLE U. L. REV. 201 (2008). In the reinsurance context, a number of courts have specifically held that the reinsurer may not access information from the cedant if the information is relevant to a dispute between the cedant and the reinsurer and would otherwise be protected. See, e.g., *North River Ins. Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363 (D.N.J. 1992) (applying New Jersey law) (rejecting several theories under which the reinsurer asserted the right to access information from the cedant protected by attorney–client privilege); *Gulf Ins. Co. v. Transatlantic Reinsurance Co.*, 13 A.D.3d 278, 279-280 (N.Y. App. Div. 2004) (holding that the provision in the reinsurance agreement allowing the reinsurer to examine records relating to the reinsurance or potential actions did not operate as a blanket waiver of attorney–client privilege in a subsequent dispute between the insurer and the insured). For further discussion of a reinsurer’s ability to access protected information from the reinsured, see Paul M. Hummer, *Discovery of Reinsurance Information in Insurance Coverage Litigation*, 68 DEF. COUNS. J. 339, 345-346 (2001); Louis Torch, *An Examination of Reinsurer’s Associations in Underlying Claims: The Iron Fist in the Velvet Glove?*, 3 PIERCE L. REV. 331, 346-356 (2005).

TOPIC 2

SETTLEMENT

§ 24. The Insurer's Duty to Make Reasonable Settlement Decisions

(1) When an insurer has the authority to settle a legal action brought against the insured, or ~~the authority to settle the action rests with the insured but~~ the insurer's prior consent is required for any settlement by the insured to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

(2) A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.

(3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

Comment:

a. Relationship to the duty of good faith and fair dealing. Because of its origins in the duty of good faith and fair dealing, courts in many jurisdictions refer to the standard for breach of the duty to make reasonable settlement decisions as one of "bad faith." That formulation suggests the need to prove ~~some~~ bad intent on the part of the insurer that goes beyond the reasonableness standard stated in this Section, and some courts do require such a showing. In most breach-of-settlement-duty cases, however, even those that invoke the language of bad faith, the ultimate test of liability is whether the insurer's conduct was reasonable under the circumstances.

This Restatement clarifies the law by making a clear distinction among several categories of insurance law cases that many courts classify together as insurance bad-faith cases but in practice treat as distinct—from each other. Two of these categories of cases deal with the settlement context; the third deals with contexts not involving settlement.

The first category is that of an insurer that allegedly made an unreasonable settlement decision that resulted in, or could result in, an excess verdict against the insured. This is the category of cases addressed in this Section. For this category of cases, courts generally apply an

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objective, commercial-reasonableness standard, as distinct from a standard that ~~requires~~relies primarily on proof of bad intent. To make clear that an insurer’s settlement duty is grounded in commercial reasonableness, this Section does not use the term “bad faith” to describe the insurer’s breach of the duty to make reasonable settlement decisions. Rather, this Section states ~~directly~~expressly the commercial reasonableness standard that most courts actually apply.

The second category of cases that many courts classify as involving insurance bad faith is that of an insurer that allegedly engaged in improper conduct outside of the settlement context. For those cases, which are much less frequently the subject of published liability insurance opinions than breach-of-settlement-duty cases, this Restatement uses the term “bad faith” and, like most courts, applies a more demanding two-prong test, as stated in § 49. Separating these first two categories of cases clarifies and improves the law by reducing the likelihood that an inexperienced judge or lawyer will mistakenly conclude that the same legal standard applies in both categories.

The third category of cases that many courts classify as involving insurance bad faith is that of an insurer whose improper conduct in the settlement context goes beyond unreasonableness and satisfies the more demanding two-prong test stated in § 49. Under the rules as clarified in this Restatement, such an insurer would be subject to additional liability for bad faith under § 49. That additional liability can include attorneys’ fees and, if the relevant state-law standard is met, punitive damages. See § 50. To be clear: a liability insurer that breaches the duty to make reasonable settlement decisions stated in this Section is subject to liability for damages under § 27, but it is not thereby subject to liability for insurance bad faith unless the insured proves that the insurer’s conduct also meets the more demanding requirements of § 49. See Comment *c* to § 49.

b. A duty to make reasonable settlement decisions rather than the “duty to settle.” The duty set forth in this Section is a longstanding rule of insurance law that is frequently referred to in shorthand by commentators and some courts as the “duty to settle.” This Section uses a more accurate term, the “duty to make reasonable settlement decisions,” to emphasize that the insurer’s duty is not to settle every legal action, but rather to protect the insured from unreasonable exposure to a judgment in excess of the limits of the liability insurance policy. Although a strict-liability standard of the sort that might be suggested by the label “duty to settle” would eliminate the need for the reasonableness evaluation, a strict-liability standard has not found

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favor in the courts. Moreover, the reasonableness standard followed in this Section is more closely tailored to the conflict of interest that underlies the legal duty.

The insurer's duty to make reasonable settlement decisions arose as a special application of the general contract-law duty of good faith and fair dealing in the context of insurance policies that granted the insurer discretion over the settlement of an insured liability action. As courts early recognized, when the insured faces a potential judgment in excess of the policy limit (an "excess judgment"), the insurer may have an incentive to undervalue the possibility of a loss at trial, since a portion of that loss will be borne by the insured rather than by the insurer, absent a legal rule assigning the risk of excess judgment to the insurer. For example, if an insurer receives a settlement offer that is equal to or just under the policy limits, the insurer has little financial incentive, other than a reduction in defense costs, to accept that offer as long as there is some chance of a judgment at trial in favor of the defense. By going to trial in such cases, the insurer maintains the possibility of eliminating its own liability by winning the case against the claimant. Moreover, as long as the insurer's liability is bounded by the policy limit, taking the case to trial imposes no added risk on the insurer, beyond the additional defense costs required to try the case. As courts have described this conflict-of-interest problem, an insurer that rejects a reasonable settlement offer in favor of going to trial is effectively "gambling with the insured's money," or gambling with the excess insurer's money, since the insured or the insured's excess insurer will have to pay any verdict in excess of the policy limit.

The duty to make reasonable settlement decisions creates an incentive for insurers to take into account this risk to insureds and excess insurers. Because the purpose of the duty to make reasonable settlement decisions is to align the interests of insurer and insured in cases that expose the insured to damages in excess of the policy limits, the duty is owed only with respect to the exposure to such excess damages. With respect to liability for damages within the policy limits, the insurer's contractual liability for those damages already provides an incentive for the insurer to make reasonable settlement decisions. Because the duty to make reasonable settlement decisions is owed only to protect the insured from damages in excess of the policy limits, an insurer can eliminate the risk that gives rise to that duty by waiving the policy limit.

c. Equal consideration and the "disregard the limits" rule. In the insurance context, the general duty of good faith and fair dealing is often described as requiring the insurer to give equal consideration to the interests of its insured. The duty to make reasonable settlement decisions can

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be similarly described as requiring the insurer to give equal consideration to the insured's exposure in excess of the policy limits. ~~When~~Where there is the potential for a judgment in excess of the policy limit, equal consideration requires managing the litigation and settlement process in a manner that neutralizes, to the extent possible, the conflict of interest described in Comment *b*. Courts and commentators use a variety of verbal formulas to articulate that requirement more precisely. The standard stated in subsection (2) implements the equal-consideration requirement in actionable terms. A reasonable settlement offer is one that would be accepted or made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment. Courts and commentators sometimes refer to this formulation of the standard as the “disregard the limits” rule, because it requires the insurer to evaluate the reasonableness of a settlement offer without regard to the policy limits, or, to put it another way, in a manner that “disregards the limits” of the policy.

d. Applying the reasonableness standard. The “reasonable insurer” referred to here is a legal construct, like that of the “reasonable person” in tort law. As such, it can be understood to incorporate both the concept of an average or ordinary insurer that sells liability insurance of the kind and in the amounts of the liability insurance policy at issue as well as a more aspirational concept that protects against circumstances in which average conduct is objectively unreasonable. See Restatement Third, Torts: Liability for Physical and Emotional Harm § 3. The duty to make reasonable settlement decisions includes the duty to accept a settlement offer that a reasonable insurer would accept and to make an offer to settle when a reasonable insurer would do so, if that reasonable insurer had sold an insurance policy with limits that were sufficient to cover any likely outcome of the legal action. See also Comment *f* (on the insurer's failure to make settlement offers).

In determining whether a settlement decision was reasonable, the factfinder should view the settlement decision from the perspective of the parties at the time the settlement decision was made. A reasonable insurer is expected, at the time of the settlement negotiations, to consider the realistically possible outcomes of a trial and, to the extent possible, to weigh those outcomes according to their likelihood. In a complex case, these evaluations are difficult, both for the insurer making the settlement decision and for the trier of fact in a subsequent suit challenging the reasonableness of the insurer's settlement decision. This difficulty, however, cannot be avoided. If a reasonableness standard is to be applied, such qualitative evaluations are inevitable.

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The insurer will be liable for any excess judgment against the insured in the underlying litigation if the trier of fact finds that the insurer rejected a settlement offer that a reasonable insurer would have accepted (or failed to consent to a settlement to which a reasonable insurer would have consented).

In evaluating the reasonableness of an insurer's settlement decisions, the trier of fact may consider, among other evidence, expert testimony as well as testimony from the lawyers and others involved in the underlying insured liability claim. Courts assessing the reasonableness of settlement offers may also consider other facts, such as the amount of time that is given to evaluate an offer and the jurisdiction in which the case would be tried. It is also appropriate for the trier of fact to consider the procedural factors addressed in Comment *e*. It is important to note that this standard considers only the interests of the insurer and the insured in relation to the legal action at issue, not the insurer's interest in minimizing the overall size of the losses in its portfolio of claims. Otherwise, the insurer would not be giving equal consideration to the interests of the insured.

The effect of this rule is that, once a claimant has made a settlement offer in the underlying litigation that a reasonable insurer would have accepted, an insurer that rejects that offer thereafter bears the risk of an excess judgment against the insured at trial. One practical effect of this rule is to give claimants an incentive during the pretrial phase to make reasonable settlement offers within the policy limits, since the insurer's rejection of such an offer sets the stage for a subsequent breach-of-settlement-duty lawsuit in the event of a verdict that produces an excess judgment that is covered by the policy. In that subsequent lawsuit, it will not be sufficient for the policyholder to simply demonstrate that the amount of the offer was reasonable; the policyholder must also demonstrate that a reasonable insurer would have accepted the offer. Nevertheless, evidence that the amount of the offer was reasonable would ordinarily be enough to make the reasonableness of the insurer's decision to reject the offer a question of fact.

Illustrations:

1. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of \$75,000 and no deductible. The claimant offers to settle for \$45,000. The insurer rejects the offer. The case proceeds

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to trial and a judgment of \$175,000 is entered against the insured. In a subsequent action for breach of the duty to make reasonable settlement decisions, the insured introduces evidence supporting the conclusion that, at the time of the settlement negotiations, \$45,000 was a reasonable settlement value of the case, based on the judgment that it was reasonable to conclude that the plaintiff had a 30 percent chance of success and likely damages of \$150,000. Based on this evidence, a trier of fact could conclude that a reasonable insurer would have accepted the offer and, thus, the insurer breached its duty.

2. Same facts as Illustration 1, except that the insurer makes a counteroffer of \$35,000 and, in the subsequent breach-of-settlement-duty case, the adjuster managing the claim for the insurer testifies that, based on her extensive experience managing similar claims, she believed that the claimant would eventually accept the counteroffer. The parties offer conflicting expert testimony regarding the reasonableness of the adjuster's decision to reject an offer that represented a reasonable settlement value of the suit in these circumstances. Even if the trier of fact concludes that the adjuster had made every reasonable effort to become informed about the suit and honestly held the opinion to which she testified and, accordingly, that the rejection of the settlement offer was in good faith, the trier of fact could nevertheless conclude that a reasonable insurer would have accepted the initial offer, and, thus, the insurer breached its duty. Based on this evidence, the trier of fact could also conclude, however, that the insurer did not breach its duty.

e. Procedural factors may be considered. The reasonableness standard requires the trier of fact in the breach-of-settlement-duty suit to evaluate the expected value of the underlying legal action at the time of the failed settlement negotiations. That inquiry may be complex and difficult in some cases. Because of the difficulty of determining, in hindsight, whether a settlement offer was reasonable, it is appropriate for the trier of fact also to consider procedural factors that affected the quality of the insurer's decisionmaking or that deprived the insured of evidence that would have been available if the insurer had behaved reasonably. Factors that may affect the quality of the insurer's decisionmaking include: a failure to conduct a reasonable investigation, a failure to conduct negotiations in a reasonable manner, a failure to follow the recommendation of its adjuster or chosen defense lawyer, and a failure to seek the defense lawyer's assessment of the settlement value of the case. Factors that may deprive the insured of evidence include: a failure to

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conduct a reasonable investigation, a failure to follow the insurer's claims-handling procedures, a failure to keep the insured informed of within-limits offers or the risk of excess judgment, and the provision of misleading information to the insured.

Such factors are not enough to transform a plainly unreasonable settlement offer into a reasonable offer, but they can make the difference in a close case by allowing the jury to draw a negative inference from the lack of information that reasonably should have been available or from the low quality of the insurer's decisionmaking and fact-gathering processes. Just as reasonable investigation and settlement procedures cannot guarantee that an insurer will make a decision that is substantively reasonable, however, the failure to employ reasonable procedures does not necessarily mean that the insurer's decision was substantively unreasonable. In breach-of-settlement-duty cases in which the facts do not make clear that the insurer's settlement decision was substantively reasonable, however, the factfinder may decide based on these other procedural factors that the settlement decision was unreasonable. In an extreme case of the breach of the duty to make reasonable settlement decisions, the insurer may be subject to liability for bad-faith breach, when all of the elements of a bad-faith breach are present. See § 49 (stating the elements of a bad-faith claim).

By the same token, it is also appropriate for the trier of fact to consider whether the claimant in fact was willing to settle within the policy limits or, instead, was attempting to manufacture a potential breach-of-reasonable-settlement-decision claim. Examples of such behavior might include ~~the~~[an unjustified](#) refusal of the claimant or the claimant's attorney to acknowledge a letter from the insurer conveying an unconditional offer of the policy limits, refusing to give the insurer a reasonable amount of time to consider an offer, or any other conduct suggesting that the claimant did not actually wish to settle the claim within the policy limits. If the trier of fact concludes that the claimant did not actually wish to settle the claim within the policy limits, then the causation element required to recover for a breach of the duty to make reasonable settlement decisions will not be satisfied and, thus, the insurer's liability will be limited to the policy limits.

Illustration:

3. A claimant files a tort suit against the insured seeking compensatory damages of \$500,000. The insured has a duty-to-defend liability insurance policy that assigns

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settlement discretion to the insurer, with a policy limit of \$100,000. Early in the litigation the claimant makes a time-limited settlement offer for the policy limits directly to the insurance-claims manager, giving the insurer 60 days to investigate and either accept or reject the offer. The insurer immediately rejects the offer without conducting a reasonable investigation. The claim goes to trial and results in a jury verdict against the insured of \$500,000. In the subsequent breach-of-settlement-duty lawsuit brought by the insured against the insurer, the trier of fact may, but need not, properly conclude from the insurer's failure to investigate that the insurer's settlement decisions were unreasonable. If the trier of fact concludes that the \$100,000 offer was unreasonably high at the time it was made and that the claimant was unwilling to accept any reasonable settlement offer, the insurer will not be held liable for the excess judgment. One relevant consideration would be a showing [of](#) what the investigation would have revealed had it been conducted.

f. The insurer's failure to make settlement offers and counteroffers. This Section adopts a reasonableness standard, not a hard-and-fast rule regarding the insurer's obligation to make settlement offers or counteroffers. As with an insurer's settlement decisions generally, the question is what a reasonable insurer would do under the circumstances. In the absence of a reasonable offer by the plaintiff, there can be circumstances in which it would be unreasonable for an insurer not to make a settlement offer before trial, such as, for example, when the facts known to the insurer make clear that the policy limits are significantly less than the reasonable settlement value of the underlying case (perhaps because the claimant's damages are indisputable and very large and the likelihood of the insured's being found liable is high). In such circumstances, the insurer's obligation to attempt to protect its insured from an excess judgment may include making a reasonable settlement offer to the claimant. By making such an offer, and by otherwise behaving reasonably in the settlement negotiations, the insurer can eliminate its potential liability for an excess judgment, even if that offer is rejected. It is important to emphasize, however, that there may be good reasons for an insurer not to make an offer. For example, it may be strategically useful, from the perspective of a reasonable insurer that bears the full risk of judgment, to refrain from making a settlement offer in order to gather more information, to encourage the claimant to reveal more about its case, or to place pressure on the claimant to initiate settlement discussions. Of course, the insurer's strategic reasons for not

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making a settlement offer must relate solely to the legal action at issue, not to the insurer's interest in managing its portfolio of legal actions. It should also be noted that an insurer has no obligation to make a settlement offer that exceeds the policy limits. However, in situations in which a reasonable insurer bearing sole responsibility for the entire judgment would make an above-limits offer, the insurer may have an obligation to invite the insured to contribute to an above-limits settlement offer.

g. The causation difference between rejecting a settlement offer and choosing not to make an offer. An insurer's decision to reject a reasonable settlement offer made by a claimant potentially has different consequences than an insurer's decision not to make its own reasonable settlement offer, even in those situations in which a reasonable insurer would have made such an offer. The difference comes from the causation requirement in an action for breach of the duty. When an insurer breaches the duty by failing to accept a settlement offer (in situations in which failing to accept such an offer constitutes a breach of the duty), and the case goes to trial resulting in an excess judgment against the insured, the causation requirement is satisfied: had the insurer accepted the settlement offer, there would have been no trial and no possibility of an excess judgment. By contrast, when the insurer breaches the duty by failing to make its own settlement offer (in situations in which failing to make its own settlement offer constitutes a breach of the duty), and the case goes to trial and an excess judgment ensues, causation remains in question. The insurer's failure to make an offer caused the excess judgment only if the claimant would have accepted a reasonable offer from the insurer. Proving causation is difficult. Before the trial, the claimant would have been in the best position to answer the question whether he or she would have accepted the settlement offer, but after the excess judgment the claimant's interests will often be too closely aligned with those of the insured defendant to be objective. Other good sources of objective evidence on the matter will be scarce. Nevertheless, a trier of fact may conclude that an insurer's decision not to make a settlement offer or counteroffer constitutes an unreasonable settlement decision.

Illustrations:

4. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of \$100,000 and no

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deductible. As found by the trier of fact in a subsequent action for breach of the duty to make reasonable settlement decisions, reasonable estimates of the value of the underlying claim range between \$30,000 and \$45,000. The claimant makes no settlement offers during the period leading up to the trial. The insurer, however, makes a settlement offer of \$35,000, which is rejected by the claimant. The jury in the personal-injury lawsuit finds for the claimant and awards damages of \$150,000. The insurer is not subject to liability for the amount of the judgment in excess of the policy limits. By making a reasonable settlement offer in a circumstance in which the claimant did not make a reasonable settlement offer, the insurer satisfied its duty to make reasonable settlement decisions.

5. Same facts as Illustration 4, except that the insurer, rather than making a \$35,000 settlement offer, makes a \$5000 settlement offer, well below the minimum reasonable offer. The claimant rejects the offer. The insurer makes no other settlement offers. The case then goes to trial, resulting in a jury verdict of \$150,000 for the claimant, which includes an excess judgment of \$50,000. The trier of fact in a subsequent action alleging breach of the duty to make reasonable settlement decisions may take into account that the insurer, having received no reasonable settlement offer from the claimant, failed to make a reasonable settlement offer of its own. Indeed, the trier of fact may conclude from this fact, in the absence of compelling reasons to the contrary, that the insurer acted unreasonably and thus breached its settlement duty. Whether the insurer is subject to liability for the amount in excess of the policy limits for any breach, however, will depend on whether the trier of fact determines that the claimant would have accepted a reasonable offer.

6. Same facts as Illustration 4, except that the claimant makes a settlement offer of \$45,000. The insurer rejects that offer and makes a counteroffer of \$35,000 in circumstances in which a reasonable insurer would have accepted the \$45,000 offer. The claimant rejects the insurer's offer, and the settlement negotiations break down. The case goes to trial, resulting in a \$150,000 judgment against the insured, which is \$50,000 more than the policy limits. In the subsequent breach-of-settlement-duty case against the insurer, the insurer is subject to liability for the full amount of the judgment, because the

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insurer rejected a settlement offer in the underlying litigation that a reasonable insurer would have accepted.

h. Settlement offers in excess of policy limits. In some cases, the expected value of the underlying legal action is greater than the limits on coverage contained in the policy. In such cases a reasonable insurer that bore the risk of the entire liability would settle the case for an amount in excess of the policy limits. The duty to make reasonable settlement decisions, however, does not obligate the insurer to accept or make such settlement offers in excess of its policy limits. In such cases the insurer may satisfy the duty by informing the insured that the insurer is prepared to offer the policy limits toward a reasonable settlement. The insurer may also make the insured aware of the option to pay the amount of the settlement in excess of the policy limits and explain why the insurer has concluded that settlement would be reasonable (for example, by pointing out the high likelihood of an excess judgment in the event of a trial). If the insured opts not to pay to settle in excess of the policy limits, the insurer is not thereby excused from its obligation to defend the claim. See § 18 (terminating the duty to defend). This duty to make the policy limits available to the insured in response to reasonable settlement offers in excess of the policy limits is sometimes referred to as the “duty to contribute.” The duty to contribute does not apply to settlement offers that are unreasonable.

Illustration:

7. A claimant files a tort suit against the insured seeking compensatory damages of \$500,000 and punitive damages of \$700,000. The insured has a duty-to-defend liability insurance policy that gives settlement discretion to the insurer and provides coverage for punitive damages, which are insurable in the jurisdiction. The policy also contains a policy limit of \$500,000 and no deductible. At the time of settlement negotiations in the underlying tort action, the reasonable settlement value of the case ranges between \$525,000 and \$600,000. The claimant makes a settlement offer of \$545,000. A reasonable insurer—a rational insurer that is the sole holder of the full \$1.2 million potential liability—would accept the offer. The insurer satisfies its obligations under the duty to make reasonable settlement decisions by notifying the insured of the offer and by offering to contribute the policy limits in support of the settlement. The insurer has no obligation to pay more than the policy limits to settle the claim.

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i. When there are covered and non-covered components of a legal action. As explained in § 25, an insurer's reservation of rights to deny coverage for all or part of a legal action does not relieve the insurer of the obligation to make reasonable settlement decisions under this Section. The application of this rule is straightforward in a circumstance in which there is a single coverage defense that either will or will not apply to the entire judgment in the legal action at issue. If the insurer decides not to accept a settlement offer that a reasonable insurer that bore the sole financial responsibility for the full amount of the potential judgment would have accepted, then the insurer's obligation to pay any excess verdict will depend on the outcome of the coverage dispute. If the insurer prevails in that coverage dispute, it will have no obligation to pay the judgment. If the insured prevails, the insurer will be obligated to pay the judgment.

The rule in this Section is similarly straightforward to apply in circumstances in which the insurer and the insured agree that there are covered and uncovered components of the damages sought in the underlying legal action. In that circumstance, the reasonableness of the insurer's settlement decisions is assessed only in relation to the covered components of the damages, because the insurer does not have an obligation to pay for the components of the damages that are not covered. Thus, the reasonableness of the insurer's decision will depend on the relationship between the amount of the settlement that the insurer is asked to pay and the potential exposure to the insured that is posed by the covered portion of the claim. Note that this Comment does not express this relationship in terms of the *percentage* of the settlement that the insurer is asked to pay, because an underlying claimant may be prepared to accept a lesser recovery for an uncovered component of its damages than for a covered component, and there may even be some circumstances in which the reverse is true.

The rule is more complicated to apply when the insurer and the insured do not agree that there are uncovered portions of the damages sought in the legal action. In such circumstances, the question whether the insurer breached the duty to make reasonable settlement decisions cannot be answered with confidence until the coverage dispute is resolved. As provided in § 25, the presence of the potential coverage dispute does not relieve the insurer of the duty to make reasonable settlement decisions. Therefore, an insurer that chooses not to settle, in a circumstance in which an insurer that bore the full responsibility for the potential judgment would settle, bears some risk.

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Illustrations:

8. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend general-liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of \$75,000 and no deductible. The insurer agrees to defend subject to a reservation of rights based on the insured's non-compliance with a notice condition in the policy. The claimant offers to settle for \$45,000, which is an amount that a reasonable insurer that bore the full responsibility for the judgment would accept. The insurer rejects the offer. The case proceeds to trial and a judgment of \$175,000 is entered against the insured. The insurer refuses to pay the judgment based on the reserved late-notice defense. The insured brings a breach of contract action against the insurer. In that action, the insurer fails to satisfy the requirements stated in § 35(1) for a late-notice defense. Thus, the insurer is obligated to pay the judgment without regard to the policy limit.

9. A claimant files a tort action against the insured seeking damages for property damage caused to the claimant's factory allegedly as the result of defective pipe that the insured sold to the claimant. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of \$500,000 and no deductible. The complaint alleges damages for the repair and replacement of the pipe and for damages to other parts of the factory. The insurer agrees to defend subject to a reservation of the right not to pay for the cost of repair and replacement of the pipe, based on the "impaired property" exclusion in the policy. The insured agrees that there is no coverage for that component of the alleged damages. The claimant offers to settle for \$500,000. The insured offers to pay \$100,000 of the settlement and demands that the insurer pay the remaining \$400,000, which is an amount that a reasonable insurer that bore the full responsibility solely for the covered portion of the damages would have accepted. The insurer rejects the offer. If the tort action proceeds to trial, the insurer will be obligated to pay the full amount of the portion of any judgment that is assessed against the insured for damages other than the cost of repairing and replacing the pipe.

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10. Same facts as Illustration 9, except that the insured does not agree that the impaired-property exclusion excludes coverage for the repair and replacement of the pipe and, therefore, demands that the insurer pay the full \$500,000 of the settlement. \$500,000 is an amount that a reasonable insurer that bore the responsibility for the full amount of a judgment would pay, but it is more than a reasonable insurer would pay if that insurer did not bear the responsibility for the costs of the repair and replacement of the pipe. Thus, the question whether the insurer breached the duty to make reasonable settlement decisions depends on whether the impaired-property exclusion excludes coverage for the repair and replacement of the pipe. If so, the insurer did not breach that duty and, thus, its obligation to pay for any judgment is capped at the policy limit.

j. No direct duty owed to excess insurers. The duty stated in this Section is owed to insureds, not to excess insurers. Excess insurers nevertheless may recover through equitable subrogation for damages incurred as a result of a breach of the duty to make reasonable settlement decisions. Excess insurers' subrogation rights are addressed in § 28.

k. No duty owed to third parties. The duty to make reasonable settlement decisions is owed to insureds, not to the third-party claimants that bring tort suits against insured defendants. A claimant has no independent common-law right to recover against the insurer for breach of the duty to make reasonable settlement decisions. The courts in a few states have interpreted state insurance consumer-protection statutes to grant tort claimants an implied statutory private right of action against insurers for unfair settlement practices in individual cases, but courts have not done so as a matter of common law. An insured may assign its rights under a liability insurance policy, including for breach of the duty to make reasonable settlement decisions, to a third-party claimant. See § 36.

[L. Settlement by insured after insurer's breach of duty. Section 27 addresses the damages payable for breach of the duty to make reasonable settlement decisions. Those damages include the amount of a judgment that is excess of the applicable policy limit and the amount of a reasonable and non-collusive settlement entered into by the insured, or another insurer acting on the insured's behalf, following a breach of the duty to make reasonable settlement decisions. See § 27, Comment b.](#)

REPORTERS' NOTE

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a. Relationship to the duty of good faith and fair dealing. For an explanation of how the duty to settle evolved from the duty of good faith and fair dealing, see generally 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 23.01[d] (Lexis ~~2012~~2017). As a result of this historical development of the doctrine, some courts have expressed a breach of the duty to settle as a bad-faith failure to settle and have hinged their rulings on whether subjective bad faith could be ascribed to the insurer. See, e.g., National Nat'l Farmers Union Prop. & Cas. Co. v. O'Daniel, 329 F.2d 60, 65 (9th Cir. 1964) (applying Montana law) (“We think it clear that, if Lucas’s knowledge and conduct are imputed to [the insurer] under recognized agency principles, there is ample evidence to sustain the finding of bad faith on the part of [the insurer] in failing to consider the interests of its insured[.]”); David Novak, Comment, *Insurance Carrier’s Duty to Settle: Strict Liability in Excess Liability Cases?*, 6 SETON HALL L. REV. 662, 671 n.58 (1972) (“Under the bad faith standard, the plaintiff in an excess case has the burden of producing evidence which demonstrates either an intent on the part of the insurance company to commit fraud or that the insurer is guilty of willful misconduct.”). However, most courts employ an objective-reasonableness standard, as this Section does. See, e.g., LensCrafters, Inc. v. Liberty Mut. Fire Ins. Co., No. C 07-2853 SBA, 2008 WL 410243, at *3 (N.D. Cal. Feb. 12, 2008) (“The duty to settle arises from the implied covenant of good faith and fair dealing, which is inherent in every contract of insurance. . . . Both primary and excess insurers have an obligation to accept a reasonable settlement.”); Hartford Acc. & Indem. Co. v. Foster, 528 So. 2d 255, 282 (Miss. 1988) (“The insurer has a duty to accept an objectively reasonable settlement demand . . . The proper execution of this implied duty is one example of good faith.”). See 1 William T. Barker & Ronald D. Kent, New Appleman Insurance Bad Faith Litigation § 2.03[2][a][iii] (2d ed. 2017) (“States requiring subjective culpability are now a small and dwindling minority.”). See also Novak, 6 SETON HALL L. REV. at 671-672 (Observing that as early as 1938, “Professor Appleman observed that the negligence test was apparently becoming the majority rule, supplanting the bad faith test”). For an example of a court adopting the terminology used in this Section, see Maine Bonding & Cas. Co. v. Centennial Ins. Co., 693 P.2d 1296, 1299 (Or. 1985):

Although our previous decisions have referred to concepts of “good faith,” “bad faith” and “due care” in stating the duty, the insurer’s duty to the insured comes down to this: In conducting the defense of a claim against an insured, including the investigation, negotiation, and litigation of the claim, the insurer must use such care as would have been used by an ordinarily prudent insurer with no policy limit applicable to the claim. The insurer is negligent in failing to settle, where an opportunity to settle exists, if in choosing not to settle it would be taking an unreasonable risk—that is, a risk that would involve chances of unfavorable results out of reasonable proportion to the chances of favorable results. Stating the rule in terms of “good faith” or “bad faith” tends to inject an inappropriate subjective element—the insurer’s state of mind—into the formula. The insurer’s

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duty is best expressed by an objective test: Did the insurer exercise due care under the circumstances.

A number of sources have noted that “[w]hether the respective court examining the matter applies a bad faith or negligence standard . . . a test often applied . . . is whether a prudent insurer without policy limits would have accepted the settlement offer.” 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 203:25 (3d ed. ~~2012~~2017). See also James Martin Truss, Case Note, *Insurance – Stowers Doctrine – A Settlement Offer Above Policy Limits Does Not Trigger an Insurer’s Stowers Duty to Act Reasonably*, 26 ST. MARY’S L.J. 673, 691 (1995) (“Although bad faith entails a nominally greater burden than negligence, many courts coalesce the bad faith and negligence standards in practice and focus upon the amount of consideration given to the insured’s interests.”); *Bollinger v. Nuss*, 449 P.2d 502, 509 (Kan. 1969) (“[T]he divergency between the good faith test and ~~the~~ negligence test may be more a difference in verbiage than results. While the terms . . . are not synonymous or interchangeable in a strict legal sense, they share common hues in the insurer’s spectrum of duty~~[.]~~”); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1123 (1990) (“The practical distinction between a negligent failure to settle and a bad faith failure to settle remains elusive”); Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1140–~~1142~~ (1954) (noting that “[t]he distinction between the ‘bad faith rule’ and the ‘negligence rule’ is less marked than these terms would suggest.”).

b. A duty to make reasonable settlement decisions rather than the “duty to settle.” ~~See Robert Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1160–1161 (1954); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1116 (1990) (“For [a century], courts have invoked a doctrine known as ‘the duty to settle’ to impose liability on insurance companies who fail to settle lawsuits against the people they insure.”). For an explanation of the advantages of insurer control over settlement decisions, see Syverud, 76 VA. L. REV. at 1138–1139. The duty to make reasonable settlement decisions not only benefits individual insureds, but also encourages efficient settlement decisionmaking by insurance companies. ~~The doctrine requires that insurers internalize “all of the costs of going to trial before rejecting a settlement.” Syverud, 76 VA. L. REV. at 1164.~~ For support that the standard stated in this Section is the most common, see 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.06[4][a] (Lexis ~~2012~~2017) (“The most widely used test is typically formulated as ‘whether a prudent insurer without policy limits would have accepted the settlement offer’.”). See also 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”); 16 WILLISTON ON CONTRACTS § 49:~~105~~107 (4th ed. ~~2014~~2017) (“Most courts require that an insurer act reasonably when deciding whether to settle a claim . . .”); Cindie Keegan McMahon, Annotation, *Duty of liability insurer to initiate settlement negotiations*, 51 A.L.R.5th 701 (originally published in 1997) (“When the claimant makes an offer to settle within the policy~~

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limits, courts generally agree that the insurer’s good-faith duty requires the insurer to accept the offer if it would be reasonably prudent to do so.”). [For a discussion of the origin of the phrase “duty to settle,” see Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1116 \(1990\) \(“For \[a century\], courts have invoked a doctrine known as ‘the duty to settle’ to impose liability on insurance companies who fail to settle lawsuits against the people they insure.”\). For an explanation of the advantages of insurer control over settlement decisions, see Syverud, 76 VA. L. REV. at 1138-1139. The duty to make reasonable settlement decisions not only benefits individual insureds, but also encourages efficient settlement decisionmaking by insurance companies by requiring insurers to internalize “all of the costs of going to trial before rejecting a settlement.” Syverud, 76 VA. L. REV. at 1164. For an early discussion of the circumstances in which the settlement duty is implicated, see Robert Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1160-1161 \(1954\).](#)

The reasonableness standard stated in this Section is analogous to the negligence standard in tort law. Some commentators have suggested a strict-liability standard pursuant to which any insurer that rejects a settlement offer within the policy limits would be subject to liability for a judgment against the insured in excess of the policy limits, without regard to whether the offer was reasonable. See, e.g., Bruce L. Hay, *A No-Fault Approach to the Duty to Settle*, 68 RUTGERS U. L. REV. 321 (2015) (arguing that making insurers liable for excess judgment following any rejected within-limits settlement offer would actually work to the benefit of insurers and policyholders); and Philip L. Deaver, Note, *Insurer’s Liability for Refusal to Settle: Beyond Strict Liability*, 50 S. CAL. L. REV. 751, 752 n.11 (1977) (listing numerous articles from the 1970s urging strict liability for the insurer when a within-limits settlement offer is rejected). By eliminating the need to undertake a reasonableness analysis, a strict-liability standard would eliminate some of the complexity and costs of breach-of-settlement-duty suits. Thus, there would be no need for the trier of fact in the settlement-duty case to gather evidence on the range of reasonable settlement values. In addition, an argument can be made that, when policyholders purchase liability insurance coverage, they are in a sense paying insurers to make lawsuits “go away,” which usually means by settlement. Thus, despite the language in liability insurance policies giving settlement discretion to the insurer, insureds are often surprised to learn, after the fact, that their insurers can refuse to accept settlement offers that are within the policy limits and can thereby expose the insureds to the risk of an excess judgment. A strict-liability rule, therefore, might be more consistent with the reasonable expectations of policyholders.

The primary criticism of the strict-liability approach, however, is that under such a rule any tort claimant could eliminate the binding effect of the policy limit simply by making a settlement offer within the limit through a “set up” letter. This effect would in turn lead to an increase in premiums. An argument can be made that both of these effects of the strict-liability rule are desirable, insofar as they encourage insurers to provide coverage that includes adequate policy limits. Moreover, given the hindsight bias that might be present in settlement-duty cases that apply a reasonableness standard (that is, the tendency of triers of fact, faced with an excess judgment against the insured, to overestimate the ex ante likelihood of that judgment occurring

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and thus to overestimate the reasonableness of some settlement offers), the effects of a strict-liability duty-to-settle rule might not be substantially different from the effects of the reasonableness/disregard-the-limits rule followed in this Section and that is already applied in many jurisdictions. Some appellate courts have gone so far as to encourage such hindsight bias by requiring that juries in settlement-duty cases be specifically instructed to consider the actual excess tort judgment in the underlying case as evidence of the expected value of the tort suit at the time the settlement offer was made and rejected. Despite the good arguments in favor of a strict-liability rule for the duty to settle, this Section does not endorse such a rule, because such a rule has not been adopted in the courts. Instead the Section follows and clarifies the prevailing reasonableness rule. The majority of jurisdictions impose on the insurer a general duty to make reasonable settlement decisions.

c. Equal consideration and the “disregard the limits” rule. [See For the proposition that most courts in “duty to settle” cases apply some version of an equal-consideration test, see, e.g., Syverud, 76 VA. L. REV. at 1122 \(“The majority of states today require the insurance company to give equal consideration” to the interests of the insured and the company in evaluating settlement”\);](#) see also *Cowden v. Aetna Cas. & Sur. Co.*, 134 A.2d 223, 228 (Pa. 1957) (“The requirement is that the insurer consider in good faith the interest of the insured as a factor in coming to a decision as to whether to settle or litigate a claim against the insured. . . . the predominant majority rule is that the insurer must accord the interest of its insured the same faithful consideration it gives its own interest.”).

The most straightforward and ~~utilized application~~ [frequently used formulation](#) of the “equal consideration” standard is the disregard-the-limits test. The disregard-the-limits standard was first articulated by Professor Keeton in 1954: “With respect to the decision whether to settle or try the case, the insurer, acting through its representatives, must use such care as would have been used by an ordinarily prudent insurer with no policy limit applicable to the claim.” Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1147 (1954). The Supreme Court of California adopted Keeton’s articulation in *Crisci v. Security Ins. Co. of New Haven, Connecticut*, 426 P.2d 173 (Cal. 1967), and the disregard-the-limits rule has since become the most common test for determining whether an insurer gave “equal consideration” to its insured’s interests in duty-to-settle cases. *Id.* at 176 (“In determining whether an insurer has given consideration to the interests of the insured, the test is whether a prudent insurer without policy limits would have accepted the settlement offer.”); *Bollinger v. Nuss*, 449 P.2d 502, 511 (Kan. 1969) (“As Professor Keeton suggests, equal consideration of the conflicting interests of the company and the insured means consideration of each portion of the total risk without regard to who is bearing that portion of the risk . . . [t]his undoubtedly is the meaning intended by courts which have said the insurer must accord the interests of its insured the same faithful consideration it gives its own interests[.]”); *Cowden v. Aetna Cas. & Sur. Co.*, 134 A.2d 223, 228 (Pa. 1957) (“[T]he fairest method of balancing the interests is for the insurer to treat the claim as if it were alone liable for the entire amount.”); see also KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* ~~664-665~~ [614-617](#) (56th

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ed. ~~2010~~2015) (“The *Crisci* rule is standard law in most jurisdictions . . .”); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.06[4][a] (Lexis ~~2012~~2017) (“The most widely used test is typically formulated as ‘whether a prudent insurer without policy limits would have accepted the settlement offer.’” [quoting *Crisci*, 426 P.2d at 176]).

For courts applying the disregard-the-limits approach to discern whether “equal consideration” was given to the insured’s interests by the insurer, see, e.g., *Herges v. Western Cas. & Sur. Co.*, 408 F.2d 1157, 1163-1164 (8th Cir. 1969) (applying Minnesota law) (using Keeton’s “no policy limits approach” to determine if the insurer had given equal consideration to the insured’s interests); *Koppie v. Allied Mut. Ins. Co.*, 210 N.W.2d 844, 848 (Iowa 1973) (“Modern decisions require the insurer . . . to view the settlement situation as if there were no policy limit applicable to the claim. When it does so, it views the claim objectively and renders equal consideration to the interests of itself and of the insured.”); *Bowers v. Camden Fire Ins. Ass’n*, 237 A.2d 857, 862 (N.J. 1968) (holding that the insurer acts in good faith “only if the insurer treats any settlement offer as if it had full coverage for whatever verdict might be recovered, regardless of policy limits[.]”).

Some courts have held that the “equal consideration” standard imposes a stricter obligation on insurers to defer to the individual insured’s greater pecuniary interests in the outcome of a single case, even when it would be reasonable for an insurer properly disregarding the limit to reject the settlement offer, see, e.g., *Loudon v. State Farm Mut. Auto. Ins. Co.*, 360 N.W.2d 575, 581-582 (Iowa Ct. App. 1984) (reasoning that even when an insurer fairly evaluates a settlement offer and claim without regard to policy limits, equal consideration mandates giving greater weight to the catastrophic effect of a judgment over the policy limits on a single insured’s financial status in comparison to the nominal effect that settling a single claim has on the insurer); *Clearwater v. State Farm Mut. Auto Ins. Co.*, 792 P.2d 719, 723 (Ariz. 1990) (“[T]he debatability of the claim is not determinative; the insurer must also weigh other considerations, such as the financial risk to the insured in the event of a judgment in excess of the policy limits[.]”); *Dumas v. State Farm Mut. Auto Ins. Co.*, 274 A.2d 781, 784 (N.H. 1971) (“The unlimited coverage approach has a superficial appearance of fairness to the insured but in fact does not give proper consideration to the insured’s interest. An unlimited risk to an insurance company with thousands of claims may in fact be minimal on the average but catastrophic to an underinsured individual with a single claim.”). ~~For two authors suggesting that the equal consideration and disregard the limits standards may function differently in some circumstances, see ABRAHAM at p. 665 (“Under the reasonable offer test, however, equal consideration is not the norm. Rather, in certain cases the insured’s interests carry more weight.”); Michael Sean Quinn, *The Defending Liability Insurer’s Duty to Settle: A Meditation upon Some First Principles*, 35 TORT & INS. L.J. 929, 960-963 (2000).~~

d. *Applying the reasonableness standard.* For examples and explanations regarding what constitutes a reasonable settlement offer, see, e.g., *Transport Ins. Co. Inc. v. Post Express Co. Inc.*, 138 F.3d 1189, ~~1190-1193 (7th Cir. 1998)~~; ~~*Buntin v. Continental*~~1192 (7th Cir. 1998)

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“Most states, of which Illinois is one, require insurers to devise a litigation strategy (and make settlement offers within the policy limits) as if the insurer bore the full exposure. That is to say, an insurer must give ‘its insured’s interests at least equal consideration with its own when the insured is a defendant in a suit in which the recovery may exceed [the] policy limits.’ Intentional or negligent failure to avert a preventable excess judgment requires the insurer to bear the full loss—avoiding the injury to the client that is attributable to unsound litigation decisions.”); Buntin v. Cont’l Ins. Co., 525 F. Supp. 1077, 1083 (D.V.I. 1981) (“We hold that an insurer’s honest but erroneous belief that there is no coverage under its policy of insurance in no way lessens the insurer’s obligation to view a settlement offer as if it alone were liable for any eventual judgment, nor does it diminish the insurer’s liability in the event it breaches its settlement obligations.”); Hartford Cas. Ins. Co. v. N.H. Ins. Co., 628 N.E.2d 14 (Mass. 1994); Eskridge v. Educator & Executive Insurers, Inc., 677 S.W.2d 887, 889-890 (Ky. 1984); ~~Parsons v. Continental~~ (“Bad faith is determined upon the basis of whether the refusal to settle subjected the insured to an unreasonable risk of having a judgment entered against him in excess of the policy limits. The factors to be considered are the probability of recovery, the likelihood that judgment will exceed the policy limits, negotiations for settlement, offers to settle within or for less than the policy limits, and whether the insured made a demand for settlement.”); Parsons v. Cont’l Nat’l Am. Group, 550 P.2d 94, 100 (Ariz. 1976); Johansen v. Cal. State Auto. Ass’n-Inter-Ins. Bureau, 538 P.2d 744, 745-751 (Cal. 1975).

For cases holding that the failure to accept a reasonable settlement offer leads to liability for the excess verdict, see, e.g., McNally v. Nationwide Ins. Co., 815 F.2d 254, 259 (3d Cir. 1987) (affirming judgment for insured in case in which insurer had failed to accept a reasonable settlement); Rupp v. Transcon. Ins. Co., 627 F. Supp. 2d 1304, 1320 (D. Utah 2008) (deciding that, although “the Utah Supreme Court has not addressed whether breach of the duty to accept reasonable settlement offers releases the insured from complying with a legal action limitation provision,” that the ~~Court~~court likely would find the insured released); Escambia Treating Co. v. Aetna Cas. & Sur. Co., 421 F. Supp. 1367, 1370 (N.D. Fla. 1976) (“Florida courts have clearly recognized the insurer’s duty to act in good faith and accept reasonable settlements.”); Hamilton v. Maryland Cas. Co., 41 P.3d 128, 132 (Cal. 2002) (citing Kransco v. Am. Empire Surplus Lines Ins. Co., 2 P.3d 1, 9 (Cal. 2000), as modified (July 26, 2000)) (“the covenant of good faith and fair dealing implied by law in all contracts” combines with the “duty to defend and indemnify covered claims” to imply a “duty on the part of the insurer to accept reasonable settlement demands on [] claims within the policy limits.”); Whitney v. State Farm Mut. Auto. Ins. Co., 258 P.3d ~~113, 2011 Alaska LEXIS 83~~113 (Alaska 2011) (the implied covenant of good faith and fair dealing obligates insurers to “accept reasonable offers of settlement in a prompt fashion.”) (quoting Guin v. Ha, 591 P.2d 1281, 1291 (Alaska 1979) (allowing insured to recoup prejudgment interest attributable to the bad faith of the insurer, regardless of policy limits); Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, ~~848-849~~846-847 (Tex. 1994) (Texas courts require insurers “to accept reasonable settlement demands within policy limits.”). See also Tran v. State Farm Mut. Auto. Ins. Co., 999 F. Supp. 1369, 1372 (D. Haw. 1998) (stating in a

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first-party case that “an insurer who does not accept a reasonable settlement offer within policy limits is also liable for violation of its duty to act in good faith regarding the interests of the insured.”). But see *Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 24, 28 (N.Y. 1993) (internal citations omitted) (New York law requires that a plaintiff in a bad-faith action show that “the insured lost an actual opportunity to settle the ~~claim~~ claim ~~at~~ at a time when all serious doubts about the insured’s liability were removed.”).

Some have suggested that the duty to make reasonable settlement decisions is breached—or the insurer is negligent—when declining to accept a reasonable within-limits settlement offer only if no reasonable insurer would have declined the offer. *Hartford Cas. Ins. Co. v. N.H. Ins. Co.*, 417 Mass. 115, 121 (Mass. 1994) (“The test is not whether a reasonable insurer might have settled the case within the policy limits, but rather whether no reasonable insurer would have failed to settle the case within the policy limits.”) Subsection (2) of this Section, however, does not adopt that version of the negligence standard in the settlement context. Rather, Subsection (2) follows the majority of courts that have spoken to the issue in stating that the duty to make reasonable settlement decisions is breached when the insurer fails to make a settlement decision that a reasonable insurer (that bears the full financial responsibility for the liability) would make under the circumstances. See, e.g., *Buntin v. Cont’l Ins. Co.*, 525 F. Supp. 1077, 1082 (“The judicial measure of an insurer’s compliance with his settlement obligations is whether a reasonably prudent insurer, without policy limits, would have accepted the settlement.”); *Baxter v. Royal Indem. Co.*, 285 So. 2d 652, 655-656 (Fla. Dist. Ct. App. 1973) (overturned on grounds other than the standard of care) (“If the circumstances are such that a reasonable and prudent man with the obligation to pay all the recoverable damages would settle for an amount within the policy limits, it is the legal duty of the insurer to do so. Failure to effect such a settlement would unreasonably risk the danger of a judgment in excess of the policy limits for which the insured would be liable but for which the insurer would not. By taking such an unreasonable risk, the insurer would be gambling with the insured’s money to the latter’s prejudice.”); *Farmers Group, Inc. v. Trimble*, 691 P.2d 1138, 1142 (Colo. 1984) (“Given the quasi-fiduciary nature of the insurance relationship, we are persuaded that the standard of conduct of an insurer in relation to its insured in a third party context must be characterized by general principles of negligence. The question of whether an insurer has breached its duties of good faith and fair dealing with its insured is one of reasonableness under the circumstances. The relevant inquiry is whether the facts pleaded show the absence of any reasonable basis for denying the claim, i.e., would a reasonable insurer under the circumstances have denied or delayed payment of the claim under the facts and circumstances.”). Likewise, the articulation of the duty to make reasonable settlement decisions in subsection (2) is consistent with the canonical formulation of the negligence standard in tort law generally, which states that a person’s negligence consists in the failure to do what a reasonable person would do under the circumstances. See, e.g., *Stephen G. Gilles, On Determining Negligence: Hand Formula Balancing, the Reasonable Person Standard, and the Jury*, 54 VAND. L. REV. 813 (2001) (“For as long there has been a tort of negligence, American courts have defined negligence as conduct

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in which a reasonable man (nowadays, a reasonable person) would not have engaged.”) (citation omitted).

An insurer has not breached its duty to settle by rejecting a settlement offer well above the range of reasonable settlement amounts. See, e.g., *Christian Builders, Inc. v. Cincinnati Ins. Co.*, 501 F. Supp. 2d 1224, 1237 (D. Minn. 2007) (holding that the insurer had not unreasonably refused to settle when the plaintiff refused to lower its \$2 million offer and the insurer had accurately assessed the reasonable settlement value between \$400,000 and \$600,000). As with any liability standard, the reasonableness standard stated in this Section does not require the insurer to do anything. Rather, the standard simply assigns to the insurer the legal responsibility for excess judgments that result from a breach of the standard. Moreover, the standard imposes no consequences on the insurer for rejecting a settlement offer that is unreasonable.

e. Procedural factors may be considered. For a general discussion of the multiple factors that courts take into account in the duty-to-settle analysis, see Kenneth S. Abraham, *The Natural History of the Insurer’s Liability for Bad Faith*, 72 TEX. L. REV. 1295, 1302-1306 (1994) (describing factors that courts take into account in duty-to-settle analysis); Douglas R. Richmond, *Bad Insurance Bad Faith Law*, 39 TORT TRIAL & INS. PRAC. L.J. 1, 5 (2003) (listing factors). For instances of these factors being relied upon in case law, see *Smith v. Gen. Accident Ins. Co.*, 697 N.E.2d 168, 170-171 (N.Y. 1998); *Truck Ins. Exch. v. Bishara*, 916 P.2d 1275, 1279-1280 (Idaho 1996); *O’Neill v. Gallant Ins. Co.*, 769 N.E.2d 100, 106-109 (Ill. App. Ct. 2002).

f. The insurer’s failure to make settlement offers and counteroffers. There is a split of authority on the question whether the duty to make reasonable settlement decisions can obligate the insurer to explore settlement negotiations should the claimant or claimants not come forward with a settlement offer. See 1 WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION* § 2.03[6][d][iii] (discussing the split of authority) (~~Lexis 20122d ed. 2017~~). At least one leading treatise has suggested that the view stated in this Section is a minority rule. See ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 840 (5th ed. 2012) (“In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless the plaintiff makes a settlement offer within policy limits ~~is made by the plaintiff~~. Without a settlement offer, it is not possible for the insurer to have breached its duty.”). But a more recent review of the authority concludes that many of the courts cited as requiring an offer by the plaintiff hold simply that the insurer did not breach the duty in the particular case, not that there must always be an offer by the plaintiff. See Dennis J. Wall, “The American Law Institute and Good Faith Settlement Duties of Liability Carriers: The Scope of a Duty to Initiate Settlement Negotiations, What the ALI Restatement of the Law of Liability Insurance Has to Say About it, and the ALI Reporters’ Notes,” 37 Ins. ~~LIT~~Litig. RPT~~Rep.~~ 597, 601 (Dec. 23, 2015). For courts holding that a settlement offer from the claimant is a prerequisite to a claim against the insurer of breach of the settlement duty, see, e.g., *Jackson v. American Am. Equity Ins. Co.*, 90 P.3d 136, 142 (Alaska 2004); *Graciano v. Mercury Gen. Corp.*, 179 Cal. Rptr. 3d 717, 726 (Cal. Ct. App. 2014) (“An insured’s claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable offer to settle the claims

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against the insured for an amount within the policy limits.”); *Rocor Int’l, Inc. v. National U. Nat’l Union Fire Ins. Co. of Pittsburgh*, 77 S.W.3d 253, 261-262 (Tex. 2002).

Other courts, however, have held that a settlement offer from the claimant is not a prerequisite to a finding of breach of the insurer’s settlement duties. For cases holding that the insurer has a duty to make an offer in certain circumstances, see, e.g., *Fulton v. Woodford*, 545 P.2d 979, 984 (Ariz. Ct. App. Div. 1, Dep’t B, 1976) (holding that the “legal duty” is not absolute but is instead one factor among many to be considered on the question of whether the carrier conducted settlement negotiations in bad faith; held that under the evidence in this case, the carrier at bar did not breach its duties); *Powell v. Prudential Property & Cas. Ins. Co.*, 584 So. 2d 12, 14 (Fla. Dist. Ct. App. 1991) (“insurer has an affirmative duty to initiate settlement negotiations,” citing cases from Kansas, New Jersey, Wisconsin, and Oregon); *Gutierrez v. Yochim*, 23 So. 3d 1221, 1226 (Fla. Dist. Ct. App. 2009); *Commercial U. Union Ins. Co. v. Medical Protective Co. Liberty Mutual Ins. Co.*, 393 N.W.2d 161, 165 (Mich. 1986) (recognizing an obligation to make an offer but “when warranted under the circumstances” and only one factor among many to consider in deciding question of carrier’s liability for bad-faith breach of settlement duties); *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 323 A.2d 495, 505 (N.J. 1974) (“Despite the fact that the holdings in [earlier New Jersey cases] involved firm claimant offers, it would be unrealistic to believe that such an offer is a prerequisite for finding the insurer to have acted other than in good faith. . . . The better view is that the insurer has an affirmative duty to explore settlement possibilities.”) (citing *Keeton, Insurance Law, § 7.8(c) (1971 Self v. Allstate Ins. Co.*, 345 F. Supp. 191 (M.D. Fla. 1972)); *Goddard v. Farmers Ins. Co. of Oregon*, 22 P.3d 1224, 1227 (Or. Ct. App. 2001), review denied, 34 P.3d 1178 (2001) (“Thus, an insurer has an affirmative duty of care to its insured, which in an appropriate case requires the insurer to initiate settlement efforts”); *Alt v. American Am. Family Mut. Ins. Co.*, 71 Wis. 2d 340, 237 N.W.2d 706, 713 (Wis. 1976) (holding that settlement offer from claimant is not prerequisite to insurer liability for breach of settlement duties and noting that “[a]ll prior Wisconsin cases indicate that an insurance company has more than a passive role—that, in some circumstances at least it has an affirmative duty to seize whatever reasonable opportunity may present itself to protect its insured from excess liability”). In addition, a number of scholars have argued that such an affirmative obligation should be imposed. See, e.g., ROBERT KEETON & ALAN I. WIDISS, *INSURANCE LAW*, § 7.8(c), at 889-890, 744-745 (2d ed. 1988) (“In most circumstances the insurer, having reserved to itself the right to control the defense and the decision whether to agree to a settlement, should be obligated to explore the possibility of a settlement even in the absence of actions by the third party or an express request by the insured. Courts have divided whether the insurer must initiate settlement discussions with the claimant. It might be argued that the dominant “disregard the limits” standard would only require the insurer to initiate settlement discussions when an insurer with only its interests at stake would do so. The better rule is that a duty to initiate settlement discussion exists.”).

g. The causation difference between rejecting a settlement offer and choosing not to make an offer. See, e.g., *Gibbs v. State Farm Mutual Insurance Mut. Ins. Co.*, 544 F.2d 423, 427 (9th

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Cir. 1976) (applying California law) (insurer may be found to have “neglect[ed] its good faith duty ~~when it fails~~ to take affirmative action in settling the claim”); *Boicourt v. Amex Assurance Co.*, 93 Cal. Rptr. 2d 763, 768 (Cal. Ct. App. 2000) (“[A] formal settlement offer is not an absolute prerequisite to a bad faith action. . .”).

h. Settlement offers in excess of policy limits. The term “duty to contribute” comes from Richard Squire. In the context in which courts and commentators refer to the “duty to settle,” the duty to contribute nicely distinguishes cases that the insurer can settle unilaterally from those in which the insurer cannot do so because the limits of the insurance policy are insufficient. See Richard Squire, *How Collective Settlements Camouflage the Costs of Shareholder Lawsuits*, 62 DUKE L.J. 1 (2012) (arguing that the duty to contribute leads to a collective-action problem among insurers in the securities-class-action settlement context). Some jurisdictions have held that an insurer’s failure to offer its policy limits in response to a reasonable above-limits settlement offer can constitute a breach of the duty to settle. See, e.g., *Fireman’s Fund Ins. Co. v. Sec. Ins. Co. of Hartford*, 367 A.2d 864, 869 (N.J. 1976). Some commentators have even characterized this as the majority position. According to some commentators, however, a majority of jurisdictions hold that an insurer does not breach any settlement obligation if it rejects an offer that exceeds the limits in the policy. See, e.g., ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW [874840](#) (45th ed. [20072012](#)) (“In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless the plaintiff makes a settlement offer within policy limits ~~is made by the plaintiff~~.”) (footnote omitted). Other commentators stop short of characterizing this as the majority position. See, e.g., 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 203:20 (3d ed. [20122017](#)) (“Some authority states that an insurer’s duty to make reasonable settlements is only triggered when a claimant makes an offer to settle within policy limits. Under this view, an offer in excess of policy limits does not give rise to the duty, even where the offer is reasonable.”). For cases holding that an insurer has no duty to accept a settlement offer in excess of policy limits, see, e.g., *Rocor Intern’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 262 (Tex. 2002) (“[A]n insurer’s settlement duty is not activated until a settlement demand within policy limits is made, and the terms of the demand are such that an ordinarily prudent insurer would accept it.”); *Haddick ex rel. Griffith v. Valor Ins.*, 763 N.E.2d 299, 305 (Ill. 2001) (noting that the duty to settle “does not arise until a third party demands settlement within policy limits.”).

i. When there are covered and non-covered components of a legal action. See generally Kenneth S. Abraham, *The Liability Insurer’s Duty to Settle Uncertain and Mixed Claims*, 68 RUTGERS U. L. REV. 337 (2015). See also WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 2.03[6][c][i] (~~Lexis-2015~~ [2d ed. 2017](#)) (“for purposes of determining what settlement contribution it will offer, the insurer may treat the case as if only the covered claims were asserted”). For case support, see, e.g., *Magnum Foods, Inc. v. Cont’l Cas. Co.*, 36 F.3d 1491, 1506 (10th Cir. 1994) (duty of good faith does not require insurer

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to contribute to settlement of uncovered punitive-damages portion of the legal action); *Camelot by the Bay Condo. Owners' Ass'n v. Scottsdale Ins. Co.*, 32 Cal. Rptr. 2d 354 (Cal. Ct. App. 1994) (insurer need not contribute to settlement of uncovered aspects of damages).

j. No direct duty owed to excess insurers. See § 28.

k. No duty owed to third parties. Because insurers lack a preexisting relationship with third-party tort plaintiffs, the majority of courts and commentators agree that insurers have no common-law tort or contractual duty to tort plaintiffs to settle. See, e.g., WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION* § 2.07[1] (~~Lexis 2011~~[2d ed. 2017](#)) (“An insurer has no ‘special relationship’ with a third party claiming against its insured and owes such a third party no unusual duties. . . . absent a contrary statute, neither [the insurer nor the defendant] owes the third party any duty to settle.”). For cases rejecting a common-law duty because of the lack of a preexisting relationship, see, e.g., *Bean v. Allstate Ins. Co.*, 403 A.2d 793, 795 (Md. 1979) ([internal citations omitted](#)) (“[T]he insurer owes no duty to a claimant to settle a claim, and . . . [a]ny obligation to deal with settlement offers in good faith runs only to the insured. . . . [T]he claimant is a stranger to the relationship between the insurer and the insured and is not in privity with them.”); *Kranzush v. Badger State Mut. Cas. Co.*, 307 N.W.2d 256, 265 (Wis. 1981) (“The insurer’s duty of good faith and fair dealing arises from the insurance contract and runs to the insured. No such duty can be implied in favor of the claimant from the contract since the claimant is a stranger to the contract and to the fiduciary relationship it signifies.”). Courts have similarly rejected the argument that accident victims are third-party beneficiaries to the tortfeasor’s insurance policy. See, e.g., *Leal v. Allstate Ins. Co.*, 17 P.3d 95, 100 (Ariz. Ct. App. 2000) (“Although accident victims may be intended beneficiaries of state-mandated insurance, this does not mean that they are intended beneficiaries of every insurance ~~contract~~[policy provision](#).”); *Long v. McAllister*, 319 N.W.2d 256, 262 (Iowa 1982) ([citation omitted](#)) (“Because plaintiff relies only on the fact that he will benefit if the contract is carried out in accordance with its terms, he has alleged only a basis for finding he is an incidental beneficiary. . . . We refuse to extend the third party beneficiary concept to the limits advocated by the plaintiff.”).

Although most states have enacted some version of an Unfair Settlement Practices Act, the vast majority of courts have declined to read the provision to give third-party plaintiffs a private right of action against the insurer for failing to settle. See, e.g., *Leal*, 17 P.3d at 100 (finding that the statute explicitly denies any private remedy); *Moradi-Shalal v. Fireman’s Fund Ins. Co.*, 758 P.2d 58 (Cal. 1988) (overturning a prior ruling granting a statutory cause of action).

Only a handful of states have interpreted their Unfair Settlement Practices statute to provide a private right of action to third-party claimants. Montana’s statute specifies that third-party claimants have an independent cause of action, and courts have therefore allowed claimants to proceed directly against insurers for a bad-faith failure to settle. *Holmgren v. State Farm Mut. Auto Ins. Co.*, 976 F.2d 573 (9th Cir. 1992) (applying Montana law). A few other states have enacted statutes granting a private right of action to “anyone” injured by a

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fair-practice violation, and some courts have interpreted this language to include third-party claimants. See, e.g., *Auto-Owners Ins. Co. v. Conquest*, 658 So. 2d ~~928, 929~~928 (Fla. 1995); *Hovet v. Allstate Ins. Co.*, 89 P.3d ~~69, 76~~69 (N.M. 2004); *Van Dyke v. St. Paul Fire & Marine Ins. Co.*, 448 N.E.2d ~~357, 360~~357 (Mass. 1983).

§ 25. The Effect of a Reservation of Rights on Settlement Rights and Duties

(1) A reservation of the right to contest coverage does not relieve an insurer of the duty to make reasonable settlement decisions stated in § ~~24.24~~, but the insurer is not required to cover a judgment on a non-covered claim.

(2) Unless otherwise stated in an insurance policy or agreed to by the insured, an insurer may not settle a legal action and thereafter demand recoupment of the settlement amount from the insured on the ~~grounds~~ground that the action was not covered.

(3) When an insurer has reserved the right to contest coverage for a legal action, the insured may settle the action without the insurer's consent ~~of the insurer~~ and without violating the duty to cooperate or other restrictions on the insured's settlement rights contained in the policy, ~~provided the following requirements are met if:~~

(a) The insurer is given a reasonable opportunity to participate and is kept reasonably informed of developments in the settlement process;

(b) The insured makes a reasonable effort to obtain the insurer's consent or approval of the settlement;

(c) The insurer declines to withdraw its reservation of rights after receiving prior notice of the proposed settlement; and

~~(e) It would be~~ (d) The settlement agreed to by the insured is one that a reasonable for a person who bears the sole financial responsibility for the full amount of the potential covered judgment to accept the settlement; and ~~(d) If the settlement includes payments for damages that are not covered by the liability insurance policy, a reasonable portion of the settlement is allocated to the insured component of the action~~ would make.

Comment:

a. Reservation of rights does not eliminate the duty to make reasonable settlement decisions, but there is no such duty for noncovered actions. Under the rule set forth in this

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subsection (1), an insurer is subject to the duty to make reasonable settlement decisions even if that insurer reasonably believes that the policy at issue does not cover the legal action. What this means in practice is that, if an insurer that is defending a legal action against an insured under a reservation of rights ~~rejects a settlement demand that a reasonable insurer facing the entire potential liability would accept, or otherwise~~ makes an unreasonable settlement decision as defined in § 24, the insurer will be responsible for any excess judgment that results at the trial of the legal action along with other appropriate damages, provided that the action is determined to be covered. If the action is determined not to be covered, the insurer will of course not be liable for any of the judgment. An insurer has no duty to settle noncovered legal actions. Thus, an insurer that reserves the right to contest coverage and then receives a settlement offer within the policy limits must choose whether to accept the settlement (and bear the cost of the settlement above the deductible) or to reject the settlement and risk the possibility of facing liability for an excess judgment against the insured if the action turns out to be covered.

This widely adopted rule allocates to the insurer a portion of the risk associated with reasonable but mistaken beliefs on the part of the insurer regarding coverage and discourages insurers from delaying settlement negotiations in the underlying lawsuit while potential coverage disputes with the insured are being resolved. A few jurisdictions, however, follow an alternative rule, which permits the insurer to take into account its doubts about coverage when deciding whether to accept a settlement demand. In other words, under ~~the~~[this](#) minority rule, the insurer may, when calculating the maximum reasonable settlement that it will accept, discount the expected value of the case further by the probability that there will be no coverage and thus no requirement that the insurer contribute to the settlement. This alternative approach places the risk of the insurer's mistaken coverage decisions upon the insured, increasing the likelihood of substantial uninsured excess judgments. This is because there will be a broader range of litigated cases that potentially will produce trials and fewer settlements, because insurers, in reservation-of-rights cases, will be willing to contribute less to a settlement than is the case under the majority rule. The majority rule is superior because it places the risk of mistaken coverage decisions upon the party best able to reduce and spread that risk.

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1. A claimant files a tort suit against the insured seeking damages of \$500,000. The insured has a duty-to-defend liability insurance policy that has policy limits of \$100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend under a reservation of rights. The insurer reasonably believes that it has a ground for contesting coverage that relieves it from any duty to indemnify the insured for the suit. As the case approaches trial, the claimant makes a reasonable settlement demand of \$80,000. The insurer rejects the settlement demand. The suit then goes to trial, resulting in a \$500,000 verdict against the insured. If the coverage dispute is resolved in the insured's favor, the insurer is liable for its coverage limit plus the excess judgment of \$400,000, along with other reasonably foreseeable consequential damages. If the coverage dispute is resolved in the insurer's favor, the insurer is not liable to the insured for any damages.

b. When a legal action has both covered and noncovered components. Some legal actions brought against a liability insured will have both covered and noncovered components. In such a situation, the reasonableness of the insurer's settlement decisions is to be evaluated based on the valuation of the covered component(s) of the action. That is, if the settlement demand is reasonable, taking into account the covered components alone (that is, as a settlement of only the covered cause(s) of action), then rejection of the settlement demand will constitute a breach of the duty to make reasonable settlement decisions. If, however, the settlement demand is unreasonable, taking into account the covered components alone, then the insurer's rejection of the settlement will not by itself be considered a breach of the duty to make reasonable settlement decisions. In such a case, whether the insurer has breached its settlement duty will depend on other factors that bear on the question of insurer reasonableness, such as the procedural factors addressed in Comment *e* of § 24. For example, when a legal action involves both a covered component and a noncovered component (such as punitive damages when such damages are expressly excluded from coverage under the policy or the law in the jurisdiction treats such coverage as a violation of public policy), the duty to make reasonable settlement decisions would include a duty on the part of the insurer to investigate the facts relevant to both the covered and noncovered components and to convey that information to the insured. The insurer would also have an obligation to inform the

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insured of the amount it (the insurer) would be willing to contribute to an overall settlement. However, the control of the settlement of the noncovered components of the legal action would rest with the insured, or, if appropriate, with the excess insurer or insurers.

c. The default rule is no right to recoupment. Subsection (2) sets forth the default rule, analogous to the default rule followed in § 21 for defense costs, that an insurer that settles a legal action brought against an insured may not later recoup the settlement amount from the insured on the grounds that the action was determined not to be covered. Because this rule is merely a default rule, it may be altered by agreement of the parties. For example, if an insurer agrees to pay for a settlement of a potentially insured legal action only on the condition that it be permitted to subsequently litigate coverage and seek recoupment if it prevails in the coverage litigation, and if the insured agrees to this condition, then the insurer would be able to seek recoupment. While most states have not addressed this issue, the clear majority of state courts that have addressed the issue have not permitted recoupment in the absence of a provision in the insurance policy granting the insurer this right or an express agreement by the insured. A few courts, primarily federal courts making an Erie prediction, have gone the other way, applying a theory of unjust enrichment that allows insurers defending under a reservation of rights the option of settling the case and seeking recoupment of the cost of the settlement from the insured if the claim turns out not to be covered. Every court that has addressed the issue, however, has held that a term inserted in the policy that clearly provides the insurer with a right of recoupment would be enforced, as would a term that denies the insurer such a right.

Because insurance policies often do not include a term expressly addressing the recoupment question, however, insurance law must determine whether to require that recoupment have an explicit contractual basis or to permit recovery based on unjust enrichment in the absence of a contractual provision. This Section follows the exclusively contractual approach—in effect, a no-recoupment default rule—for several reasons based in fairness and efficiency.

The strongest argument in favor of a no-recoupment default rule is more practical than theoretical. The current practice in most liability insurance markets is for insurers not to seek recoupment of the noncovered portion of settlements paid by insurers. Rather, in the overwhelming majority of cases in which the insurer agrees to settle a claim, insurers do not pursue recoupment. Moreover, insurers have not developed a regular practice of inserting

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settlement-recoupment provisions in their policies. Given that such provisions would be enforceable, the absence of such provisions in policies can be taken as evidence that the fairest and most efficient default rule, and the one that is most consistent with the parties' reasonable expectations, is one of no recoupment. As mentioned, insurers and insureds are of course free to alter this rule by clear contractual language. The fact that insurers, which are in the best position to revise the policy language, have so rarely attempted to include such a term in their policies suggests that there is relatively little demand for policies with such terms.

It is sometimes argued that the no-recoupment rule provides insureds with a type of coverage that the policy language itself does not. The problem with this argument is that, in cases in which the courts have adopted a no-recoupment rule (and in cases in which this Section would apply such a rule), the liability insurance policies do not expressly provide one way or the other whether there should be recoupment of noncovered settlements. It is the omission of any policy term addressing the issue that gives rise to the need for a default rule, which is what subsection (2) provides. Indeed, it is this absence of any clear language on point that has persuaded many of the courts that have adopted the no-recoupment rule. If there were a term expressly included in the policies that provided for reimbursement, courts would enforce it, which is consistent with the rule followed in this Section.

Although this Section follows the majority default rule of no recoupment, it must be acknowledged that the rule comes with some costs. For one thing, it may mean that insurance premiums are somewhat higher than they would be under an alternative, pro-recoupment default rule. In addition, this no-recoupment rule may give insurers, in a legal action in which they believe they have a strong ground for contesting coverage, an incentive to resist settlement and litigate the action, thereby delaying any payment to the claimant and preserving the possibility of shifting any resulting judgment to the insured. Of course, to follow this strategy the insurer would have to incur defense costs, and those costs may or may not be recoverable from the insured. (See § 21 dealing with recoupment of defense costs.) Nevertheless, even taking the defense costs into account, there will be some cases in which the no-recoupment rule would increase the risk to the insured of suffering a judgment that is wholly uninsured.

The insured can avoid this risk by entering into a settlement authorized by subsection (3), but that requires that the insured pay the settlement itself, or that the claimant be willing to accept an assignment of the insured's rights against the insurer, neither of which may be possible or

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desirable in many cases. Alternatively, an insured could agree at the time of settlement to allow the insurer to obtain recoupment of the settlement if it is later determined that the legal action is not covered under the policy. If the insured were to agree to allow the potential for recoupment, the insurer's incentive to continue to litigate potentially noncovered actions would be reduced, and perhaps even eliminated. For this approach to fully protect insureds from the increased risk of noncovered judgments created by the no-recoupment default rule, however, insurers and insureds would need to have a degree of foresight and judgment that is unrealistic to expect in every case. For example, the insured would need to assess not only the likelihood of a loss in the underlying legal action against the insured but also the likely size of the judgment if a loss were to occur, as well as the strength of the insurer's grounds for contesting coverage. Thus, the fact that the no-recoupment rule may be altered in the settlement process does not eliminate the additional litigation risk to insureds that such a rule poses.

By contrast, the alternative default rule, which permits insurers to seek recoupment of a settlement that is subsequently determined not to be covered, creates the opposite incentive for insurers. Under a pro-recoupment rule, insurers with grounds for contesting coverage would tend to settle more actions than otherwise and to work less hard to keep the amount of the settlements low. Thus, a pro-recoupment rule would create a moral hazard on the part of insurers. From the insured's perspective, a relevant question would be which prospect is more worrisome: the increased risk of noncovered trial judgments (resulting from a no-recoupment rule) or the increased risk of noncovered settlements (resulting from a pro-recoupment rule). This is an empirical question that has no easy answer.

d. Relationship to the Restatement Third, Restitution and Unjust Enrichment. As is the case for the no-recoupment default rule followed in § 21, the Restatement Third, Restitution and Unjust Enrichment (R3RUE), takes the contrary position as an application of general principles of unjust enrichment. See R3RUE § 35, Comment *c*, Illustrations 9-12. The special insurance law reasons for following the no-recoupment default rule in this Section, as stated in Comment *c* above, are similar to those for following the no-recoupment default rule in § 21. As with the rule in § 21, R3RUE and this Section can be reconciled by observing that R3RUE § 35 starts from a different assumption about what it refers to as “local insurance law.” Both that Restatement's premise (about extra-contractual performance) and its conclusion (about unjust enrichment) disappear once insurance law is understood to include a no-recoupment default rule. In that case

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an insurer that defends under a reservation of rights, without an explicit agreement regarding the right to recoupment, is not performing beyond its contractual obligation, because that obligation incorporates the default no-recoupment rule. Compare § 21, Comment *b*. Most restitution claims between insurers and policyholders arise in contexts unrelated to coverage disputes; they more typically involve problems of mistake or subrogation. See R3RUE §§ 6, 24. The rule of this Section has no bearing on the insurer's entitlement to restitution in these fundamentally different settings.

e. Settlements by the insured prior to coverage determination. ~~Courts~~In circumstances in which an insurer that has not accepted coverage refuses to withdraw either its coverage contest or its control over settlement, courts have reached different conclusions about whether an insured may protect its interests by accepting a settlement within the limits of the policy ~~in circumstances in which an insurer that has not accepted coverage refuses to withdraw either its coverage contest or its control over settlement.~~ While perhaps not yet the majority rule, an increasingly large number of states permit the insured to settle without the consent of the insurer ~~under the conditions stated in subsection (3)~~even if the policy contains a provision requiring consent. Subsection (3) follows this emerging rule while adding some procedural requirements designed to protect against collusive or improvident settlements. This rule allows the insured to protect itself against the risk of a large, uncovered verdict while preserving the insurer's right to contest both coverage and the reasonableness of the settlement. The insurer's liability for such settlements is subject to the policy limits, as well as any potential grounds for contesting coverage. The rule in subsection (3) does not authorize the insured to enter into a settlement or consent judgment in excess of the policy limits that obligates the insurer to pay for the amount by which that settlement or consent judgment exceeds the policy limits.

The effect of the rule is to give an insurer that is disputing coverage for a legal action the choice between (a) accepting the coverage obligation and retaining control of the defense and the settlement of the legal action or (b) preserving the right to contest coverage and permitting the insured to ~~settle~~make a reasonable settlement of the legal action. The rule encourages insurers to drop a weak ground for contesting coverage in order to maintain control over settlement of the legal action because it is primarily the insurer's money at stake in that action when its grounds for contesting coverage are weak. The rule encourages insurers with strong grounds for contesting coverage to grant control over settlement to the insured. Granting the insured control

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over settlement in such cases is appropriate: because of the strong grounds for contesting coverage, it is primarily the insured's money at stake.

Because of the potential for collusion, all such settlements should be scrutinized to ensure that they are reasonable both in substance and procedure. In addition to interrogating the reasonableness of the terms of the settlement, courts should ask questions such as the following:

- (1) Did the insurer receive all information reasonably necessary to evaluate the legal action?
- (2) Did the insurer have a ~~meaningful~~reasonable opportunity to participate in the settlement process?
- (3) Did the insurer have a reasonable amount of time to evaluate the legal action and all the terms of any proposed settlement agreement?
- (4) Were any reservations regarding the terms of the settlement expressed by the insurer fully and fairly communicated to the insured?

Illustration:

2. A claimant files a tort suit against the insured seeking damages of \$500,000. The insured has a duty-to-defend liability insurance policy with policy limits of \$100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend under a reservation of rights. As the case approaches trial, the claimant makes a settlement demand of \$100,000. The insurer rejects the settlement demand, preferring to negotiate for a lower settlement or to take the case to trial. The insured, however, believes that the settlement demand should be accepted. The insured notifies the insurer that she is in settlement negotiations with the claimant. The insurer declines to participate or to withdraw its coverage contest. The insured enters into a settlement with the claimant for \$100,000. The insured may bring a breach-of-contract action against the insurer to recover the amount of the settlement or, if the claimant is willing to wait, to require the insurer to pay the settlement. In the breach-of-contract action, the insurer's coverage contest will be resolved on the basis of all of the facts and circumstances, because the insurer did not breach the duty to defend.

REPORTERS' NOTE

a. Reservation of rights does not eliminate the duty to make reasonable settlement decisions, but there is no such duty for noncovered actions. Consistent with the principle stated in subsection (1), the majority of jurisdictions have held that an insurer defending an action under

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a reservation of rights still has a duty to accept reasonable settlement offers. See, e.g., 1 JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE CONTRACTS COVERAGE § 9.05[C] ~~at 9-160 (2010 Supplement (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.”). Cf. *Luke v. Am. Family Mut. Ins. Co.*, 476 F.2d 1015, ~~1023~~ 1021 (8th Cir. 1972), cert. denied, 414 U.S. 856 (1973) (applying South Dakota law) (citations omitted) (“[T]he vast number of jurisdictions which have considered the question hold that when an offer of settlement within policy limits ~~is~~ 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.”). For courts adopting this stance, see, e.g., *Parsons v. Cont’l Nat’l Am. Group*, 550 P.2d 94, 100 (Ariz. 1976) (“In the instant case the further fact that the carrier believed there was no coverage under the policy and so refused to give any consideration to the proposed settlement did not absolve them from liability for the entire judgment entered against the insured.”); *Johansen v. California State Auto. Assn. Ass’n Inter-Ins. Bureau*, ~~15 Cal. 3538 P.2d 9, 19744~~ (Cal. 1975) (“[A]n insurer’s ‘good faith,’ though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer’s refusal to accept a reasonable settlement offer” and a reservation of rights did not relieve the insurer of its duty to settle); *Eskridge v. Educator and Exec. Insurers, Inc.*, 677 S.W.2d 887, 890 (Ky. 1984) (“[The insurer’s] erroneous belief that the policy had lapsed is not relevant to the determination” of whether the insurer had breached its duty to settle). These courts further maintain that doubts about whether the policy provides coverage “should not affect a decision as to whether the settlement offer in question was a reasonable one.” *Johansen*, 15 Cal. 3d at 16. See also *Eskridge*, 677 S.W.2d at 890 (“The factors to be considered are probability of recovery, the likelihood that judgment will exceed policy limits, negotiations for settlement, offers to settle within or for less than the policy limits, and whether the insured made a demand for settlement.”). See generally STEPHEN S. ASHLEY, BAD FAITH ACTIONS LIABILITY & DAMAGES § 4:13 (~~database updated September 2011 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.”).

By contrast, some courts allow insurers to take coverage doubts into account and to reject otherwise reasonable settlement offers. KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 666 (~~5~~ 616 (6th ed. ~~2010~~ 2015)). See also 1 STEMPEL & KNUTSEN, § 9.05[C] ~~at 9-160-9-161~~ (“However, a substantial number of cases have found that an insurer who fails to settle a case because of a colorable or good faith belief that no coverage exists can avoid the duty to settle liability.”). See, e.g., *Mowry v. Badger State Casualty Mut. Cas. Ins. Co.*, 385 N.W.2d ~~171~~ 171, 180 (Wis. 1986) (rejecting the *Johansen* rule and holding that “[w]hether an insurer who rejects an offer to settle within policy limits because of a coverage question shall be liable . . . upon a determination of coverage depends upon whether the insurer acted in bad faith in determining that a coverage question existed.”).

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Courts and commentators advance three reasons for precluding insurers from factoring coverage doubts into their settlement decisions. First, allowing insurers to reject reasonable settlement offers while resolving coverage disputes would result in more actions reaching trial. ABRAHAM & SCHWARCZ at 666616 (“The result [of the *Johansen* approach] “is avoidance-of-to-avoid unnecessary litigation, at least in cases where the insured simply cannot produce the funds necessary to accept the claimant’s offer of settlement.”); 1 STEMPEL & KNUITSEN § 9.05[C]-at 9-162 (“[V]aluable social interests in compensation and risk spreading are served when insurers are encouraged to facilitate settlement even where coverage is in doubt.”). Second, the rule ensures that the duty to settle functions properly by allocating to the insurer the risk as well as the benefits of settlement decisions. See *Johansen*, 15 Cal. 3d at 16 (explaining that the duty-to-settle doctrine forces insurers to absorb the risks of excess judgments by requiring that they act as if they were responsible for the entire potential judgment, which necessarily precludes them from considering coverage doubts). Third, the rule places the risk of loss on the party best situated to avoid or bear the costs:

In determining who bears the loss we must remember we are dealing with an insurance contract. The policyholder buys insurance to avoid the risk of loss. The insurance company is in the business of evaluating risks, assuming risks, and spreading the costs of ~~risk~~the risks. . . . In refusing to pay policy limits [in settlement] in this case, the insurance company decided to impose a risk on the policyholder. As it turned out, the insurance company was wrong about the coverage.

Mowry v. Badger State Casualty Ins. Co., 385 N.W.2d 171, 190 (Wis. 1986) (Abrahamson, J., dissenting). See also 1 STEMPEL & KNUITSEN § 9.05[C]-at 9-161 (“*Mowry* is thus a most problematic holding in that it exposes the policyholder to substantial risk that could have been avoided at relatively low cost in order to vindicate the insurer’s interest . . . in refusing to pay claims it believes fall outside of coverage.”).

Although a reservation of rights does not eliminate the duty to make reasonable settlement decisions, there is no duty to settle claims that turn out not to be covered. See, e.g., *Rocor Int’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh*, 77 S.W.3d 253, 261 (Tex. 2002) (Insurers “generally [have] no obligation to settle a third-party claim . . . unless the claim is covered by the policy.”). Accordingly, determination that a claim is not covered precludes the insured from holding the insurer liable for failure to settle that claim, even though the issue of coverage was unresolved when the insurer rejected the settlement demand. Michael Aylward, *Other People’s Money: Insurer Liability for Failing to Settle Within Policy Limits*, 54 FDCC QUART. 267, 278 (2004) (“In short, the insurer’s obligation is only to effect a settlement of covered claims.”); 3 JEFFREY E. THOMAS, *NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION* 23.02[6][c][ii][A] (Lexis 20122017) (“An insurer may be presented with a settlement demand at a time when a coverage question is unresolved. If it refuses the demand and it turns out that there is no coverage, it will have no liability.”).

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For other cases holding that insurers cannot be held liable for failure to settle a noncovered action, see, e.g., *Twin City Fire Ins. Co. v. Colonial Life & Accident Ins. Co.*, 375 F.3d 1097, 1103 (11th Cir. 2004) (applying South Dakota law) (declining to hold an “insurer liable in tort for declining to contribute money toward a settlement of a third-party claim when there is no coverage of the claim under the ~~insurer~~insured’s policy at all.”); *Bell v. Tilton*, 674 P.2d 468, 473 (Kan. 1983) (holding that the insurer could not be liable for failure to settle when the trial court had correctly determined that the policy provided no coverage); *Rocor*, 77 S.W.3d at 261 (Tex. 2002) (“Accordingly, we hold that to trigger an insurer’s statutory duty to reasonably attempt settlement of a third-party claim against its insured, the policy must cover the claim . . .”).

b. When a legal action has both covered and noncovered components. 1 WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION* § 2.03[6][c][i] (2d ed. ~~2011~~2017) (citations omitted).

If an insurer correctly determines that there is no coverage for any of the liabilities that the insured might incur, it is not liable for failure to settle those liabilities. If the suit includes both covered and noncovered claims, the insurer need contribute ~~not~~no more than the fair settlement value of the covered claims.

See, e.g., *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*, 67 A.3d 961, ~~992~~969 (Conn. 2013) (holding that, in cases in which only some of the claims asserted against the insured are potentially covered and there is a global settlement, the insurer is required only to pay so much of the settlement as can fairly be allocated to potentially covered claims).

c. The default rule is no right to recoupment. The vast majority of states have not addressed this issue, perhaps “because until recently few observers would have thought that there could be any right to recoup indemnity payments.” KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION: CASES AND Materials* 666 (~~5~~ 616 (6th ed. ~~2010~~2015)). The courts of only one state have permitted an insurer to obtain recoupment of a settlement payment without prior agreement of the insured. See *Blue Ridge Ins. Co. v. Jacobsen*, 22 P.3d 313, 320-321 (Cal. 2001) (permitting insurers to “seek reimbursement for the settlement paid on the [insureds’] behalf even in the absence of [their] express agreement,” so long as the insurer satisfies three prerequisites: “(1) a timely and express reservation of rights; (2) an express notification to the insureds of the insurer’s intent to accept a proposed settlement offer; and (3) an express offer to the insureds that they may assume their own defense when the insurer and insureds disagree whether to accept the proposed settlement.”). For further discussion of the *Blue Ridge* rule, see Michael Aylward, *Other People’s Money: Insurer Liability for Failing to Settle Within Policy Limits*, 54 FDCC QUART. 267, 277-278 (2004). By contrast the courts in six states permit insurers to obtain recoupment of a settlement payment only when the insured has consented to a settlement ~~made with this condition~~subject to recoupment if the insurer’s coverage defenses are upheld. See *Mount Airy Ins. Co. v. Doe Law Firm*, 668 So. 2d 534, ~~536~~537-538 (Ala. 1995) (citations omitted) (“~~It~~It has been the law in Alabama for over 150 years that where

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one party, with full knowledge of all the facts, voluntarily pays money to satisfy the colorable legal demand of another, no action will lie to recover such a voluntary payment, in the absence of fraud, duress, or extortion” and “the mere threat of legal proceedings is insufficient to constitute the duress needed to make the payment of money involuntary”); [MedicalMed](#), Malpractice Joint Underwriting Ass’n [of Mass.](#) v. Goldberg, 680 N.E.2d 1121, ~~1128~~[1129](#) & n.31 (Mass. 1997) (“Where an insurer defends under a reservation of rights to later disclaim coverage, as [JUA\[insurer\]](#) did here, it may later seek reimbursement for an amount paid to settle the underlying tort action only if the insured has agreed that the insurer may commit the insured’s own funds to a reasonable settlement with the right later to seek reimbursement from the insured, or if the insurer secures specific authority to reach a particular settlement which the insured agrees to pay”); Horace Mann Ins. [Co.](#) v. Hanke, 312 P.~~23~~[3](#)d 429, 435-~~437~~ (Mont. 2013) (denying insurer’s claim for recoupment of defense costs but permitting recoupment of \$34,000 that the insurer paid to the claimant on the insured’s behalf following a settlement in which the insured agreed to pay the claimant \$34,000 from personal funds but was unable to obtain a loan for that amount of money, in circumstances in which it was clear that the insured agreed that it had an obligation to repay the insurer); Lexington Ins. Co. v. Illinois Union Ins. Co., [No. 12A668035](#), 2016 WL 4772711, at *~~7~~[8](#) (Nev. Dist. Ct. [Jul. 13](#), 2016) (“Lexington cannot assert a reservation of a right it did not have under its own insurance policy at issue in that it would be tantamount to allowing an insurer the right to a unilateral amendment to the contract of insurance.”); Excess Underwriters at Lloyd’s, London v. Frank’s Casing Crew & Rental Tools, Inc., 246 S.W.3d 42, 43 (Tex. 2008) (“In Texas, an insurer that settles a claim against its insured when coverage is disputed may seek reimbursement from the insured should coverage later be determined not to exist if the insurer obtains the insured’s clear and unequivocal consent to the settlement and the insurer’s right to seek reimbursement.”) (internal quotations omitted); U.S. Fid. & Guar. Co. v. U.S. Sports Specialty [Ass’n](#), 270 P.3d 464, 468 (Utah 2012) (“Because an insurer’s right to reimbursement from an insured substantially affects the relative levels of risk assumed by each, Utah law does not allow an insurer to seek reimbursement or restitution through an extracontractual claim of unjust enrichment. Instead, we hold that an insurer’s right to reimbursement from an insured must be expressly provided in an insurance policy before it can be enforced.”). The Texas Supreme Court provided one rationale for imposing a strict consent requirement: “[o]therwise, the insured is forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means, at a time when the insured is most vulnerable.” Texas Ass’n of Counties County Gov’t Risk [ManagementMgmt](#). Pool v. Matagorda County, 52 S.W.3d 128, 135 (Tex. 2000).

Notwithstanding the dearth of state-court authority, several federal courts have made Erie predictions that state courts would permit recoupment in the absence of the insured’s agreement. See Travelers Prop. Cas. Co. of Am. v. [NillerishHillerich](#) & Bradsby Co., [Inc.](#), 598 F.3d 257, 267 (6th Cir. 2010) (Kentucky law) (asserting that this is the majority rule and relying on an implied-in-fact contract theory based on the insured accepting the payment of defense costs under a reservation of rights that waived any right of reimbursement of defense costs but asserted the

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right to seek recoupment of any settlement payments); *Cont'l Cas. Co. v. Indian Head Indus. Inc.*, 666 F. App'x 456, 468 (6th Cir. 2016) (Michigan law) (relying exclusively on other 6th Circuit Erie predictions); *Interstate Fire & Cas. Co. v. Underwriters at Lloyd's, London*, 139 F.3d 1234, 1238 (9th Cir. 1998) (Oregon law) (permitting insurer to litigate the number of occurrences and obtain reimbursement from the insured of an amount equal to a second SIR despite lack of insured's consent); *Philips & Assocs., P.C. v. Navigators Ins. Co.*, 764 F. Supp. 2d 1174, [1175-1176](#) (D. Ariz. 2011) (in a case in which there was a dispute about whether California or Arizona law applied, court declined to make choice-of-law decision because, making an Erie prediction about Arizona law, both states would permit an insurer to recoup a settlement payment); *Melton Truck Lines, Inc. v. Indem. Ins. Co. of N. Am.*, [No. 04-CV-263-JHP-SAJ](#), 2006 WL ~~1876528~~[1876528](#), at *2 (N.D. Okla. [June 26, 2006](#)) (Oklahoma law) (relying on lower-Texas-court opinion in *Frank's Casing*, which was subsequently overruled in the opinion cited earlier in this Note); *Cincinnati Ins. Co. v. Grand Poine, LLC*, 501 F. Supp. 2d 1145, 1151-1153 (E.D. Tenn. 2007) (Tennessee law) (permitting recoupment of defense costs and settlement payment). Other federal courts have made the opposite Erie prediction. See *Am. Modern Home Ins. Co. v. Reeds at Bayview Mobile Home Park, LLC*, 176 F. App'x 363, 367 (4th Cir. 2006) (“Because neither the policy nor any subsequent agreement between American Modern and its insureds grants American Modern a right to reimbursement, we cannot conclude that American Modern has such a right.”); *Am. Motorist Ins. Co. v. Custom Rubber Extrusions, Inc.*, [No. 1:05cv2331](#), 2006 WL 2460861, at *7 (N.D. Ohio [Aug. 23, 2006](#)) (discussing the Sixth Circuit's Erie prediction that Ohio law would permit recoupment of defense costs and refusing to permit an insurer to recoup amounts paid to satisfy a judgment); *Steadfast Ins. Co. v. Sheridan Children's Healthcare Servs, Inc.*, 34 F. Supp. 2d 1364, 1367 (S.D. Fla. 1998) (relying on *Goldberg* opinion from Massachusetts and ~~*Mt. Mount Airy*~~ opinion from Alabama, both cited above, to support its Erie prediction that the Florida courts would not permit an insurer to recoup a settlement absent an agreement by the insured to this procedure).

Note that the Third Circuit has made an Erie prediction that the Pennsylvania courts would permit recoupment of an amount paid to satisfy a judgment after a contested trial. See *Essex Ins. Co. v. RMJC, Inc.*, 306 F. App'x 749, 755 (3d Cir. 2009). Because this opinion predates the Pennsylvania Supreme Court's decision in *Jerry's Sports, Sport Ctr.* (rejecting insurer's right to recoup defense costs), there is some doubt about the Erie prediction. In any event, permitting an insurer to recoup an amount paid to satisfy a judgment after a contested trial is distinguishable from permitting an insurer to recoup an amount paid to settle a claim, because it does not expose the insured to the same pressure described by the Texas Supreme Court in *Matagorda County*, as quoted above. For a general discussion of the case law on recoupment, in both the defense costs and settlement contexts, see [1 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, § 2.11](#) (2d ed. ~~2014~~[2017](#)). For a persuasive argument that the choice of default recoupment rule would be unlikely to result in different outcomes in practice, as long as the parties behave rationally and are aware whether the insured has sufficient assets to pay an uncovered claim, see Kenneth S. Abraham, *The Liability*

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Insurer's Duty to Settle Uncertain and Mixed Claims, 68 RUTGERS L. REV. 337, 353-357 (2015) (explaining the conclusion that “in many cases, and perhaps even most cases, it does not matter which approach is adopted”).

d. Relationship to the Restatement Third, Restitution and Unjust Enrichment. See generally Restatement Third, Restitution and Unjust Enrichment § 35, Comment *c* (AM. LAW INST. 2011).

e. Settlements by the insured prior to coverage determination. See 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 199:48 (3d ed. ~~2014~~2017):

A cooperation clause prohibiting an insured's settlement without the insurer's consent forbids an insured from settling only claims for which the insurer unconditionally assumes liability under the policy. Since an insurer, by reserving its right to deny coverage, loses its right to control the litigation, an insured does not breach a policy's “duty to cooperate with insurer” provision by entering into an unauthorized settlement or stipulated liability, so long as such agreements are made fairly, with notice to the insurer, and without fraud or collusion on the insurer, and the settlement is reasonable and prudent.

See also 16 RICHARD A. LORD, WILLISTON ON CONTRACTS § 49:108 (4th ed. ~~2014~~2017) (“Once the insurer . . . defends under a reservation of rights, the duty to cooperate does not preclude the insured from entering into a reasonable settlement with a claimant that is in the insured's best interests.”); Benjamin A. Kahn & Ronald H. Nemirow, *Unauthorized Settlement Agreements in a Reservation of Rights Context*, 34 TORT & INS. L.J. 799, 818 (1999) (noting increasing adoption of the rule that “an insured can enter into an unauthorized settlement agreement despite the insured's duty to cooperate . . .”).

A number of courts have held that “when the insurer defends under a reservation of rights the cooperation clause may not be invoked to prevent the insured from entering into a settlement without the insurer's consent.” *Parking Concepts, Inc. v. Tenney*, 83 P.3d 19, 24 (Ariz. 2004). See also *Kelly v. Iowa Mut. Ins. Co.*, 620 N.W.2d 637, 644-645 & n.5 (Iowa 2000) (“At the point in time that the insurer is faced with a fair and reasonable settlement demand that a reasonable and prudent insurer would pay, the insurer must either abandon its coverage defense and pay the demand or lose its right to control the conditions of settlement. If the insurer prefers to debate coverage and, accordingly, refuses to pay the settlement demand, the insured is free to either pay the settlement demand or stipulate to the entry of judgment in the amount of the demand. The insurer, if found to have coverage, will be liable for the insured's settlement if the settlement is found to be fair and reasonable.”); *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 v. Shugart*, 316 N.W.2d 729, 731, 734 (Minn. 1982) (“[T]he insureds did not breach their duty to cooperate with the insurer, which was then contesting

coverage, by settling directly with the plaintiff.”); *Chausee v. Maryland Cas. Co.*, 803 P.2d 1339, 1342 (Wash. Ct. App. 1991) (citing *United Services Auto. Ass’n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987)) (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); *Gainsco Ins. Co. v. Amoco Prod. Co.*, 53 P.3d 1051, 1079 (Wyo. 2002) (holding stipulated judgment enforceable when insurer defends under reservation of rights and declines an offer to settle within policy limits). Most recently, the Pennsylvania Supreme Court held:

we 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 and, thus, subjects an insured to potential responsibility for the judgment in a case where the policy is ultimately deemed to cover the relevant claims.

Babcock & Wilcox Co. v. AmericanAm. Nuclear Insurers, 131 A.3d 445, ~~461~~462 (Pa. 2015) (citing *United Services Auto. Ass’n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987) and the *Kelly* case from Iowa, *supra*).

Other courts, however, “expressly hold that where an insurer provides a defense to its insured, even under a reservation of rights, the insured may not settle the matter without its insurer’s consent” without breaching his or her duty to cooperate. 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 203:37 (3d ed. ~~2011~~2017) (noting the division of authority without providing guidance as to the majority rule). See, e.g., *Motiva EnterprisesEnters., LLC v. St. Paul Fire and Marine Ins. Co.*, 445 F.3d ~~381~~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, 96-97 (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”).

This Section follows a middle-ground approach by requiring insureds to notify insurers and give them ~~an~~a reasonable opportunity to participate, but ultimately allowing insureds to settle without insurer consent as long as the amount of the settlement that the insurer is asked to pay is reasonable and the insurer’s contribution is consistent with its policy obligations. This rule relieves insurers of the choice between “defend[ing] unconditionally or . . . refus[ing] to defend at its peril” while allowing “the insured to take reasonable measures to protect himself against the danger of personal liability.” *United Servs. Auto Ass’n v. Morris*, 741 P.2d 246, ~~251~~251-252 (Ariz. 1987). As the Supreme Court of Maine explained, the *Morris* rule

strikes a fair balance between the insurer and the insured By allowing the insured to control his own case when the insurer issues a reservation of rights, the insured can protect himself from the sharp thrust of personal liability, and the insurer still has a meaningful opportunity to protect its own interests in a

declaratory judgment action where it may assert, among other things, a coverage defense.

Patrons Oxford, 905 A.2d at 826 (internal quotations omitted). For further discussion, see Steven Plitt, *The Evolving Boundaries of Damron/Morris Agreements: A Search for the Missing Link, A Judicial Determination of the Length of a Reasonable Person’s Arm, and Other Progressive Issues*, 35 ARIZ. ST. L.J. 1331, 1333-1335, 1351-1353 (2003) (discussing the rationales behind Arizona’s adoption of the reservation-of-rights approach and its corresponding abridgment of insureds’ duty to cooperate).

Although subsection (3) states that the insurer must be given notice and ~~an~~ reasonable opportunity to participate in the proposed settlement in order for the settlement to be acceptable, some jurisdictions permit this type of settlement without imposing these requirements. See generally Kahn and Nemirow, 34 TORT & INS. L.J. at 822-824 (noting that only some courts require notice to the insurer of the settlement). Among jurisdictions that allow insureds to settle without insurer consent, most seem to follow Arizona’s requirement that the insured provide the insurer with notice of the settlement. See, e.g., *Morris*, 741 P.2d at 252 (“Thus, an insured being defended under a reservation of rights may” settle “fairly, with notice to the insurer, and without fraud or collusion.”); *Patrons Oxford Ins. Co.*, 905 A.2d at 828 (requiring notice but not consent); *Gainsco Ins. Co. v. Amoco Production Co.*, 53 P.3d at 1067 (“[A]n insured does not violate the cooperation clause of an insurance policy by settling a claim being defended under a reservation of rights, so long as such settlement is preceded by adequate notice to the insurer.”). See generally Kahn & Nemirow, 34 TORT & INS. L.J. at 822-823 (discussing how different courts have interpreted *Morris*). The U.S. District Court for the District of Maine determined further that the cooperation clause requires not only “notice of settlement opportunities,” but also “the option to participate therein, even where the insurer has reserved the right to contest coverage.” *Gates Formed Fibre Products, Inc. v. Imperial Cas. & Indem. Co.*, 702 F. Supp. 343, 347 (D. Me. 1988) (applying Maine law). At the other end of the notice spectrum, at least one court has held that “notice is not a separate procedural requirement . . . Instead notice is a component of the factual question of whether the insured’s settlement of the claims defended under a reservation of rights was reasonable, in good faith and without fraud or collusion.” *Insurance Ins. Co. of North America N. Am. v. Spangler*, 881 F. Supp. 539, 545 (D. Wyo. 1995) (applying Wyoming law).

§ 26. The Effect of Multiple Claimants on the Duty to Make Reasonable Settlement Decisions

(1) If ~~there are~~ multiple legal actions that would count toward a single policy limit are brought against an insured ~~that would count toward a single policy limit~~, the insurer

has a duty to the insured to make a good-faith effort to settle the actions in a manner that minimizes the insured’s overall exposure.

(2) The insurer may, but need not, satisfy this duty by interpleading the policy limits to the court, naming all known claimants, and, if the insurer has a duty to defend or a duty to pay defense costs on an ongoing basis, continuing to defend or pay the defense costs of its insured until:

(a) Settlement of the legal actions;

(b) Final adjudication of the actions; or

(c) Adjudication that the insurer does not have a duty to defend or to pay the defense costs of the actions.

Comment:

a. Minimizing the insured’s exposure. When an insured faces multiple legal actions that would count against the policy limit of a liability insurance policy (or would count against the limit of a set of insurance policies in the event there are additional insurance policies that provide coverage), the question arises how the insurer should manage the settlement of those actions when the policy limit is not sufficient to cover the full settlement value of all of them. If some claimants make early settlement offers while others delay, the insurer must decide whether to accept the early offers. Accepting the early offers may exhaust the policy limits and expose the insured to greater liability in excess of the policy limits than if the insurer had managed the legal actions as a unit. If the insurer rejects the early settlement offers, however, the insurer may later face a breach-of-settlement-duty suit if those claimants obtain excess judgments against the insured. Some jurisdictions have adopted a first-come, first-served approach to multiple claimants, allowing the insurer to accept the first reasonable, within-limits settlement offers that are made. This eliminates the insurer’s risk of a breach-of-settlement-duty suit, but it can result in increased exposure for insureds, if the non-settling parties decide to litigate their actions.

The better settlement strategy is to seek to minimize the overall liability exposure of the insured. In addition to providing greater protection to insureds, this strategy will also generally lead to more equitable results for claimants than does the rule that rewards the claimant that is fastest to the settlement table. Subsection (1) provides the basic rule that insurers are obligated to seek such a settlement with all potential claimants in a manner that minimizes the insured’s overall exposure. Often the exposure-minimizing settlement agreement will be one that allocates

the policy limits among the various claimants on the basis of the relative expected value of their claims. Of course, the obligation to seek such a settlement does not mean that it will be possible to obtain such a settlement, especially if the insured has substantial assets in addition to the available insurance limits.

b. The safe harbor. The rule stated in subsection (1) leaves the insurer subject to a considerable degree of uncertainty. For this reason, subsection (2) creates a safe harbor for insurers. Under this rule, the insurer can interplead the policy limits to the court, naming all known potential claimants, and continuing to defend the insured. When the insured has few or no assets that can be used to satisfy a judgment, this procedure will likely lead the claimants to resolve their actions within the context of the interpleader action. When the insured has substantial assets, however, one or more of the claimants may well pursue the case to trial. This result is consistent with the fact that, as a practical matter, insurers bear a greater defense burden when they sell low-limit policies to policyholders with substantial assets, because claimants will be less willing to settle for the policy limits against such defendants.

c. Complex liability insurance arrangements. The safe harbor stated in this Section is principally directed at simple liability insurance coverage situations involving a single policy period and a single, well-integrated liability insurance program consisting of a primary insurance policy and, possibly, one or more excess insurance policies. The more complex a liability insurance arrangement is, the more likely the insured will have the resources needed to actively work with its insurer(s) to manage the risk of excess liability. In complex situations, the duty stated in this Section simply obligates the insurer to act reasonably in its dealings with the insured in order to assist the insured in minimizing the overall exposure. In such situations, the safe harbor provided in subsection (2) may not be practicable.

REPORTERS' NOTE

a. Minimizing the insured's exposure. For a discussion of the problem of applying the duty to settle when there are multiple claimants and insufficient policy limits and a review of the various approaches that courts have taken to address the problem, see KEETON & WIDISS & FISCHER, INSURANCE LAW § 7.4 (1998 2d ed. 2017), and 1 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 2.03[9][A] (2d ed. 2011 2017). Keeton appears to have been the first to suggest the idea of prorating settlement offers based on the relative expected values of the various actions. Robert E. Keeton, *Preferential Settlement of Liability Insurance Claims*, 70 HARV. L. REV. 27, 40-46 (1956). See also KEETON & WIDISS

~~792-793 (1988)~~ & FISCHER 669-671 (2d ed. 2017). The two leading alternatives are the “first-come, first-served” approach and a rule that grants the insurer wide discretion. The first-come, first-served rule is preferred by some courts because it does not require delaying settlement with some claimants based upon speculation about future settlement offers, and it allows insurers to accept reasonable settlement offers. 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION 23.02[9]. For cases approving of the first-come, first-served approach, see, e.g., *Voccio v. Reliance Ins. Cos.*, 703 F.2d 1, 3 (1st Cir. 1983) (applying Rhode Island law); *Standard Accident Insurance Co. of Detroit, Mich. v. Winget*, 197 F.2d 97, 104 (9th Cir. 1952) (California law); *Bartlett v. Travelers’ Insurance Co.*, 167 A. 180, 183 (Conn. 1933); *Pekin Ins. Co. v. Home Ins. Co.*, 479 N.E.2d 1078 (Ill. App. Ct. 1985); *Bennett v. Conrady*, 305 P.2d 823, 828 (Kan. 1957); *Liguori v. Allstate Insurance Co.*, 184 A.2d 12, 17 (N.J. Ch. 1962); *Alford v. Textile Insurance Co.*, 103 S.E.2d 8, 13 (N.C. 1958); *Texas Farmers Insurance Co. v. Soriano*, 881 S.W.2d 312, 315 (Tex. 1994). See also Thomas R. Newman, *Ending Duty to Defend: Exhausting Policy Limits When Settling Less than All Lawsuits*, FOR THE DEFENSE 38, 41 (March 2013) (collecting cases).

The “wide-discretion” approach differs from the first-come, first-served in requiring the insurer to consider the possibility of other actions. See, e.g., *Shell Oil Co. v. National Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 44 Cal. App. 4th 1633, 1647 (Cal. Ct. App. 1996) (an insurer’s disbursement of its entire policy limits to indemnify a co-insured “did not discharge [the insurer’s] policy obligations . . . but rather constituted an actionable breach of those duties” to its other insured); *Schwartz v. State Farm Fire & Cas. Co.*, 88 Cal. App. 4th 1329, 1337 (Cal. Ct. App. 2001) (insurer has a “duty not to favor the interest of one of its insureds over the interests of the other.”); *Smoral v. Hanover Ins. Co.*, 37 A.D.2d 23, 322-25 (N.Y. S.2d 12 (App. Div. 1971) (“It is absolutely no answer for the company to say that it paid the full amount of its policy if in doing so it fully protected one of its insureds and left the other completely exposed.”). See also 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION 23.02[9][a][i] (Lexis 20122017) (“Of course, an insurer cannot hastily make excessive settlements that deplete its limits in order to relieve itself of the responsibility of further protecting its insured.”). The First Circuit described the obligation of the insurer as follows:

The insurer has both the right and the duty to exercise its professional judgment in settling, or refusing to settle, such claims—but it must do so mindful of the insured’s best interests and in good faith. The insurer’s goal should be to try to effect settlement of all or some of the multiple claims so as to relieve its insured of so much of his potential liability as is reasonably possible, considering the paucity of the policy limits. . . . So long as it acts in good faith, the insurer is not held to standards of omniscience or perfection; it has leeway to use, and should consistently employ, its honest business judgment. . . . The carrier . . . “will not be held to prophesy.”

Peckham v. ~~Continental~~Cont'l Cas. Ins. Co., 895 F.2d 830, 835 (1st Cir. 1990) (applying Massachusetts law) (internal citations omitted). In general, these courts have encouraged insurers to make a good-faith effort to resolve all of the claims against their insureds. If that proves impossible, some courts permit insurers to expend their limits to resolve as many of the claims that can be settled, even if that leaves some insureds without coverage. See, e.g., Underwriters ~~Guarantee~~Guar. Ins. Co. v. Nationwide Mut. Fire Ins. Co., 578 So. 2d 34 (Fla. Dist. Ct. App. 1991); Millers Mut. Ins. Ass'n of Illinois v. Shell Oil Co., 959 S.W.2d 864 (Mo. Ct. App. 1997). In many if not most cases, the result under the rule stated in this Section will be the same as the result under the wide-discretion approach.

b. The safe harbor. KEETON ~~&~~ WIDISS & FISCHER § 7.4(d), ~~fn.~~+194 (“In most jurisdictions, an insurer may institute a proceeding, usually in the nature of interpleader, to obtain a court order allocating among various claims the limited fund within the per-accident limit of policy coverage.”), citing, among other sources, Zechariah Chafee, *The Federal Interpleader Act of 1936: II*, 45 YALE L.J. 1161 (1936). For a recent example of a court creating a “safe harbor” for the insurer similar to that created by subsection (2), see McReynolds v. Am. Commerce Ins. Co., 235 P.3d 278, 284 (Ariz. Ct. App. 2010) (holding that an insurer, faced with multiple claims in excess of its policy limits, satisfied its duty to settle when it promptly and in good faith interpleaded its policy limits into court, naming all known claimants, and continued to provide a defense to its insured).

§ 27. Damages for Breach of the Duty to Make Reasonable Settlement Decisions

An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for any foreseeable harm caused by the breach, including the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits.

Comment:

a. Liability for excess judgment. If the insurer’s breach of the duty to make a reasonable settlement decision causes an excess judgment against the insured, the insured is entitled to recover from the insurer, in addition to the policy limit, the difference between the policy limit and the tort judgment. This is the paradigmatic measure of damages in a breach-of-settlement-duty lawsuit against an insurer.

b. Liability for settlement. If an insurer breaches the duty to make a reasonable settlement decision by unreasonably refusing to contribute its limit to an above-limits settlement of a covered legal action, the insured (or ~~an~~another insurer acting on the insured’s behalf) may make a reasonable, non-collusive settlement with the claimant, notwithstanding any term in the insurance

policy requiring the insurer's consent to, or approval of, the settlement of a covered claim. ~~Courts approving~~ According to the reasoning of the courts that have adopted this rule ~~reason that~~, the insurer's breach of the contractual duty to make reasonable settlement decisions relieves the insured of the obligation to comply with ~~such~~ terms in the insurance policy that ordinarily prevent the insured from settling without the insurer's consent. When an excess insurer acts for the insured ~~in settling to settle~~ a covered legal action in ~~this manner~~ such a situation, the excess insurer may recover from the underlying insurer under the doctrine of equitable subrogation. See § 28.

~~If~~ Similarly, if an insurer breaches the duty to make a reasonable settlement decision by unreasonably failing to settle a covered legal action within the policy limits, the insured (or ~~an~~ another insurer acting on the insured's behalf, such as an excess insurer) may make a reasonable, non-collusive settlement with the claimant, notwithstanding any term in the insurance policy requiring the insurer's consent to, or approval of, the settlement of a covered claim. As ~~in the first case~~ with the cases involving above-limits settlement offers, the courts adopting this rule reason that the insurer's breach of its duty to the insured relieves the insured of the obligation to comply with ~~such~~ terms in the insurance policy ~~that ordinarily prevent the insured from settling without the insurer's consent~~.

The duty to cooperate requires the insured to exercise reasonable diligence in providing information to the insurer and seeking the insurer's consent to such settlements. See § 29. Because of the potential for collusion between the insured and the claimant, ~~all~~ such settlements should be scrutinized by the court to ensure that they are reasonable in both ~~in~~ substance and procedure. In addition to interrogating the reasonableness of the terms of ~~the settlement~~ such settlements, courts should ask questions such as the following: (1) Did the insurer receive all information reasonably necessary to evaluate the legal action? (2) Did the insurer have a ~~meaningful~~ reasonable opportunity to participate in the settlement process? (3) Was the insurer informed of material developments in the settlement process? (4) Did the insurer have a reasonable amount of time to evaluate the legal action and all the terms of any proposed settlement agreement? (4~~5~~) Were any reservations regarding the terms of the settlement expressed by the insurer fully and fairly communicated to the insured? (6) Are there any indicia of collusion between the insured and the underlying claimant in the settlement process?

In the event of a dispute over the reasonableness of a settlement offer, an insurer can conclusively foreclose an argument that the insured is permitted to settle the case without the insurer's consent by waiving the policy limit and any coverage defenses. As explained in Comment *b* to § 24, the duty to make reasonable settlement decisions is owed only to protect the insured from damages in excess of the policy limits. The elimination of that risk eliminates that duty and, hence, any corresponding basis for excusing the insured's obligation to comply with any consent-to-settlement conditions in the policy.

c. Other foreseeable loss. At least a plurality of jurisdictions permit an insured to recover damages for all foreseeable loss arising out of a breach of the duty to make reasonable settlement decisions, not only the amount by which the judgment awarded in the underlying legal action exceeds the policy limit. Jurisdictions differ with regard to whether the duty to make reasonable settlement decisions is a contract duty, a tort duty, or both. Under the rules of contract law, a promisee is entitled to recover for loss that was foreseeable at the time of contracting as a probable result of a breach. By contrast, under the rules of tort law, foreseeability generally is assessed as of the time of the breach. Because of the expertise of insurers in assessing risks at the time of underwriting and in handling legal actions, they are likely in many, if not most, cases to be aware at the time of contracting of the kinds of consequences that follow from a lost opportunity to settle a legal action. Thus, it is hardly surprising that most courts have not explicitly considered the question of the timing of foreseeability, as the result would be the same either way in many cases, provided that the meaning of “foreseeable” is the same for both tort and contract law. Although the insurance-law cases generally do not highlight this distinction, some courts employ a concept of foreseeability in contract cases that is much narrower than the same concept in tort law, not because of differences in the timing of when a loss must be “foreseeable” for contract- and tort-damages purposes, but rather because of a policy preference in favor of more restricted damages in contract law than in tort law. Although this Section is agnostic as to the doctrinal label, the broader approach to whether a loss is foreseeable, which is most commonly associated with the tort-law label, is the proper approach. Taking the broader approach to foreseeability promotes more efficient and fair settlement decisions by placing the insurer in the position of the insured, responsible for the full potential loss facing the insured, consistent with the core objective of the duty: mitigating the conflict between insurer and insured

that would otherwise be present whenever there is a significant risk of a judgment that is excess of the policy limits.

No damages are available under this Section if the underlying legal action goes to trial and there is no excess judgment. Put differently, the insurer's duty to make reasonable settlement decisions does not provide protection against even foreseeable harms to the insured resulting from a judgment or settlement that is within the policy limits. The rationale for this limitation of the duty is one of practicality. It is often the case that an insurer's decision not to settle a suit against the insured will cause the insured aggravation and inconvenience, and perhaps even uninsured out-of-pocket expenditures, even when the judgment is within the limits of the policy. Such costs are typically relatively minor. To include them in the measure of damages in a settlement-duty case would encourage litigation, by creating the potential for a lawsuit alleging a breach of the duty to make reasonable settlement decisions in every case with a plaintiff's verdict. This rule does not preclude insureds from being able to recover for such costs should the insurer's actions rise to the level of bad faith, nor does it preclude statutory or administrative remedies. However, when the allegation is merely that the insurer's decision was unreasonable in an individual case, no such common-law damages will be available when a judgment or settlement is within the limits of the insurance policy. This is the prevailing rule.

Illustrations:

1. Insured is an individual consumer who has a homeowner's policy with the duty to defend and policy limits of \$100,000. A claim is brought against the insured for a bodily injury, seeking \$1 million in compensatory damages. As the case nears trial, the claimant makes a settlement demand of \$100,000, which is reasonable, since there is a high likelihood that the insured will be found liable for the harm. Because of the obviously fragile emotional state of the insured, it is foreseeable that the insured will suffer significant emotional distress ~~as a result of~~from an excess verdict that ~~would expose~~exposes the insured to significant financial distress. The insurer nevertheless rejects the settlement demand and takes the case to trial. The trial results in a \$1 million verdict against the insured. As a result of the verdict, the insured is forced into severe financial difficulties and is hospitalized with severe depression and anxiety, incurring substantial medical expenses. Because of its rejection of a reasonable settlement demand,

the insurer is liable to the insured, or to the insured's assignees, for the excess judgment of \$900,000 as well as the medical expenses and the emotional distress.

2. Same facts as Illustration 1, except that the insured prevails in the underlying litigation, and the jury returns a verdict of no liability. As a result of the stress of the trial, the insured is hospitalized with severe depression and anxiety, incurring substantial medical expenses and severe emotional distress. The insurer is not liable to the insured for breach of the duty to make reasonable settlement decisions, as the underlying litigation did not result in an excess verdict against the insured.

3. Same facts as Illustration 1, except that the verdict for the claimant produces only a \$100,000 verdict against the insured. Thus, there is no excess verdict. However, the insured is humiliated at having been found responsible for the underlying civil claim and suffers emotional distress. The insurer is not liable to the insured for any damages, despite having made an unreasonable settlement decision.

4. Commercial policyholder has a duty-to-defend liability insurance policy with policy limits of \$500,000. A claim is brought against the policyholder seeking \$1,400,000 in compensatory damages. As the date of trial approaches, the claimant makes a settlement demand of \$500,000, which is reasonable under the circumstances. It is reasonably foreseeable that the insured will suffer substantial, quantifiable damage to its business reputation as a result of an adverse judgment. The insurer, however, rejects this settlement demand and opts instead to try the case. The suit results in a verdict of \$1,400,000 against the insured. The insurer's liability for breach of its settlement duties includes the \$900,000 excess judgment as well as damages for any foreseeable loss to the insured's business reputation.

5. Same facts as Illustration 4, except that the underlying suit results in a verdict of \$500,000. Thus, there is no excess verdict; however, the insured's commercial reputation is severely damaged, causing the insured to lose substantial amounts of business. The insurer is not liable to the insured for any damages under this Section, despite having made an unreasonable settlement decision.

6. SecureCo is sued for securities violations. Primary Insurer agrees to pay for the costs of defense pursuant to a D&O policy with an applicable policy limit of \$15 million and a provision requiring the insurer's consent to any settlement. There are several

settlement meetings with underlying Plaintiffs, SecureCo, Primary Insurer, and Excess Insurer. In the last such meeting, Plaintiffs offer to settle the action for \$30 million, which SecureCo and Excess Insurer conclude is a reasonable settlement. Primary Insurer refuses to consent to the settlement. The other parties nevertheless settle. SecureCo and Excess Insurer subsequently bring an action against Primary Insurer seeking payment of the policy limit of the primary D&O policy. If SecureCo and Excess Insurer prove that Primary Insurer breached the duty to make reasonable settlement decisions, Primary Insurer may not avoid payment because of noncompliance with the consent to settlement provision in the primary D&O policy.

d. Judgment-proof insureds. A minority of jurisdictions limit the damages imposed in duty-to-settle cases when the insured has insufficient assets to cover the excess judgment. Specifically, these jurisdictions require that breach-of-settlement-duty damages may be assessed against the insurer only to the extent there has been a showing that the insured has made a payment on the judgment or that the insured has assets that are available for satisfaction of a tort judgment. The argument given for this limitation is that, as a financial matter, the insured is harmed by an excess judgment only to the extent that the insured has assets that can be used to satisfy a judgment. Thus, if the insured has no such assets (for example, the only asset is a personal residence that happens to be protected by a state homestead exemption), it is argued that the insured has not been financially harmed by a tort judgment in excess of the policy limits; the excess judgment will simply go unpaid. Under the majority rule, however, the insured's damages are measured by the difference between the policy limit and the judgment against the insured.

This Section follows the majority rule for several reasons. First, the majority rule in many cases provides a better measure of the financial harm to the insured, since the excess trial judgment remains a debt owed by the insured unless and until the insured files for bankruptcy or the tort plaintiff voluntarily waives that debt. Any assets that can be used to satisfy a judgment acquired by the insured after the verdict would have to be made available to satisfy the excess judgment. Thus, the full amount of the excess judgment does cause financial harm to the insured. Second, the minority rule is more difficult to administer, as the court is required to make an assessment of the value of the insured's assets that can be used to satisfy a judgment and, in some jurisdictions, to make predictions about the likely acquisition of additional assets. Third, the

minority rule discourages settlement compared with the majority rule. Finally, by using the amount of the excess judgment as the basic measure of damages, the majority rule encourages insurers to sell liability insurance coverage in amounts that fully cover the risks of the insured activity. That is, if the potential damages for an insurer's breach of settlement duties include the full excess judgment, and are not limited to the insured's assets that can be used to satisfy a judgment, the insurer will have an incentive to negotiate for higher policy limits and higher rates adequate to cover the full risk of the activity being insured.

e. When the underlying suit results in punitive damages. If a liability insurer's unreasonable failure to settle a legal action against the policyholder results in a compensatory-damages award in excess of the policy limits and a punitive-damages award against the policyholder in that action, the amount of that punitive-damages award is included in the consequential damages owed for breach of the insurer's duty. This rule is unproblematic in most jurisdictions, because a punitive-damages award is a foreseeable consequence of the insurer's breach and the majority rule permits insurance for punitive damages.

In jurisdictions in which insurance for punitive damages is contrary to public policy, however, there is tension between a rule forbidding the sale of liability insurance against punitive damages and a rule that requires an insurer to indemnify the insured for such damages when the insurer has breached the duty to make reasonable settlement decisions. Although most courts have not addressed this issue, the very few state courts that have addressed it have resolved the tension in favor of the public policy against insurance for punitive damages, typically in divided judgments with strong dissents indicating that there is considerable uncertainty regarding the direction insurance law should take. This Section follows the approach of the dissenting judges in those cases for several reasons. First, this approach furthers the public policy in favor of encouraging reasonable settlement decisions by insurers. Second, the contrary approach would create a conflict of interest in the defense of the claim that would increase the frequency of cases in which independent counsel would be required under § 16. See § 16, Comment *d*. Third, the incentive argument in favor of the contrary approach is implausible.

Illustration:

7. Insured has a duty-to-defend liability insurance policy with policy limits of \$1 million. A claim is brought against the insured seeking \$5 million in compensatory

damages and \$3 million in punitive damages. The liability insurance policy excludes punitive damages from coverage. Moreover, the relevant state law provides that insurance coverage for punitive damages is a violation of public policy. However, it was reasonably foreseeable at the time of contracting that, if the insured loses this kind of suit, she will be liable for both compensatory and punitive damages. As the trial approaches, the claimant makes a settlement demand equal to the value of the policy limits. According to the evidence available to the insurer at the time of the settlement negotiations, this demand was reasonable in light of the expected compensatory damages, alone, because there was a high likelihood of liability at trial. The insurer nevertheless rejects the demand and takes the case to trial, which results in a verdict against the insured for \$5 million of compensatory damages and \$3 million of punitive damages. The insurer is liable for the full amount of the excess judgment (\$7 million).

f. Assignment of the breach-of-settlement-duty claim to the plaintiff in the underlying suit.

Once there has been an excess judgment in the trial of the underlying claim, the claimant may proceed against the insured for the amount of the difference between the policy limit and the judgment. In many cases, however, the insured has insufficient assets to cover the full amount of the excess judgment and will not have an excess policy that covers the excess judgment. See Comment *d* for a discussion of the problem of judgment-proof insureds. In many cases involving insured defendants that are consumers or very small businesses, the only significant asset of the insured that can be reached by the claimant in the event of an excess judgment is the claim against the insurer. In such cases, the insured commonly assigns its breach-of-settlement-duty claim to the claimant, who in return agrees not to pursue satisfaction of the judgment against the insured. The plaintiff may then bring the claim against the insurer, standing in the shoes of the insured. Such assignments are permissible under the general rule regarding assignment of liability insurance claims stated in § 36. The primary justifications for allowing the assignment of these claims are the same as the rationale for allowing causes of action to be assigned generally: Permitting assignment maximizes the value to the insured of its claim against the insurer and enhances the deterrence provided by the duty to make reasonable settlement decisions.

REPORTERS' NOTE

a. Liability for excess judgment. The majority of jurisdictions have adopted the principle followed in this Section. See [MedicalMed](#), *Mut. Liability Ins. Soc. of Maryland v. Evans*, 622 A.2d 103, 114 (Md. 1993) (“[T]he majority rule₁ 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.”); see also [1 WILLIAM T. BARKER & RONALD D. KENT](#), *NEW APPELMAN INSURANCE BAD FAITH LITIGATION* § 9.03[2] (2d ed. ~~2011~~2017) (“At the very least, in an action for breach of the insurer’s duty to settle, an insured can recover the difference between the total amount of the judgment in the third party suit and the amount of the policy limits, plus interest and costs.”) (footnote omitted); ~~Stephen R. Pitcher~~[Eric M. Larsson](#), *Insurer’s Liability to Its Insured for Wrongful Refusal to Settle with Third Party Within Policy Limits*, [6146](#) AM. JUR. PROOF OF FACTS, [23D 247421](#) § ~~16-29~~ (Database updated ~~2013~~2017) (~~“(The normal recovery, where the insurer’s actionable bad faith or negligence is established and an excess judgment is recovered, is the amount for which the insured becomes charged in excess of his policy coverage, insofar as that amount exceeds any contribution which the insured would have had to make had the settlement been accepted.)”~~). ~~If the insurer has not already paid the policy limits, then the insured can recover that as well in the duty to settle suit.~~ ~~Id.~~ See also ~~LEE R. RUSS & THOMAS F. SEGALLA~~[\[T\]he usual recovery when an insurer is found liable for breaching its duty to settle is the amount of the policy limits, if it has not been paid, plus the amount of a judgment or settlement beyond the policy limits.”](#) See also [14 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), *COUCH ON INSURANCE* § 206:5 (3d ed. ~~2011~~2017) (“[S]ome courts have held that a liability insurer, having assumed control of the right to settle claims against the insured, may become liable in excess of its undertaking under the policy provisions if it fails to exercise ‘good faith’ in considering offers to compromise the claim for an amount within the policy limits.”). For a general discussion of the rationale for allowing the insured to recover damages in excess of the policy limits when the insurer breaches the duty to settle, see [ROBERT H. JERRY, II & DOUGLAS R. RICHMOND](#), *UNDERSTANDING INSURANCE LAW* § ~~112(f)~~[844](#) (5th ed. 2012) (“Whether the duty to settle sounds in tort or contract it is clear that the insured can recover damages in excess of the policy limits if the insurer breaches ~~the~~[this](#) duty to settle.”).

For cases allowing the insured to recover the difference between the policy limits and the total judgment, see *Comunale v. Traders & GeneralGen. Ins. Co.*, ~~50 Cal. 328 P.2d 654, 660~~[198, 201](#) (Cal. 1958) (“It is generally held that since the insurer has reserved control over the litigation and settlement it is liable for the entire amount of a judgment against the insured, including any portion in excess of the policy limits, if in the exercise of such control it is guilty of bad faith in refusing a settlement.”); *Cotton States Mut. Ins. Co. v. Brightman*, 568 S.E.2d 498, 502 (Ga. [Ct. App.](#) 2002) (“After an insurer’s liability for wrongful refusal to settle a claim against its insured is established, the insured or its assignee is entitled as a matter of law to recover damages equal to the amount by which the judgment exceeds policy coverage.”).

b. Liability for settlement. For authority supporting the settling insured's or excess insurer's ability to recover the amount of the policy limits based on breach of the insurer's duty to contribute the policy limits toward a reasonable excess settlement, see, e.g., *Fireman's Fund Ins. Co. v. Security Ins. Co. of Hartford*, 367 A.2d 864, 868-869 (N.J. 1976) (internal citations omitted) (permitting the insured to recover the policy limits from the primary insurer to defray the costs of an above-limits settlement, based on a breach of the insurer's settlement duties, stating: "while the right to control settlements reserved to insurers is an important and significant provision of the policy contract, it is a right which an insurer forfeits when it violates its own contractual obligation to the insured" and "[t]he breach of an insurer's covenant, whether it be express or implied, leaves the insured free, despite the limiting policy provisions, to protect his own interest in minimizing a potential liability in excess of the policy limits by agreeing to a reasonable good faith settlement of the negligence actions and then, on proof of the insurer's default, to recover from it the amount of its policy limits."); *Continental Casualty Cont'l Cas. Co. v. Reserve Ins. Co.*, 238 N.W.2d 862, 864-~~865~~865, 867 (Minn. 1976) ("when a primary insurer breaches its good-faith duty to settle within policy limits, it imperils the public and judicial interests in fair and reasonable settlement of lawsuits. If the excess insurer elects to settle in spite of the primary insurer's bad-faith objections, as is alleged in this case, the excess insurer risks losing the policy-limit contributions of the primary insurer and being forced to pay the entire settlement itself, even though the settlement may have been in the overall best interest of the insured.")~~);~~ "In such a case 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."; *Swedish Am. 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. Then, upon proof of the insurer's breach of its good-faith duty to settle, it may recover the amount of the policy limits from the insurer.") (citations omitted) (citing *Fireman's Fund*).

For authority supporting the insured's or excess insurer's ability to recover for an above-limits settlement entered into following breach of the insurer's settlement duties, see, e.g., *Twin City Fire Ins. Co. v. Country Mut. Ins. Co.*, 23 F.3d 1175 (7th Cir. 1994) (permitting an excess insurer to recover under equitable subrogation from the primary insurer settlement amounts in excess of the limits of the primary insurance policy based on the primary insurer's breach of settlement duties); *American Am. Ins. Co. v. Fireman's Fund Ins. Co.*, 206 Cal. Rptr. 3d 176 (Cal. Ct. App. 2d Dist. 2016) (same); *RLI Ins. Co. v. Scottsdale Ins. Co.*, 691 So. 2d 1095 (Fla. Dist. Ct. App. 1997) (same, though no finding of breach of duty in this case); *Scottsdale Ins. Co. v. Addison Ins. Co.*, 448 S.W.3d ~~818, 828~~818 (Mo. 2014) (same); *Maine Bonding & Cas. Co. v. Centennial Ins. Co.*, 693 P.2d 1296 (Or. 1985) (same); *American Am. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480 (Tex. 1992) (same); *Certain Underwriters of Lloyd's v. Gen. Accident Ins. Co.*, 909 F.2d 228 (7th Cir. 1990) (same); *Centennial Ins. Co. v.*

Liberty Mut. Ins. Co., 404 N.E.2d 759, 762 (Ohio 1980) (same); St. Paul Fire & Marine Ins. Co. v. Liberty Mut. Ins. Co., 353 P.3d 991, 992 (Haw. 2015) (same); Commercial Union Ins. Co. v. Med. Protective Co., 393 N.W.2d 479, 483 (Mich. 1986) (same); Besel v. Viking Ins. Co. of Wis., 49 P.3d 887, 890 (Wash. 2002) (permitting insured to recover for excess of limits settlement based on insurer’s breach of settlement duties). But see RLI Ins. Co. v. CNA Cas. of California, 45 Cal. Rptr. 3d 667, 673 (Cal. Ct. App. 2d Dist. 2006) (contrary to *Ace American*, declining to follow *Fortman v. Safeco Ins. Co.*, 271 Cal. Rptr. 117 (Cal. Ct. App. 2d Dist. 1990) on the grounds that an excess verdict is a necessary component of a breach-of-settlement-duty case).

For authority supporting the insured’s ability to recover for a within-limits settlement entered into to avoid an excess verdict, see, e.g., ~~Continental Casualty Co. v. Reserve~~ *Traders & Gen. Ins. Co. v. Rudco Oil & Gas Co.*, 129 F.2d 621, 627-628 (10th Cir. 1942) (interpreting Oklahoma law) (finding that an insurer lacked standing to “interpose the voluntary settlement made by [the insured] as a bar to recovery upon the policy” because the insurer failed to show that, when it previously rejected the settlement offer, “it acted in good faith and dealt fairly with the assured”); *Swedish Am. Hosp. Ass’n of Rockford v. Illinois State Med. Inter-Ins. Exch.*, 916 N.E.2d 80, 98 (Ill. App. Ct. 2009) (“[I]t would be unfair to enforce the no-action provision against [the insured] for securing a reasonable settlement if [the insurer] breached its good-faith duty to settle and exposed [the insured] to liability exceeding the policy limits. . . . [T]he no-action provision may be rendered unenforceable if plaintiffs establish that [the insurer] breached its good-faith duty to settle.”); *Rupp v. Transcon. Ins. Co.*, 627 F. Supp. 2d 1304, 1324 (D. Utah 2008) (predicting that the Utah Supreme Court would join “most of the courts that have faced th[e] issue” in “reject[ing] the proposition that a ‘no action’ provision and voluntary payment provision may be used by an insurance company accused of bad faith to avoid liability for gambling with the insured’s (and excess insurer’s) money”); *Crawford v. Infinity Ins. Co.*, 139 F. Supp. 2d 1226, 1230 (D. Wyo. 2003) (interpreting Wyoming law) (“[A]n insured may enter into a reasonable settlement agreement where the insurer acts with bad faith in failing to settle a claim within policy limits.”); *N. Am. Van Lines, Inc. v. Lexington Ins. Co.*, 678 So. 2d 1325, 1334 (Fla. Dist. Ct. App. 4th Dist. 1996) (permitting insured to bring an action to recover a within-limits settlement amount from insurer based on the allegation that the insurer had breached its settlement duties and the settlement was reasonable in light of the significant potential for an excess verdict); *Hyatt Corp. v. Occidental Fire & Cas. Co. of N.C.*, 801 S.W.2d 382, 389 (Mo. Ct. App. 1990) (“Where an insurer breaches its good faith duty to consider offers of settlement, the insured may effect reasonable good faith settlements on its own and enforce such settlements against the insurer.”); *Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Cont’l Illinois Corp.*, 673 F. Supp. 267, 274 (N.D. Ill. 1987) (claiming “all the courts that have considered the question have allowed insureds (1) to effect reasonable settlements on their own after their insurers have breached their duty to settle and (2) to enforce those settlements against the insurers if reasonable and made in good faith”); *Cent. Armature Works, Inc. v. Am. Motorists Ins. Co.*, 520 F. Supp. 283, 289 (D.D.C. 1980) (holding that “contract provisions prohibiting

settlement [by the insured] without the consent of the insurer will not be enforced” after the insurer “fail[s] to exercise diligence, good faith, and conscientious fidelity in safeguarding the interests of the insured” by rejecting an attractive settlement offer); *Cont’l Cas. Co. v. Res. Ins. Co.*, 238 N.W.2d 862, 867 (Minn. 1976) (“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” and “[s]ince bad faith failure to settle occurs prior to trial, and the relevant standard involves evaluation of the insurer’s decision at the time it is made and not from hindsight, we see no reason to allow the primary insurer to force a trial of the principal action”); ~~*North American Van Lines, Inc. v. Lexington Ins. Co.*, 678 So. 2d 1325, 1334 (Fla. Dist. Ct. App. 4th Dist. 1996) (permitting insured to bring an action to recover a within limits settlement amount from insurer based on the allegation that the insurer had breached its settlement duties and the settlement was reasonable in light of the significant potential for an excess verdict).~~”; *Fireman’s Fund Ins. Co. v. Sec. Ins. Co. of Hartford*, 367 A.2d 864, 870 (N.J. 1976) (“[W]hen, viewed as of the time the settlement offer is received, the potential loss and the proposed settlement exceed . . . the limits of the policy. In such a situation, the insured . . . should be and is permitted . . . to proceed to make a prudent good faith settlement for an amount in excess of the policy limits and then, upon proof of the breach of the insurer’s obligation and the reasonableness and good faith of the settlement made, to recover the amount of the policy limits from the insurer.”). See also 2 ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 5:16 (6th ed. 2018) (“If . . . the carrier wrongfully rejects a settlement offer, the insured should be free to accept it.”).

Courts differ on whether an insured may recover for breach of settlement duties when the insured enters into a settlement or stipulated judgment, before a contested trial on the merits, that includes a covenant not to execute against the insured’s assets, and this Section does not take a position on that issue. Compare *Hamilton v. Maryland Cas. Co.*, 41 P.3d 128 (Cal. 2002) (refusing to allow insured to recover for breach of settlement duties when the alleged breach was followed by a stipulated verdict and covenant not to execute, on the grounds that the insured suffered no harm) with *Nunn v. Mid-Century Ins. Co.*, 244 P.3d 116, 122 (Colo. 2010) (holding that insured suffered actual damages when it entered into a stipulated judgment in an amount in excess of the policy limit subject to a covenant not to execute and asserting that this approach is followed by “an increasing majority of jurisdictions”) and *Bird v. Best Plumbing Group, LLC*, 260 P.3d 209, 215-217 (Wash. Ct. App. 2011) (reasonableness of settlement with covenant not to execute is a question of fact, disagreeing with *Hamilton*).

c. Other foreseeable loss. ~~See KEETON &~~ For the general proposition that an insurer that breaches the duty to make reasonable settlement decisions is liable for all losses foreseeably caused thereby, see KEETON, WIDISS & FISCHER, INSURANCE LAW 897 (1998) § 7.8(h) at 753 (2d ed. 2017) (“[S]ome courts hold the insurer’s liability extends to all detriments that are the proximate result of an entry of a judgment in excess of the insured’s policy limits, including consequential economic loss and even emotional distress.”) (footnote omitted); see also ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 877846 (45th ed.

~~2007~~2012); 1 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 9.03[4] (2d ed. ~~2011~~2017). For cases awarding foreseeable damages beyond the judgment against the insured, see *Truestone, Inc. v. Travelers Ins. Co.*, 55 Cal. App. 3d 165, 170 (Cal. Ct. App. 1976) (holding that given the function of insurance is to provide the insured with peace of mind, damages for mental suffering are recoverable for the insurer’s breach of the duty to settle in good faith); *Birth Ctr. v. St. Paul Cos.*, Inc., 787 A.2d 376, 379 (Pa. 2001) (awarding damages for harm to the insured’s business reputation that were a foreseeable result of the insurer’s failure to settle); *Meccia v. Pioneer Life Ins. Co.*, 13 Va. Cir. 17 (Va. Cir. Ct. 1987) (“The basic principle is reimbursement for foreseeable loss resulting from the insurer’s breach of duty to settle within policy limits on a claim against the insured.”); 1 STEVEN PLITT & JORDAN R. PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 7:33 (Database updated ~~2013~~2017) (“A plurality of jurisdictions that have specifically considered the question have permitted the award of consequential damages in bad-faith litigation. Several jurisdictions limit the extent of the consequential damages to those that were reasonably foreseeable to have occurred from the breach of the duty.”). This source goes on to state that “consequential damages can include the full-value of an excess judgment . . . and also a wide variety of economic loss including lost profits, loss of income, [etc.].” *Id.* See Restatement Second, Contracts § 351 (AM. LAW INST. 1981).

There is support in the case law in various jurisdictions for treating duty-to-settle claims as sounding in contract or tort or both. As a result, insureds sometimes rely on the contract theory to avoid the shorter statute of limitations that applies to pure tort actions. KEETON & WIDISS & FISCHER, INSURANCE LAW ~~905–(1998)~~ § 7.8(j) (2d ed. 2017). See also *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 203 (Cal. 1958) (holding that a cause of action for breach of the duty to settle sounds in tort and contract, and the plaintiff may therefore take advantage of the longer statute of limitations under the contract theory). Characterizing the cause of action as a tort duty, however, may broaden the measure of damages. KEETON, BASIC TEXT ON INSURANCE LAW 509 (1971). See *Crisci v. Security Ins. Co. of New Haven, Conn.*, 426 P.2d 173, ~~174~~179 (Cal. 1967) (explaining that the plaintiff could recover damages for mental distress under the tort theory of breach of duty to settle but not under the contract theory). The majority of courts and commentators find that the duty to settle sounds in tort rather than in contract. KEETON, BASIC TEXT ON INSURANCE LAW 509 (1971). See *Swedish American Am. Hosp. Ass’n of Rockford v. Illinois State Med. Inter-Ins. Exch.*, 916 N.E.2d 80, 96 (Ill. App. Ct. 2009); *Zumwalt v. Utilities Ins. Co.*, 228 S.W.2d 750, 755 (Mo. 1950). The cleaner conceptual understanding is that the duty to settle sounds in contract. See TOM BAKER & KYLE D. LOGUE, INSURANCE LAW AND POLICY ~~504–505~~539 (3d4th ed. ~~2013~~2017).

Jurisdictions that treat the bad-faith action as entirely involving a breach of contract tend to permit fewer consequential damages. See 1 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 9.03 (2d ed. ~~2011~~2017). Some courts have interpreted the strict foreseeability requirement from the time of contracting as precluding any consequential damages. See, e.g., *DiBlasi v. Aetna Life & Casualty Cas. Ins. Co.*, 147 A.D.2d 93,

100-101 (N.Y. App. Div. 1989) (basing a decision to reject all compensatory damages from a bad-faith claim on the contract nature of the claim). Other courts that continue to hold that a bad-faith action sounds in contract have allowed consequential damages that meet the foreseeability requirements of contract law. See, e.g., *Birth Ctr.*, 787 A.2d at 380, 385. The same rule applies in the first-party context. See, e.g., 3 [RONALD J. CLARK, DIANNE K. DAILEY & LINDA M. BOLDUAN](#), LAW AND PRAC. OF INS. COVERAGE LITIG. § 28:~~42~~:42 (Database updated July 2017). “[C]onsequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted in an insurance contract context, so long as the damages were within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting.” *Stein, LLC v. Lawyers Title Ins. Corp.*, 100 A.D.3d 622, 622 (N.Y. [App. Div.](#) 2012) (internal quotations omitted). “Consequently, although breach of an insurance contract may result in consequential damages, such as economic loss, emotional distress, inconvenience, and legal expenses, insureds generally cannot recover such damages” as they are not found to be within the contemplation of the parties prior to contracting. 3 LAW AND PRAC. OF INS. COVERAGE LITIG. § 28:42.

Jurisdictions that hold that a bad-faith breach of the duty to settle is a tort action allow recovery for “damages in addition to the excess [which] have been caused proximately by the failure to effect settlement in a reasonable manner.” *Larraburu Bros., Inc. v. Royal Indem. Co.*, 604 F.2d 1208, 1215 (9th Cir. 1979) (applying California law). Thus, “there is little question that economic damages resulting from entry of an excess judgment are recoverable.” 1-9 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 9.03 (2d ed. ~~2011~~2017). The breach of the duty to settle is a tort action, and “[t]he statutory rule for measure of damages in tort cases is the amount which will compensate the injured party for all the detriment proximately caused thereby, whether it could have been anticipated or not.” *Gibson v. Western Fire Ins. Co.*, ~~210 Mont. 267, 291~~682 P.2d 725, 738 (Mont. 1984). See also *Atlas ConstConstr. Co. v. Slater*, 746 P.2d 352, 359 (Wyo. 1987). This can include emotional damages as well. *Id.*

d. Judgment-proof insureds. For a general discussion of the majority and minority rules regarding how damages should be determined in duty-to-settle cases involving judgment-proof or insolvent insureds, see 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 23.02[6][f] (Lexis ~~2012~~2017); KEETON-~~&~~ WIDISS [& FISCHER](#), INSURANCE LAW ~~898-900 (1988)~~§ 7.8(i) (2d ed. 2017). Although some older cases adopted the view that no duty-to-settle damages were owing except to the extent the insured actually made payments on the excess judgment, the vast majority of recent cases that have addressed the issue have held that no such showing is required—and that a showing of an excess judgment is sufficient to prove damages. See generally 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE § 23.02[6][f][i] (Lexis ~~2012~~2017) (surveying case law).

For cases holding an insurer liable for breach of the duty to settle without regard to whether the insured paid the excess judgment, see *Torrez v. State Farm Mut. Auto. Ins. Co.*, 705 F.2d 1192, 1201 (10th Cir. 1982) (applying New Mexico law) (“The fullness or the emptiness of

an insured’s purse should be irrelevant. It is a poor measure of liability by the insurer under its contract.”); *Purdy v. Pac. Auto. Ins. Co.*, 203 Cal. Rptr. 524, 532 (Cal. Ct. App. 1984) (rejecting the insurer’s argument that the bankrupt insured suffered no economic harm from an excess judgment); *Nunn v. Mid-Century Ins. Co.*, 244 P.3d 116, 122 (Colo. 2010) (“in our view, regardless of whether the insured can or will pay the judgment, entry of a judgment in excess of policy limits harms the insured because it may result in damage to an insured’s credit, its ability to successfully apply for loans, or its reputation.”); *Frankenmuth Mut. Ins. Co. v. Keeley*, 447 N.W.2d 691, 698 (Mich. 1989) (holding that when an insurer has exhibited bad faith in failing to settle an action on behalf of its insured, and a judgment in excess of the policy limits results, the insurer is liable for the excess without regard to whether the insured has the capacity to pay); *Carter v. Pioneer Mut. Casualty Co.*, ~~67 Ohio St. 2d 146, 148~~[423 N.E.2d 188, 190](#) (Ohio 1981) (holding that an excess judgment may be recovered from an insurer by an insured’s estate or its assignee despite the insolvency of the estate).

e. When the underlying suit results in punitive damages. Whether a liability insurer that breaches the duty to settle may be held liable for the punitive damages sustained by the insured at the trial of the underlying action—when the insured would not have been allowed to purchase punitive-damage coverage because of public-policy restrictions—has been addressed by the courts in only three states. See *PPG Indus., Inc. v. Transamerica Ins. Co.*, 975 P.2d 652, 654 (Cal. 1999); *Lira v. Shelter Ins. Co.*, 913 P.2d 514, 516-517 (Colo. 1996); *Soto v. State Farm Ins. Co.*, 635 N.E.2d 1222, 1223-1224 (N.Y. 1994). In addition, two Federal Circuits have made an Erie prediction in accord with the holdings in *PPG*, *Lira*, and *Soto*. See *Wolfe v. Allstate Property & Cas. Ins. Co.*, ~~793~~[790](#) F.3d 487, 494-495 (3d Cir. 2015) (applying Pennsylvania law); *Magnum Foods, Inc. v. Cont’l Cas. Co.*, 36 F.3d 1491, 1506-1507 (10th Cir. 1994) (applying Oklahoma law). Cf. *Carpenter v. Auto. Club Interinsurance Exch.*, 58 F.3d 1296, 1302 (8th Cir. 1995) (applying Arkansas law) (allowing recovery when the insurance contract excluded punitive damages, without considering the public policy against insurance for punitive damages). Those five courts concluded that the insurer may not be held responsible for such punitive damages, and they have offered three related rationales. The first rationale is that recovery is inappropriate because public policy and many insurance contracts prohibit indemnification for punitive damages. See *Soto*, 635 N.E.2d at 1225. Plaintiffs are not allowed to re-characterize punitive damages from an underlying lawsuit as compensatory damages in a bad-faith action and thereby circumvent both public policy and contract law. See *PPG*, 975 P.2d at 657. Second, public policy also militates against allowing the intentional wrongdoing of one to be offset by the negligence of another. *Id.* at 656. Finally, punitive damages are awarded as punishment and deterrence and must rest with the responsible party. The wrongdoer should not be allowed to shift responsibility for his or her morally culpable behavior onto an insurer and avoid punishment, while at the same time causing the insurer to pass these costs onto the public. *Id.* at 657.

The dissenting opinions in *PPG* and *Lira*, each decided by a 4-3 court, contend that the majority misinterprets the law and offer four rationales for allowing recovery. First, an insurer’s duty to defend and indemnify its insured is maintained even when an insured may suffer an

adverse judgment that includes punitive damages. Even if an insurer is not liable for the punitive-damages portion of an award, it still maintains a duty to make reasonable efforts to settle all claims against its insured within the insured’s policy limits. Justice and fairness require holding insurers liable in these cases because no damages would have resulted but for the insurer’s tortious breach of duty. See *PPG*, 975 P.2d at 658-660. Second, public policy, which disallows comparative negligence to offset punitive damages, is not implicated in these matters because “[t]he identified public policy operates by comparing the relative culpability of the plaintiff and the defendant within a single action . . . not . . . by comparing the relative culpability of the defendants in two separate actions—for example, the culpability of the insured in an action brought against it by its victim for bodily injury and property damage vis-à-vis the culpability of the insurer in an action brought against it by its insured for tortious breach of its duty to settle.” *Id.* at 661 (emphasis in the original). Third, allowing for recovery would not defeat the purpose of punitive damages as punishment and deterrence because “it is inconceivable that the insured would be enticed to engage in oppressive, fraudulent, or malicious conduct on the speculation that its insurer might perhaps tortiously breach its duty to settle, and then might perhaps be held liable to it for damages therefor.” *Id.* at 662. Accord *Lira*, 913 P.2d at 521-522. Fourth, allowing for recovery would not implicate the public-policy or contractual prohibition of indemnifying against punitive damages because the insurer’s payment to its insured is not indemnification, but rather, consequential damages in tort. The insurer should be liable for all damages proximately caused by its breach of duty. See *Lira*, 913 P.2d at 521-522; *PPG*, 975 P.2d at 662. See generally Jennifer A. Emmaneel, Note, *Hiding Behind Policy: Confusing Compensation with Indemnification*, 30 GOLDEN GATE U. L. REV. 637 (2000) (analyzing the arguments of the majority and dissent in *PPG*, summarized above, and arguing that the dissent’s position presents a better interpretation of both California law and public policy).

In addition to the opinions of the dissenting justices in *PPG* and *Lira*, support for the position taken in this Section comes from a legal-malpractice case holding that a lawyer could be liable for exemplary damages assessed against the client as a result of a default judgment due to the lawyer’s negligence, provided that the client proved that such damages would not have been assessed but for the lawyer’s negligence. See *Picadilly v. Raikos*, 555 N.E.2d 167, 168 (Ind. Ct. App. 1990), opinion vacated on other grounds, 582 N.E.2d 338 (Ind. 1991), abrogated on other grounds, by *Liggett v. Young*, 877 N.E.2d 178 (Ind. 2007) (although punitive damages were properly awarded, the Indiana Supreme Court held the cause of action was not assignable).

f. Assignment of the breach-of-settlement-duty claim to the plaintiff in the underlying suit. See V. Woerner, Annotation, *Assignability of Insured’s Right to Recover Over Against Liability Insurer for Rejection of Settlement Offer*, 12 A.L.R.3d 1158 (Originally published in 1967). See also 2 ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 9:12, n.3 (6th ed. ~~2013~~2017) (“If an insured assigns to the injured party the insured’s cause of action for breach of the duty to settle, virtually all courts will allow the injured party to sue the insurer for excess liability.”). The exception appears to be Tennessee, which appears to be the only state that does not allow the assignment of duty-to-settle claims. *Dillingham v. Tri-State Ins. Co. Inc.*, 381 S.W.2d 914, 919

(Tenn. 1964), cited in [3-23](#) JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE [LAW LIBRARY](#) [EDITION](#) § 23.05[[23](#)] ([23d](#) ed. ~~2011~~[2017](#)). For discussion of authority regarding settlements or stipulated judgments entered into after the insurer has allegedly breached the duty to make reasonable settlement decisions but before there is a contested trial on the merits in the underlying action, see Reporters' Note to Comment *b*.

§ 28. Excess Insurer's Right of Subrogation

An excess insurer has an equitable right of subrogation for loss incurred as a result of an underlying insurer's breach of the duty to make reasonable settlement decisions.

Comment:

a. The function of breach-of-settlement-duty cases brought by excess insurers. Most jurisdictions permit an excess insurer to recover, via subrogation, from a primary insurer that has breached the duty to make reasonable settlement decisions. This Section follows that rule. Such a rule provides appropriate incentives to make reasonable settlement decisions and preserves the intended allocation of risk between primary and excess insurers, consistent with the law of restitution and unjust enrichment. See Restatement Third, Restitution and Unjust Enrichment § 24.

b. Equitable subrogation. The excess insurer's ability to recover for a primary insurer's breach of the duty to make reasonable settlement decisions is derivative of the rights of the insured through the doctrine of equitable subrogation. When the excess insurer pays a judgment or settlement on behalf of the insured, it steps into the shoes of the insured and is subrogated to any breach-of-settlement-duty claim that the insured has against the primary insurer. This rule is consistent with the law in the majority of states. In some states, courts have held that excess insurers lose their subrogation claims against primary insurers if the excess insurer settles the claim before the insured is required to make a payment, but such a result is a misapplication of equitable subrogation. Failure to allow the excess insurer to bring a subrogation claim against the primary insurer in such cases would result in unjust enrichment.

Illustrations:

1. A claimant files a tort suit against the insured seeking compensatory damages of \$500,000. The insured has an underlying duty-to-defend liability insurance policy that

assigns settlement discretion to the insurer and that has a policy limit of \$100,000. The insured also has an excess liability insurance policy that covers claims in excess of \$100,000 with a policy limit of \$1 million. At the time of the settlement negotiations between the primary insurer and the claimant, the claimant makes a settlement demand of \$100,000, which a reasonable insurer would have accepted. The underlying insurer rejects this reasonable settlement demand, and the case goes to trial, resulting in a verdict against the insured of \$500,000. The excess insurer is liable to the insured for the \$400,000 excess verdict and subrogated to the insured's breach-of-settlement-duty claim against the underlying insurer for the \$400,000 excess judgment.

2. The estates of four boys killed in a bus accident file suit against Bus Company. Bus has a primary insurance policy with a \$1 million per accident limit and an excess policy with a \$5 million limit. Primary Insurer defends Bus. Primary Insurer has an early opportunity to settle within the limits for all four of the boys' estates for a total of \$1 million. Primary Insurer settles with three of the boys' estates for \$700,000. On the eve of trial, the estate of the fourth boy increases its demand from \$300,000 to \$600,000 based on new developments in the case. Primary Insurer agrees that the amount is reasonable and offers the remaining \$300,000 of its limit. Bus Company demands that Excess Insurer pay the rest. Excess Insurer agrees to pay the \$300,000 and the case settles. If Excess Insurer can demonstrate that Primary Insurer breached the duty to make reasonable settlement decisions by failing to settle all four of the claims within the limit of the primary insurance policy, Excess insurer may recover the \$300,000 from Primary Insurer under equitable subrogation.

REPORTERS' NOTE

a. The function of breach-of-settlement-duty cases brought by excess insurers. Allowing excess insurers to proceed against primary insurers for unreasonable refusal to settle provides important incentives for the primary insurer to settle when appropriate:

This right [to the excess insurer](#) encourages appropriate settlements by maintaining the primary insurer's incentive to settle within limits and to refrain from gambling with the excess insurer's money when it would not gamble with its own. It also prevents an unfair distribution of losses between primary and excess insurers and undue inflation of excess insurance premiums.

1-2 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION

§ 2.09[1] (2d ed. ~~2011~~2017). Equitable subrogation adjusts the incidence of liability between two obligors that are independently liable to a third party—here the insured—seeking to fix liability on the obligor that is primarily rather than secondarily liable for the loss in question. The distinction between primary and secondary obligors is nowhere clearer than between primary and excess insurers of the same risk. See ~~R3RUE~~Restatement Third, Restitution and Unjust Enrichment § 24 (AM. LAW INST. 2011). See also *Valentine v. Aetna Ins. Co.*, 564 F.2d 292, 298 (9th Cir. 1977) (applying California law) (“[I]f during settlement negotiations the primary insurer is allowed to force the excess insurer to cover part of the primary’s insurance exposure, the coverages and rate structures of the two different types of insurance primary and excess would be distorted On the other hand, allowing an excess insurer to enforce a primary carrier’s duty to negotiate and settle in good faith to the full limits of the primary carrier’s policy does not add to or change that carrier’s duties.”); *Truck Ins. Exchange of Farmers Ins. Group v. Century Indem. Co.*, 887 P.2d 455, 458 (Wash. Ct. App. 1995) (“Other jurisdictions have noted the application of equitable subrogation to the excess carrier’s claims against primary insurers furthers policies of encouraging reasonable settlements of lawsuits, preventing unfair distribution of losses among primary and excess insurers, preventing primary insurers from obstructing settlements in bad faith, and reducing premiums paid for excess coverage.”).

b. Equitable subrogation. Most courts allow the excess insurer to step into the shoes of the insured through equitable subrogation and bring an action for the primary insurer’s failure to settle. See *Twin City Fire Ins. Co. v. ~~County~~Country Mut. Ins. Co.*, 23 F.3d 1175, 1178 (7th Cir. 1994) (applying Illinois law) (“[T]he overwhelming majority of American cases describe the duty that a primary insurer owes an excess insurer as one derivative from the primary insurer’s duty to the insured.”); Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 DENV. U. L. REV. 29, 72 (2000) (“Under the majority rule, the duty to settle that a primary insurer owes an excess insurer derives from the primary insurer’s duty to the insured, such that an aggrieved excess insurer may sue on an equitable subrogation theory.”). See, e.g., *Westchester Fire Ins. Co. v. ~~General~~Gen. Star Indem. Co.*, 183 F.3d 578, 583 (7th Cir. 1999) (applying Illinois law) (“The duty that ~~thea~~ primary insurer owes to an excess insurer is derivative of the duty to the insured; an excess insurer can use the doctrine of equitable subrogation to assert the insured’s right to insist that the primary insurer use due care to avoid an excess judgment against the insured.”); *AmericanAm. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992) (“[W]e hold that an excess carrier may bring an equitable subrogation action against the primary carrier.”). This means that the excess insurer’s rights depend on the rights of the insured. See *American-GuaranteeAm. Guar.* and *Liability Ins. Co. v. U.S. Fidelity & Guar. Co.*, 668 F.3d 991, 994-995 (8th Cir. 2012) (applying Missouri law) (holding that the excess insurer could not recover against the primary insurer for bad-faith refusal to settle because, although the excess insurer had urged the primary insurer to settle, the insured’s bankruptcy trustee had made no settlement demand); *Puritan Ins. Co. v. Canadian Universal Ins. Co., Ltd.*, 775 F.2d 76, 80-81 (3d

Cir. 1985) (applying Pennsylvania law) (holding that the excess insurer could not proceed against the primary insurer because the insured had advocated going to trial and could not itself succeed on a bad-faith failure-to-settle action, and “[u]nder a theory of equitable subrogation the rights of the excess carrier may not rise above those of the insured,” so the excess insurer had no avenue to recovery).

For a discussion of cases holding that, if an excess insurer pays for a settlement because the primary has earlier refused to settle for a sum within its limits, the excess has no cause of action against the primary for failure to settle, because the insured was never subject to personal loss from a final judgment, see ABRAHAM & SCHWARCZ, *INSURANCE LAW* 674630 (56th ed. 20102015) (discussing *Federal Insurance Co. v. Travelers Casualty & Surety Co.*, 843 So. 2d 140 (Ala. 2002)). See also *RLI Ins. Co. v. CNA Cas. of California*, 45 Cal. Rptr. 3d 667, 672 (Cal. Ct. App. 2006) (internal citation omitted) (refusing to allow the excess insurer to proceed against the primary insurer for wrongful refusal to settle because the excess insurer had entered a pretrial settlement, and, under the doctrine of equitable subrogation, there was “no assurance that the insured will suffer any damage from the insurer’s breach of its implied obligation to accept a reasonable settlement offer until judgment is entered against the insured after trial.”). But see *National Nat’l Sur. Co. v. Hartford Cas. Ins. Co.*, 493 F.3d 752, 757 (6th Cir. 2007) (describing the *Federal Insurance* case as contrary to the majority rule and contrary to the public policy of encouraging settlement); *Ace American Am. Ins. Co. v. Fireman’s Fund Ins. Co.*, 206 Cal. Rptr. 3d 176 (Cal. Ct. App. 2016), review granted, 382 P.3d 1135 and dismissed, 390 P.3d 373 (declining to follow *RLI Ins.*, supra).

TOPIC 3 COOPERATION

§ 29. The Insured's Duty to Cooperate

When an insured seeks liability insurance coverage from an insurer, the insured has a duty to cooperate with the insurer. The duty to cooperate includes the obligation to provide reasonable assistance to the insurer:

- (1) In the investigation and settlement of the legal action for which the insured seeks coverage;**
- (2) If the insurer is providing a defense, in the insurer's defense of the action;**
- and**
- (3) If the insurer has the right to associate in the defense of the action, in the insurer's exercise of the right to associate.**

Comment:

a. Purpose of the duty to cooperate. Like much of the law governing the management of potentially insured legal actions, the duty to cooperate serves to align the incentives of insurer and insured. The duty to cooperate primarily addresses the incentives of the insured. In a full-coverage liability action, in which a liability insurance policy shifts all or most of the important legal risks of a legal action to the insurer, the insured may lack adequate incentives to assist the insurer in managing the defense. In some cases, the insured may even have an incentive to collude with the claimant—for example, because of a prior relationship with the claimant or simply to avoid the aggravation and inconvenience of a fully adversarial suit. The duty to cooperate addresses this problem by encouraging insured defendants to give an insured legal action the same attention that they would give to an uninsured legal action that puts their own assets at risk. In addition, the duty to cooperate obligates the insured to provide information that the insurer needs to investigate whether the legal action is covered, subject to the rule protecting confidential information stated in § 11(2).

b. Reasonable assistance. The duty to cooperate should take into account the position of the particular insured whose conduct is at issue, as well as the needs of the insurer. What is reasonable depends on, among other things, the knowledge and experience of the insured, the extent of the risks presented by the legal action, the complexity of the action, the ability of the

insurer to obtain the information or other object of cooperation from sources other than the insured, the good-faith effort of the insured, and the extent to which cooperation is needed to reduce the insurer's exposure.

Illustrations: Illustration:

1. A claim is filed against an insured arising out of an ~~automobile accident~~altercation that was the subject of an ~~accident~~incident report filed with the local police department. The insurer asks the insured to obtain a copy of the ~~accident~~ report for the insurer. The insured provides the insurer with the incident report number given to her by the police officer but does not go through the steps necessary to obtain the ~~accident~~ report. Because the ~~accident~~incident report is a public document that the insurer can ~~as easily~~ obtain directly from the police department ~~as the insured~~, using the incident report number provided by the insured, the insured's failure to provide the report to the insurer is not a breach of the duty to cooperate. It is unreasonable for the insurer to demand that the insured get the report when the insurer can easily do so itself.

~~2. Insured is involved in a two-car automobile accident that injures a passenger in the other car and causes damage to the insured's car. The accident occurs on the Saturday of a three-day holiday weekend. When the insured calls the insurer to report the accident that same day, the insurer asks the insured to preserve the automobile until a representative from the insurer could inspect it the following Tuesday. Instead of complying with the insurer's request, the insured immediately brings the car to an auto-repair shop run by a friend and has the damage repaired in time to drive to work on Tuesday morning. The insured has breached the duty to cooperate. A reasonable insured can understand the importance of documenting the condition of a car after an accident in order to prepare a defense. It is reasonable for the insurer to ask the insured to preserve the car in the post-accident condition until the end of the holiday weekend. The consequences of the insured's breach of the duty to cooperate will depend on the harm to the insurer arising from the breach. See § 30.~~

c. Not a trap for the insured. It is important that the duty to cooperate not become a trap for the insured. For example, the insured's duty to cooperate does not include the obligation to provide information to the insurer relating to an actual or potential conflict of interest between

the insurer and the insured that is protected from disclosure by a privilege or immunity. See § 11. In addition, the insurer may not unilaterally withdraw from the defense of an action based on noncooperation. An insurer that wishes to withdraw from the defense on the basis of noncooperation must follow the usual procedures for contesting coverage enumerated in §§ 15 and 18, such as reserving rights and instituting a declaratory-judgment action.

d. Reasonable conduct and diligence on the part of the insurer. The duty to cooperate assumes reasonable conduct and diligence on the part of the insurer. The duty to cooperate does not obligate the insured to comply with unreasonable requests. For example, in scheduling and other matters that may intrude upon the time or privacy or peace of mind of the insured, the insured is entitled to the deference that would ordinarily be accorded to a client or customer who is paying for the services on an after-the-fact basis and has the ability to hire alternative service providers if dissatisfied. In addition, the insurer must be diligent in seeking cooperation.

Illustration:

~~3.2~~^{3.2} Insured is a defendant in a tort action. The insured's deposition is scheduled at a time that is convenient for the insured. Despite receiving many notices and despite the diligent efforts of the defense lawyer, the insured does not show up at the deposition. The deposition is rescheduled two more times. Each time the insured fails to appear, without a good excuse, despite the diligent efforts of the defense lawyer (e.g., calling the insured at home the morning of each of the rescheduled depositions). The insured has breached the duty to cooperate. The consequences of the insured's breach of the duty to cooperate will depend on the harm to the insurer arising from the breach. See § 30.

e. The duty to cooperate with an insurer defending under a reservation of rights. Although an insurer's reservation of rights can affect the rights and obligations of the parties in some respects, it does not abrogate the insured's duty to cooperate with the insurer. For example, an insured that settles a legal action under the process stated in § 25 has not breached the duty to cooperate, but the insured does have an obligation to cooperate with the insurer as long as the defense continues.

f. The duty to cooperate with an insurer exercising the right to associate. When an insurer has the right to associate in the defense of an action, as enumerated in § 23, the insured's duty to cooperate is dependent on the insurer's exercise of that right. Like the right to associate itself, the insured's duty to cooperate depends on the insurer's level of engagement with the legal

action, the likelihood that the insurer will be subject to liability for the action, and other circumstances. When an insured faces a substantial risk of an excess or uninsured judgment, the incentive problem that underlies the duty to cooperate is less likely to be present. In that context, an insurer’s requests for information and involvement should be evaluated in relation to the insurer’s potential exposure, the likelihood that the insured will mismanage the defense or settlement of the legal action in a manner that is prejudicial to the insurer, and the potential for the requested cooperation to disadvantage the insured in the defense of the action (for example, through the loss of confidentiality protections for defense-related information).

g. The duty to cooperate with an insurer that has breached the duty to make reasonable settlement decisions. As explained in Comment b to § 27, when an insurer has breached the duty to make reasonable settlement decisions, the insured (or another insurer acting on the insured’s behalf) may protect itself from a potential excess verdict by entering into a reasonable and non-collusive settlement. Such a settlement does not constitute a breach of the duty to cooperate per se. As recognized in Comment b to § 27, however, the duty to cooperate does require the insured to exercise reasonable diligence in providing information to the insurer and seeking the insurer’s consent to such settlements.

REPORTERS’ NOTE

a. Purpose of the duty to cooperate. Virtually all standard-form liability policies include a cooperation clause and “[i]n instances where a policy does not include such a clause, one has been implied in law.” 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 199:3 (3d ed. ~~2011~~2017); Nicholas J. Giles, *Rethinking the Cooperation Clause in Standard Liability Insurance Contracts*, 161 U. PA. L. REV. 585, 590 (2013) (“The policyholder’s duty to cooperate is reflected in the virtual omnipresence of a cooperation clause in consumer liability insurance policies”). The duty to cooperate “protect[s] the insurer’s interests” by providing a financial incentive to assist the insurer in a fully covered case. *Waste Mgmt., Inc. v. Int’l Surplus Lines Ins. Co.*, 579 N.E.2d 322, 327 (Ill. 1991). See also *Am. Sur. Co. of N.Y. v. Diamond*, 136 N.E.2d 876, 879 (N.Y. 1956) (“The purpose of the co-operation clause is to constrain the assured to co-operate in good faith with the insurance company in the defense of claims.”). Commonly mentioned benefits of the duty to cooperate include providing the insurer with the true and complete account of the events that generated the action it needs adequately to defend the action and discouraging fraudulent or collusive actions. See *Westbrook Ins. Co. v. Jeter*, 117 F. Supp. 2d 139, 141 (D. Conn. 2000) (applying Connecticut law) (“The purpose of the cooperation clause is to enable the insurer to obtain all knowledge and facts concerning the [claim] and the loss

involved while the information is fresh” (internal quotation omitted) (alteration in original)); *State Farm Mut. Auto. Ins. Co. v. Secrist*, 33 P.3d 1272, 1275 (Colo. App. 2001) (“The purpose of a cooperation clause is to protect the insurer in its defense of claims by obligating the insured not to take any action intentionally and deliberately that would have a substantial, adverse effect on the insurer’s defense, settlement, or other handling of the claim.”); *M.F.A. Mut. Ins. Co. v. Cheek*, 363 N.E.2d 809, 811 (Ill. 1977) (noting the “objective” of the duty to cooperate “to prevent collusion between the insured and the injured”); *Iowa Mut. Ins. Co. of De Witt, Iowa v. Meckna*, 144 N.W.2d 73, 81 (Iowa Neb. 1966); 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 199:4 (3d ed. ~~2011~~2017) (noting that “the main purpose of a cooperation clause is to ~~---~~ mak[e] prevent collusion while making it possible for the insurer to make a proper investigation[.] to enable the insurer to obtain relevant information concerning the loss while the information is fresh, [and] to enable it to decide upon its obligations”). For examples of policyholders breaching the duty by not providing any information to their insurers, see *Revolution Rent A Car v. Premier Ins. Co. of Mass.*, 2005 Mass. App. Div. 155, 2005 WL 3623520, at *2 (Mass. Dist. Ct. 2005) (finding the duty breached by a policyholder who failed to attend three scheduled interviews); *Eldin v. Farmers Alliance Mut. Ins. Co.*, 890 P.2d 823, 834 (N.M. Ct. App. 1994) (finding the duty breached by a policyholder who caused an “eighteen-month delay” by refusing to answer questions under oath); *Progressive County Mut. Ins. Co. v. Trevino*, 202 S.W.3d 811, 816-818 (Tex. App. 2006) (finding the duty breached by a policyholder who refused to respond to repeated letters and phone calls from his insurer seeking information about an accident for which he was potentially covered). See also 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 3:2 (6th ed. ~~2012~~2017) (“A common sense interpretation of language requiring (an insured) to ‘fully cooperate’ and ‘assist in the preparation and trial of any claims’ ~~includes~~include(s) the duty to assist (the insurer) in its defense strategy, provide relevant documents, answer interrogatories, submit ~~to~~ depositions, and testify at trial if necessary.” (quoting *Medical Protective Co. v. Bubenik*, 594 F.3d 1047, 1052 (8th Cir. 2010))). For a note on the duty to cooperate, see generally Nicholas J. Giles, Note, *Rethinking the Cooperation Clause in Standard Liability Insurance Contracts*, 161 U. PA. L. REV. 585 (2013).

b. Reasonable assistance. Courts have consistently subjected the duty to cooperate to a reasonableness test. See *Lodgenet Entm’t Corp. v. Am. Int’l Specialty Lines Ins. Co.*, 299 F. Supp. 2d 987, 995 (D.S.D. 2003) (applying South Dakota law) (“Insureds have a duty to cooperate with an insurer’s requests allowing a *reasonable* investigation of a claim.” (emphasis added)); *Forest City Grant Liberty Assocs. v. Genro II, Inc.*, 652 A.2d 948, 951-952 (Pa. Super. Ct. 1995) (“An insured’s duty to cooperate is breached where the insured . . . ‘fails to render all reasonable assistance necessary to the defense of the suit.’”) (internal citation omitted). “It has been stated that the scope of examination under a cooperation clause of an insurance policy is broader than the statutory right of discovery,” but courts also require that the information sought be material and significant to the claim at hand. 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE

§ 199:15 (3d ed. ~~2011~~2017). See also *State Farm Mut. Auto. Ins. Co. v. Palmer*, 237 F.2d 887, 893 (9th Cir. 1956) (applying Arizona law) (finding no breach of the duty to cooperate because the ill effects of the policyholder’s failure to appear at trial could have been easily mitigated and rendered inconsequential by the insurer’s counsel); *Waste Mgmt., Inc. v. Int’l Surplus Lines Ins. Co.*, 579 N.E.2d 322, 333 (Ill. 1991) (“While the insured has no obligation to assist the insurer in any effort to defeat recovery of a proper claim, the cooperation clause does obligate the insured to disclose all of the facts within his knowledge and otherwise to aid the insurer in its determination of coverage under the policy.”).

c. Not a trap for the insured. The rule that the insurer may not request cooperation in the form of information implicating a conflict of interest or violating a privilege is well-established. See *O’Morrow v. Borad*, 167 P.2d 483, 485 (Cal. 1946) (finding that insurance “companies are estopped from taking advantage of the cooperation . . . provisions of [their] policies” when a conflict of interest exists between themselves and the policyholder); 14 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 199:9 (3d ed. ~~2011~~2017) (finding the duty to cooperate inapposite both when a conflict exists and when cooperation would potentially override the attorney–client privilege); see also *id.* (“The duty applies only when the insurer and insured are in a relationship of some trust to each other.”).

d. Reasonable conduct and diligence on the part of the insurer. The rule that the insurer must act reasonably and in good faith is well-established. See *Priority Finishing Corp. v. Hartford Steam Boiler Inspection & Ins. Co.*, No. CV 940544055S, 1998 WL 731081, at *17 (Conn. Super. Ct. Oct. 6, 1998) (“The obligations under a cooperation clause are reciprocal. The insured must cooperate; but the insurer is under a duty to exercise diligence and good faith in bringing that about.” (quoting *Imperiali v. Pica*, 156 N.E.2d 44, 47 (Mass. 1959))). Equally well-established is the rule that policyholders have no duty to cooperate with unreasonable or overly burdensome requests for cooperation. See *id.* (“The demand for cooperation by the insurer must not be unreasonable.” (quoting *Imperiali v. Pica*, 156 N.E.2d 44, 47 (Mass. 1959))); 22 ERIC MILLS HOLMES, HOLMES’ APPLEMAN ON INSURANCE 2D § 138.6 (2003) (“The duty of the insured to cooperate is triggered only if the insurer’s request for cooperation is reasonable”); see also *State Farm Fire & Cas. Co. v. King Sports, Inc.*, 827 F. Supp. 2d 1364, 1373 (N.D. Ga. 2011) (applying Georgia law) (“The failure to cooperate must be material as opposed to technical or inconsequential.”).

e. The duty to cooperate with an insurer defending under a reservation of rights. See, e.g., James M. Fischer, *The Professional Obligations of Cumis Counsel Retained for the Policyholder But Not Subject to Insurer Control*, 43 TORT TRIAL & INS. PRAC. L.J. 173, 185-186 (2008) (explaining that a reservation of rights does not excuse the insured’s duty to cooperate and that principle remains true even when a conflict of interest necessitates the appointment of independent counsel); Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857, 890 n.205 (2011) (“An insurer’s reservation of rights does not eliminate the insured’s duty to cooperate because a defense under reservation is not a breach of contract that

would excuse the insured’s performance.”). For cases stating that a reservation of rights is not a breach of the duty to defend, see, e.g., *Travelers Indem. Co. of Ill. v. Royal Oak Enters., Inc.*, 344 F. Supp. 2d 1358, 1371 (M.D. Fla. 2004) (applying Florida law); *Pink v. Knoche*, 103 S.W.3d 221, 228 (Mo. Ct. App. 2003). Note that this rule is consistent with the holding of the court in *Arizona Property Prop. & Cas. Ins. Guar. Fund v. Helme*, 75735 P.2d 451, 459 (Ariz. 1987), which permitted the insured to make a § 25 settlement on the grounds that the insurer had anticipatorily breached the duty to indemnify. The court stated “once ~~the~~an insurer breaches any duty to its insured, the insured is no longer *fully bound* by the cooperation clause.” *Id.* (Emphasis added).

f. The duty to cooperate with an insurer exercising the right to associate. There are major differences between the duty to cooperate owed to an insurer with the right to direct the defense of the claim and the duty to cooperate owed to an insurer with the right merely to associate in that defense. Because an insurer with the right to associate is not controlling the defense of the claim, the role of the duty to cooperate is slightly altered, centering more on policyholder accountability and deterring collusion and fraud. See LAW OF CORPORATE OFFICERS & DIRECTORS: INDEMNITY & INSURANCE § 84:3340 (20122017 Update) (observing that the “purpose of . . . [the cooperation] clauses is to prevent collusion between the insured and [the] allegedly injured party during a settlement”). As in the standard context, an insurer with the right to associate must diligently request cooperation before claiming that the policyholder breached the corresponding duty. See *Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Cagle*, 68 F.3d 905, 912 (5th Cir. 1995) (applying Louisiana law) (“[B]efore proving a breach by the insured of the cooperation clause, the [D&O] insurer must show a diligent effort to obtain the information.”). Similarly, the duty in this context is subject to a rule of tailored reasonableness and should not be used in a manner that causes the insured to lose immunity or privilege. See *Great Am. Ins. Co., Inc. v. Christopher*, No. 3:02–CV–2112–P, 2003 WL 21414676, at *1 (N.D. Tex. June 13, 2003) (applying Texas law) (“The D & O policy includes a so-called ‘cooperation clause,’ which requires the insured persons to ‘provide the Insurer with all information and particulars it *may reasonably request* in order to reach a decision as to [its consent to incur costs of defense].” (emphasis added)); *First Fid. Bancorporation v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. CIV.A. 90–1866, 1994 WL 111363, at *5 (E.D. Pa. Mar. 29, 1994) (applying New Jersey law) (refusing to overturn a jury verdict that the insured did not violate the cooperation clause when there was evidence suggesting that the insurer had requested access to certain privileged documents and had been denied that access). Although § 23 states that insureds should be able to provide confidential information to an insurer exercising the right to associate, without the loss of any confidentiality protections in relation to third parties, not all jurisdictions have adopted this rule.

What an insurer may reasonably request access to, pursuant to the right to associate, is highly fact-dependent. At a minimum, the insurer does “not need to know everything about the suit,” *Caterpillar, Inc. v. Great Am. Ins. Co.*, 62 F.3d 955, 966 (7th Cir. 1995) (applying Illinois law). For examples of cases adjudicating a cooperation dispute against the backdrop of an

insurer's right to associate, see *Utah Power & Light Co. v. Fed. Ins. Co.*, 983 F.2d 1549, 1558 (10th Cir. 1993) (applying Utah law) (rejecting the insurer's argument that the insured's limited involvement in settlement negotiations amounted to a breach of the duty to cooperate); *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Continental Cont'l Ill. Corp.*, 658 F. Supp. 781, 792-793 (N.D. Ill. 1987) (applying Illinois law) (involving a dispute over coverage in underlying securities litigation); *Fuller-Austin Insulation Co. v. Highlands Ins. Co.*, 38 Cal. Rptr. 3d 716, 740 (Cal. Ct. App. 2006) (holding that a policyholder's letter sent to the insurer, declining the insurer the opportunity to assume the defense but offering the right to participate in settlement negotiations in exchange for a guarantee of confidentiality, was insufficient to demonstrate a breach of the duty to cooperate).

§ 30. Consequences of the Breach of the Duty to Cooperate

(1) An insured's breach of the duty to cooperate relieves an insurer of its obligations under an insurance policy only if the insurer demonstrates that the failure caused or will cause prejudice to the insurer.

(2) If an insured's collusion with a claimant is discovered before prejudice has occurred, the prejudice requirement is satisfied as long as if the insurer demonstrates that the collusion would have caused prejudice to the insurer had it not been discovered.

Comment:

a. Relationship to existing law. Existing duty-to-cooperate law follows two main approaches. A minority of jurisdictions follow a strict-condition rule, in which any material breach of the duty to cooperate relieves the insurer of its obligations, whether or not that breach causes prejudice to the insurer in regard to the legal action, as long as the duty to cooperate is stated in the insurance policy as a condition. Consistent with the approach taken in this Section, the majority of jurisdictions impose a prejudice requirement, regardless of the language of the insurance policy, such that a breach of the duty to cooperate relieves the insurer of its obligations only if that breach prejudices the insurer in regard to the legal action. Commentators agree that the prejudice standard in the duty-to-cooperate context is difficult for insurers to satisfy. One reason is the traditional concern of liability insurance law not to interfere with the objectives of the underlying liability regime, which may depend on the presence of liability insurance. In that regard, some many courts do not enforce the duty to cooperate in automobile liability insurance cases ~~in a way that would compromise the statutory mandatory minimum coverage~~, because of

the state’s public policy in favor of compensation embodied in the state’s automobile financial-responsibility statute.

b. The standard for prejudice. Courts differ in how they apply the prejudice requirement. The approach that is most protective of insureds uses the “substantial likelihood” test, which requires the insurer to demonstrate a substantial likelihood that the insured’s cooperation would have allowed the insurer to defeat the legal action brought against the insured. The approach that is least protective of insureds employs a presumption that a breach of the duty to cooperate causes prejudice to the insurer, with the insured bearing the burden of rebutting the presumption, and an undemanding standard for prejudice to the insurer (for example, increased costs or difficulty in investigating or defending the legal action, even if the failure to cooperate did not affect the outcome of the action). In practice, this least protective approach can become the functional equivalent to the strict-condition rule and, accordingly, is inappropriate for the reasons stated in Comment *d*. Most courts articulate an intermediate position that requires the insurer to prove that it has or will suffer significant harm from the breach of the duty to cooperate, but does not require that the insurer demonstrate that the cooperation would have allowed it to defeat the legal action.

Courts rarely specify whether an increase in the cost of defending the legal action, alone, would be sufficient prejudice. Close examination of the facts in the case law reveals that, in practice, there must be some harm to the insurer that goes beyond increased defense costs before an insurer is able to avoid coverage on the basis of a breach of the duty to cooperate. Accordingly, it is appropriate to conclude that the prejudice determination focuses primarily on the impact of the failure to cooperate on the outcome of the action. It is not ordinarily enough that the insured’s failure to cooperate increased the cost or difficulty of the defense. Rather, that failure must be one that has affected or will affect the outcome of the action for the insurer—for example, by depriving the insurer of a full or partial defense to liability, substantially increasing the amount of the judgment, or depriving the insurer of an opportunity to settle the action for a substantially lower amount than the insured damages ultimately awarded.

Illustrations:

1. Insured ~~Driver collides with another car~~ [involved in an altercation outside a sporting event](#) and wakes up in the emergency room with no memory of the

~~accident~~incident or any of the events leading up to ~~the accident~~it. The ~~driver of the other car~~other person (Plaintiff) involved in the altercation brings a suit against Insured ~~Driver~~ seeking damages. ~~Driver's Insurer assumes the defense and files a cross-claim against the other driver. Insurer retains an accident reconstruction expert and develops a theory with supporting evidence that the other driver was speeding and crossed the yellow line. Insured Driver. Insurer investigates and develops a theory with supporting eyewitness evidence that Plaintiff was drunk and attacked the insured, who simply attempted to defend himself. Insurer assumes the defense and files a cross-claim against Plaintiff. Insured~~ leaves the jurisdiction and fails to attend his deposition or the trial. Insurer appropriately reserved its rights to deny coverage based on Insured ~~Driver's~~ breach of the duty to cooperate. At trial, Insurer puts on its evidence regarding the alleged ~~negligence of the other driver~~fault of Plaintiff and the actions taken in self-defense by Insured. There is a verdict in favor of ~~the other driver~~Plaintiff and against Insured ~~Driver~~ in the amount of ~~\$100,000~~50,000. Because the absence of Insured ~~Driver~~ did not affect the Insurer's defense of the case, the breach of the duty to cooperate does not relieve Insurer of its obligation to pay the judgment.

2. Insured ~~Driver is playing a video game on a mobile phone with a passenger in the car while driving. Because of this distraction, Driver fails to notice an object in the street until the last moment. Driver swerves and hits a utility pole, causing substantial injuries to the passenger. The passenger brings a claim is involved in an altercation outside a sporting event that is identical to that in Illustration 1, except that there are no witnesses aside from Insured and Plaintiff. Plaintiff brings a suit against the driver~~Insured seeking ~~\$300,000 in damages. Driver tenders the claim to Insurer, which issued a policy with a \$500,000 per person per accident policy limit. In an interview with the adjuster assigned to the claim, Driver explains how the video game contributed to the accident. When Driver~~damages. When Insured fails to appear for a deposition, Insurer reserves its rights to deny coverage based on a breach of the duty to cooperate. ~~Driver~~Insured also fails to appear at trial, with the result that Insurer is unable to prove ~~comparative~~any fault on the part of ~~the plaintiff~~Plaintiff. There is a verdict for ~~the plaintiff~~Plaintiff in the amount of ~~\$300,000. Driver~~100,000. Insured's failure to appear at a deposition or trial

substantially prejudiced Insurer by depriving Insurer of the benefits of a comparative-fault defense and increasing the amount of the insured damages.

c. Promise versus condition. Courts that adopt the prejudice requirement sometimes state that they are treating the duty to cooperate as a promise, rather than a condition. That is not completely correct. If the insured's duty to cooperate were treated entirely as a promise, the breach of this duty would subject the insured to liability for damages, not to the forfeiture of coverage. A few courts have applied the prejudice rule in a manner that approximates a true-promise approach, by reducing the insurer's obligation to pay for the legal action to the degree that it suffered any prejudice from a breach of the duty to cooperate. Similar results can also be reached by allowing the insured to cure a breach of the duty to cooperate by compensating the insurer for the harm caused by the breach. Most courts have not taken either of these true-promise approaches to the prejudice requirement. As a result, even when a high degree of prejudice is required, the prejudice requirement functions as an all-or-nothing rule, like the strict-condition approach. Thus the difference between the strict-condition and prejudice approaches is as much a matter of degree as kind. When courts set an undemanding standard for prejudice, the prejudice rule functions much like the strict-condition rule, because it provides the insurer with a complete defense to coverage even though the prejudice to the insurer is small in comparison to the resulting loss of coverage. This Section does not follow the true-promise approach because that approach could lead to excessive disputing—for example, whenever there is less than optimally cooperative behavior by insureds that could be said to have increased the costs of defense.

d. Objections to a strong-condition approach. There are a number of problems with a strong-condition approach, regardless of whether it employs the strict-condition rule or an undemanding-prejudice standard. First, these rules expose insureds to a substantial risk of disproportionate forfeiture of insurance coverage, because the value of the coverage to the insured very often substantially exceeds the harm to the insurer from the breach of the duty to cooperate. Second, these rules interfere more than is necessary with the objectives of the underlying liability regime, which depend in many instances on the presence of liability insurance. Third, by holding out the possibility that the insurer can avoid coverage altogether in more cases, these rules may discourage insurers from moving quickly to resolve claims. Finally,

the strict-condition approach may create an incentive for insurers to increase the demands on insureds to cooperate, beyond what is truly necessary, in order to increase the possibility that the insured will fail to cooperate. The purpose of the duty to cooperate is to align the incentives of insurer and insured defendants, so that defendants give insured legal actions the kind of attention that they would give to an uninsured legal action that risked their own assets. The rule stated in this Section achieves that purpose without creating the risk of disproportionate forfeiture, interfering as fully with the underlying liability regime, slowing down the resolution of insured liability actions, or creating perverse incentives.

It is worth noting that the objections to the strong-condition approach do not apply with as much force when the insured breaches the duty to cooperate by colluding with the plaintiff. Collusion with a plaintiff significantly interferes with the underlying liability regime, which presumes an adversarial relationship between plaintiff and defendant. Moreover, allowing plaintiffs to attempt to collude with the defendant in order to recover significantly larger amounts from the insurance company would create perverse incentives for both plaintiffs and defendants. Because the object of such collusion is to collect additional money from the insurer, an insurer that proves collusion will almost certainly satisfy the prejudice requirement. If the collusion is discovered before substantial harm has already occurred, the prejudice requirement is satisfied as long as the collusion would have prejudiced the insurer if the collusion had not been discovered.

Illustrations:

3. Insured ~~Driver~~ is ~~playing a video game on a mobile phone with a passenger in the car while driving. Because of this distraction, Driver fails to notice an object in the street until the last moment. Driver swerves and hits a utility pole, causing substantial injuries to the passenger. Driver and the passenger agree not to tell anyone that they were playing a video game, so that the passenger will be able to receive full compensation for the injuries without any deduction for comparative fault. The passenger brings a suit against the driver seeking \$300,000 in damages. Driver tenders the suit to Insurer, which issued a policy with a \$500,000 per person per accident policy limit. Pursuant to the agreement with the passenger, Driver does not inform Insurer about the passenger's contribution to the accident. The insurance adjuster becomes suspicious when the plaintiff's lawyer does not demand access to Driver's mobile phone records. The adjuster~~

~~investigates and determines that both Driver and the passenger were logged in to the same game service at the time of the accident~~ throwing a large party on the back patio of his townhouse and cooking hamburgers for the crowd on an old, built-in grill on his gas cooktop. His Friend tells him that cooking hamburgers for so many people on this kind of cooktop is dangerous, because the grease from the hamburgers can build up, spill off, and catch fire. Friend offers to help. After every batch of hamburgers, Friend removes the grease from the grill and collects it in a coffee can on the counter next to the cooktop. As the afternoon wears on, Friend gets distracted and stops taking this precaution. As predicted, the grease catches fire, which quickly spreads to flammable towels and mitts by the cooktop and, from there, to the can of grease on the counter. Friend picks up the burning can of grease to bring it outside and gets very badly burned (incurring medical expenses and lost wages that will eventually amount to \$500,000). Insured feels terrible about the situation and tells Friend to bring a lawsuit to collect money from Insured's insurance policy, saying that it was all the Insured's fault, and Friend simply came into the kitchen after the fire started and tried to help put it out. They agree to say nothing about Friend's involvement in the cooking and starting of the fire. Friend brings a claim against Insured, who has a homeowner's policy and an umbrella policy with total limits of more than \$2 million. Insured notifies his insurer. The adjuster from the insurer interviews both Friend and Insured, who each give the identical, false account of the events. Adjuster also interviews other people at the party, who convincingly report the true facts as described above. Insurer reserves its right to deny coverage based on a breach of the duty to cooperate and files a declaratory-judgment action seeking to terminate the duty to defend based on the collusion between Insured and Friend. This collusion is a breach of the duty to cooperate that, if it had been successful, would have substantially prejudiced Insurer by depriving Insurer of the benefits of a comparative-fault defense. Insurer is relieved from the duty to defend or settle this claim.

4. Same facts as Illustration 3, except ~~Driver~~Insured's policy limits are ~~\$50,000~~100,000. Under the comparative-fault rules of the jurisdiction, the damages payable to a plaintiff are reduced according to the percentage of fault of the victim, so that even a plaintiff who was equally or more at fault may recover from an at-fault defendant. ~~Driver~~Insured proves that ~~the passenger~~Friend would have offered to settle for the policy

limits with or without the collusion, a reasonable insurance company would have accepted the offer, and, thus, the collusion would not have substantially prejudiced Insurer even if it had not been detected. Insurer is not relieved from the duty to defend or to offer its limits in settlement of the suit.

5. Insured ~~Driver~~ negligently runs ~~into a tree, injuring~~over the foot of his neighbor and friend, ~~who is a passenger in the car. Driver~~with a lawn mower. Insured tells the neighbor, “I’m very sorry. I have lots of ~~automobile~~ liability insurance. You should go ahead and sue me so that you receive the compensation that you deserve.” This is not collusion. ~~Driver~~Insured has not breached the duty to cooperate.

e. The disproportionate-forfeiture principle. The rule stated in this Section is an application of the disproportionate-forfeiture principle in liability insurance law. Under this principle, a small and minimally blameworthy breach of a condition by an insured does not excuse the insurer from performance, because the harm to the insurer from the breach is so much less than the value of the coverage to the insured. There are both efficiency and fairness rationales for the disproportionate-forfeiture principle. The principle is efficient in the sense that it applies contract terms in a manner that most insureds would bargain for, if they had the information and bargaining power, because the principle protects insureds from the precise kinds of risks for which they purchase liability insurance: their own negligence. The principle is fair because it is consistent with widely accepted proportionality norms, as well as the public policy in favor of compensation of the underlying claimants. See also § 34 for a general discussion of the application of the disproportionate-forfeiture principle to conditions in liability insurance policies.

f. Ordinary procedure for contesting coverage. When a breach of the duty to cooperate provides a defense to coverage, the ordinary procedural rules for contesting coverage apply. The insurer must reserve its rights under § 15 and, if it wishes to withdraw from the defense of the action, it must seek adjudication that it does not have a duty to defend. See § 18.

Illustration:

6. Same facts as Illustration 3 except, instead of reserving the right to deny coverage on the grounds of breach of the duty to cooperate, Insurer withdraws from the

defense. Insurer has breached the duty to defend by withdrawing from the defense when the duty to defend has not terminated under § 18.

REPORTERS' NOTE

a. Relationship to existing law. The majority of jurisdictions impose a demanding prejudice requirement similar to that followed in this Section. ~~22-ERIC MILLS-HOLMES, HOLMES~~³⁻¹⁶ JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE ~~2D-§ 138.8 (2003)~~ (“[I]n the majority of jurisdictions, an insurer must establish that there is a substantial prejudice to the defense of the claim [before it will be relieved of obligations under a policy]” LAW LIBRARY EDITION § 16.03[4] (Lexis 2017) *id.* at § 20.02[6][a] (“[I]f a breach of the duty of cooperation can be shown, most jurisdictions will permit avoidance of coverage only on a showing of material prejudice to the insurer from the breach.”) and (“Most jurisdictions require the insurer to show that it was actually and substantially prejudiced by a violation of the duty to cooperate.”); 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 3:2 (6th ed. ~~2012~~2017) (“[T]he majority of jurisdictions . . . insist that the [insurer] demonstrate that it was prejudiced as a result of the lack of cooperation [in order for the insurer’s coverage obligation to be affected].”). See, e.g., Alcazar v. Hayes, 982 S.W.2d 845, 852 (Tenn. 1998); Oregon Auto. Ins. Co. v. Salzberg, 535 P.2d 816, 819 (Wash. 1975) (“The requirement of a showing of prejudice would pertain irrespective of whether the cooperation clause could be said to be a covenant or an express condition precedent. . . .”). At least one state has statutorily defined the duty to cooperate as a covenant rather than a condition even when the policy lists the duty to cooperate as a condition precedent. See St. Paul Fire & Marine Ins. Co. v. House, 554 A.2d 404, 406 (Md. 1989) (characterizing Md. Code § 482 of Article 48A (later recodified as § 19-110 of the Insurance Article) as making “policy provisions requiring notice to, and cooperation with, the insurer covenants and not conditions”).

In contrast, a few courts follow a strict condition-precedent rule. ~~See 22-ERIC MILLS-HOLMES, HOLMES~~⁶⁻⁶¹ JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE ~~2D-§ 138.8 (2003)~~ LAW LIBRARY EDITION § 61.08[3][a] (Lexis 2017) (concluding a minority of courts “~~have indicated that the question of whether an insured’s breach is prejudicial is irrelevant, once a substantial and only require a~~ material breach ~~is shown.~~” to avoid coverage.). For cases reflecting the strict condition-precedent approach, see *H.Y. Akers & Sons, Inc. v. St. Louis Fire & Marine Ins. Co.*, 172 S.E.2d 355, 358 (Ga. Ct. App. 1969) (“The co-operation clause is a material condition of a liability policy and a breach of it in any material respect relieves the insurer of liability.”); *New Jersey Eye Ctr., P.A. v. Princeton Ins. Co.*, 928 A.2d 25, 33 (N.J. Super. Ct. App. Div. 2007) (stating that compliance with provisions of a cooperation clause is a condition precedent to recovery under the policy and that breach of the provisions can cause a forfeiture of coverage); *N.Y. Cent. Mut. Fire Ins. Co. v. Rafailov*, 41 A.D.3d 603, 604 (N.Y. App. Div. 2007) (“Compliance with such a clause is a condition precedent to coverage.”). ~~To avoid the “harsh application of the legalistic traditional approach,” most jurisdictions require a showing of~~

~~prejudice before an insurer can avoid coverage for noncooperation. *Alcazar v. Hayes*, 982 S.W.2d 845, 852 (Tenn. 1998); *Oregon Auto. Ins. Co. v. Salzberg*, 535 P.2d 816, 819 (Wash. 1975) (“The requirement of a showing of prejudice would pertain irrespective of whether the cooperation clause could be said to be a covenant or an express condition precedent. . . .”). At least one state has statutorily defined the duty to cooperate as a covenant rather than a condition even when the policy lists the duty to cooperate as a condition precedent. See *St. Paul Fire & Marine Ins. v. House*, 554 A.2d 404, 406 (Md. 1989) (characterizing Md. Code § 482 of Article 48A (later recodified as § 19-110 of the Insurance Article) as making “policy provisions requiring notice to, and cooperation with, the insurer covenants and not conditions”).~~

Many courts and commentators agree that satisfying the prejudice requirement can be extremely difficult. See *Campbell v. Allstate Ins. Co.*, 384 P.2d 155, 157 (Cal. 1963) (acknowledging that “it may be difficult for an insurer to prove prejudice in some situations”); *Goodner v. Occidental Fire & Casualty Cas. Co.*, 440 S.W.2d 614, 617 (Tenn. Ct. App. 1968) (“[W]ho can assess the effect upon the jury of a defendant so indifferent to the outcome of the suits and to the amounts to be adjudged against him that he doesn’t deign to appear?”); 8f-198 JEFFREY E. THOMAS, APPLEMAN ON INSURANCE [LAW & PRACTICE ARCHIVE](#) § 4732 ([Lexis 20122d ed. 2011](#)) (noting that prejudice is a difficult matter to affirmatively prove).

Some courts have eliminated any penalty for a breach of the duty to cooperate in compulsory-insurance schemes. See, e.g., *Royal Indem. Co. v. Olmstead*, 193 F.2d 451, 453 (9th Cir. 1951) (“An exception to the general rule has been made in situations where the insurance policy was issued to satisfy the requirements of a statute having as its purpose the protection of the public. Under such circumstances the beneficial purpose of compulsory insurance would be thwarted in the event the insurer be permitted technical defenses under the policy relating to conditions wholly outside the ability of the injured person to secure performance of. Hence, it has been held that in cases involving compulsory insurance the insurer cannot urge lack of cooperation by the insured as a defense in a suit brought by an injured member of the public within the class sought to be protected by statute.”); *Coburn v. Fox*, 389 N.W.2d 424, 428 (Mich. 1986) (holding that a breach of the duty to cooperate cannot relieve an automobile liability insurer of its duty to indemnify up to the statutorily mandated minimum coverage); *Rodgers-Ward v. Am. Standard Ins. Co. of Wisconsin*, 182 S.W.3d 589, 593 (Mo. Ct. App. 2005); *Tibbs v. Johnson*, 632 P.2d 904, 906 (Wash. Ct. App. 1981). Motivating these courts is the notion that mandatory-insurance statutes are intended to ensure compensation for innocent accident victims and that unilateral post-loss policyholder action like noncooperation should not defeat that goal. See also *Kambeitz v. Acuity Ins. Co.*, 772 N.W.2d 632, 638 (N.D. 2009) (“an insurance company cannot avoid coverage under any compulsory automobile liability insurance policy provisions after an accident when a claim against the policy is made by an injured innocent third party,” explaining that this position “is consistent with the view of courts in other jurisdictions which prevent, based either on specific statutory provisions or the overriding purpose of statutory schemes governing compulsory automobile liability insurance, post-loss avoidance of an insurance policy to defeat the insurer’s liability to an innocent third party.”

(citations omitted) (citing many cases from other jurisdictions); Ryan v. Knoller, 695 A.2d 990, 992 (R.I. 1997) (“In circumstances in which the purpose of statutorily required insurance coverage is intended for the protection of the public, that purpose may not be thwarted by permitting an insurer to avail itself of technical defenses included in its policy relating to conditions whose performance is wholly beyond the ability of the injured person to control.”).

Similar goals motivate broader systems of both liability insurance and tort law. See Kyle D. Logue, *Solving the Judgment-Proof Problem*, 72 TEX. L. REV. 1375, 1375-1376 (1994) (“Liability insurance can ameliorate [the] judgment-proof problem [by] . . . increas[ing] the amount of assets available to compensate plaintiffs.”); see also Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313, 363 (1990) (“Liability insurance, regardless of its form, is highly desirable if compensatory justice is tort law’s objective.”).

b. The standard for prejudice. For cases applying the “substantial likelihood” test, see *Billington v. Interinsurance Exch. of S. Cal.*, 456 P.2d 982, 987 (Cal. 1969) (“[A]n insurer, in order to establish it was prejudiced by the failure of the insured to cooperate in his defense, must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured’s favor.”); *Brooks v. Haggard*, 481 P.2d 131, 134 (Colo. App. 1970) (“[I]f, after consideration of all factors involved, it appears that the presence of the insured or his testimony was so potentially valuable as to have materially affected the outcome of the trial, then his nonappearance is regarded as a material or prejudicial breach of the policy.”); *Boone v. Lowry*, 657 P.2d 64, 72 (Kan. Ct. App. 1983) (“The insurer must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood that the trier of fact, in an action against the insured, would have found in the insured’s favor.”); *Allstate Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 767 A.2d 831, 843 (Md. 2001) (“[W]e believe that the proper focus should be on whether the insured’s wilful conduct has, or may reasonably have, precluded the insurer from establishing a legitimate jury issue of the insured’s liability, either liability vel non or for the damages awarded.”); *Smith v. Nationwide Mut. Ins. Co.*, 830 A.2d 108, 114 (Vt. 2003) (“An insured’s failure to cooperate with its insurer will not relieve the insurer of its coverage obligations unless that noncooperation has, in a significant way, hindered or precluded the insurer from presenting a credible defense to the underlying claim.”). Some courts have even dismissed an insured’s claim to enforce a policy without prejudice to allow the insured the opportunity to cure the failure to cooperate and reassert the claim against the insurer. See *Yeo v. State Farm Ins. Co.*, 555 N.W.2d 893, 894 (Mich. Ct. App. 1996) (upholding the trial court’s decision to dismiss the case without prejudice and with the “hope that the parties can proceed with the examination under oath and refile [sic] this case”); *Marmorato v. Allstate Ins. Co.*, 226 A.D.2d 156, 156 (N.Y. App. Div. 1996) (holding that the insured’s noncompliance did not “warrant dismissal of the action without giving plaintiff one last chance to answer the questions”). Cf. *United Servs. Auto Ass’n v. Martin*, 174 Cal. Rptr. 835, 837 (Cal. Ct. App. 1981) (holding that it is impossible for an insurer to show prejudice until after the underlying tort action has been resolved). For an example of a court reciting a less precise

standard while finding prejudice based on facts that would satisfy the standard in this Section, see, e.g., *Medical Assurance Co., Inc. v. Miller*, 779 F. Supp. 2d 902, 909 (N.D. Ind. 2011) (applying Indiana law). Illustration 2 is loosely based on the facts in *Wildrick v. North River Ins. Co.*, 75 F.3d 432 (8th Cir. 1996).

c. Promise versus condition. For a case requiring the insurer to pay only the amount it would have paid had the insured cooperated with the insurer, see *Fid. & Cas. Co. of New York v. McConnaughy*, 179 A.2d 117, 124 (Md. 1962) (allowing the insurer to avoid only the portion of liability in excess of “the amount it would have paid if [the insured] had been frank and fair”). For cases allowing the insured to cure prejudice, see *Romano v. Arbella Mut. Ins. Co.*, 429 F. Supp. 2d 202, 208 (D. Mass. 2006) (holding that the insurer could not disclaim coverage when the insured eventually produced requested documents and the delay did not prejudice the insurer’s ability to make an assessment of the insured’s coverage claim); *Crook v. State Farm Mut. Auto. Ins. Co.*, 112 S.E.2d 241, 246 (S.C. 1960) (allowing the insured to withdraw and correct misstatements made without forfeiting coverage when the insurance company’s ability to defend was not prejudiced).

d. Objections to a strong-condition approach. For cases that discuss how the duty to cooperate interferes with the objectives of the underlying liability regime, see *Carpenter v. Superior Court in & for Maricopa County*, 422 P.2d 129, 134 (Ariz. 1966) (“Liability insurance is intended not only to indemnify the assured, but also to protect members of the public who may be injured through negligence.”); *Billington v. Interinsurance Exch. of S. Cal.*, 456 P.2d 982, 988-989 (Cal. 1969) (insurance policies “are for the protection of the public, not merely for the benefit of the contracting parties”); *Oregon Auto. Ins. Co. v. Salzberg*, 535 P.2d 816, 819 (Wash. 1975) (“[T]he risk-spreading theory of [liability insurance] policies should operate to afford to affected members of the public—frequently innocent third persons—the maximum protection possible.”).

e. The disproportionate-forfeiture principle. Courts acknowledge that disproportionate-forfeiture considerations are appropriate in the duty-to-cooperate context. See, e.g., *Mistler v. Horace Mann Ins. Co.*, No. 933430, 1994 WL 879038, at *6 (Mass. ~~Super.~~ ~~Ct.~~ App. Ct. 1994) (“[T]he requirement that the insured’s failure to perform must amount to a material breach and not result in a disproportionate loss, or forfeiture, to the breachor is tantamount to a requirement that the insurer must be ‘prejudiced’ in order to be excused from covering the loss.”). For a general statement of the disproportionate-forfeiture principle, see Restatement Second, Contracts § 229 (AM. LAW INST. 1981) (“To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange.”); Restatement Second, Contracts § 229, Comment *b* (AM. LAW INST. 1981) (“‘[F]orfeiture’ is used to refer to the denial of compensation that results when the obligee loses his right to the agreed exchange after he has relied substantially, as by preparation or performance on the expectation of that exchange.”). A forfeiture is disproportionate when the importance of the rights lost by the obligee outweigh “the importance to the obligor of the risk

from which he sought to be protected and the degree to which that protection will be lost if the non-occurrence of the condition is excused.” Id.

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CHAPTER 3
GENERAL PRINCIPLES REGARDING THE RISKS INSURED

TOPIC 1
COVERAGE

§ 31. Insuring Clauses

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

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

(3) Insuring clauses are interpreted broadly.

Comment:

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

b. Insuring agreements. Contemporary insurance policies commonly contain a section labeled “insuring agreement” that specifies what will be covered under the policy provided that all of the conditions in the policy are met and no exclusions apply. Insuring agreements always contain insuring clauses, but they may also contain exclusions and conditions. An exclusion or condition that appears in an insuring agreement is subject to the ordinary rules governing exclusions and conditions. See §§ 32 and 34.

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

d. Exception clauses in exclusions. Contemporary insurance policies commonly contain a section labeled “exclusions” that includes a set of terms that restrict the coverage that otherwise

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would be provided by the policy. See § 32. Exclusions may contain exceptions that narrow the application of the exclusion. Such exceptions operate only to narrow the exclusions in which they appear, not to expand coverage beyond that stated by other insuring clauses in the policy. See § 32(5).

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

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

REPORTERS' NOTES

a. Purpose. Appleman notes that an “insuring clause . . . sets forth the basic scope of the insured risk and represents the requirements that must be satisfied for a covered loss to be present.” 3-16 JEFFREY E. THOMAS, APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.09[1][c] (Lexis 20122017). See, e.g., Liberty ~~National Enterprises~~Nat'l Enters., L.P. v. Chicago Title Ins. Co., 217 Cal. App. 4th 62, 77 (Cal. Ct. App. 2013) (“Before considering whether any exclusions apply, we examine the insuring clause to determine whether coverage exists at all.”).

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

c. Insuring clauses in endorsements. See, e.g., 2 ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 21:21 (3d ed. 20112017) (“Endorsements, riders, marginal references, and other similar writings are a part of the contract of insurance and are to be read and construed with the policy proper.”). See also Haynes v. Farmers Ins. ~~Exchange~~Exch., 89 P.3d 381, 385 (Cal. 2004) (~~citation omitted~~) (“Coverage may be limited by a valid endorsement and, if a conflict exists between the main body of the policy and an endorsement, the endorsement prevails.”); Adams v. Explorer Ins. Co., 107 Cal. App. 4th 438, 451 (Cal. Ct. App. 2003)

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(“An [\[A\]](#)n endorsement is an amendment to or modification of an existing policy of insurance. It is not a separate contract of insurance. Standing alone, an endorsement means nothing.”); *Hart Constr. Co. v. AmericanAm. Family Mut. Ins. Co.*, 514 N.W.2d 384, 391 (N.D. 1994) (“When there is a conflict between the provisions of an insurance policy and an attached endorsement, the provisions of the endorsement prevail.”).

d. Exception clauses in exclusions. See § 32, Reporters’ Note to Comment *f*.

e. Relation between broad interpretation of insuring clauses and contra proferentem. See La. C.C. Art. 2056 (“In case of doubt that cannot be otherwise resolved, a provision in a contract must be interpreted against the party who furnished its text. A contract executed in a standard form of one party must be interpreted, in case of doubt, in favor of the other party.”); *Miller v. ContinentalCont’l Ins. Co.*, 358 N.E.2d 258, 260 (N.Y. 1976) (“The hornbook rule [states] that policies of insurance, drawn as they ordinarily are by the insurer, are to be liberally construed in favor of the insured.”); *Richards v. Std. Acc. Ins. Co.*, 200 P. 1017, 1020 (Utah 1921) (“[\[I\]](#)n insurance policies should be construed liberally in favor of the insured and their beneficiaries so as to promote and not defeat the purpose of insurance.”). See also *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1376 (E.D.N.Y. 1988) (applying New York law) ([citations omitted](#)) (“At this stage, ‘after it has exhausted every effort to derive the meaning of the terms that accurately reflects the intent of the parties,’ the court must follow the rule of contra proferentem to construe any ambiguity against the insurer as drafter.”). For a discussion of how the maxim of construing an insuring clause broadly represents an application of the ambiguity principle, see *Woodson v. Manhattan Life Ins. Co. of New York, N.Y.*, 743 S.W.2d ~~835~~, ~~838~~835 (Ky. 1987).

§ 32. Exclusions

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

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

(3) Exclusions are interpreted narrowly.

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

(5) An exception to an exclusion narrows the application of the exclusion; the exception does not grant coverage beyond that provided in the insuring clauses ~~in the insurance policy~~.

Comment:

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

Illustration:

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

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

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

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

c. Severability of exclusions. Liability insurance policies often contain exclusions whose application depends upon specified conduct of the insured that serves as the basis for the alleged liability. Examples include exclusions for liability arising out of expected-or-intended injury, criminal or malicious acts, the use of intoxicating substances, sexual molestation, corporal punishment, physical or mental abuse, fraud, wrongful profit or advantage, and knowing violation of rights. The default rule is that such exclusions are severable, meaning that they apply only to insureds whose conduct meets the requirements of the exclusion. This rule is an application of the general rule regarding the narrow interpretation of exclusions. In addition, this rule reflects the underlying purposes of such exclusions: limiting the impact of liability insurance on incentives to engage in highly wrongful conduct, and preventing those who in fact engage in such conduct from drawing on the resources of those in the insurance pool. Applying these

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exclusions to insureds who did not engage in the wrongful conduct does not promote these purposes of the exclusions. Because these insureds did not engage in the wrongful conduct, there is less concern that the presence of insurance changed their incentives to engage in that conduct, nor is there the same concern about using the resources of the insurance pool on their behalf.

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

Illustrations:

2. Insured fires a .22 caliber rifle high and away from A, B, and C, who are 200 yards away, intending to scare them away from stealing his watermelons. One of the shots hits C. C files a tort action against Insured alleging that Insured negligently injured C. Insured has a standard ~~homeowners’~~homeowner’s insurance policy that excludes coverage for suits arising out of bodily injury that is expected or intended from the

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standpoint of the insured. Insurer defends the action, properly reserving the right to deny coverage on the basis of the exclusion. The judgment entered in the action against Insured is not excluded by the expected-or-intended exclusion because the Insured did not expect or intend the injury.

3. Insured kicks A from behind, believing that person to be his wife. A is not in fact his wife. A brings a tort action against Insured alleging that Insured negligently injured A. Insured has a standard homeowner's insurance policy that excludes coverage for suits arising out of bodily injury that is expected or intended from the standpoint of the insured. Insurer defends the action, properly reserving the right to deny coverage on the basis of the exclusion. The judgment entered in the action against Insured is excluded by the expected-or-intended exclusion because Insured intended to injure A even though he was mistaken about the identity of A.

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

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

f. An exception to an exclusion. The rule in subsection (5) regarding exceptions to exclusions is a straightforward application of logic to the interpretation of a liability insurance

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policy. An exception to an exclusion narrows the application of the exclusion; it does not extend the coverage provided by the insuring clauses in the policy. See also § 31, Comment *d*.

REPORTERS' NOTES

a. Exclusions can appear anywhere in an insurance policy. See, e.g., *Borough of Moosic v. Darwin Nat. Assur. Assurance Co.*, 556 F. App'x 92, 97 (3d Cir. 2014) (applying Pennsylvania law) (“While the Related Claims provision appears in the section titled ‘Conditions,’ rather than the section titled ‘Exclusions,’ the location of the provision in the policy is not determinative.”); *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1205 (2d Cir. 1995), *op. modified on other grounds*, 85 F.3d 49 (2d Cir. 1996) (applying New York law) (“[U]nder New York law, the exclusionary effect of policy language, not its placement, controls allocation of the burden of proof.”); *United Pac. Ins. Co. v. McGuire Co.*, 281 Cal. Rptr. 375, 378 (Cal. Ct. App. 1991) (“It does not matter that the [provision limiting coverage] appears in the ‘definitions’ section of the policy rather than the ‘exclusions’ section; in either case it performs the function of an exclusion.”); *Jones v. Philip Atkins Const. Constr. Co.*, 371 N.W.2d 508, 512 (Mich. Ct. App. 1985) (holding that an exclusion that appeared on a separate endorsement to the policy barred coverage for plaintiff’s injuries).

b. Interpretation. Courts regularly state that exclusions should be narrowly construed. See, e.g., *Gore Design Completions, Ltd. v. Hartford Fire Ins. Co.*, 538 F.3d 365, 370 (5th Cir. 2008) (applying Texas law) (“Exclusions are narrowly construed.”); *An-son Corp. v. Holland-Am. Ins. Co.*, 767 F.2d 700, 703 (10th Cir. 1985) (applying Oklahoma law) (“An insurance policy’s words of exclusion are to be narrowly viewed.”) (citing *Conner v. Transamerica Insurance Co.*, 496 P.2d 770, 774 (Okla. 1972)); *First Ins. Co. of Hawaii, Ltd. v. Contl. Cas. Co.*, 466 F.2d 807, 809 (9th Cir. 1972) (applying ~~Hawaii~~Hawai'i law) (“Insurance exclusions are narrowly construed against the insurer.”); *Reserve Ins. Co. v. Pisciotta*, 640 P.2d 764, 770 (Cal. 1982) (holding that the policy’s family exclusion did not apply by reasoning that “[b]ecause the word ‘family’ is susceptible of several reasonable definitions, the most appropriate resolution is to construe the term narrowly, i.e., in favor of the insured.”); *Eyler v. Nationwide Mut. Fire Ins. Co.*, 824 S.W.2d 855, 859 (Ky. 1992) (“Kentucky law is crystal clear that exclusions are to be narrowly interpreted.”); *Snell v. Stein*, 259 So. 2d 876, 879 (La. 1972) (internal citation omitted) (“Construing the exclusionary clause strictly, as we must, . . . we cannot conclude it applies here.”); *Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272, 275 (N.Y. 1984) (“[Exclusions] are to be accorded a strict and narrow construction.”); 7A ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 108:6 (3d ed. ~~2011~~2017) (“~~Exclusions~~[E]xclusions from coverage in insurance policies are to be strictly construed.”).

c. Severability of exclusions. See generally 7A ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 103:37 (3d ed. ~~2011~~2017) (“Liability insurance policies employ any number of exclusions that attempt to describe certain types of behavior, liability for the

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consequences of which the insurer intends to exclude from coverage.”). For cases determining the applicability of exclusions by examining whether the insured engaged in the excluded conduct, see, e.g., *Aetna Cas. and Sur. Co. v. Dow Chem. Co.*, 28 F. Supp. 2d 421, 431 (E.D. Mich. 1998) (applying Michigan law) (“It should also be noted that it is important to focus on whether the insured engaged in culpable conduct in order to enforce the important public policies at issue.”); *Arenson v. Nat’l. Auto. & Casualty Cas. Ins. Co.*, 286 P.2d 816, 818 (Cal. 1955) (concluding that an intentional-act exclusion did not exclude coverage for parents for intentional act of vandalism committed by son, who also was an insured under policy); *Catholic Diocese of Dodge City v. Raymer*, 840 P.2d 456, 462 (Kan. 1992) (holding that the intentional-act exclusion did not apply to parents who had been found to have been negligent in supervising their minor child.); *Worcester Mut. Ins. Co. v. Marnell*, 496 N.E.2d 158, 160-161 (Mass. 1986) (finding that severability clause in policy created separate insurable interests and did not exclude parents from coverage for damage caused by son, who was also an insured under the policy). For cases holding that a policy’s exclusion applies only if it applies with respect to the specific insured seeking coverage, see, e.g., *Float–Away Door Co. v. Continental-Casualty Cont’l Cas. Co.*, 372 F.2d 701 (5th Cir. 1966) (applying Georgia law); *Phoenix Assur-Assurance Co. v. Hartford Ins. Co.*, 488 P.2d 206 (Colo. App. 1971); *Shelby Mut. Ins. Co. v. Schuitema*, 183 So. 2d 571 (Fla. Dist. Ct. App. 1966), *aff’d per curiam*, 193 So. 2d 435 (Fla. 1967); *American Am. Nat’l Fire Ins. Co. v. Estate of Fournelle*, 472 N.W.2d 292 (Minn. 1991); *Pennsylvania Nat’l Mut. Casualty Cas. Ins. Co. v. Bierman*, 292 A.2d 674 (Md. 1972); *Travelers Ins. Co. v. Auto–Owners Ins. Co.*, 203 N.E.2d 846 (Ohio Ct. App. 1964); *Commercial Standard Ins. Co. v. American-Gen. Am. Gen. Ins. Co.*, 455 S.W.2d 714 (Tex. 1970); *Bankers & Shippers Ins. Co. v. United States Fire Ins. Co.*, 224 S.E.2d 312 (Va. 1976).

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

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

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

Finally, our decision is in keeping with the long-standing rule of construction that the favored interpretation of an insurance policy is one which “best effectuates the main manifested design of the parties.” [citation omitted] Clearly, the manifest design of homeowners’ insurance is to protect homeowners from risks associated with the home and activities related to the home. Contrary to

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the position taken by Worcester Mutual, negligent supervision, unlike negligent entrustment, is a theory of recovery that is separate and distinct from the use or operation of an automobile. Thus, the negligent supervision theory advanced by Alioto and the cause of action pertaining to the negligent failure of the Marnells to prevent their son from drinking relate only to activities that are alleged to have taken place within the Marnells' home. Therefore, the Marnells could reasonably expect to be protected by their homeowners' policy in an action based on those activities.

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

d. The default rule in favor of a subjective standard for expectation and intent. The expected-or-intended exclusion originally appeared as part of the definition of occurrence, as part of the shift from accident- to occurrence-based coverage, see Donald F. Farbstein & Francis J. Stillman, *Insurance for the Commission of Intentional Torts*, 20 HASTINGS L.J. 1219, 1220-1221 & 1236-1237 (1969) (describing the two ambiguities of the term “accident” in relation to gradual events and the perspective from which to consider whether an event is accidental and explaining that “[b]y replacing the term ‘accident’ with that of ‘occurrence,’ and by supplying the definition [of occurrence] quoted above, the new policy seeks to eliminate the major ambiguities noted earlier”). The formulation for what it means to subjectively expect harms is taken from *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal. Rptr. 2d 815, 835-836 (Cal. Ct. App. 1993) (adopting subjective standard for expected):

Our conclusion on the meaning of “expected or intended” is not unique. *Patrons–Oxford Mut. Ins. Co. v. Dodge*, 426 A.2d [888] 892, [(Maine 1981)] adopted essentially the same interpretation, albeit without examining the words’ ordinary and popular meanings. The court decided that damage “. . . which is either expected or intended from the standpoint of the Insured” refers only to damage “that the insured in fact *subjectively wanted* (‘intended’) to be a result of his conduct or in fact *subjectively foresaw as practically certain* (‘expected’) to be a result of his conduct.” (Ibid., original emphasis.) Similarly, *Quincy Mut. Fire Ins. Co. v. Abernathy* (1984) 393 Mass. 81, 469 N.E.2d 797, 800, held that “expected” requires a showing that the insured “knew to a substantial certainty” that damage would ensue. “Had the insurer intended a different result, it could have used more appropriate language in the exclusion clause.” (Ibid.)

Most courts have held that liability insurance uses the subjective expected-or-intended standard to determine if an accident took place. See, e.g., *Hecla Mining Co. v. New Hampshire Ins. Co.*, 811 P.2d 1083, 1088 (Colo. 1991) ([citations omitted](#)) (“[W]hat make injuries or damages expected or intended rather than accidental are the knowledge and intent of the insured. It is not enough that an insured was warned that damages might ensue from its actions, or that, once warned, an insured decided to take a calculated risk and proceed as before. Recovery will be barred only if the insured intended the damages, or if it can be said that the damages were, in a

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broader sense, ‘intended’ by the insured because the insured knew that the damages would flow directly and immediately from its intentional act.”); *SL Indus. Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266, ~~1279~~1278 (N.J. 1992) (“[If the insured] subjectively intends or expects to cause some sort of injury, that intent will generally preclude coverage. If there is evidence that the extent of the injuries was improbable, however, then the court must inquire as to whether the insured subjectively intended or expected to cause that injury. Lacking that intent, the injury was ‘accidental’ and coverage will be provided.”); *Brooklyn Law School v. Aetna Casualty Cas. & Surety Sur. Co.*, 849 F.2d 788, 789 (2d Cir. 1988) (citations omitted) (“Ordinary negligence does not constitute an intention to cause damage; neither does a calculated risk amount to an expectation of damage. To deny coverage, then, the fact finder must find that the insured intended to cause damage.”). Cf. *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal. Rptr. 2d 815 (Cal. Ct. App. 1993) (adopting subjective standard for expected); *S. Macomb Disposal Auth. v. Am. Ins. Co.*, 572 N.W.2d 686, 696 (Mich. Ct. App. 1997) (“The citation omitted) (“[T]he subjective test applies where an insurance policy uses the term ‘accident’ but is otherwise silent with respect to from whose perspective the event is to be deemed an accident.”); *Am. Family Ins. Co. v. Walser*, 628 N.W.2d 605, 612 (Minn. 2001) (“Where citation omitted) (“[W]here there is specific intent to cause injury, conduct is intentional for purposes of an intentional act exclusion, and not accidental for purposes of a coverage provision. . . . [W]here there is no intent to injure, the incident is an accident, even if the conduct itself was intentional.”); *State Farm Fire & Cas. Co. v. Ete CTC Dev. Corp.*, 720 So. 2d 1072, 1076 (Fla. 1998) (“Uzdevenes did not expect or intend for damages to result from his act of constructing the home. He did not openly defy the setback requirements; he mistakenly believed that he had received a variance for the construction. Therefore, the fact that he intentionally constructed the house knowing that it was outside of the setback line does not preclude a finding of coverage under his liability policy for this ‘occurrence.’”); *Physicians Insurance Ins. Co. of Ohio v. Swanson*, 569 N.E.2d ~~906, 915~~906 (Ohio 1991) (adopting subjective standard). But see *City of Carter Lake v. Aetna Casualty Cas. & Surety Sur. Co.*, 604 F.2d 1052, 1058-1059 (8th Cir. 1979) (applying Nebraska law) (“For the purposes of an exclusionary clause in an insurance policy, the word ‘expected’ denotes that the actor knew or should have known that there was a substantial probability that certain consequences will result from his actions.”). For an example of a case from a jurisdiction with an objective standard adopting an exception, see *Amco Ins. Co. v. Haht*, 490 N.W.2d 843, 848 (Iowa 1992) (finding an exception to an intentional tort-like standard in a case in which a young boy killed a friend by throwing a baseball bat at him).

For an example of a case involving the broader exclusion for intentional harm contained in a criminal-acts exclusion, see *Allstate Ins. Co. v. Peasley*, 932 P.2d 1244, 1247 (Wash. 1997) (excluding losses from “any bodily injury which may reasonably be expected to result from the intentional or criminal acts of an insured person or which are in fact intended by an insured person.”). Cf. Eric S. Knutsen, *Fortuity Victims and the Compensation Gap: Re-envisioning Liability Insurance Coverage for Intentional and Criminal Conduct*, 21 CONN. INS. L.J. 209, 243

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(2014) (proposing that the subjective standard should also be applied to the criminal-acts exclusion).

Illustration 2 is based on the facts in *State Farm Mut. Auto Ins. Co. v. Worthington*, 405 F.2d 683 (8th Cir. 1968). Illustration 3 is based on *American Am. Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952 (Colo. 1991).

e. Burden of proof. Courts generally require the insurer to bear the burden of proving that a claim fails within the scope of an exclusion in the policy. See, e.g., *Ment Bros. Iron Works Co., Inc. v. Interstate Fire & Cas. Co.*, 702 F.3d 118, 121 (2d Cir. 2012) (applying New York law) (“Under New York law . . . an insurer bears the burden of proving that an exclusion applies.”); *New Hampshire Ins. Co. v. Martech USA, Inc.*, 993 F.2d 1195, 1199 (5th Cir. 1993) (applying Texas law) (“[U]nder . . . Texas law, the burden is on the insurer to prove the applicability of policy exclusions.”); *Capital Envtl. Services Servs., Inc. v. N. River Ins. Co.*, 536 F. Supp. 2d 633, 640 (E.D. Va. 2008) (applying Virginia law) (“~~The citations omitted~~ (“[T]he insurer bears the burden of proving that any coverage exclusion applies.”); *HLTH Corp. v. Clarendon Nat’l Ins. Co.*, ~~CIV No. A-07C-09-102 RRC~~, 2009 WL 2849779, at *22 (Del. Super. Ct. Aug. 31, 2009), *aff’d sub nom. Axis Reinsurance Co. v. HLTH Corp.*, 993 A.2d 1057 (Del. 2010), as corrected (May 10, 2010) (“Under Delaware law, because the Plaintiffs have established, and the parties do not dispute, that their loss is within the terms of the policies, Defendants, as insurers, bear the burden of establishing that the Prior Notice Exclusion bars coverage.”); *Great American Am. Ins. Co. v. Gaspard*, 608 So. 2d 981, 984 (La. 1992) (“As with any exclusion in an insurance policy, the insurer bears the burden of proving that the intentional injury provision is applicable.”); *Int’l Paper Co. v. Cont’l Cas. Co.*, 320 N.E.2d 619, 622 (N.Y. 1974) (citation omitted) (“The insurer is cloaked with the burden of proving that the incident and claim thereunder came within the exclusions of the policy.”); *Madison Constr. Co. v. Harleysville Mut. Ins. Co.*, 735 A.2d 100, 106 (Pa. 1999) (“Where an insurer relies on a policy exclusion as the basis for its denial of coverage and refusal to defend, the insurer has asserted an affirmative defense and, accordingly, bears the burden of proving such defense.”); 17A ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 254:12 (3d ed. 2017) (“The insurer bears the burden of proving the applicability of policy exclusions and limitations or other types of affirmative defenses, in order to avoid an adverse judgment after the insured has sustained its burden and made its prima facie case.”).

f. An exception to an exclusion. See, e.g., *Sikirica v. Nationwide Ins. Co.*, 416 F.3d 214, 228 (3d Cir. 2005) (applying Pennsylvania law) (“The Contractual Liability provision broadens the definition of ‘incidental contract’ as used in the exception to the exclusion provision, but it does not extend coverage of the Policy to injury or damages that are not the result of an ‘occurrence’ or ‘accident.’”); *Sheehan Constr. Co. v. Cont’l Cas. Co.*, 935 N.E.2d 160, 162 (Ind. 2010) (citations omitted) (“Exceptions to exclusions narrow the scope of the exclusion and, as a consequence, add back coverage. However, it is the initial broad grant of coverage, not the exception to the exclusion, that ultimately creates (or does not create) the coverage sought.”); K

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& L Homes, Inc. v. Am. Family Mut. Ins. Co., 829 N.W.2d 724, 728 (N.D. 2013) (“Likewise, although an exception to an exclusion from coverage results in coverage, an exception to an exclusion is incapable of initially providing coverage; ~~rather~~, an exception to an exclusion may become applicable if, and only if, there is an initial grant of coverage under the policy and the relevant exclusion containing the exception operates to preclude coverage.”); Nav-Its, Inc. v. Selective Ins. Co. of Am., 869 A.2d 929, 939 (N.J. 2005) (“We interpret that exception to limit the reach of the pollution clause, i.e. if the environmental pollution occurs within a building within a single forty-eight hour period, and the other conditions are met, then the insured may receive coverage for that environmental pollution claim. Simply put, if the pollution exclusion is not applicable, neither is the exception to the pollution exclusion.”). For an example of a court using an exception to an exclusion as a guide to interpretation of coverage, see Panfil v. Nautilus Ins. Co., No. 12 C 6481, 2014 WL 52774, at *2 (N.D. Ill. Jan. 7, 2014), *aff’d*, 799 F.3d 716 (7th Cir. 2015) (applying Illinois law):

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

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

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§ 33. Timing of Events That Trigger Coverage

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

(2) A liability insurance policy may define a harm, event, wrong, loss, activity, occurrence, claim, or other happening that triggers coverage under a liability insurance policy to have taken place at a specially defined time, the timing of which is also a question of fact, even if it would be determined for other purposes to have taken place at a different time.

Comment:

a. Trigger of coverage. Liability insurance policies typically contain a requirement that a covered legal action must arise out of a specified class of events that take place during a specified time period. Such requirements are sometimes referred to as the “trigger of coverage” for a liability insurance policy. An insurance policy is “triggered” when certain events take place that activate the coverage, subject to any applicable exclusions or other terms in the policy. In most liability situations, it is clear whether the relevant events took place within the relevant policy period. For example, automobile liability insurance policies generally contain an accident trigger of coverage that is linked to the policy period. Thus, if an insured driver has an auto liability action brought against him or her, only an auto liability insurance policy in effect at the time of the accident may be obligated to provide coverage for the action. A determination that a particular policy is triggered does not necessarily mean that the policy covers that legal action. For example, there may be exclusions that prevent the triggered policy from providing coverage.

Illustrations:

1. The insured owns and operates a car that is covered under a standard auto liability policy, which contains the following language as part of its insuring agreement: “The company will pay damages which an insured becomes legally obligated to pay because of bodily injury, sustained by a person, and damage to or destruction of property, arising out of the ownership, maintenance or use of the owned auto.” In the “conditions”

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section of the policy, there is a term stating that “this policy applies only to bodily injury or property damage that occurs during the policy period.” The declarations page of the policy contains the following term: “Policy period: 01/01/Year 1 – 01/01/Year 2.” On April 25, Year 1, the insured, while driving his covered car negligently runs into the rear of another vehicle at a traffic light. The driver of the other car suffers neck and head injuries, and her car sustains damage to its rear bumper and to the trunk, all as a result of the accident. She files a personal-injury suit against the insured in May of Year 2 seeking recovery for these losses, as well as for damages for pain and suffering. The insured’s Year 1 auto liability policy is triggered by these events. Therefore, the insurer issuing that policy may owe a duty to defend and a duty to indemnify the insured with respect to any bodily-injury and property-damage claims brought by the other driver, depending on other terms in the insured’s policy.

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

The company will pay on behalf of the insured all sums which the insured shall be legally obligated to pay as damages because of injury arising out of the rendering of or failure to render, during the policy period, professional services in the practice of the named insured’s profession as a physician or surgeon by the named insured or by any person for whose acts or omissions the named insured is legally responsible, and the company shall have the right and duty to defend any suit against the insured seeking damages, even if any of the allegations of the suit are groundless, false, or fraudulent, and may make such investigation and such settlement of any claim or suit as it deems expedient.

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

On November 5, Year 5, a medical-malpractice suit is filed against the insured alleging that the insured, while performing routine back surgery on the claimant in Year 4, negligently severed a nerve that left the claimant, who is a professional violinist, permanently unable to play the violin. The insured’s Year 4 medical-malpractice policy is

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triggered because the bodily injury in question allegedly arose out of the rendering, or failure to render, services during that policy period.

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

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

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

e. Clauses providing special definitions of triggering events. Some liability insurance policies contain terms, sometimes referred to as “deemer” clauses, that define a triggering event

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to take place at a designated time even when that event did not only take place at that time, or perhaps not even at that time at all. For example, some policies have clauses that deem a triggering event, such as “property damage,” to take place at a specific time, such as “only on the last day of the last exposure to such conditions,” with the result that only one policy is triggered, notwithstanding that the harm or other happening took place over multiple policy periods. Such clauses reduce insurers’ exposure for a continuing-harm or “long-tail” claim to a single policy limit. As an additional example, many claims-made policies contain a “notice of circumstances” clause that grants the policyholder the option of providing the insurer with notice of circumstances that may lead to a claim. Such clauses typically provide that, if such circumstances do result in a claim, that claim will be deemed to have been first made at the time of the notice of circumstances. Such clauses provide policyholders the option to secure coverage under an existing claims-made policy for a legal action that may be brought in the future.

f. Trigger theories in long-tail-harm cases involving occurrence-based policies. Liability actions arising out of long-tail (or continuous-injury, progressive or latent) harms present difficult issues of contract interpretation and application for commercial general-liability insurance policies as well as for other similarly worded insurance policies. The term “long-tail harms” describes a series of indivisible harms, whether bodily injury or property damage, that are attributable to continuous or repeated exposure to the same or similar substances or conditions that take place over multiple years or that have a long latency period. The paradigmatic examples of long-tail harms are asbestos-related bodily injuries and environmental property damage.

In the context of long-tail harms, the trigger-of-coverage question can be especially problematic. In such cases, it is difficult, sometimes impossible, to determine precisely when bodily injury and property damage occur. Reflecting this difficulty, courts in long-tail-harm cases have developed many different approaches to the question of when bodily injury or property damage occurs. Under the exposure theory, bodily injury or property damage is said to occur during the years in which the claimants are exposed to the harm-causing circumstance, irrespective of when the harm is made manifest. Under the manifestation theory, bodily injury or property damage occurs in the first year in which such injury or damage either is or reasonably can be detected by the claimant. The manifestation theory, therefore, could result in a single

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year's policy being triggered, even though the exposure occurs over many years. Under the continuous-trigger theory, by contrast, bodily injury or property damage is presumed to occur over the course of the entire period of exposure and manifestation, subject to proof by the insurer to the contrary. Under the double-trigger theory, courts have held that the injury occurs both at the time of exposure and at the time of manifestation, though not necessarily during the intervening period. Finally, under the injury-in-fact or actual-injury trigger theory, courts make the effort—even in these difficult latent-harm cases—to determine in which years the injury or damage in fact occurs.

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

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

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

REPORTERS’ NOTES

a. Trigger of coverage. Trigger-of-coverage concepts have been used to help define when a policy goes into effect and what effects are covered. See *Keene Corp. v. Insurance Ins. Co. of N. Am.*, 667 F.2d 1034, 1042 (D.C. Cir. 1981) (“Trigger of Coverage; The first step in the analysis of this problem is to determine what events, from the point of exposure to the point of manifestation, trigger coverage under these policies. In the language of the policies, the question is when did ‘injury’ occur?”); *Owens-Illinois, Inc. v. Aetna Casualty Cas. & Surety Sur. Co.*, 597 F. Supp. 1515, 1518 (D.D.C. 1984) (applying Ohio law) (“Under that decision O-I asserts that the ‘trigger’ of coverage, the events or conditions that determined that the insurance policies apply to the asbestos claims, were the exposure of the claimants to asbestos fibers, or the continuing development of the disease after exposure, or manifestation of the injury.”); *Montrose*

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Chemical Corp. of Cal. v. Admiral Ins. Co., 913 P.2d 878, 880 n.2 (Cal. 1995) (defining trigger of coverage as “what must take place within the policy’s effective dates for the potential of coverage to be ‘triggered.’”); *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 468 (Ind. 1985) (“The basic dispute concerns what must happen during a particular policy period to invoke insurance coverage for that period, described by the insurers as the trigger of coverage.”). In run-of-the-mill personal-injury and property-damage cases, which policies are triggered is obvious. 1-16 RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~537~~§ 16.01 (3d ed. 2015). The issue can be much more difficult in long-tail-harm cases, such as those involving progressive asbestos or environmental harms. *Id.* The trigger issue also arises in construction-defect cases. See, e.g., *Pepperell v. Scottsdale Ins. Co.*, 62 Cal. App. 4th 1045, 1053 (Cal. Ct. App. 1998) (“[T]he continuous injury trigger of coverage should be applied to third party claims of continuous or progressively deteriorating damage or injury.”); *Rando v. Top Notch Properties Props., L.L.C.*, 879 So. 2d 821, 827 (La. Ct. App. 2004); see also MANILOFF & STEMPEL, *supra*, chapter 17 (surveying construction defect and other non-latent-harm trigger cases). Courts have also had to select among trigger theories in the first-party property context. See *Prudential-LMI Com-Commercial Ins. v. Superior Court*, ~~789~~798 P.2d 1230, 1246 (Cal. 1990) (“[W]e conclude that in first party progressive property loss cases, when, as in the present case, the loss occurs over several policy periods and is not discovered until several years after it commences, the manifestation rule applies.”).

b. Categories of coverage triggers. For an example of a harm-based coverage trigger, see *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1188 (2d Cir. 1995) (applying New York law) (“Because the policies are triggered by injury or damage that occurs during the policy period, the trials focused extensively on when asbestos-related bodily injury and property damage occurs for purposes of these policies.”); 7 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 102:25 (3d ed. ~~2011~~2017) (“~~Coverage~~Coverage is triggered when the harm first manifests, and the insurer on the risk at the time of first manifestation is liable for the entire loss even if the damage progresses after the policy expires.”). For an example of a cause-based coverage trigger, see *President v. Jenkins*, 853 A.2d 247, 249 (N.J. 2004) (“Generally, an ‘occurrence’ policy provides coverage for any asserted misconduct that occurs during the policy period, even if the claim is asserted after the policy expires.”); see also 7 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 102:23 (3d ed. ~~2011~~2017) (“The peril insured is the occurrence itself, and once the occurrence takes place, coverage attaches even though the claim may not be made for some time thereafter.”). For an example of a claims-based coverage trigger, see *St. Paul Fire & Marine Ins. Co. v. House*, 554 A.2d 404, 407 (Md. 1989) (“The ordinary meaning of ‘claim made’ refers to the assertion of a claim by or on behalf of the injured person against the insured. In this case Platzer’s claim was made, in the ordinary meaning, during the policy period. St. Paul reads the

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policy specially to define ‘claim made’ as the reporting of a claim or potential claim by the insured to the insurer. On that basis the claim was not made until after the policy had expired. Reading the policy as a whole leaves St. Paul’s interpretation far from clear.”); 7 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 102:30 n.5 (3d ed. ~~2011~~2017) (“Insurers may be held responsible for losses caused by defects created before issuance of policy, in light of existence of ‘manifestation rule’ under which insurer is responsible for claims on loss manifesting during policy period even though cause may have been present, and damage begun, before inception of policy.”).

c. Dual triggers of coverage. For examples of dual triggers of coverage, see *Ballow v. Phico Ins. Co.*, 875 P.2d 1354, 1366 (Colo. 1993) (“Some insurers offer policies that have a retroactive date identical to the beginning of the coverage with the insurer. This type of policy is a combination of claims-made and occurrence policies. This type of claims-made coverage (hybrid claims-made policy) covers negligent acts or omissions which occur *and* are the subject of a claim during the policy period.”) (emphasis in original); *T.H.E. Ins. Co. v. P.T.P., Inc.*, 628 A.2d 223, ~~224~~224, n.1 (Md. 1993) (“The policy acquired by P.T.P. from T.H.E. was written on a claims made basis. The policy period was from April 2, 1987, to April 2, 1988, with a retroactive date of April 2, 1987. ” “Injuries occurring before the retroactive date are not covered by the policy.”); *Stine v. Continental Casualty Cont’l Cas. Co.*, 349 N.W.2d 127, ~~134~~129 (Mich. 1984) (“The insurance afforded by this policy applies to errors, omissions or negligent acts which occur on or after the date stated in item 6 of the declarations (the effective date of the first policy issued and continuously renewed by the Company) provided that claim therefor is first made against the insured during this policy period and reported in writing to the Company during this policy period or within 60 days after the expiration of this policy period.”); *Rotwein v. General Acci-Group Gen. Accident Grp.*, 247 A.2d 370, 379 (N.J. Super. Ct. Law Div. 1968) (“This policy applies only to errors, omissions or acts which occur within the United States of America, its territories or possessions, or Canada during the policy period and then only if claim is first made against the insured during the policy period.”).

d. A question of fact. Whether a liability insurance policy is triggered with respect to a particular legal action ordinarily is a question of fact to be determined by the factfinder. See *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1195-1196 (2d Cir. 1995) (applying New York law) (“[T]he New York Court of Appeals had considered the triggering issue in the property damage context . . . [T]he Court noted that ‘application of the term accident in such contexts as that before us provides a question of fact.’”) (citing *McGroarty v. Great Am. Ins. Co.*, 329 N.E.2d 172, 174 (N.Y. 1975)); *Montrose Chem. Corp. of Cal. v. Admiral Ins. Co.*, 913 P.2d 878, 888 (Cal. 1995) (“[T]he proper resolution of a trigger of coverage issue in any given case may turn on whether the court is addressing underlying facts involving a single event resulting in immediate injury (e.g., an explosion causing instantaneous bodily injuries and destruction of property), a single event resulting in delayed or progressively deteriorating injury (e.g., a chemical spill), or a continuing event (referred to in CGL policies as ‘continuous or

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repeated exposure to conditions’) resulting in single or multiple injuries (e.g., exposure to toxic wastes or asbestos over time.”); *Mayor & City Council of BaltimoreBalt. v. Utica Mut. Ins. Co.*, 802 A.2d 1070, 1095 (Md. 2002) (“According to the Michigan Supreme Court, reference to specific trigger paradigms ‘can be deceiving,’ because in the final analysis the court must apply policy language in particular factual contexts.”) (citing *Gelman Sciences, Inc. v. Fidelity & Casualty Co.*, 572 N.W.2d 617, 622 (Mich. 1998)); *Domtar, Inc. v. Niagara Fire InsuranceIns. Co.*, 563 N.W.2d 724, 733 (Minn. 1997) (“The proper scope of coverage also will depend on the facts of the case.”); *Towns v. N. Sec. Ins. Co.*, 964 A.2d 1150, 1165, 1165 n.6 (Vt. 2008) (“The record here also supports the trial court’s application of the continuous-trigger test to conclude that environmental damage occurred during the policy period. . . . Under the facts presented here . . . the evidence leaves no doubt that both exposure and injury-in-fact occurred while the Northern policy was in effect.”); see also *E.R. Squibb & Sons, Inc. v. Lloyd’s & Cos.*, 241 F.3d 154, 164 (2d Cir. 2001) (applying New York law) (“In general, a liability insurer’s ‘duty to indemnify is “triggered” by a determination that fortuitous bodily injury or property damage took place during the policy period.’” (quoting BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 9.01, at 408 (9th ed. 1998)); ~~7 LEE R. RUSS & THOMAS F. SEGALLA~~; 7 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 102:23 (3d ed. ~~2011~~2017) (“In order to trigger coverage under occurrence clause in comprehensive general liability insurance policy, damage must be sustained during policy period.”).

e. Clauses providing special definitions of triggering events. For cases regarding the first type of deemer clause, see *Liberty Mut. Ins. Co. v. Black & Decker Corp.*, 383 F. Supp. 2d 200, 212 (D. Mass. 2004) (applying Massachusetts law) (“The purpose of the deemer clause was to prevent ‘stacking’ of claims, by assigning a claim to a single policy—not by completely excluding coverage. The clause’s effect is to limit each individual accident to a single policy year.”); *Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*, 928 F. Supp. 176, 182 (N.D.N.Y. 1996) (applying New York law) (“The Court notes that the clause was included in policies before there was a general awareness of environmental pollution problems. . . . As a result, just as the Court held in its previous summary judgment decision, coverage for property damage caused by gradual pollution is afforded by the policy or policies in force when the property damage occurred.”); *United TechnologiesTechs. Corp. v. Liberty Mut. Ins. Co.*, No. 877172, 1993 WL 818913, at *19 (Mass. Super. Ct. Aug. 3, 1993) (“The purpose of the ‘deemer’ clause, according to Liberty, is to limit the insurer’s risk to the coverage limit of one policy.”). Application of a deemer clause is also a fact-intensive question. See *Cincinnati Ins. Co. v. ACE INA Holdings, Inc.*, 886 N.E.2d 876, 887 (Ohio Ct. App. 2007) (“The question we must answer is whether the multiple exposures constituted the ‘same general conditions’ under the deemer clause.”).

In claims-made policies, a “notice of circumstances” clause allows the policyholder to provide its insurer with notice of circumstances that may lead to a claim. See *City of Sterling Heights v. United Nat’l Ins. Co.*, No. 03–72773, 2004 WL 252091, at *6–7 (E.D. Mich. Feb. 11, 2004) (applying Michigan law) (“[B]ecause all the claims in the State and Federal Actions are

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claims asserting losses to the same person or organization as a result of wrongful acts, they are all deemed under United’s policy to have been made at the time the first of them was made. . . . [A]rguments that the State and Federal Actions state several claims . . . miss the point. There is no dispute that Plaintiffs were aware of and gave notice of circumstances that might give rise to claims . . . during the 9/1/00 to 9/1/01 policy period. . . . In light of the deemer clause . . . all claims asserted . . . are to be deemed first made during the earlier . . . policy period.”); *KPFF, Inc. v. CaliforniaCal. Union Ins. Co.*, 56 Cal. App. 4th 963, 973 (Cal. Ct. App. 1997) (“[I]f the pleadings contain material relevant both to the reporting of a claim and to circumstances covered by the awareness provision, they can serve the dual purpose of both reporting a claim and giving written notice of circumstances which may subsequently give rise to other claims.”).

f. Trigger theories in long-tail-harm cases involving occurrence-based policies. In the context of long-tail, progressive-harm cases, such as those involving asbestos or environmental harm, there are five types of trigger theories: the exposure theory, the manifestation theory, the continuous-trigger theory, the double- or triple-trigger theory, and the injury-in-fact trigger theory. See *Atchinson, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 71 P.3d 1097, ~~1135~~1125 (Kan. 2003) (listing all five trigger theories) (citing to *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994)); see also *Montrose Chem. Corp. v. Admiral Ins. Co.*, 913 P.2d 878, 893-895 (Cal. 1995) (listing and describing four trigger theories—all of those listed above, except for the double/triple trigger theory).

For examples of courts applying the exposure-trigger theory, see *Hancock Labs. Inc. v. Admiral Ins. Co.*, 777 F.2d 520, 523 (9th Cir. 1985) (applying California law) (“Under the exposure theory, which applies to diseases that are cumulative and progressive, bodily injury occurs when an exposure causing tissue damage takes place and not when physical symptoms caused by the disease manifest themselves.”); *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1217-1218 (6th Cir. 1980) (applying Illinois and New Jersey law); *Cole v. Celotex Corp.*, 599 So. 2d 1058, 1077 (La. 1992). For examples of courts applying the manifestation theory, see *Eagle-Picher Industries, Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12, 20 (1st Cir. 1982) (The manifestation theory holds that insurance kicks in when a disease “becomes ‘manifest or active’”; coverage is not defeated by a showing that the disease previously lay dormant in the body.”); *Clutter v. Johns-Manville Sales Corp.*, 646 F.2d 1151, 1157 (6th Cir. 1981) (applying Ohio law) (“Ohio products liability cases implicitly use the date a latent defect manifests itself by causing injury, this Court concludes that it should continue to adhere to *Brush Beryllium* and hold that Ohio would apply a manifestation rule for determining when the cause of action from asbestosis should accrue under Ohio law.”). For examples of courts applying the continuous-trigger theory, see *Carey Canada, Inc. v. CaliforniaCal. Union Ins. Co.*, 748 F. Supp. 8, 12 (D.D.C. 1990) (citing to *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981) (“[C]ontinuous trigger applies because bodily injury caused by asbestos begins with inhalation of fibers and ends with manifestation.”); *Lac D’Amiante Du Quebec, Ltee. v. AmericanAm. Home Assurance Co.*, 613 F. Supp. 1549, 1556 (D.N.J. 1985) (applying New Jersey law) (footnote omitted) (“[C]overage is triggered by a claim that a victim was either

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exposed to asbestos products, suffered exposure in residence, *or* manifested an asbestos-related disease during the policy period. Because the policies’ ‘trigger’—the occurrence of injury—is a continuing process beginning with the inhalation of asbestos fibers and ending years later with the manifestation of an asbestos-related disease, any insurer whose policy was in effect at any point in this process would be, under this theory, jointly and severally liable for the whole of this single injury with the insurers to determine amounts of contribution among themselves.”) (emphasis in original). For courts applying the double-trigger theory, a combination of the manifestation and exposure theories, see *Zurich Ins. Co. v. Raymark Indus., Inc.*, 514 N.E.2d 150, 160 (Ill. 1987) (“[A]n insurer whose policy was in force at the time a claimant was exposed to asbestos . . . [W]e agree that the evidence supports the conclusion that disease occurs, and therefore triggers coverage, when it becomes manifest . . . [H]aving a ‘sickness,’ . . . would also trigger coverage under the policies.”); *John Crane, Inc. v. Admiral Ins. Co.*, 991 N.E.2d 474, 495, 474 (Ill. App. Ct. 2013) (reaffirming *Zurich*). For courts applying the injury-in-fact approach, see *Emhart Indus., Inc. v. Century Indem. Co.*, 559 F.3d 57, 78, 57 (1st Cir. 2009) (applying Rhode Island law); *Olin Corp. v. Certain Underwriters at Lloyd’s London Ins. Co. of N. Am.*, 221 F.3d 307, 327, 307 (2d Cir. 2000) (applying New York law); *American Am. Home Products Prods. Corp. v. Liberty Mut. Ins. Co.*, 748 F.2d 760, 764, 760 (2d Cir. 1984) (applying New York law).

g. When the facts cannot be determined. Ordinarily, the insured has the burden of proving that a liability insurance policy is triggered. See *Carey Canada, Inc. v. California Cal. Union Ins. Co.*, 748 F. Supp. 8, 12, 8 (D.D.C. 1990) (applying Florida law); *Banco Nacional De Nicaragua v. Argonaut Ins. Co.*, 681 F.2d 1337, 1340, 1337 (11th Cir. 1982); *N. States Power Co. v. Fid. & Cas. Co. of New York N.Y.*, 523 N.W.2d 657, 663–664 (Minn. 1994) (“Consistent with long-standing principles of insurance law, the insured bears the burden of proving the policy was ‘triggered’ and therefore that coverage is available.”); *Tillman v. Lincoln Warehouse Corp.*, 72 A.D.2d 40, 43, 40 (N.Y. App. Div. 1979) (same). In cases involving long-tail risks, especially asbestos cases, some jurisdictions have determined that fairness and efficiency require that the burden of proof be shifted to insurers. See, e.g., *Keene Corp. v. Insurance Ins. Co. of North America N. Am.*, 667 F.2d 1034, 1034, n.42 (D.D.C. 1981) (internal citation omitted) (“We recognize that the insured generally bears the burden of proving coverage. The injuries at issue in these cases, however, are unique and traditional procedural rules cannot be allowed to defeat Keene’s or its insurers’ substantive rights under the policies. We recognize that burdens of proof are matters of state law. . . . We believe, however, that this case is so different from the cases in which the insured’s burden of proof developed, that those cases provide no authority for this case. Reversal of the ordinary burden of proof will be more equitable for all parties and will prevent unnecessary litigation.”); *Insurance Ins. Co. of North America N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1225 n.27 (6th Cir. 1980) (applying New Jersey and Illinois law) (“If an insurance company can show that a certain manufacturer’s products were not or could not have been involved for certain years, it will be absolved from paying its pro-rata share for those years. Given the impossibility in most cases of ascertaining which company provided asbestos products in different years, we think that this is the fairest way to apportion liability.

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Thus, we simply reverse the ordinary burden of proof and place it on the insurer. We are keenly aware of the need to apply a straightforward formula and not one which will lead to additional litigation.”).

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Liability Insurance

**TOPIC 2
CONDITIONS**

§ 34. Conditions in Liability Insurance Policies

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

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

(3) The failure of an insured to satisfy cooperation conditions, under the rules stated in § 30, and notice-of-claim conditions, under the rules stated in § 35(1), does not relieve the insurer of its obligations under the policy unless the failure caused prejudice to the insurer.

Comment:

a. Conditions in insurance policies as compared to contract-law conditions generally.
The concept of “condition” in contract law is a very broad one that includes any event that must occur, or that must not occur, before performance under a contract becomes due. See Restatement Second, Contracts § 224. Under this broad definition, almost all insurance-policy provisions would be understood to contain conditions. For example, insuring clauses commonly require that a specified event must take place within the policy period in order to trigger coverage under the policy, and exclusions commonly apply only when a specified event has taken place. In insurance law and practice, however, the term “condition” typically is employed only in connection with events that are under the control of insureds or insurers. (Note that this Restatement follows the terminology of the Restatement Second, Contracts, which does not distinguish between conditions precedent and subsequent. In jurisdictions that retain that distinction, the conditions that are specifically addressed in this Section would generally be regarded as conditions precedent. Thus, when applying the rules stated in §§ 34 to 36 in such jurisdictions, the term “condition precedent” can generally be substituted for the term “condition” as it appears in this Restatement.)

Illustrations:

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

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We will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” . . . to which this insurance applies . . .

This insurance applies to “bodily injury” . . . only if . . . the “bodily injury” . . . is caused by an “occurrence” that takes place in the “coverage territory.”

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

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

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

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

(2) Notify us as soon as practicable.

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

b. Interpretation of conditions. Because the nonoccurrence of a condition may lead to a forfeiture, contract law has developed a special canon of construction stated in Restatement Second, Contracts § 227, pursuant to which, in case of doubt, a term in a contract should be construed to impose a duty upon a party, rather than a condition. See Restatement Second, Contracts § 227, Comment *d*. The application of the ordinary rules of insurance- policy interpretation stated in §§ 3 and 4 of this Restatement reaches the same result. If the plain meaning of the policy makes a requirement a condition, then it will be treated as such under § 3 of this Restatement unless the circumstances clearly indicate to the contrary. If the policy does not have a plain meaning in this regard, then under § 4 of this Restatement the term should not be treated as a condition unless the circumstances clearly indicate that to be the only reasonable approach.

c. The prejudice requirement. The prejudice requirement for cooperation and notice-of-claim conditions is an application of the more general contract- law principle of disproportionate forfeiture, pursuant to which a nonmaterial breach of a condition by an insured does not excuse the insurer from performance because the harm to the insurer from the breach is

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so much less than the value of the coverage to the insured. See Restatement Second, Contracts § 228. Under that principle, the failure of the insured to satisfy these conditions relieves the insurer of its obligations under the policy only if the insured's failure caused substantial harm to the insurer. There are both efficiency and fairness considerations for this principle that have special force in the liability insurance context. The principle is efficient in the sense that it applies these insurance- policy terms in a manner that most insureds would be willing to pay for, if they had the information and bargaining power, because the principle protects insureds from the same kinds of risks for which they buy liability insurance: their own negligence. The principle is fair because it is consistent with widely accepted proportionality norms as well as the public policy in favor of compensation of underlying claimants.

The conditions in liability insurance policies for which courts have applied a prejudice requirement include cooperation conditions, notice-of-claim conditions, and, in some cases, voluntary-payment conditions. See § 30 (cooperation) and § 35 (notice of claim). There is little authority regarding other conditions, as defined in subsection (1). Whether other conditions are subject to a prejudice rule should be determined on a case-by-case basis by comparison to the conditions for which the law is well developed.

d. What constitutes prejudice. When applying a prejudice requirement courts generally take a case-by-case approach to evaluating the substantiality of the asserted harm. What is required is that the failure to satisfy the condition prevented the insurer from protecting its interests in a significant way. Ordinarily, an increase in the costs of defense or other burden of defense or investigation is not sufficient. Examples of harm that meets the prejudice requirement include: the loss of a defense in the underlying legal action, a significant increase in the amount of damages or the settlement value of the legal action, the loss of evidence needed for the insurer to prove that the legal action is not covered, and the extinction of the insurer's subrogation rights in a context in which the insurer would have had a meaningful possibility of recovery pursuant to those rights.

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

REPORTERS' NOTES

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a. Conditions in insurance policies as compared to contract- law conditions generally. Regarding the narrow, insurance- law use of “condition,” it is difficult to prove that courts never use the term in a broader contract- law sense in insurance- law cases. All the insurance- law citations to the conditions Sections in the Restatement Second of Contracts (AM. LAW INST. 1981) involve events that are under the control of the insurer or insured. The monumental article on claims-made insurance by Professor Works demonstrates some of the analytical complications that would result from applying disproportionate-forfeiture analysis to insurance- policy requirements that are not under the control of an insurer or insured. See Bob Works, *Excusing Non Occurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case*, 5 CONN. INS. L.J. 505 (1999). As his discussion illustrates, the “conditions” (in the broad, contract- law sense of that term) in exclusions and insuring agreements are strictly enforceable under the Restatement’s disproportionate-forfeiture analysis because they are a “material part of the agreed exchange,” as that term is used in the Restatement Second of Contracts (AM. LAW INST. 1981).

b. Interpretation of conditions. See Beckenheimer’s [Inc. v. Alameda Assocs. Ltd. Partnership](#), 611 A.2d 105, 113, 114 (Md. Ct. Spec. App. 1992) (citing § 227 of the Restatement Second of Contracts (AM. LAW INST. 1981)) to support the conclusion that a proof-of-loss requirement was a covenant rather than a condition).

c. The prejudice requirement. The case law regarding the application of a prejudice requirement to liability insurance conditions generally involves conditions that are specifically addressed in this Restatement: notice-of-claim conditions, cooperation conditions, settlement conditions, and anti-assignment conditions. See § 25, Reporters’ Note to Comment *e* (circumstances in which a settlement condition is not enforced, without regard to prejudice); § 27, Comment *b* (circumstances in which a settlement condition is not enforced, without regard to prejudice); § 30, Comment *a* (cooperation clause prejudice requirement); § 35, Comment *a* (notice-prejudice rule authority); and § 36, Comments *b* and *c* (circumstances in which anti-assignment clauses not enforced, without regard to prejudice). Not surprisingly, most of the reasoning in the recent cases relies entirely on precedent-based justifications that do not shed light on whether there is or should be a prejudice requirement that applies to conditions more broadly. Although the reasoning in published decisions in cases in which there was no prior controlling authority in the jurisdiction is often consistent with the proposition that a prejudice requirement is the general rule, subject to exceptions, there is insufficient authority to state that the prejudice requirement is a general rule for conditions. See, e.g., *Allstate Floridian Ins. Co. v. Farmer*, 104 So. 3d 1242, 1246-1247 (Fla. Dist. Ct. App. 2012) (applying the notice-prejudice rule to notice-of-claim conditions); *Bond/Tec, Inc. v. Scottsdale Ins. Co.*, 622 S.E.2d 165, 168 (N.C. Ct. App. 2005) (holding that, as a matter of first impression, an insurer must show prejudice in order to be relieved of liability when the insured has breached the voluntary-payments clause of the policy); *State Farm Mut. Auto. Ins. Co. v. Fennema*, 110 P.3d 491, 492 (N.M. 2005) (“For the first time we consider whether an insurance company must demonstrate substantial prejudice from the breach of a consent-to-settle provision before it can be

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relieved from paying underinsured motorist benefits. We answer this question in the affirmative”); *Roberts Oil Co., Inc. v. Transamerica Ins. Co.*, 833 P.2d 222, 228-229 (N.M. 1992) (denying summary judgment in case in which the insured made payments to abate environmental contamination, because there were issues of material fact as to whether insurers were prejudiced by insured’s breach of voluntary-payment provision); *Bond/Tec, Inc. v. Scottsdale Ins. Co.*, 622 S.E.2d 165, 168-169 (N.C. Ct. App. 2005) (denying insurer’s motion for summary judgment because insurer failed to show it was prejudiced by the insured’s violation of the policy’s voluntary-payment provision); *Nationwide Mut. Ins. Co. v. Lehman*, 743 A.2d 933, 940 (Pa. Super. Ct. 1999) (“We hold that in order for an insurer to deny UIM coverage to an insured, where the insured settles with a tortfeasor for the limits of available liability insurance, and in contravention of the insurance policy’s consent-to-settle clause, the insurer must show that its interests were prejudiced.”); *Coastal Refining & Mktg., Inc. v. U.S. Fid. and Guar. Co.*, 218 S.W.3d 279, 296 (Tex. App. 2007) (granting summary judgment for the insured, because the insurer failed to meet its burden of showing that it had sustained prejudice—monetary or otherwise—from the insured entering into a settlement without its consent); *Columbia Cas. Co. v. Gordon Trucking, Inc.*, 758 F. Supp. 2d 909, 916 (N.D. Cal. 2010) (applying Washington law) (concluding that an insurer must show actual prejudice before it can enforce a voluntary-payment provision).

For cases holding that there is no prejudice requirement, see *Tradewinds Escrow, Inc. v. Truck Ins. Exch.*, 118 Cal. Rptr. 2d 561, ~~565~~566 (Cal. Ct. App. 2002) (enforcing a no-voluntary-payments provision without regard to prejudice in case in which insured incurred defense expenses before notifying insurer of the claim); *Travelers Ins. Companies Comps. v. Maplehurst Farms, Inc.*, 953 N.E.2d 1153, ~~1160~~-1161 (Ind. Ct. App. 2011) (“[W]here an insured enters into a settlement agreement without the insurer’s consent in violation of a voluntary payment provision, that obligation cannot be recovered from the insurer, and prejudice is irrelevant.”); *Champion Spark Plug Co. v. Fid. & Cas. Co. of New York*, 687 N.E.2d 785, ~~792~~793 (Ohio Ct. App. 1996) (in Ohio “there is no burden to show that a voluntary payment or settlement made by the insured in violation of a term in the insurance contract prejudiced the insurer before a ruling can be made that a material breach of the contract occurred which relieves the insurer of the obligation to make payment.”).

d. What constitutes prejudice. When deciding whether an insurer can deny coverage because the insured failed to satisfy a condition, courts that impose a prejudice requirement generally require the insurer to show that it suffered actual prejudice that caused an impairment or loss of the insurer’s substantial rights. 13 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 193:68 (3d ed. ~~2014~~2017). For cases finding that the insurer met the prejudice requirement, see, e.g., *West Bay Exploration Co. v. AIG Specialty Agencies of Texas, Inc.*, 915 F.2d 1030, 1036-1037 (6th Cir. 1990) (applying Michigan law) (finding insurers prejudiced by delay where evidence that might have proved that the claim was not covered was destroyed prior to the insurers receiving notice); *Atlantic Atl. Cas. Ins. Co. v. Value Waterproofing, Inc.*, 918 F. Supp.

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2d 243, 248 (S.D.N.Y. 2013) (applying New York law) (concluding that CGL insurer was prejudiced by six-month delay in receiving notice because the delay prevented insurer from being able to ascertain potential causes of the loss); Hyde Athletic ~~Industries~~Indus., Inc. v. ~~Continental~~Cont'l Cas. Co., 969 F. Supp. 289, 300 (E.D. Pa. 1997) (applying Pennsylvania law) (finding prejudice where insured did not notify insurer of claim until after insured decided to proceed to trial and incurred over \$1.3 million in legal costs for \$100,000 in liability); Port ~~Services~~Servs. Co. v. ~~General~~Gen. Ins. Co. of ~~America~~Am., 838 F. Supp. 1402, 1403 (D. Or. 1993) (finding prejudice where delay deprived insurer of the opportunity to investigate possible claims against third parties); Martin v. Fireman's Fund Ins. Co., A-4206-09T1, 2011 WL 1584333, at *2 (N.J. Super. Ct. App. Div. Apr. 28, 2011) (holding that insurer was appreciably prejudiced after insured waited four years to notify insurer of injuries he sustained in an accident, resulting in insurer's inability to intervene in insured's lawsuit against the tortfeasor); Maryland Cas. Co. v. ~~American~~Am. Home ~~Assur-~~Assurance Co., 277 S.W.3d 107, 115 (Tex. App. 2009) (finding prejudice where delay in notice caused insurer to lose its ability to defend the suit and rights to subrogation). For cases finding that an increase in the cost or other burden of defense is not sufficient to show prejudice, see, e.g., Franco v. Selective Ins. Co., 184 F.3d 4, 8-9 (1st Cir. 1999) (applying Maine law) (holding that entry of default judgment does not constitute prejudice unless insurer can demonstrate that it would not have been able to have the default set aside if it had intervened and petitioned to have the default removed); Old Republic Ins. Co. v. Underwriters Safety & Claims, Inc., No. 3:05-CV-343-S, 2010 WL 3069066, at *1 (W.D. Ky. Aug. 2, 2010) (Prejudice resulting from late notice cannot be proven by the insurer merely disclosing that it was not able to partake in any of the judicial proceedings; the insurer must demonstrate that there was "some reasonable possibility that the outcome would have been different had it received notice.").

e. Burden of proof of prejudice. For cases placing the burden of proving prejudice on the insurer, see, e.g., Ingalls Shipbuilding v. Fed. Ins. Co., 410 F.3d 214, 227 (5th Cir. 2005) (applying Texas law) (placing burden to prove prejudice on insurer); Arrowood Indem. Co. v. Pendleton, 39 A.3d 712, 725-726 (Conn. 2012) (adopting majority rule that assigns burden of proof to the insurer and overruling Aetna v. Murphy, 538 A.2d 219 (Conn. 1988) to that limited extent); Best v. W. Am. Ins. Co., 270 S.W.3d 398, 405 (Ky. Ct. App. 2008) ("[A]n insurer may not deny coverage because the insured failed to provide prompt notice of loss unless the insurer can prove that it is reasonably probable that it suffered substantial prejudice from the delay in notice."); ~~Michoud v. Mut. Fire, Marine & Inland Ins. Co., 505 A.2d 786, 787 (Me. 1986) (concluding the insurer failed to demonstrate prejudice)~~; Fox v. Nat'l Sav. Ins. Co., 424 P.2d 19, 25 (Okla. 1967) ("[I]t is in accord with the public policy of this State . . . to place the burden upon the insurer to show prejudice from noncompliance with the policy's provisions concerning written notice."); Cooper v. Gov't Employees Ins. Co., 237 A.2d 870, 874 (N.J. 1968) (holding that the burden to prove prejudice is on the insurer); Brakeman v. Potomac Ins. Co., 371 A.2d 193, ~~196~~198 (Pa. 1977) ("[T]he insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its

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position.”); *Hardwick Recycling & Salvage, Inc. v. Acadia Ins. Co.*, 869 A.2d 82, 96 (Vt. 2004) (holding that insurer was not relieved of its obligations under policy because insurer failed to prove that it suffered prejudice as a result of the delay); *Felice v. St. Paul Fire & Marine Ins. Co.*, 711 P.2d 1066, 1070 (Wash. Ct. App. 1985) (insurer asserting prejudice has burden of demonstrating prejudice).

§ 35. Notice and Reporting Conditions

(1) Except as stated in subsection (2), the failure of the insured to satisfy a notice-of-claim condition excuses an insurer from performance of its obligations under a liability insurance policy only if the insurer demonstrates that it was prejudiced ~~as a result~~by the failure.

(2) With respect to claims first reported after the conclusion of the claim-reporting period in a claims-made-and-reported policy, the failure of the insured to satisfy the claim-reporting condition in the policy excuses an insurer from performance under the policy without regard to prejudice, except when:

- (a) The policy does not contain an extended reporting period;**
- (b) The claim at issue is made too close to the end of the policy period to allow the insured a reasonable time to satisfy the condition; and**
- (c) The insured reports the claim to the insurer within a reasonable time.**

Comment:

a. Notice-of-claim conditions. Liability insurance policies commonly contain terms that condition coverage on the timely provision by the insured of a notice of claim. The purpose of such conditions is to allow insurers to obtain the information that they need to investigate and defend legal actions. Notice-of-claim conditions are the most frequently excused conditions in liability insurance policies. The courts in almost all states have recognized the notice-prejudice rule followed in this Section. When applying a prejudice requirement, courts generally take a case-by-case approach to evaluating the substantiality of the asserted harm. What is required is that the failure to satisfy the condition prevented the insurer from protecting its interests in a significant way. See § 34, Comment *d*. The insurer bears the burden of proving prejudice. See §

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Comment *e*.

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

Illustrations:

1. Insured Driver hits Pedestrian causing serious injuries that lead to more than \$100,000 in medical expenses. Police arrive at the scene and charge Driver with Driving Under the Influence. Pedestrian sues Driver. Driver ignores the suit and never provides notice to Insurer. Two years later, Pedestrian obtains a default judgment against Driver and, for the first time, notifies Insurer, seeking payment of the applicable \$100,000 limit of coverage under the automobile insurance policy Insurer issued to Driver that was in force at the time of the accident. Insurer denies coverage based on Driver's failure to satisfy the notice condition in the policy. Insurer cannot show that it was prejudiced by the extensive delay in receiving notice because Driver was plainly at fault and Pedestrian's damages exceeded the policy limits and, thus, Insurer would have had to pay the full policy limits even if it had received prompt notice of the accident. Driver's failure

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to satisfy the notice condition in the policy does not excuse Insurer's obligation to cover the suit.

2. Insured Driver 1 is in an accident with Driver 2 at an intersection. The accident causes serious injuries to Driver 2 leading to more than \$25,000 in medical expenses. There is a witness at the scene who reported to a police officer that Driver 1 was proceeding through the intersection at a modest speed, with a green light, and that Driver 2 was running a red light. Driver 2 files a lawsuit against Driver 1. Driver 1 ignores the suit and never provides notice to Insurer. Two years later, Driver 2 obtains a default judgment against Driver 1 and, for the first time, notifies Insurer seeking payment of the applicable \$25,000 limit of coverage under the automobile liability insurance policy Insurer issued to Driver 1 that was in force at the time of the accident. Insurer denies coverage based on Driver's failure to satisfy the notice condition in the policy. Even if Insurer would be able to set aside the default judgment, it was prejudiced by the extensive delay in receiving notice because it cannot now locate the witness, despite making reasonable efforts, and there is no other evidence that demonstrates that Driver 1 was not at fault. Thus, Driver 1's failure to satisfy the notice condition in the policy excuses Insurer's obligation to cover the suit.

c. Claim-reporting conditions in claims-made-and-reported policies. A claims-made-and-reported policy is a claims-made policy that includes a term in the insuring-agreement section of the policy that conditions coverage on the insured reporting the claim within a specified period. Courts have referred to such conditions in a claims-made-and-reported policy as "claim-reporting conditions," to distinguish them from other notice-of-claim conditions. Courts generally conclude that putting the reporting requirement in the insuring agreement of a claims-made-and-reported policy makes that condition sufficiently material to the contract that the ordinary notice-prejudice rule does not apply. This conclusion is based on a determination that a claim-reporting condition in a claims-made-and-reported policy has additional purposes beyond the traditional claims-management purpose of a notice-of-claim condition. These additional purposes are: (a) simplifying insurers' reserving practices and (b) reducing the amount of uncertainty in insurance pricing.

Typically, the claim-reporting condition in contemporary claims-made-and-reported policies requires the claim to be reported before the end of what is known as an "extended

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reporting period,” which is the period between the end of the policy period and the deadline for reporting claims, although there are still some claims-made-and-reported policies sold in which the claim-reporting deadline is the end of the policy period. Claims-made-and-reported policies typically also contain a second, traditional notice-of-claim condition in the policy. A claims-made policy that contains only the traditional notice condition, and not the claim-reporting condition in the insuring agreement, is not a claims-made-and-reported policy and, thus, only the ordinary notice-prejudice rule would apply to such a policy.

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

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

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The significance of this IBNR difference can be overstated, however. The uncertainty attendant to liability insurance reserving is not eliminated when the insurer can set a zero-dollar IBNR reserve. There is ample room for uncertainty regarding the case reserves set on the claims for which the insurer has received the required report. Moreover, modest extensions of the time before the insurer can set the zero-dollar IBNR reserve do not have a material impact on the insurer's financial condition. Put another way, it is the ability of the insurer to set an enforceable deadline on when a claim may be reported that can be material to the insurer's financial reports, not the precise date of the deadline. Moreover, there is no reason that the deadline must be coterminous with the end of the policy period, especially because setting that deadline at the end of the policy period would lead to a disproportionate forfeiture in cases in which the insured learns of the claim too close to the end of the policy period to allow the insured a reasonable time to report that claim to the insurer by the deadline.

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

It is important to note, however, that this potential increase in pricing uncertainty also does not provide adequate justification for strict enforcement of a claim-reporting condition in all cases in which a claim is first reported close to the end of the policy period. As with the reserving benefit, the reduction in pricing uncertainty comes from the presence of an enforceable deadline on receiving claim reports. The insurer receives substantially the same reduction in pricing uncertainty from a claim-reporting condition that provides the insured with a reasonable time to

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report a claim. Accordingly, the application of a deadline for reporting a claim to a claim that the policyholder cannot reasonably report by that deadline would create a disproportionate forfeiture, unless the insurer is somehow prejudiced by the delay.

f. An extended reporting period. To avoid the forfeiture that would otherwise result in circumstances in which a claim is made too close to the end of the policy period to allow the policyholder sufficient time to report the claim to the insurer, contemporary claims-made-and-reported policies commonly provide for an additional period of time, after the end of the policy period, during which the insured may report a claim that was first made during the policy period. This additional period of time is generally referred to as an “extended reporting period.” Typically, claims-made-and-reported policies include an extended reporting period of at least 60 days, often longer. Some states have statutes that mandate the inclusion of an extended reporting period in certain policies. When a claims-made-and-reported policy includes an extended reporting period, subsection (2)’s narrow exception to the general rule regarding strict enforcement of the claim-reporting condition does not apply.

g. When the policy does not contain an extended reporting period. Published opinions rarely address the situation in which an insured did not have a reasonable time in which to report a claim. Most published opinions that strictly enforce claims-reporting conditions in claims-made-and-reported policies involve claims in which the policy contained an extended reporting period or the insured reported the claim unreasonably long after the end of the policy period. Published opinions often describe claims that are reported over a year after the policy period ended, and there are few published opinions, especially in recent years, that involve claims that are reported less than three months after the end of the policy period. This is likely the result of the fact that most insurers wisely choose not to press to judgment denials of coverage that are based on claim-reporting requirements that an insured could not reasonably comply with in the circumstances. Among the few published opinions to address this situation, the majority strictly enforce the claim-reporting condition, but there is recent authority concluding that the loss of coverage due to the failure of the insurer to provide the insured with a reasonable time to report the claim in the circumstances is a disproportionate forfeiture. That is the source of the exception stated in subsection (2).

Relaxing the requirement that a claim must be reported during the policy period, by requiring that the insured must have had a reasonable time to satisfy the condition, does not pose

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a material increase in risk to the insurer. An insurer that grants the insured a reasonable time to report a claim receives all the legitimate benefits of strict enforcement of a claim-reporting condition that is included in the insuring agreement of a claims-made policy. While there are undoubted benefits to prompt reporting, the modest delay needed to allow the insured a reasonable time to report a claim should rarely, if ever, harm the insurer. And, if the delay does harm the insurer, the ordinary prejudice rule would protect the insurer. The only additional benefit that an insurer receives when it fails to grant the insured a reasonable time to provide notice is an illegitimate one: cost savings attributable to nonpayment of claims that are forfeited by insureds because there was insufficient time to report those claims. Under the rule stated in this Section an insurer can achieve the desired certainty by including an extended reporting condition in the policy.

Note that subsection (2) contemplates that the presence of an extended reporting period will adequately protect the policyholder from a disproportionate forfeiture attributable to the policyholder's inability to satisfy the claim-reporting condition in a claims-made-and-reported policy. Were a claims-made-and-reported policy to have an extended reporting period that was too short to allow the policyholder to avoid a disproportionate forfeiture in a particular case, a court could apply the contract-law disproportionate-forfeiture doctrine to excuse the policyholder's failure to satisfy the reporting condition. See Restatement Second, Contracts § 229 (Excuse of a Condition to Avoid Forfeiture).

h. Prejudice is required when notice is late but given before the end of the reporting period. The notice-prejudice rule applies to claims reported to the insurer before the end of the reporting period under the policy because the justifications for the claims-made-and-reported exception to the notice-prejudice rule do not apply until that period is over. Until that time, the insurer remains subject to additional claims and, thus, subject to uncertainty about the number and severity of the claims that will be reported under the policy as well as the IBNR reserve.

Illustrations:

3. Attorney is insured under a claims-made-and-reported lawyers' professional liability insurance (LPL) policy issued by Insurer A with no extended reporting period, meaning that the reporting period is coterminous with the policy period, which ends on midnight, December 31, Year 1. On the morning of Christmas Eve day (December 24), Attorney receives a voice mail from a reporter asking for a comment about a lawsuit that

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Attorney's former client is said to be preparing to file against Attorney. Under the terms of the Attorney's LPL policy, this voice mail constitutes the making of a claim on December 24. Attorney calls his former client and speaks to the client's spouse, who says that he knows nothing about this and that the former client is away for the holidays. The spouse promises to make sure the former client returns the call the first week in January. As of midnight December 31, Insurer B issues Attorney a new LPL policy with a policy period from December 31, Year 1, to December 31, Year 2. The new LPL policy provides coverage only for claims first made during Year 2. On January 6, Attorney is served with a complaint filed by the former client alleging malpractice. Attorney immediately sends the complaint to Insurer A. Because the claim was made too close to the end of the policy period to allow Attorney a reasonable time to satisfy the claim-reporting condition in the circumstances and Attorney reported the claim to Insurer A within a reasonable time, Attorney's failure to satisfy the condition does not excuse Insurer from its obligation to perform.

4. Same facts as Illustration 3, except that Attorney waits until March 1 to send the complaint to Insurer A and has no justification for the additional delay. Because Attorney did not report the claim to Insurer A within a reasonable time, the insurer's obligation to perform is excused.

5. Same facts as Illustration 3, except that the LPL policy contains a statutorily mandated 30-day extended reporting period, which ends on January 30, Year 2, and Attorney does not report the claim to Insurer A until February 1, Year 2. Because the policy contained an extended reporting period and Attorney failed to report the claim before the end of that period, Insurer A's obligation to perform is excused.

6. Attorney is insured under an LPL policy issued by Insurer with a one-year policy period and a 180-day extended reporting period. Halfway through the policy period, Attorney receives a letter from a former client alleging that Attorney committed malpractice. Under the terms of the Attorney's LPL policy, this letter constitutes the making of a claim that must be reported "as soon as practicable" and before the end of the extended reporting period. For many months, Attorney unsuccessfully attempts to resolve the matter with the former client. Shortly before the 180-day extended reporting period is over, Attorney reports the matter to Insurer as a claim under the LPL policy. Insurer

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reserves the right to contest coverage based on Attorney’s failure to comply with the requirement in the policy that the claim be reported “as soon as practicable.” Because Attorney reported the claim within the reporting period specified in the LPL policy, Attorney’s failure to satisfy the “as soon as practicable” notice condition excuses Insurer from its obligations under the policy only if Insurer can demonstrate that it was prejudiced as a result of the delay.

REPORTERS’ NOTES

a. Notice-of-claim conditions. For cases adopting the notice-prejudice rule, see Allstate Floridian Ins. Co. v. Farmer, 104 So. 3d ~~1242, 1249-1250~~1242 (Fla. Dist. Ct. App. 2012); Johnson Controls, Inc. v. Bowes, 409 N.E.2d ~~185, 187~~185 (Mass. 1980); Brakeman v. Potomac Ins. Co., 371 A.2d 193, 196 (Pa. 1977); Alcazar v. Hayes, 982 S.W.2d 845 (Tenn. 1998); PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008). For authority regarding the insurer bearing the burden of proof of prejudice, see § 34, Reporters’ Note to Comment *e*.

b. Reasons for the notice-prejudice rule. See *Brakeman*, 371 A.2d at 196-197:

The rationale underlying the strict contractual approach reflected in our past decisions is that courts should not presume to interfere with the freedom of private contracts and redraft insurance policy provisions where the intent of the parties is expressed by clear and unambiguous language. We are of the opinion, however, that this argument, based on the view that insurance policies are private contracts in the traditional sense, is no longer persuasive. Such a position fails to recognize the true nature of the relationship between insurance companies and their insureds. An insurance contract is not a negotiated agreement; rather its conditions are by and large dictated by the insurance company to the insured. The only aspect of the contract over which the insured can ‘bargain’ is the monetary amount of coverage. . . . A strict contractual approach is also inappropriate here because what we are concerned with is a forfeiture.

See also *Cooper v. GovernmentGov’t Employees Ins. Co.*, 237 A.2d 870, 873-874 (N.J. 1968):

~~(A)~~ Although the policy may speak of the notice provision in terms of ‘condition precedent,’ . . . nonetheless what is involved is a forfeiture, for the carrier seeks, on account of a breach of that provision, to deny the insured the very thing paid for. This is not to belittle the need for notice of an accident, but rather to put the subject in perspective. Thus viewed, it becomes unreasonable to read the provision unrealistically or to find that the carrier may forfeit the coverage, even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds.

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For an explanation of the source of the notice-prejudice rule in the disproportionate-forfeiture doctrine, see *Aetna Cas. & Sur. Co. v. Murphy*, 538 A.2d 219 (Conn. 1988).

c. Claim-reporting conditions in claims-made-and-reported policies. For cases in which courts declined to apply the notice-prejudice rule to claims-made-and-reported policies, see, e.g., *Slater v. Lawyers' Mut. Ins. Co.*, 227 Cal. App. 3d 1415, 1421-1422 (Cal. Ct. App. 1991) (claim reported six months after end of the policy period); *Zuckerman v. Nat'l Union Fire Ins. Co.*, 495 A.2d 395, 404 (N.J. 1985) (strictly enforcing provision in claims-made-and-reported policy that limited coverage to claims filed within the policy period); *Anderson v. Aul*, 862 N.W.2d 304, 317 (Wis. 2015) (holding that the Wisconsin notice-prejudice statute did not apply to reporting requirements of claims-made-and-reported professional-liability insurance policies; more than one year delay in reporting). See also *Craft v. Phila. Indem. Ins. Co.*, 343 P.3d 951, 952-953 (Colo. 2015) (declining to apply notice-prejudice rule to claims-made-and-reported policies; claim reported more than one year after end of the policy period). Cf. *Sherlock v. Perry*, 605 F. Supp. 1001, 1004-1005 (E.D. Mich. 1985) ([applying Michigan law](#)) (declining to strictly enforce a traditional notice-of-claim condition in a claims-made policy that was not a claims-made-and-reported policy).

Two of the most common citations courts provide when explaining the difference between claims-made-and-reported policies and occurrence policies in a manner that justifies strict enforcement of the reporting condition are law-review articles written by a prominent insurance attorney, Sol Kroll (who served, for example, as U.S. General Counsel to Lloyd's of London and director of the New York Insurance Federation), in the 1970s, before courts had substantial experience with claims-made policies. See, e.g., *Zuckerman v. Nat'l Union Fire Ins. Co.*, 495 A.2d 395, 398, 399 (N.J. 1985) (citing Sol Kroll, *The Professional Liability Policy "Claims Made,"* 13 FORUM 842, 850 (1978) and Sol Kroll, *"Claims Made"—Industry's Alternative: "Pay as You Go" Products Liability Insurance*, 637 INS. L.J. 63, 64 (Feb. 1976)); *Anderson v. Aul*, 862 N.W.2d 304, 312 n.20 (Wis. 2015) (citing Sol Kroll, *"Claims Made"—Industry's Alternative: "Pay as You Go" Products Liability Insurance*, 1976 INS. L.J. 63, 64 (1976)). Perhaps because they were written before there was substantial experience with claims-made-and-reported insurance policies, these articles do not reflect the more nuanced explanation of the potential impact of a reporting condition on pricing and reserving provided in the Comments to this Section.

d. The reserving justification for strict enforcement of the claim-reporting condition. See, e.g., *Hasbrouck v. St. Paul Fire & Marine Ins. Co.*, 511 N.W.2d 364, 368 (Iowa 1993) (“the ‘claims made’ policy reporting provision serves a different purpose. It provides a certain date after which an insurer knows that it is no longer liable under the policy. So the insurer can more accurately fix its reserves for future liabilities and compute premiums with greater certainty.”).

e. The pricing-uncertainty justification for strict enforcement of the claim-reporting condition. See *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 30 (Mass. 1990) (holding that the purpose of a claims-made policy is “to minimize the time between the insured

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event and the payment . . . If a claim is made against an insured, but the insurer does not know about it until years later, the primary purpose of insuring claims rather than occurrences is frustrated.”); see also *Anderson v. Aul*, 862 N.W.2d 304, 317 (Wis. 2015) (adopting the reasoning of *Chas. T. Main* and concluding that notice-prejudice statutes do not apply to the reporting requirements in claims-made policies).

f. An extended reporting period. See Stacey Kalberman, *Director and Officer Liability: An Overview of Corporate and Insurance Indemnification*, 16 ANDREWS OFF. & DIR. LIAB. LITIG. R. 16 (2001) (“Many [D&O claims-made] policies also contain a 30- or 60-day automatic extended reporting period which does not require any additional premium.”). For sources noting that claims-made-and-reported policies often grant the policyholder the option of paying an additional fee to further extend the reporting period, see CALIFORNIA PRACTICE GUIDE: INSURANCE LITIGATION Ch. 7A-C ([Aug. 2017 update](#)) (“To extend the time within which the claim may be made, the insured may purchase ‘tail coverage’ or a separate ‘extended reporting period’ endorsement (e.g., six months) for a particular claims-made policy year. This provides insurance protection if the wrongful act took place during that policy year and the claim is made before expiration of the extended reporting period.”); Joseph P. Monteleone, *Notice-Prejudice Requirements in D&O Policies: Diverse Trends in Contract Language and Case Law*, THE D&O DIARY, [November 23, 2015](#) [Updated February 17, 2016](#) (reporting that D&O policies commonly contain 180-day extended reporting periods and, increasingly, include language explicitly requiring the insurer to prove prejudice in order to avoid coverage on the basis of late notice). For a compilation of statutes requiring the inclusion of extended reporting periods, see BARRY R. OSTRAGER & THOMAS R. NEWMAN, *Survey of Jurisdictions on Issue of Whether Public Policy Requires Claims-Made Policies to Include an Extended Reporting Provision*, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 4.02[b][E] (~~17~~[18](#)th ed. ~~2015~~[2016](#)).

g. When the policy does not contain an extended reporting period. Among the few published opinions to address this situation, a majority strictly enforce an unreasonably short notice-of-claim condition contained in the insuring agreement of a claims-made policy, but recent, more persuasive authority concludes that the loss of coverage due to the failure of the insurer to provide the insured with a reasonable time to provide notice is a disproportionate forfeiture. See *Root v. AmericanAm. Equity Specialty Ins. Co.*, 30 Cal. Rptr. 3d 631, 646-647 (Cal. Ct. App. 2005) (finding coverage under a claims-made-and-reported policy despite the insured’s failure to notify insurer of claim during the policy period because the policy did not provide the insured a reasonable time to report the claim.); ~~13 LEE R. RUSS & THOMAS F. SEGALLA~~; [13 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 186:13 (3d ed. ~~2011~~[2017](#)) (“[T]he ‘prompt’ requirement [appearing in claims-made policies] may be deemed to allow coverage for claims of which the insurer receives notice ‘promptly’ even if that notice is given a short time after the policy period ended.”). Cf. *Craft v. Philadelphia Indem. Ins. Co.*, 343 P.3d 951 (Colo. 2015) (strictly enforcing a claims-reporting condition when the policyholder failed to report the claim until after the expiration of a 60-day extended reporting condition). That is the approach followed in this

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Section. For contrary authority, see Catholic ~~Medical-Center~~Med. Ctr. v. ~~Executive~~Exec. Risk ~~Indemnity~~Indem., Inc., 867 A.2d 453 (N.H. 2005) (hospital not entitled to E&O coverage for notices of claims that it delivered to insurer nine hours after policy expired).

h. Prejudice is required when notice is late but given before the end of the reporting period. 13 ~~LEE R. RUSS & THOMAS F. SEGALLA~~STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 186:13 (3d ed. ~~2011~~2017) notes that “promptness” provisions are “directed at ensuring promptness of notice, maximizing the insurer’s opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured.” For cases applying the notice-prejudice rule to an insured’s breach of a claims-made policy’s prompt-notice provision, see, e.g., Fulton Bellows, LLC v. Fed. Ins. Co., 662 F. Supp. 2d ~~976, 990~~976 (E.D. Tenn. 2009); Fin. Indus. Corp. v. XL Specialty Ins. Co., 285 S.W.3d 877, 879 (Tex. 2009) (“an insurer must show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured’s breach of the policy’s prompt-notice provision, but the notice is given within the policy’s coverage period.”). Illustration 1 is an adaptation of the facts in Root v. ~~American~~Am. Equity Specialty Ins. Co., 30 Cal. Rptr. 3d 631 (Cal. Ct. App. 2005).

§ 36. Assignment of Rights Under a Liability Insurance Policy

(1) Except as otherwise stated in this Section, rights under a liability insurance policy are subject to the ordinary rules regarding the assignment of ~~rights under a contract~~ rights.

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

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

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

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

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

Comment:

a. Assignment of rights under a liability insurance contract generally. Under modern contract law, the owner of a contractual right—the “obligee” to whom the “obligor” owes a contractual obligation—may transfer that right to a third party. The old common-law rule forbidding the transfer of a “chose in action” is, at least with respect to contractual rights, no longer in force. The only continuing limitations are that (a) the assignment not materially change the duty or increase the risk of the obligor or materially impair the obligor’s chance of obtaining, or materially reduce the value of, return performance, (b) the assignment not violate a state statute or public policy, and (c) the assignment not contradict an enforceable anti-assignment provision in the contract. This Section addresses certain circumstances in which anti-assignment provisions in liability insurance policies are not enforceable.

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

c. Assignment of liability insurance rights in mergers and acquisitions. The question of what rights under a liability insurance policy can be assigned as part of a corporate sale or reorganization has proved controversial in some contexts in light of the presence of an anti-assignment condition in most liability insurance policies. When there is a corporate merger, the law treats the resulting entity as the continuation of each of the merged entities, with the result that the resulting entity retains the liability insurance rights of each of the merged entities. In that merger context, there is no assignment of rights under a liability insurance policy that could be subject to any conditions that might be present in the merged entities’ liability insurance policies. By contrast, when one corporation acquires a business from another corporation through

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an asset sale, or when part of a business is placed into a newly formed corporation, the acquiring entity is a legally separate entity that is not ordinarily treated as the continuation of the entity transferring the assets. In that context, the liability insurance rights that have been associated with the business that is being transferred must be transferred to the acquiring entity through an assignment that is either express or implied.

Traditionally, liabilities and the associated rights under occurrence- or accident-based liability insurance policies issued in the past were routinely transferred as part of an asset purchase or the creation of a new corporation, apparently without significant challenge from liability insurers, at least as indicated by reported cases and the insurance trade literature, and in some cases even without an express assignment term in the asset-purchase documents. Such transfers came under challenge in the late 20th century, however, as a violation of a liability-insurance-policy term that prohibits the assignment of rights under the policy without the consent of the insurer. Although some courts have concluded that the failure to obtain the insurer's consent does lead to a forfeiture of coverage, the majority rule is to the contrary.

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

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

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addressed in this Section. The rule stated in this Section simply preserves the right to insurance for the liabilities insured under the pre-merger or pre-acquisition insurance policy.

Illustrations:

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

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

e. Assignment of liability insurance rights in other contexts. In specifying that liability insurance rights may be assigned in the context of specific claims already made against an insured and in the context of mergers and acquisitions, this Restatement does not take a position on whether liability insurance rights may be assigned without the consent of the insurer in other contexts in which there is no material increase in the risk borne by the insurer.

REPORTERS' NOTES

a. Assignment of rights under a liability insurance contract generally. See Restatement Second, Contracts §§ 317 (AM. LAW INST. 1981) (assignment of a right) and 322 (contractual prohibition of assignment).

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b. Assignment of a right to payment for a specific claim. For those jurisdictions following the majority rule and permitting post-loss assignment of payment for a specific claim, see *Ohio v. Baird*, 567 F.3d 1207, 1214 (10th Cir. 2009) (applying Utah law) (finding that an anti-assignment clause is no longer enforceable once the event giving rise to the claim has occurred); *Colo. Cas. Ins. Co. v. Safety Control Co.*, ~~230 Ariz. 560, 565-566~~ [288 P.3d 764](#) (Ariz. Ct. App. 2012); *Glenn v. Fleming*, ~~247 Kan. 296~~ [799 P.2d 79, 91](#) (Kan. 1990) (“[A]n insured’s breach of contract claim for bad faith or negligent refusal to settle may be assigned.”); *Wehr Constructors Inc. v. Assur. Assurance Co. of Am.*, 384 S.W.3d 680, 683 (Ky. 2012) (stating that once the loss has occurred, the chose in action can be assigned, notwithstanding the existence of an anti-assignment clause, as such a clause would be void as against public policy); *Egger v. Gulf Insurance Ins. Co.*, 903 A.2d 1219, 1229 (Pa. 2006) (holding that “whether or not the assignment was made prior to the jury verdict is irrelevant, as the obligation . . . arose on the date of the occurrence. . . .”); *In re Ambassador Ins. Co. Inc.*, 965 A.2d 486, 490-491 (Vt. 2008) (holding that the post-loss assignment of a claim is permissible regardless of an anti-assignment clause because once the event triggering the claim occurs, the risk to the insurer does not change).

A few jurisdictions do not permit the assignment of claims post-loss if the policy contains an anti-assignment clause. See *In re Katrina Canal Breaches Litigation Litig.*, 63 So. 3d 955, 964 (La. 2011) (“There is no public policy in Louisiana which precludes an anti-assignment clause from applying to post-loss assignments. However, the language of the anti-assignment clause must clearly and unambiguously express that it applies to post-loss assignments. ~~Thus, and thus it must be evaluated~~ [it is necessary for the . . . court to evaluate the relevant anti-assignment clauses on a policy -by -policy basis- . . .](#)”); *Holloway v. Republic Indemnity Indem. Co. of Am.*, 147 P.3d 329, 335 (Or. 2006) (holding that the anti-assignment clause in a workers’-compensation and employers’-liability policy prohibited the assignment of the “insured’s rights or duties without regard to whether they arose pre-loss or post-loss.”); *Dillingham v. Tri-State Ins. Co.*, 381 S.W.2d 914, 917-919 (Tenn. 1964) (holding that defendants may not assign choses in action against their insurers). For more general discussions of the history of assignments of choses in action, see, e.g., *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 705-711 (Tex. 1996); Walter W. Cook, *The Alienability of Choses in Action*, 29 HARV. L. REV. 816, 816-821 (1916); Kevin Pennell, *On the Assignment of Legal Malpractice Claims: A Contractual Solution to a Contractual Problem*, 82 TEX. L. REV. 481, 483-484 (2003).

c. Assignment of liability insurance rights in mergers and acquisitions. The majority of jurisdictions have found that anti-assignment clauses are not enforceable against post-loss assignments of insurance rights through mergers and acquisitions. 3 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 35:8 (~~2004, updated 2014~~ [3d ed. 2017](#)) (“[T]he great majority of courts adhere to the rule that general stipulations in policies prohibiting assignments of the policy, except with the consent of the insurer, apply only to assignments before loss, and do not prevent an assignment after loss. . . .”); 3-16 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW

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LIBRARY EDITION 2011 § 16.05(2)(c) (Lexis ~~2012~~2017) (“This rule [that anti-assignment clauses do not preclude post-loss assignments] is generally applied to rights under liability insurance policies. . . .”). See, e.g., *Elliot Co. v. Liberty Mutual Insurance Mut. Ins. Co.*, 434 F. Supp. 2d 483, 491 (N.D. Ohio 2006) (applying Delaware, New York, Ohio, Pennsylvania, and Connecticut law) (holding that a purchase agreement could assign former subsidiaries’ coverage for pre-assignment occurrences, even when there was an anti-assignment clause in the policy); *Century Indem. Co. v. Aero-Motive Co.*, 2004 U.S. Dist. Lexis 31180, WL 5642427, at *10, *143 (W.D. Mich. Mar. 12, 2004) (applying Michigan law) (stating that anti-assignment clauses are inapplicable once a claim “amounts to an accrued cause of action against the insurer,” which happens at the occurrence of the events leading to liability); *Viking Pump, Inc. v. Century Indem. Co.*, 2 A.3d 76, 82 (Del. Ch. 2009) (asserting that New York law treats a loss as occurring at the event where the liability arises, such that after that event it can be transferred); *Ill. Tool Works, Inc. v. Commerce & Indus. Ins. Co.*, 962 N.E.2d 1042, 1053 (Ill. App. Ct. 2011) (affirming that for third-party occurrence-based policies, anti-assignment clauses do not prevent the assignment after the loss has occurred, and that the event giving rise to liability is the loss itself); *Arrowood Indem. Co. v. Atl. Mut. Ins. Co.*, 96 A.D.3d 693, 694-695 (N.Y. App. Div. ~~2011~~2012) (stating that the anti-assignment provision is not enforceable as the liabilities, the personal injuries from exposure to products, arose prior to the transfer of insurance benefits); *Pilkington North America N. Am., Inc. v. Travelers Casualty Cas. & Surety Sur. Co.*, 861 N.E.2d 121, 126 (Ohio 2006) (holding that the right to bring an action under an occurrence-based policy arises as soon as the injury occurs, which creates a chose in action, such that the duty to indemnify can be transferred even when there is an anti-assignment clause). California, the most significant jurisdiction to enforce an anti-assignment condition in an asset-purchase context, recently overruled its earlier opinion, ~~adopting and adopted~~ the majority rule. See *Fluor Corporation Corp. v. Superior Court*, 354 P.3d 302 (Cal. 2015) (overruling *Henkel Corp. v. Hartford Accident & Indem. Co.*, 29 Cal. 4th 934, 945, 62 P.3d 69, 76 (2003)).

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

d. Coverage for pre-merger or acquisition liabilities. See, e.g., *Total Waste Mgmt. Corp. v. Commercial Union Ins. Co.*, 857 F. Supp. 140, 150 (D.N.H. 1994) (applying New Hampshire

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law) (holding the successor’s policies “do not provide coverage for an entity which was acquired by the named insured after the expiration of the policies and which entity allegedly caused damage [] during the policies’ periods.”); see also *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 723, 726 (Cal. Ct. App. 1996) (holding the policies did not provide coverage for the acts of the merged company prior to the merger and stating “a corporate acquisition taking place after the policy has expired can have no retroactive effect on the identity of the named insured during the policy period.”); *Caterpillar, Inc. v. Aetna Cas. & Sur. Co.*, 668 N.E.2d ~~1152, 1159-1160~~1152 (Ill. App. Ct. 1996). See generally Michael A. Kotula & Gary D. Centola, *After-Acquired and After-Involved Liabilities in Insurance Coverage Disputes*, 12-9 MEALEY’S LITIGATION REPORT: INSURANCE 8 (Jan. 6, 1998).

TOPIC 3

APPLICATION OF LIMITS, RETENTIONS, AND DEDUCTIBLES

§ 37. Policy Limits

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

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

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

Comment:

a. The function and effect of policy limits. Policy limits allow insurers to manage their exposure in a manner that reduces the cost of insurance by reducing the uncertainty faced by insurers. Policy limits also allow policyholders to choose the amount of liability insurance protection that they are buying. In addition, policy limits reduce the risk of insurer insolvency. These benefits come at a cost, however. The presence of a policy limit means that insureds, and, potentially, liability claimants, bear the risk of judgments in excess of those limits. This risk of excess judgments creates the potential for a conflict of interest between the primary insurer, which often has control over settlement decisions, and the insured and excess insurers. It is this conflict of interest to which the duty to make reasonable settlement decisions is a response. See § 24, Comment *b*. For a discussion of multiple claimants and inadequate policy limits, see § 26.

b. Types of policy limits. Liability insurance policies sold in the United States generally contain some form of policy limit, typically a policy limit that sets the maximum amount that the insurer may be obligated to pay under the policy for a defined circumstance, such as an

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

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

REPORTERS’ NOTES

a. The function and effect of policy limits. The amount of coverage provided by an insurance policy is its policy limits or limit of liability. This term sets an insurer’s maximum obligation to pay under the policy. See [1-1 RANDY MANIHOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE](#) ~~6(2)~~ [KEY ISSUES IN EVERY STATE § 1.02 \(3d ed. 20122015\)](#); [3-16 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW AND PRACTICE LIBRARY EDITION](#) § 16.09[3][a][i] (Lexis ~~2015~~2017). In some circumstances, however, an insurer may be liable for damages in excess of its policy limits, such as when it breaches its duty to defend and the excess amount arose from the breach. See ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 819-820 (5th ed. 2012).

Policy limits are an important term in insurance contracts that limit an insurer’s total risk based on the premiums paid by the policyholder. See *Brohawn v. Transamerica Ins. Co.*, 347 A.2d 842, 851 (Md. 1975) (“The promise to defend the insured, as well as the promise to indemnify, is the consideration received by the insured for payment of the policy premiums.”). Policy limits are commonly written on a per-occurrence basis. In addition, a policy limit may have an “aggregate limit” that represents the total amount the company promises to pay for all occurrences or claims covered by a particular policy. See *Cincinnati Ins. Co. v. Television Eng’g Corp.*, 265 F. Supp. 2d 1078, 1081 (E.D. Mo. 2003) (applying Missouri law) ([internal citations](#)).

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omitted) (“An aggregate limit is [t]he maximum limit of coverage available under a liability policy during a specified period of time . . . regardless of the number of claims that may be made. . . . Its counterpart is the per occurrence limit, which expressly limits the amount to be paid under an insurance policy for liability arising out of each compensable occurrence.”); ~~TOM BAKER & KYLE D. LOGUE, INSURANCE LAW AND POLICY 504-505 (3d ed. 2013).~~

b. Types of policy limits. Ordinarily, the policy limit is a fixed term in an insurance contract. See *Mesmer v. Maryland Auto. Ins. Fund*, 725 A.2d 1053, 1061 (Md. 1999) (“Under the typical liability insurance policy, the insurer has a duty to indemnify the insured, up to the limits of the policy . . . The source of [the] dut[y] is solely the insurance contract.”). See also *Miller v. Lewis*, 21 Pa. D. & C. 684, 685-686, 684 (Pa. C.P. 1934); *De Pasquale v. Union Indem. Co.*, 149 A. 795, 796, 795 (R.I. 1930); ~~LEE R. RUSS & THOMAS F. SEGALLA~~, STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 172:3 (3d ed. 2013, 2017) (“[T]he liability of an insurer and the extent of the loss under a policy of liability and or indemnity insurance must be determined, measured, and limited by the terms of the contract.”) (citing *Vrabel v. Scholler*, 85 A.2d 858 (Pa. 1952)).

The policy language determines whether an insurer’s defense costs contribute towards the policy limits. See generally ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 812-816 (5th ed. 2012) (“In sum, the question of whether an insurer can discharge its duty to defend by fulfilling its duty to indemnify is a confused one.”). Most courts interpreting both the 1966 and 1980s CGL policy language have held the costs of defense do not count against the policy limits. *Id.*; see also 3-17 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW AND PRACTICE LIBRARY EDITION § 17.03 (Lexis 2015, 2017) (“Under most general liability policies, defense costs are not subject to the policy limits.”). However, some general-liability policies, referred to as “self-consuming” or “burning limits,” reduce the policy limits by both the insurer’s indemnity and defense payments. ~~See 3-17 JEFFREY E. THOMAS, APPLEMAN ON INSURANCE LAW AND PRACTICE § 17.03 (Lexis 2015)~~ *Id.*

A policyholder may purchase multiple policies to insure the same risk. Second- and third-level excess policies “stack” additional coverage beginning at the preceding policy’s policy limits. See 1 ~~LEE R. RUSS & THOMAS F. SEGALLA~~, STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 6:35 (3d ed. 2015, 2017) (“In modern business practice, it is common to find that a single insured is covered under two or more different policies of liability insurance, each of which ‘kicks in’ at a different dollar value of liability, with the beginning coverage level of one policy designed to kick in at the maximum policy amount for the next lower level.”).

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

§ 38. Number of Accidents or Occurrences

For liability insurance policies that have per-accident or per-occurrence policy limits, retentions, or deductibles, ~~the number of accidents or occurrences is determined by~~

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~~reference to the cause(s) of the~~all bodily injury, property damage, or other harm ~~that forms the basis for the claim, unless otherwise stated in the policy~~caused by the same act or event constitutes a single accident or occurrence.

Comment:

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

The term “occurrence” itself is typically defined within a general-liability insurance policy to mean “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” Determining the number of accidents or occurrences that have taken place during the policy period is notoriously difficult. From the perspective of the policy limits, the more occurrences there are, the better the result will be for the insured, because the larger the total amount of coverage will be. However, the opposite is true from the perspective of deductibles or retentions: all else equal, the fewer the occurrences, the better the result for the insured will be, because the smaller will be the share of a covered claim that must be borne by the insured. Unfortunately, the question how many “accidents” there were and the question whether all the losses at issue in a given claim were the result of “continuous or repeated exposure to substantially the same general harmful conditions” often has no clear answer. As a result, courts have developed two general doctrinal tests for determining the number of accidents

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or occurrences for purposes of calculating both the number of policy limits and the number of deductibles or retentions that will apply: the “effects test” and the “cause test.”

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

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

The cause test itself takes a number of forms. Some courts and commentators have helpfully organized the various versions of the cause test into two different subtests: the “proximate-cause” or “immediate-cause” test, on the one hand, and the “liability-event” test, on the other. Under the proximate- or immediate-cause test, the court looks to the significant causal actions or events that are most proximate—closest in time and/or space—to the harm to determine the number of occurrences. By contrast, the liability-events test focuses on the cause

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that is within the control of the insured: the act or omission on the part of the insured that would constitute an alleged breach of a duty and thus give rise to a potential tort action. These two versions of the cause test often result in the same number of occurrences, because the alleged negligence of the insured will often also be the most proximate (immediate) cause of the harm.

Although a majority of courts have adopted some version of the cause test for determining the number of occurrences, no single version of that test seems clearly to dominate. Moreover, no version of the cause test generates precise and predictable outcomes across the entire range of cases. Nevertheless, the cause test is generally considered more consistent than the effects test with the reasonable expectations of both insurers and insureds. As with other issues related to the application of insurance- policy language to specific cases, if there are disputed facts, such questions will typically be decided by a jury. If the facts are not in dispute, the court can make as-a-matter-of-law determinations of the number of causes and thus the number of per-occurrence or per-accident policy limits or deductibles to apply in a given case. In making such determinations courts may take into account the structure of the overall insurance program to determine what number of causes is most consistent with the intent of the parties. In such cases, the court should follow the ordinary rules of insurance- policy interpretation, assuming the policy contains standard-form terms, and, to the extent that the policy is ambiguous as applied to the claim at issue, choose the interpretation that favors the insured, unless the insurer persuades the court that this interpretation is unreasonable. See § 4.

Illustrations:

1. A retail store owner has a commercial general-liability insurance policy with a per-occurrence policy limit of \$1 million, a deductible of \$50,000 per occurrence, and no aggregate limit. Wrongly believing that the store is being robbed, the owner takes out a gun and fires a shot over the head of each of the three individuals who the owner believes are involved in the robbery. Because the owner is a poor shot, each of the bullets strikes the individuals in question, who turn out not to be involved in a robbery at all. Each of the three individuals files suit against the owner, alleging three separate negligence actions. There are three occurrences, corresponding to the three alleged acts of negligence by the owner. The maximum

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amount of potential coverage in this case is \$2,850,000: (\$3 million policy limits) – (\$150,000 deductibles).

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

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

There are two reasonable conclusions regarding the number of occurrences. First, one could reasonably conclude that there were four occurrences, corresponding to four acts of negligence: the four shipments of flame retardant. Under this interpretation, the losses associated with each of the four shipments would be aggregated, and the insured would have \$38 million of coverage: (4 x \$10 million

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

REPORTERS' NOTE

a. Determining the number of accidents and occurrences. For commentary on the large implications of the number of occurrences, see ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW ~~§ 65~~[482-489](#) (5th ed. 2012); [1-9](#) RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~ch. § 9~~ (3d ed. 2015). On the World Trade Center, see *World Trade Ctr. Props., LLC v. Hartford Fire Ins. Co.*, 345 F.3d ~~154, 170~~[154](#) (2d Cir. 2003), *aff'd sub nom. SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props., LLC*, 467 F.3d 107, 114 (2d Cir. 2006) (applying New York law) (citing *World Trade Ctr. Props.*, 345 F.3d at 180) ([abrogated by *Wachovia Bank v. Schmidt*, 546 U.S. 303 \(2006\) on different grounds](#)). For another set of insurers, whose obligations were determined to be governed by the standard-policy-form definition of “occurrence,” a jury, taking into account extrinsic evidence, determined that there were two occurrences. Both holdings were upheld on appeal. See *SR Int'l Bus. Ins. Co.*, 467 F.3d 107 (2d Cir. 2006) (applying New York law).

b. The effects test. Most courts analyze the number-of-occurrences issue in terms of the effects test or the cause test. [1-9](#) RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~256~~[§ 9](#) (3d ed. 2015); 3-16 JEFFREY E. THOMAS, [NEW](#) APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.09[3][a][iv] (Lexis ~~2012~~[2017](#)). The effects test derives originally from *Anchor Cas. Co. v. McCaleb*, 178 F.2d 322, 324 (5th Cir. 1949) (exploding oil well damaging many individual properties was an occurrence for each damaged property) and is widely regarded as the minority view. See, e.g., *State Auto Prop. & Cas. Co. v. Matty*, 690 S.E.2d 614, 618 (Ga. 2010) (concluding that the test “[violates/violate\[s\]](#) common sense”).

Tennessee and Louisiana are among the few jurisdictions that still have an effects test. See, e.g., *Lexington Ins. Co. v. St. Bernard Parish Gov't*, Civ. No. 11-1865, 2013 WL 55908, at *8 (E.D. La. [Jan. 3, 2013](#)) motion for relief from judgment denied, Civ. No. 11-1865, 2013 WL 870365 (E.D. La. Mar. 7, 2013) and *aff'd as modified and remanded*, 548 F. App'x 176 (5th Cir.

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2013) (applying Louisiana law) (“In cases in which the injuries at issue were discrete and occurred at different times, courts have followed the holding of [Lombard v. Sewerage and Water Board of New Orleans, 284 So. 2d 905 (La. 1973)] and assessed the number of occurrences from the point of view of the people who experienced damage, *i.e.*, the effects, not the cause, of the occurrence.”); *Am. Modern Select Ins. Co. v. Humphrey*, No. 3:11–CV–129, 2012 WL ~~529576~~, ~~at~~ *~~4~~529576 (E.D. Tenn. Feb. 17, 2012) (applying Tennessee law); *Kuhn’s of Brownsville, Inc. v. Bituminous Cas. Co.*, 270 S.W.2d ~~358~~, ~~360~~358 (Tenn. 1954).

c. The cause test(s). By far the majority rule is that the number of occurrences is based on the relevant “cause” of the damage. See, e.g., *Liberty Mut. Ins. Co. v. Pella Corp.*, 631 F. Supp. 2d ~~1125~~, ~~1135~~1125 (S.D. Iowa 2009). See ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § ~~65~~482-489 (5th ed. 2012); 1-9 RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~ch.~~ § 9 (3d ed. 2015); Michael Murray, Note, *The Law of Describing Accidents: A New Proposal for Determining the Number of Occurrences in Insurance*, 118 YALE L.J. ~~1484~~, ~~1499~~1484 (2009). The cause rule, however, has a number of variations. Application of any subcategory of the “cause” analysis, however, tends to result in fewer occurrences than application of the effects test. See generally *Mitsui Sumitomo Ins. Co. of Am. v. Duke Univ. Health Sys., Inc.*, 509 F. App’x 233 (4th Cir. 2013) (applying North Carolina law). Under the proximate-cause theory, courts consider an event to constitute one occurrence when there was but one proximate, uninterrupted, and continuing cause that resulted in all of the injuries and damage. *Id.* at 239. This approach has been criticized for not leading to consistent results. See, e.g., *Champion Int’l Corp. v. Cont’l Cas. Co.*, 546 F.2d 502, 506 (2d Cir. 1976) (dissent) (applying New York law) (“We agree that the issue is whether in the circumstances indisputably established by the record there has been one or more than one “occurrence” within the meaning of the Liberty Mutual policy. We also agree that this issue can be resolved by the plain meaning of the words in the policy. We reach opposite conclusions as to that plain meaning.”).

Courts that take the proximate-cause view generally follow the lead of *Appalachian Insurance Co. v. Liberty Mut. Ins. Co.*, in which the Third Circuit explicitly adopted the proximate-cause test and found a single occurrence when the insured company was sued for its discriminatory employment policies. 676 F.2d 56, 61 (3d Cir. 1982) (applying Massachusetts law) (“As long as the injuries stem from one proximate cause there is a single occurrence.”). These courts “tend to look to the direct, physical cause of the injuries as being the yardstick for measuring whether the claims had a common origin.” Michael F. Aylward, *Twin Towers: The 3.6 Billion Question Arising From the World Trade Center Attacks*, 69 DEF. COUNS. J. 169, 172 (2002). Even within the proximate-cause view there is some inconsistency, as courts sometimes look to more “direct, immediate” causes, while other times looking deeper for “single, underlying” causes or more “remote” causes. Cf. *Diocese of Winona v. Interstate Fire & Cas. Co.*, 858 F. Supp. 1407, 1422 (D. Minn. 1994), *aff’d in part, rev’d in part on other grounds*, *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386 (8th Cir. 1996) (applying Minnesota law) (finding a single occurrence when sexual abuse by a priest spanned 20 years and

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six victims, which parties agreed to) with *State Farm Fire & Cas. Co. v. Elizabeth N.*, 9 Cal. App. 4th 1232, 1236 (Cal. Ct. App. 1992) (finding a separate occurrence for each victim of sexual abuse in a day care, but not for each act of abuse).

Under the liability-events causal test, courts look at the insured's act or omission that allegedly constitutes a breach of a duty to the claimant, rather than at the most "direct" or "immediate" causes of the injury that are outside the insured's control. An example of this type of analysis, though one that does not use the term "liability event test," is *Donegal Mutual Mut. Insur. Co. v. Baumhammers*, 938 A.2d 286 (Pa. 2007). In this case, the insureds' son shot and killed a number of people in different locations over a two-hour period. Using the cause test, the court concluded that there was one occurrence, because the relevant cause was the insureds' negligent failure to confiscate the son's weapon or notify authorities of his unstable condition. Maniloff and Stempel characterize the *Baumhammers* case as "a typical example of a court adopting the 'cause' test." 1-9 RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE 256-257§ 9 (3d ed. 2015). To illustrate the difference between the liability-event causal test and the proximate-cause test, contrast *RLI Ins. Co. v. Simon's Rock Early Coll.*, 756765 N.E.2d 247, 251 (Mass. App. Ct. 2002) ("We conclude that when the issue is the number of occurrences, we must look to the 'cause' of the injury by reference to the conduct of the insured for which coverage is afforded, and that 'cause' and 'occurrence' are indistinguishable for purposes of this analysis.") with *Koikos v. Travelers Ins. Co.*, 849 So. 2d 263, 271 (Fla. 2003) ("We conclude, consistent with the 'cause theory,' that in the absence of clear language to the contrary, when the insured is being sued for negligent failure to provide security, 'occurrence' is defined by the immediate injury-producing act and not by the underlying tortious omission."). Another jurisdiction applying the liability-event causal test is *Pennsylvania. Cincinnati Ins. Co. v. Devon Int'l, Inc.*, 924 F. Supp. 2d 587, 590-592 (E.D. Pa. 2013) (applying Pennsylvania law).

New York applies a unique, "unfortunate-events" test, which determines the number of occurrences by viewing the number of "unexpected events" that result, seen from the standpoint of the ordinary person. The leading case is *Arthur A. Johnson Corp. v. Indem. Ins. Co. of N. Am.*, 164 N.E.2d 704, 707 (N.Y. 1959), finding two occurrences when two walls on the same property collapsed during a single storm. Commentators have struggled to categorize this approach. Some view the "unfortunate-events" test as a variation of the liability-event view that simply employs different terminology. See, e.g., Murray, *supra*. Others consider it an entirely separate doctrine. See generally 2010-42 Sarah E. Millin & Robyn L. Anderson, *Issues as to Number of Occurrences under Comprehensive General Liability Policies*, NEW APPLEMAN ON INSURANCE: CRITICAL ISSUES IN INSURANCE LAW (Lexis, Spring 2010, updated 2017). A more recent application of the unfortunate-events test is *Appalachian Ins. Co. v. General Electric Gen. Elec. Co.*, 863 N.E.2d 994, 999-1000 (N.Y. 2007) (rejecting arguments made by the policyholder that all claims arising out of exposure to any asbestos-containing product manufactured by the policyholder should be deemed a single occurrence, concluding instead that each claim constituted a separate occurrence).

Ch. 3. General Principles Regarding the Risks Insured§ 39**§ 39. Excess Insurance: Exhaustion and Drop Down**

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

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

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

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide coverage in the place of the underlying insurer.

Comment:

a. Scope. This Section addresses true excess insurance policies, which are purchased as part of a layered insurance program. The rules in this Section do not apply to policies that are considered to be excess by virtue of the operation of “other insurance” clauses. See § 20 (rules governing circumstances in which multiple insurers have a duty to defend a legal action); and § 42 (rules governing contribution among multiple insurers whose indemnification or defense obligations are triggered).

b. The nature and function of excess liability insurance. Policyholders facing substantial liability risk often purchase multiple layers of liability insurance coverage. Such policyholders often purchase a layer of “primary” coverage from one insurer and one or more “excess” layers of coverage from other liability insurers. This structure of liability insurance coverage, sometimes referred to as a “tower” of coverage, permits policyholders to insure large amounts of liability risk without relying on the solvency of any single insurer. Structuring liability insurance in layered towers also permits insurance companies to specialize in particular levels of coverage and to manage their exposure to the risk of any single insured. When liability insurance is structured in layered towers, a lower level of insurance that must be paid out before a higher layer

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of coverage is obligated to pay is referred to as the “underlying insurance.” Primary insurance is the term typically given to the lowest level of liability coverage. “Umbrella” insurance is a special type of excess insurance that, unlike generic excess insurance, drops down to fill gaps left by underlying insurance in specified circumstances. Umbrella insurance also sometimes covers risks not covered by the underlying policy.

Because excess insurance policies are expected to provide coverage only after the lower-level policies or underlying policies are exhausted, excess policies are priced differently from lower-level insurance policies. The company that issues the primary insurance policy is much more likely than the excess insurer to be called upon to defend a suit brought against an insured or to settle a suit, simply because of the statistical regularity that small claims are more frequent than large claims. As a result, premiums for excess insurance are lower on average than premiums for lower-level insurance. For this division of function among primary and excess insurers to work, however, excess insurers must know that their policies will not be called on to pay judgments, settlements, or defense costs until the underlying limits have been paid out, or will with certainty be paid out, by someone. In other words, the layered structure and pricing of insurance depends upon what are known in insurance trade practice as “exhaustion” requirements in excess policies.

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

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make the payment, a credit from the third-party claimant can take the place of a payment by the insured, but in such cases the reasonableness of the settlement should be scrutinized so that the purpose of the exhaustion requirement is not thereby evaded.

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

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

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

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These are valid concerns. That is why the rule in this Section is merely a default rule. If policyholders and excess insurers determine that the “case vetting” benefits of tying exhaustion to the payment by the underlying insurers of the full policy limits are essential, the parties can alter the default rule set forth in this Section simply by including a provision in the excess policy similar to the following: (1) “Liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits,” or (2) “Coverage under this policy shall attach only after the full amount of the underlying limits has been paid by the underlying insurers.” Some liability insurance policies already contain such language in their exhaustion clauses, and courts have typically enforced those terms, recognizing that such terms are subject to the normal rules applicable to insurance policy provisions, such as those relating to creation, interpretation, satisfaction, excuse, frustration, and waiver of conditions. In light of the importance of such language, an insurance broker’s duty of reasonable care may require the broker to advise a customer of the presence of such a term and the consequences thereof and to present an alternative excess-insurance program that does not contain such a term.

Illustrations:

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

Primary and Excess reserve their rights based on an exclusion in their policies. Insured has the opportunity to settle the underlying suit with the claimants for \$14 million. Company seeks consent from the insurers to settle the suit. The insurers refuse to grant consent but agree not to raise the failure to obtain their consent as grounds for non-payment. Company then settles for \$14 million and seeks reimbursement from Primary for \$10 million and from Excess for \$4 million. (Assume that the defense costs paid by Company are equal to the amount of the Company’s retention in the Primary

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policy.) Company settles with Primary for \$7 million. Because the exhaustion term in the Excess policy is ambiguous with respect to whether payments must be made by insurer or whether instead payments made by insured also count toward the exhaustion requirement, exhaustion is governed by the default rule in this Section. If Company prevails against Excess with respect to coverage, Excess will be obligated to pay \$4 million of the settlement.

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

“Excess Insurer shall be liable to make payment under this policy only after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder.”

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

e. The no-drop-down default rule. Under the rule stated in subsection (3), the exhaustion requirement applies even if an underlying insurer becomes insolvent. Thus, if an underlying insurer becomes insolvent before it pays out the full underlying policy limit, the excess insurer has no obligation to pay until the insured or some other party pays the remaining amount of the policy limit in settlements, judgments, or related costs. The no-drop-down rule, implicit in subsection (1) and explicit in subsection (3), is consistent with the rule that has been adopted in the substantial majority of jurisdictions. In defense of this rule, courts often note that the alternative rule would make excess insurers, in effect, responsible for monitoring and insuring the solvency of underlying insurance carriers. This same observation is sometimes used in support of a drop-down rule, since excess insurers may be better at monitoring the business practices of another insurer than the average liability policyholder is. Indeed, there is evidence that, when excess insurers price their policies, they take into account various facts about the underlying insurer, including the likelihood of insolvency. Nevertheless, the excess insurer does not choose the underlying insurer. In fact, the party most responsible for “assembling the tower”

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of liability coverage, at least in commercial settings, is the insurance broker. If the broker determines that the underlying insurer poses a serious risk of insolvency, then the insurance broker's duty of reasonable care may require the broker to advise the policyholder to purchase underlying coverage from a different insurer or, alternatively, to insist that the excess policy include an express drop-down provision. In any event, the no-drop-down default rule can be altered, and in some excess liability insurance policies is altered, by language in the excess policy expressly stating that the excess insurance drops down in the event of insolvency of the underlying insurer. For example, courts have generally held that, when excess policies are written specifically to be excess over "amounts collectible" or "amounts recoverable" from the underlying policy, such language obligates the excess insurer to drop down in the event of the insolvency of the underlying insurer.

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b. The nature and function of excess liability insurance. For a general discussion of the nature and function of excess liability insurance, see 15 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 220:32 (3d ed. ~~2012~~2017). ("Both true excess and umbrella policies require the existence of a primary policy as a condition of coverage."); 4-24 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 24.02 (Lexis ~~2012~~2017). See also *Fireman's Fund Ins. Co. v. Md. Cas. Co.*, 77 Cal. Rptr. 2d 296, 311 (Cal. Ct. App. 1998) (internal citations omitted) ("'Excess' coverage means 'coverage whereby, *under the terms of the policy*, liability attaches only after a predetermined amount of primary coverage has been exhausted.'"); ~~National~~ (*italics in original*); Nat'l *Union Fire Ins. Co. v. Glenview Park Dist.*, 594 N.E.2d 1300, ~~1307~~1306 (Ill. App. Ct. 1992) ("[T]he excess liability coverage obligated [excess insurer] 'to pay . . . all sums which the Insured shall become obligated to pay as . . . covered by the Primary Policy', but only in excess of the primary policy's limits. This type of coverage constitutes traditional 'excess' coverage."), *aff'd in part, rev'd in part on other grounds*, *Nat'l Union Fire Ins. Co. of Pittsburgh, Pennsylvania v. Glenview Park Dist.*, 632 N.E.2d 1039 (Ill. 1994); *Archunde v. Int'l Surplus Lines Ins. Co.*, 905 P.2d 1128, 1129 n.1 (N.M. Ct. App. 1995) ("An excess liability insurance policy is a policy 'designed to protect against catastrophic loss and intended to "kick-in" only at large dollar-amounts of liability.'"), quoting Lisa K. Gregory, Annotation, "*Excess" or "Umbrella" Insurance Policy as Providing Coverage for Accidents With Uninsured or Underinsured Motorists*, 2 A.L.R.5th 922, 932 n.1 (Originally published in 1992); ~~United States~~ U.S. *Fid. & Guar. Co. v. Federated Rural Elec. Ins. Corp.*, 37 P.3d 828, 831 (Okla. 2001) ("An excess insurance policy is one which by its terms provides coverage that is secondary to the primary coverage; there is usually no obligation to the insured until after the primary coverage limits have been exhausted.").

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c. The exhaustion default rule. For the idea that some sort of exhaustion requirement is typically found in an excess insurance policy, see *Barrett v. Chin*, 843 F. Supp. 783, 787 (D. Mass. 1994) (applying Massachusetts law) (“[E]xcess policies, attach[] only in excess of underlying insurance. Liability commences only when all underlying insurance is exhausted.”); *State Farm Mut. Auto. Ins. Co. v. Cramer*, 857 P.2d 751, 754 (Nev. 1993) (“An excess insurer becomes liable once the primary insurer’s policy limits have been exhausted.”); ~~JEFFREY E. THOMAS~~¹⁵ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, *COUCH ON INSURANCE* § 220:32 (3d ed. ~~2011~~²⁰¹⁷) (“[I]t is only after the underlying primary policy has been exhausted does the excess or umbrella coverage kick in.”); see also *Inst. for Shipboard Educ. v. Cigna Worldwide Ins. Co.*, 22 F.3d 414, 426 (2d Cir. 1994) (applying Pennsylvania law) (“[T]rue umbrella policy will be triggered only after all other excess policies have been exhausted.”); *Occidental Fire and Cas. Co. of North Carolina v. Brocius*, 772 F.2d 47, 54 (3d Cir. 1985) (applying Pennsylvania law) (“[P]rimary policies or policies with excess clauses must be exhausted before the carrier of an umbrella policy is required to pay.”); *Sharp Realty & Mgmt., LLC v. Capitol Specialty Ins. Corp.*, No. CV-10-AR-3180-S, 2012 WL 2049817, at *~~17~~¹⁶, n.7 (N.D. Ala. May 31, 2012) (applying Alabama law) (true excess-insurance carrier has no obligation to do anything for insured until such time as primary policy is exhausted); *C.B. Fleet Co. v. Aspen Ins. UK Ltd.*, 743 F. Supp. 2d 575, ~~583~~⁵⁷⁸ (W.D. Va. 2010) (“in [] multi-layer insurance arrangement, any insurer that issued a policy in “excess” of the primary policy would only become liable after primary insurer’s coverage, as well as that of any underlying excess insurers, was exhausted.”); *Reliance Nat’l Indem. Co. v. Gen. Star Indem. Co.*, 85 Cal. Rptr. 2d 627, 638-639 (Cal. Ct. App. 1999) (“[A]n excess insurer does not accept premiums with the knowledge that it will be called upon to satisfy a full judgment.”).

d. Counting payments by insureds toward exhaustion is merely a default rule. The two major questions in exhaustion cases are whose payments count towards exhaustion of the underlying limit and what form that payment must take. Some commentators have concluded that the prevailing rule is one that is consistent with the rule followed in this Section. See, e.g., ~~4-24~~ JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 24.02[2][b] (Lexis ~~2012~~²⁰¹⁷) (“As a general rule, payments of the underlying limits from any sources count toward exhaustion.”); see also *Waste Mgmt. of Minn., Inc. v. Transcont’l Ins. Co.*, 502 F.3d ~~769~~⁷⁷³⁻⁷⁷⁴~~769~~ (8th Cir. 2007) (applying Minnesota law). Many of the courts that have adopted a *Zeig*-based interpretation of exhaustion terms have used some combination of *contra proferentem* and public-policy doctrine, including the *Zeig* court itself. That is, courts that have favored the *Zeig* interpretation have often relied both on the fact that the term is ambiguous (and thus likely to be construed in favor of the insured) and on the fact that, because counting insured payments towards exhaustion tends to favor settlement and usually does little harm to the excess insurer, public policy favors the insured’s position. See, e.g., *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 658-659 (7th Cir. 2010) (applying Indiana law) (adopting the *Zeig* approach and reasoning that the excess insurer is not adversely affected by this construction of their ambiguous policy and that Indiana’s public policy favors an interpretation that encourages

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settlement); *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665, 666 (2d Cir. 1928) (“A result harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it.”); *Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998, 999-1000 (Fla. Dist. Ct. App. 2001) (holding that public-policy interests require an interpretation of the ambiguous language that encouraged settlements). However, when unambiguous language in the exhaustion term in the policy clearly requires that policy limits be paid by the underlying insurer or insurers, courts have enforced that language, reasoning that the public-policy interest favoring settlements cannot override a contract’s plain meaning. See, e.g., *Ali v. Fed. Ins. Co.*, 719 F.3d 83, 94 (2d Cir. 2013) (applying New York and Pennsylvania law) (interpreting the plain language of the relevant excess insurance policies reading “payment of losses” as requiring actual payment of losses, not merely the accrual of *liability*); *Goodyear Tire & Rubber Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 694 F.3d 781, 782 (6th Cir. 2012) (applying Ohio law) (holding a clear and unambiguous contract outweighed public-policy interests); *Citigroup Inc. v. Fed. Ins. Co.*, 649 F.3d 367, 372-374 (5th Cir. 2011) (applying Texas law) (relying on the plain language of the contracts); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (applying Michigan law) (observing that *Zeig* allowed for parties writing such a condition into the contract); *Qualcomm, Inc. v. Certain Underwriters At Lloyd’s, London*, 73 Cal. Rptr. 3d 770, 776-778 (Cal. Ct. App. 2008) (holding that explicit exhaustion clause meant that excess insurer was not obligated to pay if the insured settled with the underlying insurer for less than the policy limits); *Quellos Grp. LLC v. Fed. Ins. Co.*, 312 P.3d 734, 741-743, 734 (Wash. Ct. App. 2013). See also 4-24 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 24.02[2][b] (Lexis ~~2012~~2017) (“~~C]ourts~~Courts generally enforce an express requirement of *actual payment* of full underlying limits.”). For criticism of the rule followed in this Section, see Jeffrey W. Stempel, *An Analytic “Gap”: The Perils of Relentless Enforcement of Payment-By-Underlying-Insurer-Only-Language in Excess Insurance Policies*, 52 TORT TRIAL & INS. PRACTICE LAW J. 807 (2017).

Courts have not addressed the question of whether the *Zeig* rule should be mandatory when the underlying insurer is not available to pay a claim or contribute to a settlement because of insolvency. As a doctrinal matter, the question would be phrased as whether the insured’s failure to satisfy the payment-by-insurer condition should be excused. One approach would be to use a disproportionate-forfeiture analysis similar to that followed in the context of notice-of-claim and cooperation conditions, the satisfaction of which is routinely excused. See §§ 30, 34, and 35.

e. The no-drop-down default rule. With most excess liability insurance policies, the drop-down question is addressed expressly in the excess policy, one way or the other. If there is a provision requiring the excess insurer to drop down under certain circumstances (such as if the underlying insurer should become insolvent), those terms are enforced. Compare *Hocker v. N.H. Ins. Co.*, 922 F.2d 1476, 1481-1483 (10th Cir. 1991) (applying Wyoming law) (holding that the excess insurer had a duty to drop down and defend), with *Ticor Title Ins. Co. v.*

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~~Employers~~Emp'rs Ins. of Wausau, 48 Cal. Rptr. 2d 368, 374 (Cal. Ct. App. 1995) (holding that excess insurer was not obligated to drop down and defend). However, in the absence of any policy language addressing the question, the majority rule, as mentioned in the Comment, is consistent with the rule followed in this Section: the excess insurer is not required to drop down. See, e.g., Hartford Accident & Indem. Co. v. ~~Chicago~~Chi. Housing Auth., 12 F.3d ~~92, 95-96~~92 (7th Cir. 1993) (applying Illinois law); Revco D.S., Inc. v. Gov't ~~Employees~~Emps. Ins. Co., 791 F. Supp. 1254, 1264-1269 (N.D. Ohio 1991), quoting Wurth v. Ideal Mut. Ins. Co., 34 Ohio App. 3d 325, 518 N.E.2d 607 (Ohio Ct. App. 1987) (applying Ohio law) (“~~[T]~~To adopt, due to public policy, a theory of ‘drop down’ liability would fundamentally alter the risk an excess coverage provider is obligated to provide by agreeing to issue excess liability insurance protection. Therefore, we hold ‘drop down’ liability protection should not be judicially imposed on Ohio excess insurance providers as a matter of public policy.”); Highlands Ins. Co. v. Gerber ~~Products~~Prods. Co., 702 F. Supp. 109, 112 (D. Md. 1988) (applying Maryland law) (“[E]xcess carriers ordinarily are not required to provide drop-down coverage in the event of the insolvency of an underlying insurer.”); Vickodil v. Lexington Ins. Co., 587 N.E.2d 777, 780 (Mass. 1992) (holding that where the policy language says nothing about the excess-coverage lower limit dropping below the specified attachment point, there is no basis to hold that it drops down). See generally ~~LEE R. RUSS & THOMAS F. SEGALLA~~14 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 200:44 (3d ed. ~~2011~~2017); ~~4-24~~ JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 24.06 (Lexis ~~2012~~2017).

§ 40. Indemnification from Multiple Policies: The General Rule

(1) When more than one insurance policy provides coverage to an insured for a legal action, the insurers are independently and concurrently liable ~~to the insured~~ under their policies, subject to the limits of each policy, except as otherwise provided in subsection (2) and § 41.

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

(3) When ~~multiple insurers have~~ more than one insurer has a duty to defend an insured, the insurers’ defense obligations are governed by § 20.

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Comment:

a. Multiple triggered policies. Multiple liability insurance policies can be triggered with respect to a single claim or underlying cause of action. See § 33 for a discussion of trigger of coverage. This can happen when multiple policies cover a particular loss or occurrence within a single policy period. Such overlapping policies are sometimes referred to as “concurrent policies.” Multiple policies also can be triggered by harm or activity that takes place over multiple policy periods. Such policies are sometimes referred to as “successive policies.” This Section recognizes the insurer’s independent, concurrent liability as the general default allocation rule, subject to the exception in § 41 for claims in which multiple successive policies are triggered by continuing or repeated harm for long-tail claims. For the latter claims, the default allocation rule is pro rata by years, as stated in § 41.

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

Independent, concurrent liability is the prevailing default rule across the United States in the case of concurrent policies. Courts uniformly analyze coverage from multiple concurrent policies by considering whether there are terms in the insurance policies that purport to create an order of priority of payment among the policies—typically referred to as “other insurance”

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clauses—and, if so, whether to enforce those terms. This approach treats independent, concurrent liability as the default rule because that is the rule that applies unless there is a term in the insurance policy that provides to the contrary.

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

Illustrations:

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

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

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

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

The insurance afforded by this policy is primary insurance, except when otherwise stated. If the insured has other insurance against a loss covered by this policy, the company shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

The hospital’s policy has the following term:

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

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

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

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Illustration:

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

This insurance policy does not apply to any liability for such loss as is covered on a primary, contributory, excess, or any other basis by insurance issued by another insurance company.

Because a literal interpretation of both allocation terms would leave the insured with no coverage for the liability in question, the terms are ignored and the two insurers share the indemnification obligations on an independent and concurrent basis, up to the limits of the policies.

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

REPORTERS' NOTE

a. Multiple triggered policies. For a general discussion of the circumstances in which concurrent coverage can arise, see 15 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 217:1 (3d ed. ~~2014~~ 2017) (“Circumstances may be such as to result in there being concurrent coverage of the insured by two [or more] different insurers. This may occur where the insured intentionally obtained more than one primary policy covering the same risk, where an insured inadvertently obtained more than one policy covering the same risk, as where he or she falsely believed that a policy terminated and purchased a ‘replacement’ policy, or where the insured is an ‘other insured’ under a policy issued to a different named insured.”). Early cases confronting the issue of concurrently issued insurance policies include, e.g., *Globe & Rutgers Fire Ins. Co. v. Alaska-Portland Packers’ Ass’n*, 205 F. 32, 34 (9th Cir. 1913) (“Concurrent insurance is that which to any extent insures the same interest, against the same casualty, at the same time, as the primary insurance, on such terms that the insurers would bear proportionally the loss happening within the provisions of both policies. It is this last quality, of sharing proportionally in the loss,

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that distinguishes concurrent insurance from mere double insurance.”) (quoting *New Jersey Rubber Co. v. Commercial Union Assur. Co. of London*, 46 A. 777, 778 (N.J. 1900)); *E. Tex. Fire Ins. Co. v. Blum*, 13 S.W. 572, 576 (Tex. 1890) (“To be concurrent, the insurance must operate at the same time, upon the same property, and look to the indemnity of the insured in case of its loss or destruction from casualty insured against.”). For recent cases that deal with the problem of concurrent coverage, see, e.g., *Penton v. Hotho*, 601 So. 2d 762, 765 (La. Ct. App. 1992) (“[C]oncurrent insurance policies (i.e. two or more primary policies or two or more excess policies) or non-concurrent policies (i.e. a primary policy and a true excess policy.”); *Nesheim v. Iowa Mut. Ins. Co.*, 305 N.W.2d 320, 321 (Minn. 1981) (“[Insurance](#)[Insurance](#) policies are not concurrent unless they are on the same property, the same interest in the property, in favor of the same party, and against the same risks.”) (citing *Nobbe v. Equity Fire Insurance Co.*, 297 N.W. 349 (Minn. 1941)).

b. Independent, concurrent liability as the general default allocation rule. For courts recognizing independent, concurrent liability for concurrent policies, see, e.g., *Ranallo v. Hinman Bros. Const. Constr. Co.*, 49 F. Supp. 920, 925 (N.D. Ohio 1942), *aff’d sub nom. Buckeye Union Cas. Co. v. Ranallo*, 135 F.2d 921 (6th Cir. 1943) (applying Ohio law) (holding that without contrary language, two policies that insure against the same loss “constitute co-insurance for the same liability”); *Fid. & Cas. Co. of New York v. Fireman’s Fund Indem. Co.*, 100 P.2d 364, 366 (Cal. Dist. Ct. App. 1940) (recognizing that when two companies insure the same risk, they are cosureties to that risk); *Penton v. Hotho*, 601 So. 2d 762, 764 (La. Ct. App. 1992) (recognizing two policies’ independent, concurrent liability obligations when there was “no question” that the policies were in effect and provided coverage at the same time); *Hanover Fire Ins. Co. v. Brown*, 25 A. 989, 991 (Md. 1893) (explaining that when more than one insurer issues a policy to cover the same loss, each insurer owes indemnification that is equal and concurrent to the amount owed by the other insurers); *Commercial Cas. Ins. Co. v. Knutsen Motor Trucking Co.*, 173 N.E. 241, 242 (Ohio [Ct. App.](#) 1930) (“[W]here two or more parties become liable for the same obligation . . . as between themselves they are cosureties. . . . each or both are liable and may be sued . . . and a judgment against one does not bar the right to a judgment against the other.”). See also *Restatement Second, Contracts* § 289 (AM. LAW INST. 1981) (“Where two or more parties to a contract promise the same performance to the same promisee, each is bound for the whole performance thereof.”). For a discussion of independent, concurrent liability for defense obligations, see generally sources cited in the Reporters’ Note to § 20.

c. Altering the default rule. For a general overview of the case law dealing with “other insurance” clauses, see ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 700-716 (5th ed. 2012); 3-22 JEFFREY E. THOMAS, *APPLEMAN ON INSURANCE LAW LIBRARY EDITION* § 22.02[1] (Lexis ~~2012~~2017) (“Other insurance’ situations arise where two or more insurers provide concurrent coverage for the same risk at the same level. . . . ‘Other insurance’ issues arise only as to multiple policies on the same level, and not as to the relationship between, for example, a primary and excess policy.”); see also *Contrans, Inc. v. Ryder Truck Rental, Inc.*, 836 F.2d 163, 166 (3d Cir. 1987) (applying Pennsylvania law)

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("[T]here are three general types of 'other insurance' clauses—excess, pro rata and escape. Excess insurance 'kicks in' to provide additional coverage once the policy limits of other available insurance are exhausted. Pro rata provisions allocate financial responsibility between concurrent policies based upon the percentage of coverage each policy bears to the net amount of coverage under all applicable policies. An escape clause attempts to release the insurer from all liability to the insured if other coverage is available."); *N. River Ins. Co. v. Am. Home Assurance Co.*, 257 Cal. Rptr. 129, ~~134~~[132](#) (Cal. Ct. App. 1989) ("An 'other insurance' dispute can only arise between carriers on the same level, it cannot arise between excess and primary insurers.") (citing *Olympic Ins. Co. v. Employers Surplus Lines Ins. Co.*, ~~126 Cal. App. 3d 593, 598~~, 178 Cal. Rptr. 908, 911 (Cal. Ct. App. 1981)); *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116, 1121 (N.J. 1998) ("'[O]ther insurance' clauses . . . [are] provisions typically designed to preclude a double recovery when multiple, concurrent policies provide coverage for a loss."); Douglas R. Richmond & Darren S. Black, *Expanding Liability Coverage: Insured Contracts and Additional Insureds*, 44 DRAKE L. REV. 781, 820 (1996) ("In order for courts or insurers to allocate liability according to other insurance clauses, concurrent policies must cover the same interest.").

Most courts attempt to reconcile the language of multiple other-insurance clauses in overlapping concurrent policies. See generally 3-22 JEFFREY E. THOMAS, [NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 3-2222.02\[3\]\[a\]](#) (Lexis ~~2012~~[2017](#)) ("When 'other insurance' clauses first became prevalent in the 1940s, courts grappled with their application. . . . Courts increasingly rejected theories that were not tied to the language of the 'other insurance' clauses, resulting in a majority approach under which courts attempt to reconcile the applicable clauses of the conflicting policies to give effect to the intention of all parties.") (citing *Putnam v. New Amsterdam Cas. Co.*, 269 N.E.2d 97, 101 (Ill. 1970)) ("Of the six possible combinations of the three basic clauses, three combinations find identical clauses in conflict. . . . [A]nd thus identical clauses are deemed incompatible. Most cases do not involve identical clauses, however; when the conflict between clauses is escape v. excess, Pro rata v. escape, or Pro rata v. excess, as here, the majority of jurisdictions reconcile the conflict by giving effect to one clause and finding the other to be inapplicable. . . ."). See also *Jones v. Medox, Inc.*, 430 A.2d 488, 491 (D.C. 1981) ("Most courts attempt to reconcile dissimilar 'other insurance' clauses by giving effect to the intent of the parties through an examination of the language of the clauses whenever possible."); *Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch.*, 444 S.W.2d 583, 587 (Tex. 1969) (collecting cases). For contrary authority, see *Werley v. U.S. Auto. Ass'n*, 498 P.2d 112, 114 (Alaska 1972); *Sloviaczek v. Estate of Puckett*, 565 P.2d ~~564, 568~~[564](#) (Idaho 1977); *Ky. Nat'l Ins. Co. v. Empire Fire & Marine Ins. Co.*, 919 N.E.2d ~~565, 599-600~~[565](#) (Ind. Ct. App. 2010); *Lamb-Weston, Inc. v. Oregon Auto. Ins. Co.*, 341 P.2d ~~110, 118-120~~[110](#) (Or. 1959).

d. When an allocation term in one policy cannot be harmonized with an allocation rule in another. For a general discussion of how courts have handled conflicting allocation terms, see 7 ~~LEE R. RUSS & THOMAS F. SEGALLA~~[STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 98:19 (3d ed. ~~2011~~[2017](#)) ("In addressing the

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problem of conflicting other insurance clauses, the rule adopted by the majority of jurisdictions is that the ‘other insurance’ clauses are mutually repugnant. When this occurs, the courts disregard the clauses, and the claimant is entitled to recover up to the full coverage afforded by both policies. Some courts have held that where two policies cover the same occurrence and both contain ‘other insurance’ clauses, the clauses are mutually repugnant and must be disregarded. Each insurance company will then be liable for a pro rata [share] of the settlement or judgment. This is the general rule throughout the country.” (internal citations omitted).

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

e. No additional allocation to the insured. See generally 15 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ [STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT](#), COUCH ON INSURANCE § 219:1 (3d ed. ~~2011~~2017) (“‘Other insurance’ clauses govern the relationship between insurers, they do not affect the right of the insured to recover under each concurrent policy.”); Susan Randall, *Coordinating Liability Insurance*, 1995 WIS. L. REV. 1339, 1353 n.48 (1995) (explaining that “other insurance” clauses do not apply to policyholders and are included in insurance policies only because there is no contractual vehicle in which to define how to apportion liability among insurance companies.); Douglas R. Richmond, *Issues and Problems in “Other Insurance,” Multiple Insurance, and Self-Insurance*, 22 PEPP. L. REV. 1373, 1380-1381 (1995):

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

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See also *Am. Family Mut. Ins. Co. v. Regent Ins. Co.*, 846 N.W.2d 170, ~~188~~189 (Neb. 2014) (“[C]ontribution in a concurrent insurer scenario is a right of the insurer flowing from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. It is a right independent of the rights of the insured.”).

§ 41. Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies

(1) Except as stated in subsection (2), when indivisible harm occurs over multiple ~~years~~ policy periods, the amount of any judgment entered in or settlement of any liability action arising out of that harm is subject to pro rata allocation under occurrence-based liability insurance policies as follows:

(a) For purposes of determining the share allocated to an occurrence-based liability insurance policy that is triggered by harm during the policy period, the amount of the judgment or settlement is allocated equally across years, beginning with the first year in which the harm occurred and ending with the last year in which the harm would trigger an occurrence-based liability insurance policy; and

(b) An insurer’s obligation to pay for that pro rata share is subject to the ordinary rules governing any deductible, self-insured retention, policy limit, or exhaustion terms in the policy.

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

(3) Defense obligations relating to multiple triggered policies are subject to the rules in § 20.

Comment:

a. The special case of long-tail harm. Liability claims for long-tail harm present difficult issues of contract interpretation and application for occurrence-based commercial general-liability (“CGL”) insurance policies as well as for other similarly worded insurance policies. As discussed in Comment *f* of § 33, the term “long-tail harm” describes indivisible harm, whether bodily injury or property damage, that is attributable to continuous or repeated exposure over time to the same or similar substances or conditions or that has a long latency period.

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b. Divisible harm. The rule in this Section addresses allocation in liability claims involving indivisible harm. For liability claims involving divisible harm, courts generally will attempt to allocate among the policy periods according to the actual injury or harm that occurred during the policy period even if the total harm occurred over a long period of time. For example, in some toxic-tort cases, courts have allocated harm among policy periods and thus among multiple triggered insurers based on the relative amount of harm that occurred, or the relative volume of the injuring substance that was released, in each period.

c. Theories of allocation for long-tail harms. Once the trigger question has been decided in a long-tail harm claim (see § 33, Comment *f*), the question arises how to allocate the amount of any settlements or judgments arising out of that claim among the triggered policies and, to the extent the insured does not have coverage for part of the triggered period, to the insured. Courts have developed two general approaches to this allocation question when applying occurrence-based liability insurance policies: the “all sums” approach and the “pro rata” approach. Under the all-sums approach, the insured may recover from any of the triggered policies for the full amount of that policy’s coverage limits. The insurance case law uses the term “all sums” to refer to this approach because one of the justifications commonly provided for this approach is the presence of the words “all sums” in the insuring agreement of the version of the standard commercial general-liability insurance policy at issue in the cases that have adopted this approach. The contrary, pro rata approach adopted as the default rule in this Section is sometimes referred to as the pro rata by years or “time on the risk” approach. Under this method of allocation, courts allocate the amounts paid to claimants in long-tail liability actions equally across all triggered years, beginning with the first year in which harm occurred and ending with the last year in which harm triggered an occurrence-based policy, including years for which the insured does not have liability insurance coverage.

The all-sums approach is also sometimes referred to as the joint-and-several liability approach, because it is analogous to joint and several liability in tort, with the obvious difference being that, under the all-sums approach no insurer can be held responsible for more than the applicable policy limit (unless there is a breach of the duty to make reasonable settlement decisions or a violation of the duty of good faith and fair dealing). Under the most common all-sums approach—sometimes called the all-sums-with-stacking approach—an insured may seek recovery from one triggered insurer until the limits of that policy are exhausted, then seek

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recovery from another triggered insurer until the limits of that policy are exhausted, and so on, until either the claim is fully paid or the limits of all the triggered policies are exhausted. Under this approach, the insured becomes responsible for the costs of covered claims only after all triggered policies have exhausted their policy limits (ignoring deductibles and self-insured retentions). Under this approach, the risk of uninsured years is borne by the triggered insurers, subject to those insurers' policy limits.

Under the pro rata rule, by contrast, the maximum amount that an insured may recover from any triggered policy is the lesser of (a) the pro rata amount of the covered losses allocated to that policy period and (b) the coverage limits of that policy. Under this pro rata by years approach, each year during the triggered period is assigned an equal fraction of the total loss as if that portion of the loss in fact occurred during that year. Therefore, the insured bears financial responsibility for any uninsured or underinsured periods during which some portion of the long-tail harm occurred.

There is some disagreement over the precise number of jurisdictions that have adopted each position, in part because of variation in policy language and in part because of differing possible interpretations of the holdings in some cases. While the all-sums approach has been adopted by a significant number of courts and many courts have not yet taken a position, a clear majority of the jurisdictions that have addressed the question have adopted the pro rata approach. Among the courts that have adopted a pro rata rule, there is a split of authority regarding whether to allocate losses to years in which the policyholder could not have purchased insurance. Some courts that have adopted the pro rata approach allocate all uninsured years to the insured without regard to the reason for the lack of insurance in a given year, while other courts follow the "unavailability rule" and allocate losses to uninsured years only if liability insurance covering the risks in question was available during those years. See Comment *h*.

This Restatement follows the pro rata by years default rule for allocation in the case of long-tail harms, because that approach is the most consistent, simplest, and fairest solution to this problem. It is consistent because it provides the same result for every triggered year. It is simple because it requires very little information to determine the pro rata percentage to be applied, and it presents the fewest complications regarding exhaustion, deductibles, and settlement. It is fair because all triggered years, including the years in which the insured did not purchase insurance, share equally in the indivisible losses. In addition, this approach reflects the best effort to

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accommodate the language in insurance policies that links the coverage to harm that occurs during the policy period. Of all the alternative theories, this approach comes closest to allocating to each policy only those bodily injuries or property damage that occurred during each policy period, given the indivisibility of the harms at issue.

d. Pro rata versus all sums as a matter of interpretation. The split of authority regarding the allocation rule reflects the fact that the liability risks presented by the rise of mass toxic-tort suits and environmental-cleanup and property-damage causes of action were not adequately anticipated and addressed in the standard commercial general-liability (CGL) insurance policies sold before the nature and extent of those risks became apparent in the 1980s. A careful assessment of the relevant policy language in those earlier policies must acknowledge that the language is susceptible to both pro rata and all-sums interpretations. The earliest edition of the occurrence form of the CGL provides that the insurer will pay “all sums that the policyholder shall become legally obligated to pay as damages because of bodily injury or property damage to which the insurance applies caused by an occurrence.” The term “occurrence” is then defined to mean “an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage.” In later versions of the CGL, the language regarding bodily injury or property damage during the policy period was moved out of the definition of occurrence, first into the bodily-injury and property-damage definitions and then into the insuring agreement.

In all three of these versions of the CGL, it is possible to read the during-the-policy-period requirement as applying only to the trigger of coverage and not to allocation, thus leaving open the possibility that the policy covers all the damages awarded in a legal action as long as any part of the harm upon which the damages are based occurred during the policy period. According to this interpretation, for a standard CGL policy to be potentially available to cover a given legal action, there must at least be *some* bodily injury or property damage that occurs during the policy period. However, once it is determined that there is some bodily injury or property damage during the policy period, and thus that the CGL policy issued to cover that policy period has been triggered, the during-the-policy-period language has no other effect. On this view, the during-the-policy-period language does not provide any justification for limiting an insurer’s responsibility to harm that occurs during the policy period. At most, the

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during-the-policy-period language creates an ambiguity regarding the question of allocation, and such ambiguity should be construed against the drafter.

As the latter concession indicates, however, it is also possible to read the timing requirement as applying to both trigger of coverage and allocation, meaning that the policy covers only the damages that are attributable to the harm that occurred during the policy period. Indeed, many courts have found this to be the more reasonable interpretation of the relevant policy language and some courts have determined that it is the plain meaning of that language. Given the indivisible nature of the harm in such cases, the pro rata by years approach provides the best method under the circumstances for achieving the goal of limiting the insurer's liability to the harms that occur during the policy period. Because it is impossible to determine how much harm occurred in each year, the best that can be done is to spread those costs evenly across all triggered years. (If it were possible to determine how much harm occurred during the policy period, the harm would be divisible and this Section would not apply.) By contrast, the all-sums approach allows an insurer to be held responsible for a large amount of losses that did not occur during the policy period that the insurer agreed to cover.

Most of the courts that have considered this issue have rejected the all-sums approach in favor of the pro rata approach. Not all these courts provide the same reasons for their choice, but their results are all consistent with the following reasoning: (a) pro rata by years is the default allocation rule for long-tail claims under occurrence policies with harm-based triggers, (b) ambiguous or uncertain terms that can be read in two ways—as consistent with the default rule or to the contrary—are insufficient to alter that default rule, and (c) the “all-sums” wording in the pre-1986 policies is, at best for policyholders, ambiguous or uncertain in that regard and, thus, insufficient to displace the default rule. It is important to note that most of the cases reaching the contrary, all-sums result are also consistent with a pro rata default rule, with the crucial difference that the courts in these cases differ from the majority in treating the “all-sums” language in the earlier CGL policies as sufficient to alter that default rule.

e. The expectations argument in favor of pro rata. Proponents of the pro rata rule contend that to hold an insurer that issued a policy to cover one year responsible for harms that are statistically certain to have occurred in other years not only runs counter to the language of the policy but also conflicts with commonsense expectations regarding the difference between buying and not buying insurance. A policyholder who does not buy insurance for liability

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attributable to harm that occurs during a given period should bear greater financial responsibility for harm that in fact occurs during that period than a policyholder who does buy insurance for that liability. This argument can be seen in a simple hypothetical example. Insured A purchases a CGL policy with \$1 million coverage limits in each of years one through five and does not purchase a CGL policy in years six through 10. Insured B purchases a CGL policy with \$1 million coverage limits in each of years one through 10. Both Insured A and Insured B experience a liability claim totaling \$5 million that results from continuous exposure to a long-tail harm over years one through 10. Under the most common all-sums approach, which includes stacking, both Insured A and Insured B would have, in effect, the same amount of coverage for the \$5 million claim. Under the pro rata by years approach, however, the amount of coverage would be different: Insured A would have a total of \$2.5 million of coverage, which results from \$5 million of damages allocated over 10 years of exposure (\$500,000 per year) times five years of coverage. Insured B would have a total of \$5 million of coverage for the \$5 million claim. The pro rata by years result makes the amount of total insurance coverage provided to the insureds over a given period of time a function of the number of years in which coverage was purchased.

f. The extrinsic evidence in favor of the all-sums approach. All-sums proponents contend that the available extrinsic evidence supports their approach. Specifically, based on records from the drafting history of the earlier standard CGL forms, as well as statements made by industry representatives who were involved in the drafting process, they contend that (a) the insurance industry itself interpreted the language in the pre-1986 CGL forms consistently with the all-sums-with-stacking approach and (b) the industry considered several explicit allocation terms that were consistent with the pro rata approach and ultimately rejected them. On that basis, they contend that it is reasonable to interpret the drafting history as supporting the conclusion that the insurance industry acknowledged and accepted, or at least acquiesced in, the all-sums interpretation of the pre-1986 standard-form CGL insuring agreement.

Careful analysis of these materials, however, reveals that many of the records and statements referenced by the all-sums proponents primarily if not exclusively support the concept of stacking (i.e., the proposition that multiple per-occurrence policy limits are available in the event of harm that takes place over multiple years), which is consistent with a pro rata approach as well as an all-sums approach. Although some of the records and statements are inconsistent

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with the pro rata approach, these records and statements primarily serve to demonstrate that it is possible to interpret the policy language in favor of the all-sums approach. They cannot change the fact that the policy language is also susceptible to the pro rata interpretation. All things considered, the records and statements by the drafters simply corroborate the point made in Comment *d*: the rules for allocating liability risks presented by the rise of mass toxic-tort suits and environmental-cleanup and property-damage causes of action were not adequately anticipated and addressed in the standard general-liability insurance policies before the nature and extent of those risks became apparent in the 1980s. This Restatement follows the pro rata rule for the earlier CGL policies for the same reasons of consistency, simplicity, and fairness that lead to the conclusion that the default rule is pro rata, and because a majority of the courts that have considered the question have concluded that the pro rata rule represents the more reasonable interpretation of the language in those policies.

Illustrations:

1. A series of asbestos-related lawsuits is brought against the insured involving \$40 million of total liability costs. The bodily injuries that give rise to the suits occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the \$40 million of harm occurred in each of the 10 years. During this 10-year period, the insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4 with annual policy limits of \$500,000; Insurer B issued policies covering years 5-8 with annual policy limits of \$5 million; and Insurer C issued policies covering years 9 and 10 with annual policy limits of \$20 million.

Under the pro rata by years allocation method, 10 percent of the total \$40 million liability cost (\$4 million) is allocated to each of the 10 years, as if that portion of the harm occurred in that year. Thus, in the absence of any deductibles or self-insured retentions in any of the policies, the insured is entitled to a total of \$26 million of liability coverage allocated as follows: \$2 million from Insurer A (4 x \$500,000 annual policy limit), \$16 million from Insurer B (4 x \$4 million annual allocation), and \$8 million from Insurer C

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(2 x \$4 million annual allocation). The insured is responsible for the remaining \$14 million in liability costs.

2. Same facts as Illustration 1, except that in years 5-8 Insurer B issued policies with annual limits of \$10 million rather than \$5 million, and the insured chose not to purchase liability insurance policies for years 9 and 10. Under the pro rata by years approach, again \$4 million of the \$40 million total costs is allocated to each of the 10 years. As a result, Insurers A and B are responsible for \$2 million and \$16 million, respectively. The insured is responsible for the remaining \$22 million of losses.

g. Pro rata by limits. A few courts have adopted a pro rata by limits rule, which is a common formula used for contribution among insurers in the context of concurrently overlapping policies with no or conflicting other-insurance clauses. See § 42, Comment *b*. The pro rata by limits rule differs from the ordinary pro rata by years rule in two respects. First, the pro rata by limits approach uses policy limits in the calculation of the amount allocable to each of the relevant years, so that more of the indemnity obligation is allocated to policies with higher limits. Second, the pro rata by limits approach allocates long-tail losses to uninsured years only to the extent that the policyholder intentionally opted not to purchase coverage that was available—and then only to the extent of that available coverage. This second aspect of the pro rata by limits approach is sometimes called the “unavailability rule,” which is addressed separately in Comment *h*.

Proponents of the pro rata by limits approach contend that it is more consistent with the pricing of those policies and thus with the parties’ expectations. On this view, the higher the limit of a policy, the larger was the premium paid for the coverage in that year (all other things being equal), and hence the greater the amount of the long-tail harm that should be allocated to that year. Further, it is argued that the pro rata by limits formula has the beneficial effect of encouraging the purchase of relatively high policy limits, because the higher the limits of coverage purchased for any year, the larger the fraction of total losses will be allocated to that year. In addition, this approach provides some relief to an insured—and to the claimants of the insured—who was unable to purchase coverage for reasons beyond its control. Finally, the courts adopting this approach have concluded that strong public-policy considerations justify rewriting the insurance policy in the special circumstances of unanticipated long-tail harm.

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The pro rata by limits approach is subject to several critiques. First, the pro rata by limits rule puts a disproportionate burden on the higher-limit insurer by increasing the share of the loss that insurer must pay if the policyholder purchased less insurance in another year. There are fairness concerns about making insurers that issued policies in one year more (or less) responsible because the policyholder purchased lower (or higher) policy limits in another year; and there are fairness concerns about making insurers that, by assumption, expressly chose not to provide coverage in the years in which liability insurance was unavailable, responsible for those harms under other policies that they sold that covered different policy periods. Second, there is no textual basis for either aspect of the pro rata by limits rule in the standard-form commercial general-liability insurance policies to which it is applied. Third, the treatment of uninsured years in the pro rata by limits rule can be complicated and information intensive. Finally, it is by no means certain that the pro rata by limits approach in fact does more to encourage the purchase of insurance than any other allocation method. Any time an insured purchases greater policy limits, whatever the allocation method, there is more coverage potentially available to pay claims.

h. The unavailability rule. Some courts that have applied the pro rata by years approach to long-tail indivisible claims have adopted the unavailability rule aspect of the pro rata by limits approach. These courts allocate to the policyholder a share for an uninsured year only if liability insurance coverage was available in that year for the risks in question, based on public-policy considerations similar to those relied upon by the courts adopting the pro rata by limits approach to allocation. In these jurisdictions, the burden of proof is generally on the policyholder to show that insurance was unavailable during the relevant policy period. Among the jurisdictions that follow some version of the pro rata approach, the courts that have considered the issue are evenly split on the application of the unavailability rule. When the number of jurisdictions adopting the all-sums approach to allocation is combined with the number of jurisdictions adopting the unavailability rule, however, it can be said that most courts that have considered the issue do not allocate to insureds the costs of damage that occurs during years in which insurance was unavailable. Courts that reject the unavailability rule do so on the grounds that it is inconsistent with the language of the insurance policy. Other objections include: the treatment of uninsured years can be complicated and information intensive and the rule imposes responsibility on insurers for harm that occurred during periods for which the insurers expressly chose not to provide coverage.

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i. Exhaustion, deductibles, SIRs, and settlement. In addition to the issues of trigger and allocation, long-tail-harm claims raise related issues such as the application of deductibles, self-insured retentions (SIRs), exhaustion, and the effect of settlements. The pro rata by years rule addresses each of these issues in a more straightforward and easier to administer manner than the all-sums rule. Long-tail harms are allocated to each policy period as if the pro rata portion of the loss occurred in each triggered year, with the application of deductible, SIR, policy-limit, and exhaustion provisions following the usual course without the need for any special rules for the long-tail-harm situation. As soon as one policy in a given year is exhausted, the next-level policy takes over for the remaining portion of the liability allocated to that year, and so on, until that tower of insurance is exhausted, at which point the insured is financially responsible for losses allocated to that policy period. This is a form of “horizontal exhaustion,” which is the majority approach to exhaustion in pro rata by years jurisdictions. Under the all-sums approach, by contrast, insureds exhaust the coverage available in one year using a “vertical-exhaustion” approach before accessing the coverage available in another year, once again requiring all of the insurers that have not yet exhausted to track the payments. Moreover, vertical exhaustion under the all-sums approach puts some excess insurers in the position of paying long before primary insurers, which is inconsistent with the pricing of excess and primary coverage. One of the benefits of the pro rata allocation approach is that it avoids these problems as well.

Under the pro rata rule, deductibles and SIRs are also easy to administer. Because a pro rata share of the liability is allocated to each policy year, the deductibles and SIRs for each policy period are applied to that pro rata amount, just as they would apply to any other liability that occurred during the period. Moreover, because the amount allocated to each policy period is identical, no insurer needs to keep track of how much coverage remains under any other insurance policy. Further, under the pro rata rule, there need be no subsequent contribution action, as the allocation of responsibility among multiple triggered insurers is determined by the pro rata by years rule. (If an insurer pays more than its share under the pro rata by years rule, contribution is nevertheless ordinarily available under § 42.)

The treatment of settlements under the pro rata approach is also simple. Because each year is allocated a pro rata portion of the overall liability, settlements by insurers during one policy period have no effect on the liability of insurers in other policy periods. By contrast, under

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the all-sums approach, a complex and difficult decision must be made regarding how much to credit one insurer's settlement payment against the other insurers' overlapping liability taking into account exhaustion. See § 43 (regarding the effect of partial settlements). Moreover, because the all-sums approach requires contribution actions to allocate among insurers, it is susceptible to agreements between the insured and one or more insurers that work to the disadvantage of other insurers. See § 42 (regarding contribution).

Illustrations:

3. A series of asbestos-related lawsuits is brought against Insured involving \$100 million of total liability costs. The bodily injuries that give rise to the suits occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the harm occurred in each of the 10 years. During this 10-year period, the insured was covered under several different towers of CGL policies, as follows: For years 1-4, Insurer A issued primary policies with annual policy limits of \$500,000, and Insurer B issued excess policies that attached at \$500,000 with annual policy limits of \$5 million; for years 5-6, Insured did not purchase liability insurance; for years 7-10, Insurer C issued primary policies with annual policy limits of \$5 million, and Insurer D issued excess policies attaching at \$5 million with annual limits of \$30 million. There were no deductibles or retentions.

Under the pro rata by years allocation method, 10 percent of the total \$100 million liability cost (\$10 million) is allocated to each of the 10 years, as if that portion of the harm occurred in that year. For each of the policy years 1 through 4, all \$500,000 of primary coverage is exhausted, as well as all \$5 million of excess coverage, with the remaining \$4.5 million of annual asbestos liability being borne by Insured. Insured bears all of the asbestos losses for years 5 and 6. For each of the policy years 7 through 10, all \$5 million of the primary coverage is exhausted, as well as \$5 million of the \$30 million excess coverage. Insured bears no losses for those years.

4. A series of asbestos-related lawsuits is brought against the insured involving \$40 million of total liability costs. The bodily injuries that give rise to the suits occurred continuously over a period of 10 years. Although it can be determined that some bodily

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injury occurred in each of the 10 years, it cannot be determined precisely how much of the harm occurred in each of the 10 years. During this 10-year period, the insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4 with annual policy limits of \$500,000 and annual deductibles of \$25,000, written as a standard deductible; Insurer B issued policies covering years 5-8 with annual policy limits of \$5 million and annual deductibles of \$100,000, written as a standard deductible; and Insurer C issued policies covering years 9 and 10 with annual policy limits of \$20 million and annual self-insured retentions of \$1 million.

Under the pro rata by years allocation method, 10 percent of the total \$40 million liability cost (\$4 million) is allocated to each of the 10 years, as if that portion of the harm occurred in that year. Thus, Insured is entitled to a total of \$23.5 million, allocated as follows: \$1.9 million from Insurer A for years 1-4 [(4 x \$500,000 annual policy limit) – (4 x \$25,000 annual deductible)]; \$15.6 million from Insurer B [4 x \$4 million annual allocation) – (4 x \$100,000 annual deductible)]; and \$6 million from Insurer C [(2 x \$4 million annual allocation) – (2 x \$1 million retention)]. The insured is responsible for the remaining \$16.5 million (\$40 million – \$23.5 million) in liability costs.

j. Other-insurance clauses. While some pro rata proponents have suggested, and a few courts have agreed, that the other-insurance clauses found in most CGL policies should be understood as a sort of allocation provision for the long-tail-harm situation, the majority of courts that have addressed the question conclude that such other-insurance clauses address a different situation: namely, the situation in which multiple insurance policies issued during the same policy period cover the same insured concurrently for a given loss. See § 40, Comment *c*.

k. Opting out of the default rule. The default rule of pro rata allocation can be altered by contractual terms that provide an alternative method of allocation or priority. For example, if an insurance policy contains a term that clearly specifies the all-sums approach to allocation (perhaps by eliminating the “during the policy period” language), such a term will be enforced. However, if such allocation terms conflict with each other, courts should apply the pro rata method of allocation as a matter of public policy. For example, if multiple policies contain allocation terms that purport to apply to the long-tail-claim situation and that amount to escape

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clauses, such terms should not be enforced. Rather, the pro rata default rule should apply in such situations. This result is analogous to how courts have interpreted other-insurance clauses. See § 40, Comments *d* and *e*.

1. Independent and concurrent allocation of defense costs. Defense costs for long-tail claims are subject to the ordinary default rule for multiple triggered policies, pursuant to which there is an independent and concurrent obligation to pay the defense costs under each triggered policy. See Comment *e* to § 20. This rule is a corollary to the rule that the duty to defend includes the obligation to defend the insured from all of the causes of action and remedies sought in a potentially covered legal action, including those not covered by the liability insurance policy. See § 15. Notably, the textual argument in favor of the pro rata allocation of the costs of settlement and judgments, which relies on the “during the policy period” language in standard liability insurance policies, does not apply with the same force to the costs of defense, because standard liability insurance policies typically ~~promise~~[obligate the insurer](#) to defend the insured against a suit that seeks covered damages, without regard to whether the suit also seeks other damages. In this regard, there is nothing unusual about multiple insurers, which are on the risk for different portions of the period of damage at issue in a covered legal action, each having an independent and concurrent obligation to defend that action. An insurer that pays more than its pro rata share of the defense costs may seek contribution from other insurers. See § 20. Moreover, adopting a pro-rata approach to defense costs would mean that an insured would not be able to receive a fully funded defense unless and until it succeeded in persuading all of its insurers to agree upon an allocation formula. It should be noted, however, that some jurisdictions that have adopted pro rata allocation for the costs of judgments and settlements have also done so for defense costs.

REPORTERS’ NOTE

a. The special case of long-tail harm. For a general discussion of the problem of long-tail harms in connection with liability insurance coverage questions, see, e.g., *State v. Cont’l Ins. Co.*, 281 P.3d 1000, 1005 (Cal. 2012) (“[A] ‘long-tail’ injury, is characterized as a series of indivisible injuries attributable to continuing events without a single unambiguous ‘cause.’ Long-tail injuries produce progressive damage that takes place slowly over years or even decades.”); 3-22 JEFFREY E. THOMAS, [NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION](#) § 22.01[1] (Lexis ~~2012~~[2017](#)) (“In modern coverage litigation, many underlying claims are long-tail or delayed-manifestation claims where injury or harm takes place over a period of years.”); Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85, 95 (2001) (“[A] ‘long tail’—that is, coverage under a policy that was in effect at the

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time of injury or damage, even though a claim alleging liability for this injury or damage is not filed against the policyholder until many years later.”); Rebecca M. Bratspies, *Splitting the Baby: Apportioning Environmental Liability Among Triggered Insurance Policies*, 1999 B.Y.U. L. Rev. 1215, 1217 (1999) (“Long-tail injuries are progressive—that is, they take place slowly, over an extended period of time. Because these long-tail injuries occur gradually, PRPs often claim coverage under multiple insurance policies issued over the course of many years.”). Researchers estimate that long-tail environmental and asbestos claims cost insurance companies more than \$1 billion every year. A significant percentage of those costs are spent defending, rather than indemnifying, the catastrophic social harms. See Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. ~~257~~, ~~259~~[257](#) (1997). For an overview of the history and costs of long-tail silicone-implant claims, see Deborah R. Hensler & Mark A. Peterson, *Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis*, 59 BROOK. L. REV. 961, 996-997 (1993).

b. Divisible harm. For an example of a court deciding that a long-tail harm was divisible, using volumes of a harmful agent released in each period, see *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1391-1392 (E.D.N.Y. ~~1998~~[1988](#)) (apportioning damages in proportion to the respective volumes of Agent Orange delivered by the insured to the military during each policy year).

c. Theories of allocation for long-tail harms. The consensus among commentators and courts is that a slim majority of jurisdictions have adopted some version of the pro rata method for allocating long-tail harms. See Shane R. Heskin, *Allocation of Latent Injury and Damage Claims*, ~~in~~[in](#) [1-18 RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE § 18 597 \(Maniloff and Stempel eds.\)](#) (3d ed. 2015) (“The clear majority of jurisdictions has adopted the pro rata method, where, in its purest form, damages are allocated evenly among all years in which bodily injury or property damage has occurred.”); William P. Shelley, *Fundamentals of Insurance Coverage Allocation* (Jan. 5, 2000), [14-9 MEALEY’S LITIGATION REPORT: INSURANCE 25-13](#).

Among the jurisdictions that have arguably adopted some version of the pro rata approach for policies containing the old “all sums” and “during the policy period” language are Colorado, Connecticut, Illinois (for asbestos property damage and environmental claims),⁵ Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, New York, South Carolina, Utah, and Vermont. See, e.g., *Pub. Serv. Co. of Colorado v. Wallis & Companies Cos.*, 986 P.2d ~~924~~, ~~929~~[924](#) (Colo. 1999) (adopting pro rata time-on-the-risk, or by years); *Sec. Ins. Co. of Hartford v. Lumberman’s Mut. Cas. Co.*, 826 A.2d 107 (Conn. 2003) (adopting pro rata by years); *AAA Disposal Systems, Inc. v. Aetna Cas. & Sur. Co.*, 821 N.E.2d 1278, 1290 (Ill. 2005) (adopting pro rata for environmental liability claims, distinguishing earlier Illinois Supreme Court decision regarding asbestos bodily injury claims); *Mid Am. Energy Co. v. Certain Underwriters at Lloyd’s London*, No. CL 107142, [2011 WL 2011374](#) slip op. at 3 (Iowa Dist. Ct. Apr. 13, 2011) (adopting pro rata for long-tail indivisible-harm cases); *Atchison, Topeka & Santa Fe RyR.R. Co. v. Stonewall Ins. Co.*, 71 P.3d

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1097 (Kan. 2003) (in context of claims for indivisible noise-induced hearing loss, court applies pro rata time-on-the-risk); *Aetna Cas. & Sur. Co. v. Commonwealth*, 179 S.W.3d 830 (Ky. 2005) (adopting pro rata time-on-the-risk for claims involving indivisible harm from nuclear-waste disposal); *S. Silica of Louisiana, Inc. v. Louisiana Ins. Guaranty Association*, 979 So. 2d 460 (La. 2008) (adopting pro rata time-on-the-risk to long-tail indivisible silicosis claims); *Mayor & City Council of Baltimore v. Utica Mut. Ins. Co.*, 802 A.2d 1070 (Md. Ct. Spec. App. 2002) (adopting time-on-the-risk for asbestos claims); *Boston Gas Co. v. Century Indemnity Co.*, 910 N.E.2d 290, 306, 310 (Mass. 2009) (applying pro rata time-on-the-risk to claims of indivisible oil and tar contamination); *Arco Indus. Corp. v. Am. Motorists Ins. Co.*, 594 N.W.2d 61 (Mich. Ct. App. 1998) (adopting time-on-the-risk approach to apportion pollution remediation costs); *Northern States Power Co. v. Fidelity & Casualty Co. of N.Y.*, 523 N.W.2d 657 (Minn. 1994) (adopting pro rata time-on-the-risk for claims involving indivisible soil and groundwater contamination); *Dutton-Lainson Co. v. Continental Ins. Co.*, 778 N.W.2d 433 (Neb. 2010) (adopting pro rata time-on-the-risk for indivisible environmental claims); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's*, 934 A.2d 517 (N.H. 2007) (adopting the pro rata by limits and years approach); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 995 (N.J. 1994) (applying New Jersey law, the original pro rata by limits approach); *Consolidated Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, 774 N.E. 2d 208 (N.Y. 2002) (adopting pro rata allocation generally but not requiring any particular version of that method); *Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589 (S.C. 2011) (applying pro rata time-on-the-risk approach for indivisible progressive-harm cases); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997) (adopting pro rata time-on-the-risk by limits for defense costs); *Bradford Oil Co., Inc. v. Stonington Ins. Co.*, 54 A.3d 983, 988-991 (Vt. 2011) (confirming that Vermont applies the pro rata by years approach).

Courts adjudicating a long-tail-harm case in which the policy language at issue contained the phrase “those sums” rather than “all sums” have tended to allocate the loss pro rata. See, e.g., *Stryker Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 4:01-CV-157, 2005 WL 1610663, at *3 (W.D. Mich. July 1, 2005); *Crossmann Communities of N. Carolina, Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589, 601 (S.C. 2011); *Ohio Cas. Ins. Co. v. Unigard Ins. Co.*, 268 P.3d 180, 182 (Utah 2012); and *Thomson Inc. v. Insurance Co. of North America*, 11 N.E.3d 982 (Ind. Ct. App. 2014). Under the pro rata by years method, courts generally allocate losses incurred in years with no insurance coverage or insufficient coverage to the insured as a self-insurer. See, e.g., *In re Wallace & Gale Co.*, 385 F.3d 820, 833 (4th Cir. 2004) (applying Maryland law) (“The allocation of risk to the insured is for periods for which there is no insurance in force or for which there is no coverage by an insurance policy which is in force.”); S. M. SEAMAN & J. R. SCHULZE, ALLOCATION OF LOSSES IN COMPLEX INSURANCE COVERAGE CLAIMS § 4.3[c] (Dec. 2017 update). For a discussion of jurisdictions that apply pro rata in a way that limits policyholders’ liability for uninsured years in which insurance was unavailable for purchase, see Comment *h*.

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The New York Court of Appeals, in the case of *In Re Viking Pump, Inc. & Warren Pumps, LLC*, ~~Insurance Appeals, No. 59~~[52 N.E.3d 1144](#) (N.Y. ~~May 3,~~ 2016) (“*Viking Pump*”), articulated and applied a version of the pro rata by years rule that is consistent with, and illustrative of, the pro rata default rule adopted in this Section. In a previous case, *Consolidated Edison Co. of N.Y. v. Allstate Ins. Co.* (N.Y. 2002), the court had clearly adopted the pro rata by years approach for claims under the old CGL policies that contained the “all sums” and “during the policy period” language. In so holding, the court had concluded that the “all sums” language alone was not sufficient to alter the pro rata allocation method. As the court later noted in *Viking Pump*, the rule in New York is that, “in the absence of language [other than merely the ‘all sums’ language] weighing in favor of a different conclusion, pro rata allocation [is] the preferable method of allocation in long-tail claims in light of the inherent difficulty of tying specific injuries to particular policy periods . . . [but that] ‘different policy language’ might compel all sums allocation.” *Viking Pump*, ~~slip op. at 13~~[1152](#). The policy at issue in *Viking Pump* itself did in fact contain additional language—a “non-cumulation clause”—that the court determined was sufficient to require an all-sums allocation approach. In other words, the non-cumulation clause was sufficient to alter the pro rata default rule. *Id.* See *Keyspan Gas East E. Corp. v. Munich Reinsurance America, Inc.*, ~~37 N.Y.S.3d 85, 96 (App. Div. 2016)~~[Am. Inc., No. 20, 2018 WL 1472635 \(N.Y. Mar. 27, 2018\)](#) (applying pro rata rule in a case with policy language that was distinguishable from that at issue in *Viking Pump*), ~~appeal pending~~.

Among the jurisdictions that have arguably adopted the all-sums approach to the standard CGL “all sums”/“during the policy period” policy language are California, Delaware, District of Columbia, Illinois (for asbestos bodily injury claims only), Missouri, Ohio, Pennsylvania, Texas, Washington, and Wisconsin. See, e.g., *State v. Cont’l Ins. Co.*, ~~55~~[281 P.3d 1000](#) (Cal. ~~4th~~[186](#) (2012)); *Hercules Inc. v. AIU Ins. Co.*, 784 A.2d 481 (Del. 2001); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981); *Zurich Ins. Co. v. Raymark Industries Indus. Inc.*, 514 N.E.2d 150 (Ill. 1987); *Doe Run Res. Corp. v. Certain Underwriters at Lloyd’s London*, 400 S.W.3d 463 (Mo. Ct. App. 2013); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, ~~95~~[769 N.E.2d 835](#) (Ohio ~~St. 3d~~[512](#) (2002)); *J.H. France Refractories Co. v. Allstate Ins. Co.*, ~~534~~[626 A.2d 502](#) (Pa. ~~29~~ (1993)); *Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d ~~750, 758~~[759750](#) (Tex. 2013); *American Am. Nat’l Fire Ins. Co. v. B&L Trucking & Constr. Co.*, ~~134~~[Wash. 951 P.2d 413250](#) (Wash. 1998); and *Plastics Eng’g Co. v. Liberty Mut. Ins. Co.*, ~~315~~[759 N.W.2d 613](#) (Wis. ~~2d~~[556](#) (2009)). Some states are less easy to characterize. For example, although the Indiana Supreme Court’s decision in *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001), is often cited as adopting the all-sums method of allocation, subsequent lower-court opinions in Indiana have called that interpretation into question. *Federated Rural Elec. Ins. Exch. v. Nat’l Farmers Union Prop. & Cas. Co.*, ~~805~~[N.E.2d 456, 466](#) (Ind. Ct. App. 2004) (“The parties err when they attempt to extract from Dana I and Dana II an ‘all sums’ rule and apply it out of context.”) ~~opinion vacated by~~ [Federated Rural Elec. Ins. Exchange v. Nat’l Farmers Union Prop. & Cas. Co.](#), ~~816~~[N.E.2d 1157](#) (Ind. 2004). Similarly, whereas some consider Rhode Island an all-sums jurisdiction, in part because of *Emhart Indus., Inc. v. Century Indem. Co.*, 559 F.3d 57

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(1st Cir. 2009) ([applying Rhode Island law](#)), others suggest that Rhode Island cannot be a true all-sums state because it has adopted a manifestation trigger for long-tail harms.

Most of the courts adopting the all-sums approach have also adopted stacking. See, e.g., *State v. Cont'l Ins. Co.*, 281 P.3d 1000, 1009 (Cal. 2012) (“In the present case, consistent with this court’s precedent, principles of equity, and sound insurance policy interpretation considerations, we conclude that the all sums approach to insurance indemnity allocation applies to the State’s liability for successive or long-tail property damage. In addition, we conclude that allocation of the cost of indemnification under these circumstances should be determined with stacking.”); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 494 (Del. 2001) (“Joint and several liability does not result in a ‘windfall’ to [insured] because of the continuing coverage [insured] purchased. Under the contract, [insured] is entitled to coverage for damages occurring after the insurer’s time on the risk once a policy has been triggered.”); *John Crane, Inc. v. Admiral Ins. Co.*, 991 N.E.2d 474, 491 (Ill. App. Ct. 2013) (“We adhere to our supreme court’s decision in *Zurich* and hold that where coverage for asbestos-related injury claims is triggered by bodily injury or sickness or disease, all triggered policies are jointly and severally liable”); *Doe Run Res. Corp. v. Certain Underwriters at Lloyd’s London*, 400 S.W.3d 463, 474 (Mo. Ct. App. 2013) (“The plain language of the applicable insurance policies requires the adoption of the all sums allocation scheme in this case.”); *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 509 (Pa. 1993) (“When the policy limits of a given insurer are exhausted, [insured] is entitled to seek indemnification from any of the remaining insurers which was on the risk during the development of the disease. Any policy in effect during the period from exposure through manifestation must indemnify the insured until its coverage is exhausted.”). A few jurisdictions have adopted the all-sums rule without stacking. See *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d ~~1034, 1049-1050~~[1034](#) (D.C. Cir. 1981) (applying Florida law); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 769 N.E.2d ~~835, 841~~[835](#) (Ohio 2002); and *Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d ~~750, 758-759~~[750](#) (Tex. 2013). Some jurisdictions have adopted the all-sums approach in a long-tail-harm case without answering the stacking question. See, e.g., *Emhart Indus., Inc. v. Century Indem. Co.*, 559 F.3d ~~57, 70-74~~[57](#) (1st Cir. 2009) (applying Rhode Island law); *Plastics Eng’g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d ~~613, 627~~[613](#) (Wis. 2009).

Oregon is the only state to require a specific allocation method by statute. In all environmental long-tail-harm cases, Oregon courts are required to apply the “all sums” with stacking approach to insurers on the risk. See Or. Rev. Stat. § 465.480(3)(a). But see *Cascade Corp. v. Am. Home Assur. Assurance Co.*, 135 P.3d 450, 457 n.9 (Or. [Ct. App.](#) 2006) (“Because of our conclusion that [insured] is entitled to prevail under a proper construction of the *Lamb–Weston* doctrine, we do not need to consider its argument that ORS 465.480 mandates the same result.”).

d. Pro rata versus all sums as a matter of interpretation. For courts finding that the plain language of the 1976 all-sums CGL policy requires pro rata by years allocation, see, e.g., *Atchison, Topeka & Santa Fe RyR.R. Co. v. Stonewall Ins. Co.*, 71 P.3d ~~1097, 1134~~[1097](#) (Kan. 2003); *Norfolk S. Corp. v. California Union Ins. Co.*, 859 So. 2d ~~167, 196~~[167](#) (La. Ct. App.

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2003); *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d ~~290, 306, 310~~290 (Mass. 2009). Other courts have found that the pro rata by years approach is at least consistent with or satisfies the plain meaning of the 1976 CGL policy. See *Dutton-Lainson Co. v. Cont'l Ins. Co.*, 778 N.W.2d ~~433, 445~~433 (Neb. 2010); *Consol. Edison Co. of New York v. Allstate Ins. Co.*, 774 N.E.2d ~~687, 695~~687 (N.Y. 2002).

Some courts adopting the pro rata by years approach rely on the argument that, because it is impossible to determine how much of the long-tail damage occurred in each of the triggered policy years, the most reasonable solution is to conclude that the damage occurred evenly across the triggered years. See, e.g., *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d ~~290, 314~~290 (Mass. 2009); *N. States Power Co. v. Fid. & Cas. Co. of New York*, 523 N.W.2d 657, 663 (Minn. 1994) (“This method assumes that the damages in a contamination case are evenly distributed (or continuous) through each policy period from the first point at which damages occurred to the time of discovery, cleanup or whenever the last triggered policy period ended.”). These courts have also relied on their interpretation of the contracting parties’ reasonable expectations to require “pro rata by years.” See, e.g., *Pub. Serv. Co. of Colorado v. Wallis & Companies Cos.*, 986 P.2d 924, 939 (Colo. 1999) (“We do not believe that these policy provisions can reasonably be read to mean that one single-year policy out of dozens of triggered policies must indemnify the insured’s liability for the total amount of pollution caused by events over a period of decades, including events that happened both before and after the policy period.”); *Crossmann Communities Comtys. of N. Carolina, Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589, 594 (S.C. 2011) (“In our view, the ‘time on risk’ approach best conforms to the terms of a standard CGL policy and to the parties’ objectively reasonable expectations.”).

Some courts adopting the pro rata by years approach also rely on the public-policy considerations of simplicity in administration, spreading the risk to the maximum number of insurers, and reduced subsequent litigation costs between insurers. See, e.g., *N. States Power Co. v. Fid. & Cas. Co. of New York*, 523 N.W.2d 657, 663 (Minn. 1994) (“[A] ‘pro rata by time on the risk’ allocation scheme could reduce the costs of litigation because it is more or less a per se rule.”); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd’s*, 934 A.2d 517, 527 (N.H. 2007) (“[T]he joint and several allocation method is improvident. . . . [D]espite its advocates’ claims to the contrary, the joint and several method does not decrease litigation costs, does not give courts guidance as to how to allocate liability, and requires insurers to factor the costs of uncertain liability into their premiums.”) (internal quotations omitted); *Towns v. N. Sec. Ins. Co.*, 964 A.2d 1150, 1166 (Vt. 2008) (“Courts and commentators have also recognized that the time-on-the-risk method offers several policy advantages, including spreading the risk to the maximum number of carriers, easily identifying each insurer’s liability through a relatively simple calculation, and reducing the necessity for subsequent indemnification actions between and among the insurers.”) (citing *Olin Corp. v. Ins. Co. of N. Am.*, 221 F.3d 307, 323 (2d Cir. 2000)).

Another policy advantage relied upon by courts adopting the pro rata by years approach is that it creates an incentive for businesses to continue purchasing insurance over time to maximize

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the number of years with coverage under the pro rata approach. See *Crossmann CommunitiesCmtys. of N. Carolina, Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589, 601 (S.C. 2011) (“Further, this interpretation forwards important policy goals. Specifically, it preserves the incentive for businesses to purchase sufficient insurance, which in turn promotes stability in the marketplace.”); see also *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, ~~306~~, 311 (Mass. 2009) (“[J]oint and several allocation . . . ‘creates a false equivalence between an insured who has purchased insurance coverage continuously for many years and an insured who has purchased only one year of insurance coverage.’”) (quoting *Public Serv. Co. of Colo. v. Wallis & Cos.*, 986 P.2d 924, 939-940 (Colo. 1999)).

For courts finding that the plain language of the CGL policy requires the all-sums approach to allocation, see, e.g., *State v. Cont’l Ins. Co.*, 281 P.3d ~~1000~~, ~~1005~~ 1000 (Cal. 2012); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d ~~481~~, ~~494~~ 481 (Del. 2001); *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d ~~30~~, ~~35~~ 30 (Del. 1994) (applying Missouri law); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 769 N.E.2d ~~835~~, ~~841~~ 835 (Ohio 2002). Some courts adopting the all-sums allocation method emphasize that the standard 1976 CGL policy does not reference periods of self-insurance nor contain mandatory proration provisions, and refuse to craft such terms into the insurance contract. See, e.g., *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d ~~1034~~, ~~1048~~ ~~1049~~ 1034 (D.C. Cir. 1981). Other courts have relied on the principle of construing ambiguous insurance contracts in favor of coverage to justify the all-sums approach. See *Am. Nat. Fire Ins. Co. v. B & L Trucking & Const. Constr. Co.*, 951 P.2d ~~250~~, ~~256~~ 250 (Wash. 1998); *Plastics Eng’g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d ~~613~~, ~~626~~ 613 (Wis. 2009).

f. The extrinsic evidence in favor of the all-sums approach. For a thorough review of the extrinsic evidence suggesting that the drafters of the CGL policy did not intend for long-tail risks to be allocated pro rata between insurers and insureds, see generally EUGENE ANDERSON, JORDAN S. STANZLER & LORELIE S. MASTERS, *INSURANCE COVERAGE LITIGATION* § 4.07 (2d ed. 2015). For a court finding the 1976 CGL policy’s drafting history consistent with the “all sums” approach, see *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d ~~974~~, ~~990~~ ~~991~~ 974 (N.J. 1994). But see *Arco Indus. Corp. v. Am. Motorists Ins. Co.*, 594 N.W.2d ~~61~~, ~~69~~ 61 (*Mich. Ct. App.* 1998), *aff’d*, 462 Mich. 896 (Mich. ~~Ct. App.~~ 2000). For a review of extrinsic evidence related to “stacking” in long-tail claims, see Tom Baker & Eva Orlebeke, *The Application of Per Occurrence Limits from Successive Policies*, 3 ENVIRONMENTAL CLAIMS JOURNAL 411 (1991).

g. Pro rata by limits. Only two jurisdictions have adopted the pro rata by limits approach. See, e.g., *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 995 (N.J. 1994) (classic articulation of the pro rata by limits doctrine); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd’s*, 934 A.2d 517, 527 (N.H. 2007) (“While we need not select a particular method of pro-ration in this case, we observe that in future cases, trial courts should, where practicable, apply the pro-ration by years and limits method described in *Owens-Illinois* for the reasons set forth in that case. If pro rating liability by years and limits is not feasible, trial courts should pro rate by years.”).

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h. The unavailability rule. For a recent statement of public-policy reasons supporting the unavailability rule, see *R.T. Vanderbilt Co., Inc. v. Hartford Acc. & Indem. Co.*, 156 A.3d 539, 581-582 (Conn. App. Ct. 2017), appeal pending (Conn. 2017) (public-policy considerations include maximizing resources to victims and creating incentives for insurers to identify and manage risks). See also *Mayor & City Council of Baltimore v. Utica Mut. Ins. Co.*, 802 A.2d 1070, 1101 (Md. Ct. Spec. App. 2002) (adopting time-on-the-risk for asbestos claims, limiting insured’s responsibility for triggered uninsured periods when insurance was unavailable); *Wooddale Builders, Inc. v. Maryland Cas. Co.*, 722 N.W.2d 283, 297-298 (Minn. 2006) (adopting unavailability rule). See also *Stonewall Ins. Co. v. Asbestos Claims MtgMgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995) (making an Erie prediction about New York, subsequently rejected in *Keyspan*, cited above, and Texas law, which appears to subsequently have adopted the all-sums approach in *Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750, 758-759 (Tex. 2013)); *ContinentalCont’l Cas. Co. v. Indian Head IndustriesIndus., Inc.*, 666 F. App’x 456 (6th Cir. 2016) (applying Michigan law) (dicta making an Erie prediction that the Michigan courts would adopt the unavailability rule but then ruling that the policyholder did not meet its burden of proof regarding unavailability). Cf. *Keene Corp. v. InsuranceIns. Co. of N. Am.*, 667 F.2d 1034, 1058 & n.6 (D.C. Cir. 1981) (Wald, J., concurring) (arguing that proration should be confined to “the period prior to the time when such coverage could no longer be obtained” and stating “I agree, however, that the manufacturer may target one insurance company to defend the suit and that if judgment is awarded for the victim, the targeted insurance company must pay the victim to the extent of coverage and then seek contribution from other on-line insurers. I disagree only to the extent that self-insurers are excluded from contributing.”).

For cases rejecting the unavailability rule, see *Sybron Transition Corp. v. SecuritySec. Ins. of Hartford*, 258 F.3d 595, 600 (7th Cir. 2001) (disagreeing with *Stonewall*, citation above, and making an Erie guess about New York law that was approved in *Keyspan*); *Keyspan Gas EastE. Corp. v. Munich Reinsurance America, Inc.*, 37 N.Y.S.3d 85, 95-96 (App. Div. 2016 Am., Inc., No. 20, 2018 WL 1472635 (N.Y. Mar. 27, 2018)) (rejecting unavailability rule), ~~appeal pending (NY 2017)~~; *AAA Disposal Systems, Inc. v. Aetna Cas. & Sur. Co.*, 821 N.E.2d 1278, 1290 (Ill. 2005) (“weWe understand that insurance coverage was not available for the period at issue, but intervenors cannot shift responsibility for the uninsured years to American Employers.”); *Midamerican Energy Co. v. Certain Underwriters at Lloyds London*, No. CL 107142, 2011 WL 2011374 (Iowa Dist. Ct. Apr. 13, 2011) (“‘unavailability’ exception disproportionately allocate[s] damage[s] to insurers for periods of time when no coverage was agreed to or bargained for”); *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, 315 (Mass. 2009) (“We decline to adopt such an unavailability exception because to do so would contravene the limitation of coverage in the Century policies to liability attributable to property damage during the policy periods. As Century argues in its brief, the unavailability exception ‘effectively provides insurance where insurers made the calculated decision not to assume risk and not to accept premiums. In effect, because the policyholder could not buy insurance, it is treated as though it did by passing those uninsurable losses to insured periods.’”); *Crossman*

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~~Communities~~Cmtys. of ~~North~~N. Carolina, Inc. v. Harleystown Mut. Ins. Co., 717 S.E.2d 589, 598-603 (S.C. 2011) (overruling prior decision adopting the all-sums approach and adopting a pro rata rule that does not include the unavailability rule); Bradford Oil Co. v. Stonington Ins. Co., 54 A.3d 983, 988-991 (Vt. 2011) (confirming that Vermont applies the pro rata by years approach without application of the unavailability rule).

i. Exhaustion, deductibles, SIRs, and settlement. Under the pro rata by years approach to allocation followed in this Section, each year is allocated its pro rata portion of the overall losses, and then, within that year, self-insured-retentions are satisfied and policy limits are consumed according to the terms of the policies in that year. This approach, which best comports with the pro rata by limits allocation theory, is sometimes referred to as “pro rata by time with vertical exhaustion,” but it can also be understood as a form of horizontal exhaustion. ~~ALAN S. RUTKIN, ROBERT TUGANDER & JOHN W. EGAN~~4-39 LEO P. MARTINEZ, MARC S. MAYERSON, DOUGLAS R. RICHMOND & JEFFREY E. THOMAS, NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE § 39.13 (2015). Pro rata with vertical exhaustion is used by the New Jersey courts. See, e.g., Owens-Illinois Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994); Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d ~~116~~1116 (N.J. 1998); and Benjamin Moore & Co. v. Aetna Cas. & Sur. Co., 843 A.2d 1094 (N.J. 2004). For courts adopting the pro rata by years approach and applying a different version of horizontal exhaustion, see, e.g., Atchison, Topeka & Santa Fe ~~Ry~~R.R. Co. v. Stonewall Ins. Co., 71 P.3d ~~1097, 1132~~1097 (Kan. 2003); Cole v. Celotex Corp., 599 So. 2d ~~1058, 1080~~1058 (La. 1992); Mayor & City Council of Baltimore v. Utica Mut. Ins. Co., 802 A.2d ~~1070, 1105~~1070 (Md. Ct. Spec. App. 2002); Olin Corp. v. Ins. Co. of N. Am., 221 F.3d ~~307, 324~~307 (2d Cir. 2000) (applying New York law); Pub. Serv. Co. of Colorado v. Wallis & ~~Companies~~Cos., 986 P.2d 924, 941-~~942~~ (Colo. 1999) (“Within each policy-year, the allocation of that \$100,000 of liability depends on the structure of the insurance. Primary insurance, or alternatively, any SIRs, must first be exhausted. If liability remains after that, then policies in the first layer of excess for that year are required to respond, then policies in the second layer of excess, and so on. Where there are two or more policies within the same layer of excess, then liability is apportioned according to the degree of risk assumed by each policy.”); Thomson Inc. v. Ins. Co. of N. Am., 11 N.E.3d ~~982, 1011~~982 (Ind. Ct. App. 2014); Norfolk Southern Corp. v. California Union Ins. Co., 859 So. 2d ~~167, 198-199~~167 (La. Ct. App. 2003); Boston Gas Co. v. Century Indem. Co., 910 N.E.2d ~~290, 303-n.28~~290 (Mass. 2009). Some courts that purport to apply pro rata by years with horizontal exhaustion seem in fact to be applying what the New Appleman refers to as “pro-rata by time with vertical exhaustion,” confirming the view that the exhaustion rule followed in this Section is a form of horizontal exhaustion. See, e.g., Mayor and City Council of Baltimore v. Utica Mut. Ins. Co., 802 A.2d 1070, ~~1104~~1105 (Md. 2002) (“Because the allocation will be based on the time on the risk, some primary policies that provide less coverage will be exhausted sooner than others, and their excess insurers, if any, would accordingly have to respond at an earlier point.”). Other courts do not use the term vertical stacking or horizontal stacking, but appear to be deploying an approach similar to the one followed in this Section. See, e.g., Lincoln Elec. Co. v. St. Paul Fire & Marine Ins. Co., 210 F.3d

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~~672, 690-691~~[672](#) (6th Cir. 2000).

Under the pro rata by years approach, one insurer’s settlement has no effect on other insurers’ obligations to indemnify the insured for their respective policy periods. See *Pub. Serv. Co. of Colorado v. Wallis & Companies Cos.*, 986 P.2d 924, 942 (Colo. 1999) (“Wallis has conceded that if liability is allocated according to the time-on-the-risk method, then it is not also entitled to a set-off for the amounts that PSC received in settlement agreements with its other insurers. We agree.”); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 139 (Utah 1997) (“We therefore conclude that it is more equitable to hold that an insurer who is on notice that another insurer has been paying significant defense costs should not be allowed to settle for a minimal sum to avoid having to contribute its fair share.”). For a discussion of how settlement is handled under all-sums approaches, see § 43.

j. Other-insurance clauses. For cases holding that other-insurance clauses do not apply to successive insurance policies, see, e.g., *Alticor, Inc. v. Nat’l Union Fire Ins. Co. of Pennsylvania*, 916 F. Supp. 2d 813, 828-829 (W.D. Mich. 2013) (“Federal courts have consistently held that successive or consecutively issued insurance policies do not implicate ‘other insurance’ provisions within those policies.”) (collecting cases); *Plastics Eng’g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613, 624 (Wis. 2009) (“The purpose of an ‘other insurance’ clause is to define which coverage is primary and which coverage is excess between policies.”) (citing *ARNOLD P. ANDERSON, WISCONSIN INSURANCE LAW* § 11.2 (5th ed. 2004)) (“Whenever there are two policies that apply to the same insured at the same time, the issue of which policy must pay first—or which is primary and which is excess—is dealt with by other insurance clauses.”). Courts adopting both the “all sums” and pro rata allocation approaches have found that other-insurance clauses are meant to apply only to overlapping coverage among policies issued within a given policy year and should not be interpreted to apply to the allocation issue among the relevant years. See, e.g., *Arco Indus. Corp. v. Am. Motorists Ins. Co.*, 594 N.W.2d 61, 70 (Mich. Ct. App. 1998) (“‘Other insurance’ clauses do not provide a solution to the allocation problem here because they were not meant to allocate liability among successive insurers. . . . Rather, they relate to the effect of concurrent coverages of a single occurrence.”) (citing Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257, 278 (1997)); *Ohio Cas. Ins. Co. v. Unigard Ins. Co.*, 268 P.3d ~~180, 184~~[180](#) (Utah 2012); *Plastics Eng’g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d ~~613, 624-625~~[613](#) (Wis. 2009). But see *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1050 (D.C. Cir. 1981) (“When more than one policy applies to a loss, the ‘other insurance’ provisions of each policy provide a scheme by which the insurers’ liability is to be apportioned. . . . These provisions of the policies must govern the allocation of liability among the insurers in any particular case.”).

l. Independent and concurrent allocation of defense costs. For authorities adopting the rule of independent and concurrent responsibility for defense costs in cases in which injury occurs in successive policy periods, see, e.g., *Haskel, Inc. v. Superior Court*, 39 Cal. Rptr. 2d 520, 526 ([Cal.](#) Ct. App. 1995) (insurer’s offer to pay only a pro rata portion of the defense costs

is a breach of the duty to defend as long as there is any potential for coverage); ~~Continental~~Cont'l Western Ins. Co. v. Colony Ins. Co., 69 F. Supp. 3d 1075 (D. Colo. 2014) (applying Colorado law) (successive insurers each have an independent obligation to provide a complete defense); Ray Indus. Inc. v. Liberty Mut. Ins. Co., 974 F.2d 754, 770 (6th Cir. 1992) (applying Michigan law) (the insurer was liable for all of the defense costs even though its coverage period was limited to five of 14 years triggered by insured's environmental liability). (Abrogation recognized by Employers Ins. of Wausau v. Petroleum Specialties, Inc., 69 F.3d 98 (6th Cir. 1995) on different grounds.) For courts that have adopted the pro rata approach to defense costs in cases involving multiple triggered policies over consecutive policy periods, see, e.g., Arceneaux, ~~et al.~~ v. Amstar Corp., ~~et al.~~, 200 So. 3d 277, 289 (La. 2016) (allocating defense costs according to the insurer's time on the risk); Cont'l Cas. Co. v. Indian Head Industries, Inc., 666 F. App'x 456, ~~466, 2016 WL 7321362~~466 (6th Cir. 2016) (applying Michigan law) (applying pro rata allocation of defense costs under a general-liability policy for claims for bodily injury arising from exposure to the insured's asbestos-containing products, disagreeing with *Ray Indus.*); Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 826 A.2d 107, 123 (Conn. 2003) (allocating defense costs based on time on the risk, "because the duty to defend arises solely under contract and because the insurance companies have not contracted to defend the insured for periods outside the policy period."); Towns v. N. Sec. Ins. Co., 964 A.2d 1150, 1167 (Vt. 2008) (pro rata allocation of both defense and indemnity costs between the policyholder and the insurer, based on the portion of defense costs the insured must bear itself, because "property where the policyholder is self-insured for any period of time on the risk, ... it is equally fair and reasonable to hold the policyholder responsible for that portion of the total defense and indemnity costs over which he or she chose to assume the risk."); Sharon Steel Corp. v. Aetna Cas. & Sur. Co., 931 P.2d 127, 142 (Utah 1997) ("[P]roperty owners must be prepared to pay their 'fair share' of defense costs for those years that they were without insurance coverage.") (agreeing with Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980).)

§ 42. Contribution

(1) An insurer that indemnifies an insured for a legal action has a right of contribution against any other insurer with an indemnification obligation to that insured for that action to the extent that:

- (a) The first insurer has paid more than its share of the costs;**
- (b) The other insurer has not settled with and been released by the insured;**

and

- (c) The other insurer has paid less than its share of the costs.**

(2) In determining the insurers’ share of the costs, principles of restitution and unjust enrichment apply, subject to any ~~consistent~~–allocation terms contained in the liability insurance policies at issue that are consistent with each other.

Comment:

a. The basic rule. It is frequently the case that liability insurance policies issued by more than one insurer provide coverage for the same legal action. This can happen when multiple concurrent policies cover a legal action. It can also happen when a harm or activity triggers liability insurance policies covering multiple successive policy periods. An insurer that pays more than its share of the costs for a legal action has a right of contribution against another insurer that has not paid its share of those costs, even if there is no term in the insurance policy that grants such a right. This equitable right of contribution rests on principles of restitution and unjust enrichment. See generally §§ 23 and 24 of the Restatement Third, Restitution and Unjust Enrichment (governing performance of a joint obligation and equitable subrogation).

b. The role of allocation terms and the pro rata default contribution rule. When multiple insurance policies with overlapping indemnification obligations contain consistent allocation terms, those allocation terms also determine the contribution obligations among the insurers. For example, when multiple concurrently issued policies have consistent other-insurance terms, those terms determine the scope of the contribution obligation among the insurers. See § 40, Comment *c*. The same is true when multiple successively issued policies covering the same costs have consistent allocation terms. See § 41, Comment *j*. In both settings, courts generally attempt to reconcile allocation terms. See also § 20 (regarding the order of priority of defense obligations).

When, however, the overlapping insurance policies do not contain allocation terms or contain inconsistent terms, the contribution obligation among the insurers is determined based on principles of restitution and unjust enrichment. Those principles typically lead to a pro rata contribution rule among insurers. See Restatement Third, Restitution and Unjust Enrichment § 24, Illustration 17 (illustrating a pro rata contribution rule among primary insurers that “separately insured C in the same amount against identical risks”). With regard to defense costs under duty-to-defend policies in which defense costs are paid in addition to the limits of the insurance policies, the pro rata contribution rule is an equal division of costs among all triggered policies, subject to the order of priority rules stated in § 20.

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Liability Insurance

With regard to the costs of settlements or judgments or to defense costs that are included within the limit of liability insurance policies, the pro rata contribution rule depends on the nature of the overlap among the policies. In the context of successively overlapping policies and indivisible harms, there is generally no need for one insurer to seek contribution from another (as long as there are no concurrently overlapping policies in the insurance program at issue), since each insurer is liable in the first instance only for its pro rata share of the covered costs. This is one of the primary advantages of the pro rata by years approach to allocation in such cases: contribution is made moot because no one is liable for more than their share, similar to several liability in tort. See § 41, Comment *c* (describing the pro rata by years formula). Thus, in jurisdictions that follow the pro rata by years allocation rule stated in § 41 as the rule governing allocation between insurers and insureds in cases of indivisible long-tail harm, there should be no need for any contribution actions in a long-tail-harm case, because the application of that allocation rule would mean that no insurer would be required to pay more than its pro rata share of the liability.

In the context of concurrently overlapping policies, however, the pro rata contribution rule generally follows a pro rata by limits formula, pursuant to which the insurers' respective shares are a function of the percentage of the total available insurance represented by each of the policies. See § 41, Comment *g* (describing the pro rata by limits formula). In such policies the independent, concurrent nature of each insurer's obligation could well lead to a situation in which one insurer has paid more than its pro rata share of a settlement or judgment and, thus, contribution is required.

Whatever contribution rule is applied, an insurer's contribution obligation is subject to the limits of the liability insurance policy in question. Once the insurer has exhausted those limits in the payment of costs insured under the policy, the insurer no longer has an indemnification obligation that could serve as the basis for a contractual or equitable contribution claim (except and to the extent that the insured has a special right against the insurer in the circumstances, for example, for breach of the duty to make reasonable settlement decisions or for insurance bad faith).

c. No contribution from settling insurers. As reflected in subsection (1)(b), the prevailing rule is that an insured has the power to settle with an insurer and release that insurer from any equitable subrogation or contribution obligations that might be asserted by another insurer with

regard to the same legal action. This rule promotes settlements between insured and insurer by allowing a settlement to conclusively and finally determine the settling parties' obligations. In the absence of such a rule, the settling insurer would face the risk of future contribution actions, and the settling insured would face the risk that future contribution actions would provide a basis for the insurer to seek recovery from the insured under the settlement agreement. Of course, denying the non-settling insurer a right of contribution against the settling insurer may result in the former paying more than its share of the costs. To prevent the non-settling insurer from paying more than is required to indemnify the insured for its costs (and thereby giving the insured a double recovery) the non-settling insurer receives a credit against its liability to the insured that reflects the fact of these settlements. See § 43. In addition, that credit compensates the non-settling insurance company for loss of its contribution claim.

Illustrations:

1. Driver is sued by Pedestrian for injuries arising out of an auto accident. Driver is the named insured under an auto liability insurance policy issued by Insurer A and an insured under the omnibus clause of an auto liability insurance policy issued by Insurer B. Both policies contain an applicable "other insurance" clause which provides that in such a situation covered costs will be allocated between the two policies on a pro rata by limits basis. Insurer A issued a policy with an applicable policy limit of \$100,000. Insurer B issued a policy with an applicable policy limit of \$50,000. Insurer A agrees to provide that defense. The case results in a verdict of \$100,000. Driver directs Insurer A to pay the verdict. Subject to the exercise of any appeal rights, Insurer A must do so, but Insurer A may then seek contribution from Insurer B for one third of the costs Insurer A incurred defending the suit, pursuant to § 20, and one third of the verdict pursuant to this Section. In that contribution action, Insurer B may assert any grounds for contesting coverage that it has with regard to the suit.

2. Same facts as Illustration 1, except that the policies issued by Insurers A and B do not have consistent other-insurance clauses. Applying § 20 and the equitable doctrine of restitution, Insurer A must defend and pay the claim, but may seek recovery for half of the costs from Insurer B, subject to Insurer B's coverage defenses.

3. A series of asbestos-related lawsuits is brought against Insured. The bodily injuries that give rise to the suits occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the harm occurred in each of the 10 years. During this 10-year period, Insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4; Insurer B issued policies covering years 5-8; and Insurer C issued policies covering years 9 and 10. Assuming there is no consistent allocation term in the relevant policies dealing with successively overlapping coverage, under the pro rata by years allocation method adopted in § 41, 10 percent of the total liability costs is allocated to each of the 10 years, as if that portion of the harm occurred in that year. Thus, each of the insurers is responsible to the insured for no more than the lesser of that insurer’s policy limits or its pro rata share of the total liability costs attributable to the years in which that insurer’s policy was on the risk, subject to that insurer’s defenses against coverage. Because no insurer can be held liable for more than its pro rata portion of the liability costs, no separate contribution action is necessary.

REPORTERS’ NOTE

a. The basic rule. For cases affirming and applying the general equitable right of contribution among insurers, see, e.g., *Am. Emp-^{rs} Ins. Co. v. Maryland Cas. Co.*, 218 F.2d 335, 338 (4th Cir. 1954) (applying Virginia law) (“The doctrine of contribution does not rest upon contract but upon general principles of equity and natural justice.”); *Am. States Ins. Co. v. Nat’l Fire Ins. Co. of Hartford*, 135 Cal. Rptr. 3d 177, 183 (Cal. Ct. App. 2011) (“[T]he reciprocal contribution rights of coinsurers who insure the same risk are based on the equitable principle that the burden of indemnifying or defending the insured with whom each has independently contracted should be borne by all the insurance carriers together, with the loss equitably distributed among those who share liability for it.”) (quoting from *Fireman’s Fund Ins. Co. v. Maryland Casualty Co.*, ~~65 Cal. App. 4th 1279, 1293, 1294-1295~~, 77 Cal. Rptr. 2d ~~296~~296, 304 (1998)) (“In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others.”); *State Farm Mut. Auto. Ins. Co. v. Union Ins. Co.*, 147 N.W.2d 760, 763 (Neb. 1967) (“[W]e conclude that where both companies stand on an equal footing, equity requires an equal apportionment of the loss.”); *Cosmopolitan Mut. Ins. Co. v. Cont’l Cas. Co.*, 147 A.2d 529, 534 (N.J. 1959) (collecting cases) (“We therefore conclude that as both companies stand on an equal footing

equity requires an equal apportionment of the amount of the settlement and expenses.”); Mutual Mut. of Enumclaw Ins. Co. v. USF Ins. Co., 191 P.3d ~~866, 874-875~~ 866 (Wash. 2008).

For a general discussion of the law of contribution and the related concept of subrogation in terms of restitution, see generally Restatement Third, Restitution and Unjust Enrichment § 23 (AM. LAW INST. 2011) (on indemnity and contribution) and id. § 24 (on equitable subrogation). For a general discussion of the rules governing contribution among insurance companies with overlapping coverage obligations, see generally ~~LEE R. RUSS & THOMAS F. SEGALLA~~ 15 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE ch. 217 et seq. (3d ed. ~~2011~~ 2017). For a general discussion of the rules regarding subrogation as applied to insurance companies and the relationship between these rules and the rules governing contribution, see 16 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE ch. 222 (3d ed. ~~2011~~ 2017).

b. The role of allocation terms and the pro rata default contribution rule. Absent other-insurance terms in the respective policies, the majority default rule for overlapping concurrent policies is to apply a pro rata by limits contribution method among the insurers. See 15 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 217:9 (3d ed. ~~2011~~ 2017) (“The dominant view . . . appears to be that the insurance obligation should be shared by the various insurers pro rata in the proportion that their respective policy limits bear to the entire loss, even though the policies contain no provisions for such a pro rata allocation. Within this approach, proration has been computed based on the insurer’s actual exposure for the accident, not on its maximum policy limits.”) (collecting cases); see also Great Am. Ins. Co. of New York v. N. Am. Specialty Ins. Co., 542 F. Supp. 2d 1203, 1212 (D. Nev. 2008) (“As a general rule, an insured’s loss should be ‘equitably distributed among those who share liability for it in direct ratio to the portion each insurer’s coverage bears to the total coverage provided by all the insurance policies.’”) (quoting Fireman’s Fund Ins. Co. v. Md. Casualty Co., ~~65 Cal. App. 4th 1279, 1294 n.4~~, 77 Cal. Rptr. 2d ~~296~~ 296, 304 (1998)).

The minority rule is to allocate the loss equally among the insurers. See 15 ~~LEE R. RUSS & THOMAS F. SEGALLA~~ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 217:9 (3d ed. ~~2011~~ 2017) (collecting cases). See also E.R. Squibb & Sons, Inc. v. Accident & Cas. Ins. Co., 860 F. Supp. 124, 127 (S.D.N.Y. 1994) (“The pro rata approach does not mean that an insurer’s duty to pay another insurer takes priority over its obligation to pay the insured where other insurers are not responsible for a given claim because of exhaustion of policy limits or inapplicability of other policies to the time period involved.”). In some jurisdictions, insurers’ contribution requirements are prescribed by statute. See, e.g., Minn. Stat. Ann. § 65A.08 Subd. 4 (“If there are two or more policies upon the property, each shall contribute to the payment of the whole or partial loss in proportion to the amount specified.”). Cf. Restatement Third, Restitution and Unjust Enrichment § 23, Comment *a* (AM. LAW INST. 2011) (where contracts specify how to divide the parties’ joint obligations, “a claim to indemnity or contribution is governed by the parties’ agreement, not by the law of

restitution.”). Although the ~~R3RUE~~ [Restatement Third, Restitution and Unjust Enrichment](#) specifies that contribution rights among insurers in this situation derive from equitable subrogation, which is covered by § 24 of that Restatement, not by § 23, the underlying principle that equity should recognize the obligations that the parties agreed by contract to assume is the same. It is not unjust for an insurer with a pro rata allocation clause in its policy to be able to obtain contribution from another insurer that has paid less than its pro rata share of the liability.

For cases discussing the fact that no separate contribution action is necessary in jurisdictions that have adopted the pro rata allocation method for long-tail successively overlapping insurance situations, see, e.g., *Towns v. N. Sec. Ins. Co.*, [184-964 A.2d 1150, 1167](#) (Vt. ~~322, 346~~ (2008)) (“Courts and commentators have also recognized that the time-on-the-risk method offers several policy advantages, including . . . easily identifying each insurer’s liability through a relatively simple calculation, and reducing the necessity for subsequent indemnification actions between and among the insurers.”) (citing *Olin Corp. v. Ins. Co. of N. Am.*, 221 F.3d 307, 323 (2d Cir. 2000)); *Olin Corp. v. Ins. Co. of N. Am.*, 221 F.3d 307, 323 (2d Cir. 2000) (“[W]here the policies triggered are provided by multiple insurers, [pro rata] allocation avoids . . . the burden of bringing a subsequent contribution action . . .”).

c. No contribution from settling insurers. For courts holding that insurers do not have a contribution right against settling insurers, which is the rule followed in this Section, see, e.g., *Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1453 (3d Cir. 1996) (applying Pennsylvania law) (providing a “set-off” of the settling insurers’ apportioned share of liability instead of the right to contribution); *GenCorp, Inc. v. AIU Ins. Co.*, 297 F. Supp. 2d 995, 1001-1002 (N.D. Ohio 2003), *aff’d*, 138 F. App’x 732 (6th Cir. 2005) (applying Ohio law) (providing non-settling insurers with settlement credits instead of contribution rights). This is also the rule adopted by the Restatement Third, Torts: Apportionment of Liability § 24 (AM. LAW INST. 2000). Some jurisdictions do permit non-settling insurers to maintain contribution actions against a settling insurer. See, e.g., *Fireman’s Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App. 4th 1279, 1289 (Cal. Ct. App. 1998) (“[W]e hold that one insurer’s settlement with the insured is not a bar to a separate action against that insurer by the other insurer or insurers for equitable contribution or indemnity.”); *Potomac Ins. Co. of Illinois ex rel. OneBeacon Ins. Co. v. Pennsylvania Mfrs. Ass’n Ins. Co.*, 41 A.3d 586, 598 (N.J. Super. Ct. App. Div. 2012) (holding settlement between one insurer and insured did not extinguish another insurer’s right to seek contribution). Other courts rely on a case-by-case analysis and equitable principles to determine contribution rights between settling and non-settling insurers. See *Maryland Cas. Co. v. W.R. Grace & Co.*, 218 F.3d 204, 211 (2d Cir. 2000) (applying New York law) (“[T]he contract of settlement an insurer enters into with the insured cannot affect the rights of another insurer who is not a party to it. Instead, whatever obligations or rights to contribution may exist between two or more insurers of the same event flow from equitable principles.”).

§ 43. The Effect of Partial Settlements on Amounts Owed by Non-Settling Insurers

In determining the declaration of rights and amount of any judgment to be entered against a liability insurer with respect to the insurer's obligation to provide coverage for a legal action brought against an insured, the amount of the insured's losses that are the subject of the declaration or judgment **are reduced by the amount paid for those losses by any insurers that settled with and were released by the insured with respect to that legal action.**

Comment:

a. Settlement credits generally. Under the contribution rules followed in § 42, an insurer that has paid more than its share of a defense or indemnification obligation has a right of contribution against any other insurer that has not paid its share. This right of contribution, however, does not extend to insurers that have settled with the insured, for reasons stated in Comment *c* to § 42. Granting a non-settling insurer credit for the amounts paid for a covered legal action by a settling insurer eliminates the potential for a double recovery by the insured. Under the rule followed in this Section, a non-settling liability insurer is entitled to a credit against its coverage obligations of the amount paid by a released settling insurer.

b. Settlement credits when the allocation rule is pro rata. In circumstances in which the rule of allocation is pro rata, as provided under § 40(2) (when concurrently overlapping policies all have a consistent pro rata other-insurance clause) and § 41 (in the case of long-tail indivisible harms), there ordinarily should be no need for contribution actions or, accordingly, for a settlement-credit rule (unless there is a policy year in which there are multiple concurrently overlapping policies). Under the pro rata rule of allocation, each year is apportioned its pro rata share of liability. Once that allocation is made, each insurer is responsible for, and is *only* responsible for, its share of the portion of the liability allocated to that year. Therefore, if one insurer enters into a settlement agreement with respect to its pro rata share of the liability costs, such a settlement agreement has no bearing on the pro rata liability of insurers in other policy periods.

c. Settlement credits when insurers are independently and concurrently liable for a covered legal action. When insurers are independently and concurrently liable for a covered action, there often will be a need for a contribution action and, thus, a settlement-credit rule. There are two competing settlement-credit rules in the insurance case law: the minority pro rata rule and the majority pro tanto rule. Under the pro rata rule, the credit is determined on the basis

of the settling insurer's apportioned pro rata share of the liability. Under the pro tanto rule, the non-settling insurer is entitled to a credit equal to the amount of the actual settlements of the settling insurers. This amount will tend to be significantly smaller than the credit produced by the pro rata rule. Note that courts often apply a pro tanto rule in insurance cases without describing it as such. Instead, they generally describe what they are doing as granting a credit against the amount owed by one insurer that is equal to the amount already paid by another insurer in order to prevent a double recovery by the policyholder.

As discussed in the Restatement Third, Torts: Apportionment of Liability § 16, Comment *c*, where the question is the effect of partial settlements on jointly and severally liable tortfeasors' liability, "[n]o perfect method exists." Each of these approaches has advantages and disadvantages relative to the other. Note that, although courts sometimes refer to the independent, concurrent liability of insurers as "joint and several" liability, this Restatement does not do so, because importing that tort-law terminology into insurance-contract law has the potential to confuse the nature of the insurers' responsibility.

A putative advantage of the pro tanto rule followed in this Section is that it tends to encourage early, partial settlements relative to the pro rata settlement-credit rule. Under the pro tanto rule, the insured knows that an early, relatively low amount with one insurer does not eliminate the chance to obtain a full recovery for the remainder of its losses from a non-settling insurer at trial, subject to the non-settling insurer's policy limit. Whether encouraging such early, partial settlements is socially desirable, however, is not clear. Early partial settlements can be good for insureds if those insureds have an acute and immediate need for money. However, encouraging early partial settlements has ambiguous effects on the likelihood of overall settlements. Settling relatively early with some insurers may induce insureds to be less willing to settle with the non-settling insurers later in the process. Thus, if encouraging overall resolution of the coverage controversy is a goal of the choice of the appropriate settlement-credit rule, it is not clear which rule is better.

Moreover, by encouraging relatively low early partial settlements, the pro tanto rule also raises the risk of unfairly excessive liability for non-settling insurers. See Restatement Third, Torts: Apportionment of Liability § 16, Comment *c* (discussing this effect in the context of joint and several tortfeasors). Notwithstanding this risk, this Section follows the pro tanto rule—which is the prevailing liability insurance law rule—when there are multiple insurers with independent

contractual obligations to cover the same legal action (that is, when the court determines that pro rata allocation is inapplicable). Courts considering pro tanto credits can ameliorate the concern about excessive liability for non-settling insurers by examining the good-faith nature of the settlements between the insured and the settling insurers.

Another primary justification for the pro tanto rule is that, by definition, in such situations each insurer has an independent, concurrent obligation to provide separate coverage for the costs in question. By contrast, when courts apply the pro rata allocation rule (as discussed in Comment *b*), they have determined that the insurers' obligations are not independent and overlapping. In the case of a long-tail claim subject to the rule in § 41, the insurers' obligations are independent, but not overlapping; each insurer is independently and only responsible for coverage for its pro rata time on the risk. In the case of concurrent policies that have contracted around the default rule in § 40(1), the insurers' obligations are not independent; the availability of coverage under one policy affects the amount owed under another. Adopting a pro rata settlement-credit rule would have a similar effect as a pro rata allocation rule, undermining the independent, concurrent nature of the insurers' obligations.

In adopting the pro tanto rule for settlement credits, liability insurance law differs from the tort-law rule in the context of joint and several liability in tort, as adopted in the Restatement Third, Torts: Apportionment of Liability § 16, Comment *c*. This difference follows from the difference between the rules of allocation in tort and insurance law. In tort law, most jurisdictions have adopted a rule that allocates responsibility for the harms caused by joint tortfeasors among those tortfeasors on the basis of their comparative fault, so that each joint tortfeasor bears the costs of the jointly caused tort according to the degree of that tortfeasor's responsibility for the harm. The more negligent a tortfeasor is relative to the other tortfeasors, the greater its share of the liability should be. In the context of overlapping insurance policies, there is no concept of fault that corresponds to that underlying comparative responsibility in tort law. No insurer in such situations is more or less at fault or responsible for the insured's losses. When insurers have independent, concurrent liability for a legal action, no insurer is at fault for the insured's losses and, thus, a partial settlement by one insurer results in no injustice or unfairness to a non-settling insurer, even if the partial settlement is for a relatively low amount. While a non-settling insurer may pay more than the early settling insurer, the non-settling insurer is not worse off than it

would have been had there been no other independently liable insurer, and it will never have to pay more than the cost of the legal action for which it is independently liable.

Illustrations:

1. A series of asbestos-related lawsuits is brought against the insured involving \$100 million of total liability costs. The bodily injuries that give rise to the suits occurred continuously over a period of 10 years. Although it can be determined that some bodily injury occurred in each of the 10 years, it cannot be determined precisely how much of the \$100 million of harm occurred in each of the 10 years. During this 10-year period, the insured was covered under an array of CGL policies issued by three different insurers, as follows: Insurer A issued policies covering years 1-4; Insurer B issued policies covering years 5-8; and Insurer C issued policies covering years 9 and 10. Each of the policies at issue has annual limits greater than \$10 million. Assuming there is no consistent allocation term in all of the policies, under the pro rata by years method of allocation adopted in § 41, the total liability costs are allocated on a pro rata by time on the risk basis, with each insurer being responsible for \$10 million per year of coverage, subject to the insurer's defenses against coverage for those years. Insurers A and B raise a coverage issue. In response, the insured settles with Insurers A and B for \$2 million each. If the insured secures a judgment against non-settling Insurer C, because that judgment will be no greater than Insurer C's pro rata share of liability, the settlement has no effect on the judgment.

2. Plaintiff sues Insured Retailer for product liability. The product-liability suit is potentially covered by two general-liability policies: Retailer's general-liability policy, issued by Insurer A, and the manufacturer's general-liability policy, issued by Insurer B. (The latter policy has a "broad form" vendor endorsement that covers Retailer.) The two policies have identical policy limits. Both liability insurers reserve their rights to contest coverage, while arranging for the retailer to receive a defense. Following the procedure stated in § 25, Retailer settles the product-liability suit without the consent of the insurers. Following this settlement, Retailer seeks coverage from both Insurer A and Insurer B. Retailer settles the coverage dispute with Insurer A for an amount equal to 20 percent of the settlement amount of the product-liability suit. Retailer secures a judgment against

Insurer B for 100 percent of the retailer’s tort settlement. Insurer B is entitled to a settlement credit equal to the amount Insurer A paid to Retailer to settle the coverage dispute.

REPORTERS’ NOTE

a. Settlement credits generally. Most courts place the burden on the insurer to prove it is entitled to settlement credits. See, e.g., *United Techs. Corp. v. Am. Home Assurance Co.*, 237 F. Supp. 2d 168, 173 (D. Conn. 2001) (insurer “bears the burden of establishing the existence of a double recovery.”); *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115, ~~126-127~~ (Wash. 2000) (“The burden of showing entitlement to an exclusion of liability based upon the existence of other insurance is properly [the insurer’s].”). But see *Litho Color, Inc. v. Pacific Employers Pac. Emp’rs Ins. Co.*, 991 P.2d 638, 644-645 (Wash. Ct. App. 1999) (placing the burden on the insured, which it failed to meet, and thus off-setting non-settling insurer’s liability by the full settlement amount). Note that in discussing this burden the underlying policy justification is assumed to be preventing a double recovery, not a concern about fairness to the non-settling insurer.

c. Settlement credits when insurers are independently and concurrently liable for a covered legal action. The majority of jurisdictions that have addressed the settlement-credit question in cases in which insurers are independently and concurrently liable have used the pro tanto approach, though not always describing what they are doing using the term “pro tanto.” See, e.g., *Childs v. New Jersey Mfrs. Ins. Co.*, 531 A.2d 723, 727 (N.J. 1987) (applying pro tanto credits to auto policies); *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115, 125 (Wash. 2000) (allowing settlement credit only to prevent a double recovery); *Stewart Title Guaranty Guar. Co. v. Sterling*, 822 S.W.2d 1 (Tex. 1991) (applying Texas “one satisfaction rule” to insurance and allowing settlement credit equal to amount of settlement); *Mass. Elec. Co. v. Commercial Union Ins.*, [No. 9900467B](#), 2005 ~~Mass. Super. LEXIS 548~~, [WL 3489874](#), at *~~52-73~~ (Mass. Super. Ct. [Oct. 25, 2005](#)) (choosing pro tanto credits over pro rata credits in a cleanup case); *Liberty Mut. Ins. Co. v. Black & Decker Corp.*, 383 F. Supp. 2d 200, 216-217 (D. Mass. 2004) (choosing pro tanto credits in cleanup case). Especially in long-tail cases that take the “all sums” approach to allocation rejected in § 41, some courts have adopted a pro rata or proportionate-share approach to settlement credits in circumstances in which the insurers are considered independently responsible for the loss in question. See, e.g., *Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1453 (3d Cir. 1996) (adopting a pro rata setoff rule for insurer settlements in an all-sums regime). See also [1-18](#) RANDY MANILOFF & JEFFREY STEMPEL, GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE ~~60~~[§ 18](#) (3d ed. 2015) (“The most equitable approach to reallocation is the ‘apportioned share setoff’ method recognized by the Third Circuit Court of Appeals in applying Pennsylvania law.”) (citing *Koppers*).

Ch. 3. General Principles Regarding the Risks Insured

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CHAPTER 4 ENFORCEABILITY AND REMEDIES

TOPIC 1 ENFORCEABILITY

§ 44. Implied-in-Law Terms and Restrictions

(1) A term that is required by law to be included in a liability insurance policy is so included by operation of law notwithstanding its absence in the written policy.

(2) A liability-insurance-policy term is unenforceable ~~on public-policy grounds if:~~

(a) legislation ~~provides that it is unenforceable~~ prohibits enforcement, or

(b) the interest in its enforcement is clearly outweighed in the circumstances by a public policy against ~~the enforcement of such term.~~

Comment:

a. Implied-in-law terms generally. This Section contains liability insurance law applications of general contract-law rules regarding implied-in-law terms and restrictions. Any authoritative source of positive law may lead to an implied-in-law liability insurance term or restriction. Generally, those sources are statutes, regulations, and the common law. Typically, the applicable statutes and regulations are part of the state insurance code or regulations, but there can be liability insurance requirements in other parts of state statutes or regulations.

b. Terms that are unenforceable on public-policy grounds. Subsection (2) restates for the liability insurance context the general contract-law rule regarding terms that are unenforceable on grounds of public policy. See Restatement Second, Contracts § 178(1). As in that Restatement, the term “legislation” is used in this Section in a broad sense to include any fixed text enacted by a body with authority to promulgate rules, including not only statutes but also constitutions and local ordinances, as well as administrative regulations issued pursuant to them. See Restatement Second, Contracts § 178, Comment *a*.

c. Terms or coverage contrary to judicially declared public policy. Although it is rare for courts to declare that a term in, or coverage provided by, a liability insurance policy is unenforceable because of a judicially recognized public policy, such examples exist, most commonly in relation to the topics addressed in § 45.

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d. Factors to be considered. Under Restatement Second of Contracts § 178, the factors to be considered in weighing the interest in the enforcement of a term are: (a) the parties' justified expectations, (b) any forfeiture that would result if enforcement were denied, and (c) any special public interest in the enforcement of the particular term. The factors to be considered in weighing a public policy against enforcement of a term are: (a) the strength of that policy as manifested by legislation or judicial decisions, (b) the likelihood that a refusal to enforce the term will further that policy, (c) the seriousness of any misconduct involved and the extent to which it was deliberate, and (d) the directness of the connection between that misconduct and the term.

e. Effect of violation of a state form-review law. State insurance regulatory codes generally require insurance companies to submit all consumer liability insurance forms and most commercial liability insurance forms to the state insurance department for review before those forms may be used in insurance policies sold in the state. The remedy for violating such requirements is a matter of state administrative law. Remedies include fines and other measures directed at encouraging compliance with these requirements. Courts uniformly enforce a liability insurance policy, or a term in a policy, that has not been subject to a required form-review process, except to the extent that the term is otherwise contrary to public policy. If the insured demonstrates that the form-review process would have resulted in a determination that the term could not lawfully be used in the insurance policy at issue, then the term is contrary to public policy and, thus, subject to the balancing-test analysis stated in subsection (2).

REPORTERS' NOTE

a. Implied-in-law terms generally. For examples of courts refusing to enforce policy terms that conflict with implied-in-law terms, see Nat'l City Cnty. Mut. Fire Ins. Co. v. Johnson, 879 S.W.2d 1, 3-5 (Tex. 1993) (holding that an auto liability insurance policy's household exclusion was void because it conflicted with a statute whose purpose was to ensure that all claims for losses arising out of all vehicles' operation were covered by insurance); Nationwide Mut. Ins. Co. v. Aetna Life & Cas. Co., 194 S.E.2d 834, 838 (N.C. 1973) (holding that an auto liability insurance policy's exclusion purporting to eliminate coverage when a vehicle was used by a person employed or engaged in the automobile business was unenforceable because it conflicted with the mandatory requirements of a statute). For examples of insurance policies being held to *include* terms through the operation of law, see Flewellen v. Atlanta Cas. Co., 300 S.E.2d 673, 676 (Ga. 1983) (including \$50,000 worth of personal-injury protection in an auto liability insurance policy because a statute required that the policy offer such coverage and that the offer could only be rejected in a manner that had not in fact occurred); Watson v. United

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Servs. Auto Ass'n, 566 N.W.2d 683, ~~689~~692 (Minn. 1997) (holding that a homeowner's insurance policy's intentional-loss exclusion "must be reformed to comply with the Minnesota standard fire insurance policy," such that coverage was excluded only for insureds who themselves intentionally cause a loss, rather than to all innocent people co-insured for that loss as well).

b. Terms that are unenforceable on public-policy grounds. According to the Restatement Second of Contracts § 178 (AM. LAW INST. 1981), public policies that affect the enforcement of contracts are "manifested by legislation or judicial decisions." "The term 'legislation' is used here in the broadest sense to include any fixed text enacted by a body with authority to promulgate rules." *Id.*, Comment *a*. For examples of public policy being supplied by statutes in state insurance codes, see *Severs v. Country Mut. Ins. Co.*, 434 N.E.2d ~~290, 291-292~~290 (Ill. 1982); *Bartell v. Am. Home Assur-Assurance Co.*, 49 P.3d ~~623, 624-626~~623 (Mont. 2002); *Attorneys Liab. Prot. Soc'y, Inc. v. Ingaldson Fitzgerald, P.C.*, 370 P.3d ~~1101, 1107-1111~~1101 (Alaska 2016); *Bishop v. Allstate Ins. Co.*, 623 S.W.2d ~~865, 867~~865 (Ky. 1981). For examples of public policy being supplied by state insurance department regulations, see *Liberty Mut. Fire Ins. Co. v. Nat'l Cas. Co.*, 935 N.Y.S.2d ~~319, 321~~319 (N.Y. App. Div. 2011); *Diaz v. Progressive Direct Ins. Co.*, No. CV146047082S, 2015 WL ~~8487876, at *5~~8487876 (Conn. Super. Ct. Nov. 18, 2015). For examples of public policy affecting the enforceability of liability insurance policies being supplied by non-insurance statutes and regulations, see *Nat'l Cty. Mut. Fire Ins. Co. v. Johnson*, 879 S.W.2d 1, 2-5 (Tex. 1993) (relying on a traffic statute); *Sensebe v. Canal Indem. Co.*, 58 So. 3d 441, 446-451 (La. 2011) (relying on a motor vehicle and traffic statute); *Jones v. Bituminous Cas. Corp.*, 821 S.W.2d 798, 802 (Ky. 1991) (relying on an administrative regulation that made liability insurance coverage a precondition for obtaining a mining license); *F.D.I.C. v. AmericanAm. Cas. Co. of Reading, Pa.*, 843 P.2d 1285, 1290 (Colo. 1992) (relying on state banking code).

c. Terms or coverage contrary to judicially declared public policy. For example, the highest court in New York held that public policy prohibits insurers from indemnifying their insureds for punitive damages, without reference to any statute or regulation. *Hartford Aee-Accident & Indem. Co. v. Vill. of Hempstead*, 397 N.E.2d 737, 744 (N.Y. 1979). The court explained that it "reach[ed] that conclusion primarily because to allow insurance coverage is totally to defeat the purpose of punitive damages." *Id.* Similarly, the Supreme Court of Kansas has held, without reference to any statute or regulation, that "an insurance policy is void as against public policy if its intent is to indemnify the insured against liability for his criminal acts." *Herrman v. Folkerts*, 446 P.2d 834, 837 (Kan. 1968) (citing 44 C.J.S. Insurance § 242b, p. 1005). For examples of courts applying a judicially created public policy against coverage for liabilities stemming from intentional harm, see § 45, Reporters' Note to Comment *g*.

e. Effect of violation of a state form-review law. For examples of terms being enforced even though they were not submitted for legally required administrative review, see *Cage v. Litchfield Mutual Insurance Company*, ~~45~~Mut. Ins. Co., 713 A.2d ~~281, 285~~ (Conn. ~~Supp. 298, 305~~) (Super. Ct. 1997) ("The majority of jurisdictions which have addressed this issue have

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concluded that the failure to file the policy or endorsement does not render it invalid.”); *Penn Am. Ins. Co. v. Miller*, 492 S.E.2d 571, 573 (Ga. Ct. App. 1997) (holding that despite lacking approval “no reason exists to invalidate [the endorsement] as a matter of law”); *Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Ambassador Grp., Inc.*, ~~556 N.Y.S.2d 549, 553~~ (~~157 A.D.2d 293, 298 (N.Y. App. Div. 1990)~~) (“The failure of plaintiff to file Endorsement 11 with the New York Superintendent of Insurance for approval would not mandate rejection of its application herein. Failure to file under Insurance Law §§ 2307 and 3102 does not, by itself, void the policy clause, but rather carries its own penalties for non-filing. Further, such clause is void only if the substantive provisions of the clause are inconsistent with other statutes or regulations.”); *Powell v. Am. Cas. Co. of Reading, Pa.*, 772 F. Supp. 1188, 1191 (W.D. Okla. 1991) (positing that the Oklahoma legislature would have explicitly declared endorsements issued in violation of the state’s form-review law void if that was the remedy it had intended). In *Gen. Refractories Co. v. First State Ins. Co.*, a district court interpreting Pennsylvania law held that the burden was on the policyholder to show that an exclusion that was never submitted for legally required review violated public policy. No. ~~CIV.A.~~-04-3509, 2012 WL 568936, at *3 (E.D. Pa. Feb. 22, 2012). To meet that burden, the policyholder had “to demonstrate ‘a plain indication of that policy through long governmental practice or statutory enactments, or of obvious ethical or moral standards.’” *Id.* at *4 (quoting *Heller v. Pa. League of Cities & Mun.*, 32 A.3d 1213, 1220-1221 (Pa. 2011)).

§ 45. Insurance of Liabilities Involving Aggravated Fault

(1) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for defense costs incurred in connection with any legal action is enforceable, including but not limited to defense costs incurred in connection with: a criminal prosecution; an action seeking fines, penalties, or punitive damages; and an action alleging criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(2) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for civil liability arising out of aggravated fault is enforceable, including civil liability for: criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(3) Whether a term in a liability insurance policy provides coverage for the defense costs and civil liability addressed in subsections (1) and (2) is a question of interpretation governed by the ordinary rules of insurance- policy interpretation.

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Comment:

a. Scope. This Section addresses the insurability of defense costs and damages incurred in legal actions involving aggravated fault. Following the example of the Restatement Second of Contracts, the term “legislation” is used here in a broad sense to include any fixed text enacted by a body with authority to promulgate rules, including not only statutes but also constitutions and local ordinances, as well as administrative regulations issued pursuant to them. As subsection (3) makes clear, this Section does not address the question whether an insurance policy contains terms that would provide such coverage. This latter question is one of interpretation that is addressed using the rules of insurance-contract interpretation set forth in §§ 3 and 4. The rules in this Section apply only if the application of the ordinary rules of insurance-contract interpretation determines that the insurance policy provides the coverage in question. A term in an insurance policy excluding such coverage is enforceable.

b. Defense coverage for criminal proceedings. Payment of the costs of defending criminal proceedings brought against an insured is among the forms of defense coverage that are permissible for liability insurers to provide. Whether such defense costs are insured under a liability insurance policy is a question of interpretation. Although there are no public-policy-based restrictions on such defense coverage under prevailing insurance law, this Section recognizes that such restrictions could be imposed by legislation. See § 44. Courts generally hold that such coverage does not violate public policy, among other reasons because such insurance promotes the presumption of innocence and other constitutionally protected aspects of a criminal defense.

c. Defense coverage for uninsurable civil liabilities. Courts also generally enforce liability insurance defense coverage for uninsurable civil actions. The public-policy objections to insurance of certain liabilities are based upon the premise that the insured is liable for the wrong upon which the remedy is based. Defense coverage provides the means for the insured to contest liability, not to avoid the financial consequences of liability actually assessed. Although there are no public-policy-based restrictions on such defense coverage under prevailing insurance law, this Section recognizes that such restrictions could be imposed by legislation. See § 44.

d. Insurability of civil liability arising out of criminal acts. There is no blanket, public-policy-based objection in insurance law to insuring a civil liability that arises out of a criminal act, even in jurisdictions with public-policy-based restrictions on the insurability of

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certain kinds of liabilities. In such jurisdictions, the insurability of civil liability arising out of a criminal act generally depends on whether the insured intended to injure the victim or whether punitive damages are assessed. To the extent that public-policy-based limits on insurance coverage are based on a concern about moral hazard, the fact that a wrong is also a crime should reduce that concern, because the presence of criminal penalties will increase whatever deterrence is provided by liability.

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

f. Insurability of liabilities based on morally offensive acts. There is some old legal authority supporting the proposition that liability insurance law should limit coverage for morally offensive acts, without regard to the presence of applicable exclusions or absence of incentive effects created by insurance, but recent authority is to the contrary. Such a prohibition would have the unfortunate consequence that the victims of some of the most offensive wrongs would be least likely to be able to obtain redress for those wrongs. That such a situation presently exists for certain liabilities because of exclusions in liability insurance policies (exclusions for certain sexual-molestation suits provide a ready example) does not provide a basis for a common-law prohibition of such coverage.

g. Insurability of liability for intentional harm. Insurance law recognizes the potentially deleterious consequences that could result from the incentives created by liability insurance for intentional harm. Because intentional harm is ordinarily under the conscious control of the insured, and because such harm may even be part of the objective of the insured's wrongful act, insurance of the liabilities arising out of such wrongful acts poses a potential threat to the deterrence and retribution purposes of liability law. Nevertheless, these deterrence- and retribution-based concerns do not support a blanket prohibition on insurance of all liabilities arising out of intentional injuries. In many cases, the presence or absence of insurance has no effect on the behavior of the wrongdoer. The case of an assault that occurs in the heat of passion is an obvious example, but many wrongs are committed without regard for the consequences or the presence or absence of insurance covering the potential liability. Moreover, the presence of liability insurance can promote, rather than hinder, the objectives of tort law, by providing compensation for the victim as well as the means to employ the civil-justice system to name,

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blame, and shame the defendant. Although there are some state statutes and judicial opinions that state that intentional injuries are not insurable, those statutes and decisions have generally not been tested in relation to liability insurance policies that explicitly provide coverage for intentional torts as described in Comment *h*.

h. Insurance coverage of liability for intentional harm. The contemporary liability insurance market includes a variety of policy forms that cover intentional common-law or statutory torts, for example: defamation, disparagement, trademark infringement, unfair competition, false imprisonment, employment discrimination, wrongful termination, malicious prosecution, invasion of privacy, and certain statutory violations. Courts regularly enforce insurers' promises to provide these coverages, even in cases involving intentional injuries, typically without any mention of the tension between these coverages and the traditional public-policy-based concern about insurance for intentional harm. Those relatively few cases that do discuss the insurability issue generally resolve that issue by explaining that providing liability insurance (a) does not undercut the purpose of the underlying liability and (b) promotes the compensation purpose of that liability. Cases enforcing the "final adjudication" clause in certain intentional-harm or misconduct exclusions also result in coverage for liabilities involving intentional harm. The final-adjudication clause in such exclusions generally states that the exclusion only applies to a legal action if there has been final adjudication of the designated misconduct in that legal action. The practical impact of the clause is that even a post-trial settlement of the underlying legal action prevents the exclusion from being applied, because the settlement means that there was no "final adjudication" of the misconduct.

i. Insurability of liability for punitive damages. There is a split in the authority regarding the insurability of liability for punitive damages. The courts in the majority of states that have considered the issue have held that liability for punitive damages is insurable, leaving the question of whether a liability insurance policy provides coverage for punitive damages to the interpretation of the insurance policy. Courts in nearly as many states have held that liability insurance for directly assessed punitive damages contravenes the public policy of the state, in some cases as expressed in legislation and in other cases as a matter of judicially declared public policy.

Courts that prohibit insurance for direct punitive damages provide both deterrence- and retribution-based justifications for this decision. As with insurance of liabilities arising out of

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intentional injuries, these justifications do not apply with equal force in all cases involving punitive damages. Under the deterrence justification, punitive damages are sometimes necessary to create incentives for parties to take reasonable care to avoid accidents, and insurance could dampen the incentive effect of such awards. However, punitive damages can be assessed in situations in which there is little or no reason to believe that the presence of liability insurance for punitive damages will have any effect on behavior, for example in the drunk-driving context or other contexts in which there are widely known criminal penalties. Under the retributivist justification, punitive damages represent a consequence for highly wrongful conduct, and insurance lessens the sting of that consequence. However, the availability of insurance for punitive damages may promote the retributive objectives of punitive damages, especially when defendants lack the resources to pay a substantial punitive-damages judgment. The availability of insurance against liability for punitive damages helps to motivate the plaintiff to bring an action against the wrongful actor and thereby express the public commitment to the value of persons that is one of the core principles of retribution.

Moreover, a declaration that insuring against liability for punitive damages violates the public policy of a state often turns out to have little or no effect, other than to lead insureds to find the coverage elsewhere. Specifically, large organizations and wealthy individuals can procure, and regularly do procure, insurance that covers direct punitive damages even when those damages are assessed in jurisdictions in which courts have declared that such insurance violates the public policy of the state. Policyholders obtain such insurance by purchasing insurance issued with insurance-policy forms that contain favorable choice-of-law and venue clauses and, often, arbitration clauses. Sometimes this insurance is purchased in offshore jurisdictions. This means that a prohibition against insurance for punitive-damages awards primarily affects legal actions brought against individuals and small- to medium-sized businesses, significant numbers of which are likely to be, for practical purposes, judgment proof and, thus, unaffected by whatever incentive effects might in theory result from that insurance.

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b. Defense coverage for criminal proceedings. Directors' and Officers' liability insurance regularly provides coverage for criminal-defense costs. See Tom Baker & Sean Griffith, *The Missing Monitor in Corporate Governance: The Directors' and Officers' Liability Insurer*, 95 GEO. L.J. 1795, 1805 (~~2009~~[2007](#)). For a discussion of criminal-defense coverage provided by the

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National Rifle Association, see generally Tom Baker, *Liability Insurance at the Tort-Crime Boundary*, in *FAULT LINES: TORT LAW AS CULTURAL PRACTICE* (David M. Engel & Michael McCann eds., Stanford U. Press 2009).

c. Defense coverage for uninsurable civil liabilities. See Sean W. Gallagher, *The Public Policy Exclusion and Insurance for Intentional Employment Discrimination*, 92 MICH. L. REV. 1256, [1326](#)[1261](#)[n.22](#) (1994) (“Courts are generally willing to enforce insurance to cover defense costs even in cases in which the underlying liability might be uninsurable as a matter of public policy.”). For cases allowing coverage of defense costs, see, e.g., *Andover Newton Theological Sch., Inc. v. ContinentalCont’l Cas. Co.*, 930 F.2d 89, 95 (1st Cir. 1991) (applying Massachusetts law) (“Although an argument can be made that a public policy is to some extent subverted by insurance against defense costs, the basic fact is that this is not insurance against liability.”); *B&E Convalescent Ctr. v. State CompensationComp. Ins. Fund*, 9 Cal. Rptr. 2d 894, 903 (Cal. Ct. App. 1992) (“[E]ven though public policy . . . precludes an insurer from indemnifying an insured in an underlying action the duty to defend still exists so long as the ‘insured reasonably expect[s] the policy to cover the types of acts involved in the underlying suit.’”) (quoting *Republic Indem. Co. v. Superior Ct.*, 273 Cal. Rptr. 331, 335 (Cal. Ct. App. 1990)).

d. Insurability of civil liability arising out of criminal acts. See generally Tom Baker, *Liability Insurance at the Tort-Crime Boundary*, in *FAULT LINES: TORT LAW AS CULTURAL PRACTICE* (David M. Engel & Michael McCann eds., Stanford U. Press 2009); see also Sean W. Gallagher, *The Public Policy Exclusion and Insurance for Intentional Employment Discrimination*, 92 MICH. L. REV. 1256, 1325 (1994) (“[Courts](#)[C](#)[ourts](#) do not necessarily void insurance for civil liability arising out of criminal misconduct, and several courts have even enforced insurance to cover civil liability for criminal sexual assault.”). Careful examination of opinions stating that a liability is uninsurable because it arises out of a criminal act reveals that these cases fall into one of two categories: (1) the insurance policy contains an exclusion for liabilities arising out of criminal acts; (2) the criminal act involved an intentional injury. For cases stating that the insurability of liability arising out of a criminal act depends on whether the insured intended to injure the victim or whether punitive damages are assessed, see, e.g., *Penzer v. Transp. Ins. Co.*, 545 F.3d 1303, 1310-1311 (11th Cir. 2008) ([applying Florida law](#)) (explaining that Florida public policy against insuring for intentional misconduct does not apply where liability is not predicated on intent); *Nationwide Mut. Ins. Co. v. Machniak*, 600 N.E.2d 266, 268 (Ohio Ct. App. 1991) (holding that intentional-injury exclusion did not apply to insured’s conviction for felonious assault because the crime is not statutorily defined as a specific-intent crime); *Nielsen v. St. Paul Cos.*, 583 P.2d 545, 547-548 (Or. 1978) (explaining that the public policy against insurability does not attach to all unlawful acts or even all intentional acts but attaches only in the specific scenario where the actor’s purpose is to inflict harm).

e. Insurability of vicarious liability. See Catherine M. Sharkey, *Revisiting the Noninsurable Costs of Accidents*, 64 MD. L. REV. 409 (2005) (discussing insurability of vicariously assessed punitive damages); Sean G. Gallagher, *The Public Policy Exclusion and*

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Insurance for Intentional Employment Discrimination, 92 MICH. L. REV. 1256 (1994) (discussing insurance coverage for intentional discrimination by an employee that is imputed to an employer).

f. Insurability of liabilities based on morally offensive acts. See generally Mary Coates McNeeley, *Illegality as a Factor in Liability Insurance*, 41 COLUM. L. REV. 26 (1941); Tom Baker, *Liability Insurance at the Tort-Crime Boundary*, in *FAULT LINES: TORT LAW AS CULTURAL PRACTICE* (David M. Engel & Michael McCann eds., Stanford U. Press 2009). For cases demonstrating a concern for victim compensation, see, e.g., *Aetna Life & Cas. Co. (Cas. & Sur. Div.) v. McCabe*, 556 F. Supp. 1342, 1353 (E.D. Pa. 1983) ([applying Pa. law](#)) (holding that physician’s intentional malpractice would be covered under insurance policy because (1) nothing suggested that the physician bought the insurance in contemplation of committing malpractice, (2) there was no basis to believe denying coverage would have a deterrent effect, and (3) Pennsylvania’s interest in compensating victims of malpractice outweighed Pennsylvania’s recognized interest in deterring intentional torts); *Grinnell Mutual Mut. Reinsurance Co. v. Jungling*, 654 N.W.2d 530, 538, 541 (Iowa 2002) ([internal citations omitted](#)) (noting that the interest in victim compensation was found to “outweigh[] the public interest in forcing the willful wrongdoer to pay the consequences of the wrongdoing” and “the ultimate and primary beneficiaries of coverage [for intentional wrongdoing] will be innocent third parties”); *Burd v. Sussex Mut. Ins. Co.*, 267 A.2d 7, 15-16 (N.J. 1970) (noting that the public interest in victim compensation and the insured’s interest in maximum protection under the contract weigh against an overly broad reading of the public-policy exclusion). For cases finding that a liability insurance policy, absent a pertinent exclusion, covers morally offensive acts, see, e.g., *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 384-385 (Mich. Ct. App. 1982) (Finding coverage for malpractice where a doctor induced his patient to engage in a sexual relationship with him as part of her therapy, the court reasoned, “coverage does not allow the wrongdoer unjustly to benefit from his wrong. It is not the insured who will benefit, but the innocent victim who will be provided compensation for her injuries.”); *Bailer v. Erie Ins. Exch.*, 687 A.2d 1375, 1376, 1385 (Md. 1997) (finding coverage for an invasion-of-privacy suit where an insured surreptitiously videotaped an au pair while she was showering); *S. Carolina State Budget & Control Bd., Div. of Gen. Servs., Ins. Reserve Fund v. Prince*, 403 S.E.2d 643, 647 (S.C. 1991) (determining that it would be unreasonable to exclude coverage for defamation when the insurance policy specifically provided for that coverage). See also *Ill. Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575, 579-578 (Ill. App. Ct. 2011) (finding coverage for malicious-prosecution suit because “it is . . . a fundamental policy in Illinois that when an insured pays a premium and an insurance company accepts it and promises coverage based on the premium paid, the insurer should be required to fulfill its obligation.”).

g. Insurability of liability for intentional harm. For cases finding intentional harm uninsurable, see, e.g., *Regence Grp. v. TIG Specialty Ins. Co.*, 903 F. Supp. 2d 1152, 1161 (D. Or. 2012) ([applying Oregon law](#)) (“Oregon has long recognized the principle that ‘a clause in a contract of insurance purporting to indemnify the insured for damages recovered against him as a

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consequence of his intentional conduct in inflicting injury upon another is unenforceable by the insured on the ground that to permit recovery would be against public policy.”) (citations omitted); *Thomas v. Benchmark Ins. Co.*, 179 P.3d 421, 425 (Kan. 2008) (“Kansas public policy prohibits insurance coverage for intentional acts: ‘[A]n individual should not be exempt from the financial consequences of his own intentional injury to another.’”) (citations omitted); see also *Nat’l Fire Ins. Co. of Hartford v. Lewis*, 898 F. Supp. 2d 1132, 1146 (D. Ariz. 2012) ([applying Arizona law](#)) (holding that policy provisions extending to intentional acts are prohibited by public policy under Arizona law); *Chiquita Brands Int’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 988 N.E.2d 897, 900 (Ohio Ct. App. 2013) (citations omitted) (“Ohio public policy generally prohibits obtaining insurance to cover damages caused by intentional torts.”). For a discussion of how the justifications for the “public policy exception” are overbroad, see generally Christopher C. French, *Debunking the Myth That Insurance Coverage Is Not Available or Allowed for Intentional Torts or Damages*, 8 HASTINGS BUS. L.J. 65 (2012). For cases demonstrating a concern for victim compensation, see Reporters’ Note to Comment *f*, *supra*. On the difficulty of collecting money from an uninsured defendant, see Steven G. Gilles, *The Judgment Proof Society*, 63 WASH. & LEE L. REV. 603 (2006).

Note that, for the purposes of the public-policy exception, intent is often defined in a very restrictive manner that severely constrains the scope of the exception. *Nielsen v. St. Paul Cos.*, 583 P.2d 545, 547-548 (Or. 1978) (explaining that the public policy against insurability does not attach to all unlawful acts or even all intentional acts but attaches only in the specific scenario where the actor’s purpose is to inflict harm). As a result, actions taken in self-defense, which are intentional but are not taken for the purpose of injuring another, are often covered by insurance policies. *Fire Ins. Exch. v. Berray*, 694 P.2d 191, 193 (Ariz. 1984) (“[A]n act committed in self-defense should not be considered an ‘intentional act’ within the meaning of the exclusion.”) (citation omitted). Further, even intentional harm may not fall within the public-policy exclusion if the underlying violation does not require intent. *Penzer v. Transp. Ins. Co.*, 545 F.3d 1303, 1310-1311 (11th Cir. 2008) (explaining that Florida public policy against insuring intentional misconduct does not apply [wherewhen](#) liability is not predicated on intent); see also *Nationwide Mut. Ins. Co. v. Machniak*, 600 N.E.2d 266, 268 (Ohio Ct. App. 1991) (holding that intentional-injury exclusion did not apply to insured’s conviction for felonious assault because the crime is not statutorily defined as a specific-intent crime). As these cases illustrate, the reach of the public-policy exception is limited and, thus, the emerging rule is not likely to cause significant change in liability insurance practice.

h. Insurance coverage of liability for intentional harm. Couch describes the case law enforcing insurance for intentional torts as follows:

Even though it may be against public policy to insure for an insured’s intentional or willful conduct, some jurisdictions may find coverage for the conduct when the policy language specifically provides coverage for that conduct; a statute allows insurance for intentional conduct; or the court finds that the public interest in

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having victims compensated for their injuries, outweighs public interest in forcing the willful wrongdoer to pay the consequences of the misconduct.

~~LEE R. RUSS & THOMAS F. SEGALLA~~⁷ STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 101:24 (3d ed. ~~2011~~2017). For cases finding coverage under liability insurance provisions that cover intentional wrongs, see, e.g., *Cincinnati Ins. Co. v. Zen Design Group Grp., Ltd.*, 329 F.3d 546, 549 (6th Cir. 2003) (applying Michigan law) (enforcing a business liability policy that covered “slander,” “libel,” “misappropriation of advertising ideas or style of doing business,” and “infringement of copyright, title, or slogan.”); *North Bank v. Cincinnati Ins. Cos.*, 125 F.3d 983, ~~984~~985 (6th Cir. 1997) (applying Michigan law) (finding coverage for employment discrimination under a policy that explicitly covered discrimination); *Ill. Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575, 577-579 (Ill. App. Ct. 2011) (finding coverage for malicious prosecution under a homeowner’s policy that explicitly covered “false arrest, imprisonment, malicious prosecution, and detention.”); *Dixon Distributing Distrib. Co. v. Hanover Ins. Co.*, 641 N.E.2d 395, ~~396~~402 (Ill. 1994) (concluding that providing coverage for an allegedly intentional wrongful termination did not violate the public policy of Illinois); *Bailer v. Erie Ins. Exch.*, 687 A.2d 1375, 1376-1377 (Md. 1997) (finding coverage for an invasion-of-privacy suit under a personal-catastrophe liability policy); *S.C. State Budget & Control Bd., Div. of Gen. Servs., Ins. Reserve Fund v. Prince*, 403 S.E.2d 643, 644 (S.C. 1991) (holding that an insurer had a duty to indemnify under a policy that explicitly provided coverage for defamation). For cases finding coverage for intentional conduct and demonstrating a concern for victim compensation, see Reporters’ Note to Comment *f*, supra.

For sources noting that covering intentionally caused harm does not undercut the purpose of the underlying liability, see, e.g., *Yousuf v. Cohlmi*, 741 F.3d 31, 41 (10th Cir. 2014) (applying Oklahoma law) (“ANPAC’s policies covering Dr. Cohlmi specifically provide indemnification for certain intentional conduct, and there is no evidence that the availability of insurance coverage induced Dr. Cohlmi to engage in intentional conduct. Furthermore, the interest in compensating an innocent third party, Dr. Yousuf, outweighs the concern that Dr. Cohlmi would unjustly benefit from the coverage.”); *St. Paul Fire & Marine Ins. Co. v. Jacobson*, 826 F. Supp. 155, 157 (E.D. Va. 1993), *aff’d*, 48 F.3d 778 (4th Cir. 1995) (applying Virginia law) (enforcing insurance against intentionally caused harm, noting that the existence of criminal sanctions for the doctor’s behavior served as a greater deterrent than civil liability and that no evidence suggested the presence of insurance encouraged his behavior); *Aetna Life & Cas. Co. (Cas. & Sur. Div.) v. McCabe*, 556 F. Supp. 1342, 1353 (E.D. Pa. 1983) (applying Pennsylvania law) (holding that physician’s intentional malpractice would be covered under insurance policy because (1) nothing suggested that the physician bought the insurance in contemplation of committing malpractice, (2) there was no basis to believe denying coverage would have a deterrent effect, and (3) Pennsylvania’s interest in compensating victims of malpractice outweighed Pennsylvania’s recognized interest in deterring intentional torts); *Ill. Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575, 579 (Ill. 2011) (“[T]here is nothing inherently unreasonable or inconsistent with Illinois public policy in allowing an individual to insure

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himself against damages caused by certain intentional acts, except to the extent that the insured wrongdoer may not be the person who recovers the policy proceeds.”); *N. Bank v. Cincinnati Ins. Cos.*, 125 F.3d 983, 988 (6th Cir. 1997) (applying Michigan law) (enforcing insurance against intentional discrimination, noting that high premiums, bad publicity for businesses, and the “trauma of litigation” likely eliminated any effect that insurance may have in encouraging an insured to commit intentional torts); ~~*St. Paul Fire & Marine Ins. Co. v. Jacobson*, 826 F. Supp. 155, 157 (E.D. Va. 1993) (enforcing insurance against intentional harm, noting that the existence of criminal sanctions for the doctor’s behavior served as a greater deterrent than civil liability), aff’d, 48 F.3d 778 (4th Cir. 1995)~~; see also Christopher C. French, *Debunking the Myth That Insurance Coverage Is Not Available or Allowed for Intentional Torts or Damages*, 8 HASTINGS BUS. L.J. 65, 94 (2012) (noting that other deterrents, including the threat of jail time or concern with injuring oneself, loom much larger than any concern with civil liability that the presence of insurance may alleviate); Donald F. Farbstein & Francis J. Stillman, *Insurance for the Commission of Intentional Torts*, 20 HASTINGS L.J. 1219, 1254 (1969) (suggesting that uninsurability could be roughly limited to areas of civil damages intended to deter the wrongdoer rather than compensate the victim). Cf. *Ranger Ins. Co. v. Bal Harbour Club, Inc.*, 549 So. 2d 1005, 1005-1006 (Fla. 1989) (refusing to enforce insurance coverage for intentional religious discrimination based on a two-part test that would permit insurance for intentional injuries in other contexts: (1) whether the conduct of the insured is the type that will be encouraged by insurance; and (2) whether the purpose of the imposition of liability is to deter wrongdoers or to compensate victims).

On the final-adjudication clause, see, e.g., *Pendergest-Holt v. Certain Underwriters at Lloyd’s of London*, 600 F.3d 562, 572-573 (5th Cir. 2010) (applying Texas law) (“When a D&O policy requires a ‘final adjudication’ to trigger an exclusion, courts have consistently held that the adjudication must occur in the underlying D&O proceeding, rather than in a parallel coverage action or other lawsuit. . . . In contrast, courts have generally imbued ‘in fact’ language with a broader scope than ‘final adjudication,’ holding, for example, that the term requires a final decision on the merits in either the underlying case or a separate coverage case, or an admission by the insured.”) (quotations omitted); *Atl. Permanent Fed. Sav. & Loan Ass’n v. Am. Cas. Co. of Reading, Pa.*, 670 F. Supp. 168, 172 (E.D. Va. 1986) (applying Virginia law) (“The Court finds that under the Directors and Officers Policy issued by the defendant, the exclusion for the dishonesty of the directors and officers must have been finally adjudicated in the underlying action in order for the defendant to assert it as an exclusion under the policy. The Court is of the opinion that the wording of the exclusion supports this result.”); Alan Rutkin & Robert Tugander, *Dishonesty and Personal Profit Exclusions As Bars for Coverage for Suits Arising from the Subprime Crisis*, 44 TORT TRIAL & INS. PRAC. L.J. 169, 177 (2008) (Courts have tended to hold that the adjudication must take place in the underlying litigation, not in coverage litigation.); JOHN H. MATHIAS, JR., MATTHEW M. NEUMEIER, TIMOTHY W. BURNS & JERRY J. BURGDOERFER, *DIRECTORS AND OFFICERS LIABILITY: PREVENTION, INSURANCE AND INDEMNIFICATION* at § 8.04 (2003) (collecting cases holding that “[i]f the exclusion requires a

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final adjudication, that adjudication generally must take place in the underlying action for which coverage is sought”). For discussion of the practical impact of the final-adjudication language based on field research, see TOM BAKER & SEAN GRIFFITH, *ENSURING CORPORATE MISCONDUCT* 49 & 187 (2010).

i. Insurability of liability for punitive damages. Some courts refuse on public-policy grounds to enforce contracts that cover punitive damages, while other courts leave the question of liability insurance coverage for all punitive damages, both vicarious and direct, to the insurance contract. See generally Catherine M. Sharkey, *Revisiting the Noninsurable Costs of Accidents*, 64 MD. L. REV. 409 (2005) (discussing jurisdictions’ differing approaches to the insurability of punitive damages, including an appendix with a 50-state survey, and noting how underwriters and insurance brokers have begun to circumvent public-policy objections to insuring punitive damages by including “most favorable venue” language, “a kind of ‘choice-of-law’ provision that specifies, for example, that if an issue arises regarding punitive damages, the carrier will apply the law and public policy of an applicable state with the ‘most favorable’ view of insurance coverage for punitive damages.”); BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES*, ~~ch. §~~ 14 Insurance Coverage for Punitive Damages Assessed Against an Insured, and § 14.06 Survey of the Insurability of Punitive Damages in Various Jurisdictions (18th ed. 2016). For a discussion of why a deterrence- and retribution-based justification for an implied-in-law exclusion for direct punitive damages is overbroad, see generally Tom Baker, *Reconsidering Insurance for Punitive Damages*, 1998 WIS. L. REV. 101 (1998). Acknowledgment that the common law is, as a practical matter, unable to prevent the sale or purchase of such insurance could have the salutary effect of prompting action by regulatory authorities, which have greater powers than courts to detect and prevent the sale or purchase of, or payment under, such policies, and greater expertise in the determination of when such insurance is likely to have undesirable consequences.

§ 46. Insurance of Known Liabilities

(1) Unless otherwise stated in the policy, a liability insurance policy provides coverage for a known liability only if that liability is disclosed to the insurer during the application or renewal process for the policy.

(2) For purposes of the rule stated in subsection (1), a liability is known only when, prior to the inception of the policy period, the policyholder is substantially certain that:

(a) A person insured under the policy will incur otherwise covered defense costs that will ~~reach the level of coverage provided under~~ exceed the amount of any deductible or self-insured retention in the policy that applies to defense costs or

(b) A person insured under the policy will, absent a settlement, be subject to an adverse judgment establishing the liability in an amount that would ~~reach the~~

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~~level of coverage provided under~~ exceed the amount of any applicable deductible or self-insured retention in the policy.

Comment:

a. History and rationale for the known-loss doctrine. This Section addresses the known-loss doctrine, a first-party insurance-law doctrine that was extensively litigated in the context of early 1990s environmental liability insurance coverage litigation involving coverage under occurrence-based commercial general-liability insurance policies. Most jurisdictions that have considered the known-loss doctrine in that liability insurance context have adopted the narrow version of the doctrine followed in this Section; but there are few reported decisions in which the doctrine serves as the sole ground for decision, and there are nearly as many reported decisions rejecting or raising questions about the doctrine. Two rationales have been proposed for the doctrine: the fortuity principle in insurance law and protecting the insurance pool from policyholders who conceal known losses.

b. The fortuity principle. The fortuity principle reflects the historic and analytical connections between risk and insurance. Historically, insurance institutions developed to provide protection from losses that were contingent or uncertain (referred to in early sources as losses that were subject to chance), and many justifications for the value of insurance focus on how the reduction in financial uncertainty provided by insurance promotes individual and social welfare. From this history has come the idea that fortuity—a synonym for words such as risk, chance, contingency, and uncertainty, all of which have subtly different meanings—is the essence of insurance. That idea has been incorporated in many state statutes that have been drafted for the purpose of identifying the jurisdiction of state insurance departments, although those statutes use the word “contingency” rather than fortuity. But, just as the concept of contingency has proven to provide little guidance to courts regarding boundaries on the jurisdiction of state insurance departments, so, too, has the fortuity principle proven to provide little guidance to courts regarding what liabilities are insurable. As courts have recognized, the degree of fortuity that is required for the insurance market to be able to insure losses is not something that courts are well equipped to determine. Accordingly, at least in the liability insurance context, most courts have adopted a standard for the known-loss doctrine that represents a very nondemanding application of the fortuity principle. By adopting that standard as a default rule, however, courts have allowed insurers to choose to impose a more demanding fortuity requirement by contract. See §

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1(9) (defining “default rule”) and § 1, Comment *f* (explaining the difference between mandatory and default rules). In addition, because the known-loss doctrine excludes coverage only for an *undisclosed*, known liability, a policyholder can obtain coverage for a known liability by disclosing it to the insurer in the application or renewal process, subject of course to the insurer’s discretion regarding whether to insure that liability.

c. Rationale for the known-liability standard. There are two competing known-loss standards in the case law. Some courts have applied a broader, *known-harm* standard that is more common in the first-party insurance context. In the liability insurance context, the better, more widely applied rule is the narrower, *known-liability* standard. The known-liability standard better reflects the fortuity principle in the liability insurance context, because the fortuity that the liability insurance market requires is not uncertainty about whether a *harm* has occurred that might lead to an insured liability, but rather uncertainty about whether there is an insured *liability* that will reach the level of coverage provided by the insurance policy in question. Even if a harm has already occurred and even if it is foreseeable that the insured will be the subject of a liability action, there remains substantial uncertainty about whether there in fact will be a liability action, whether the plaintiff will succeed in the action, and, if so, for how much and when the judgment will be entered. Liability insurance coverage can be available in some circumstances even when it is a certainty that the insured will be found liable, as long as there is uncertainty about the timing or amount of that liability.

Insurers that wish to avoid coverage for liability arising out of known harms can and do draft their liability insurance policies to exclude that coverage, thereby replacing the known-liability rule followed in this Section with a contractually specified known-harm rule. If insurers are willing to provide coverage for known harms only after evaluating the risk, they can and do ask questions about known harms on their insurance applications to require policyholders to disclose those harms, on pain of losing coverage for misrepresentation.

The known-loss doctrine can produce different results when policyholders have large self-insured retentions than when they have first-dollar coverage. When a policyholder has a large self-insured retention, the known-loss doctrine may not apply to an action involving continuing harm, such as a pollution-liability claim, even if a suit seeking damages attributable to the pollution is filed against the insured prior to the policy period, depending on the amount of potential damages and defense costs and the size of the self-insured retention. By contrast, when

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a policyholder has first-dollar coverage—whether for defense costs or damages or both—a suit filed before the policy period regarding harm that the insured knows will continue into the policy period implicates the known-loss doctrine. The touchstone for whether the doctrine applies is substantial certainty that, absent the application of the doctrine, the insurer will be required to pay some amount of money on behalf of an insured under the policy that is about to be issued.

Illustrations:

1. ChemCo purchases property in Year 1. In Year 5, ChemCo begins preparing the property for use and discovers hazardous chemicals in soil borings. ChemCo informs the U.S. EPA and the corresponding state agency of the findings and reports to the local media that it intends to comply with all legal requirements and remediate the site, in cooperation with the environmental authorities. At the time, ChemCo reasonably estimates that the cost of the remediation will be at least \$3 million. ChemCo subsequently renews its CGL policy with Insurer. The policy has a policy limit of \$5 million excess of a \$1 million SIR. ChemCo does not inform insurer of the potential remediation liability at the time of the renewal. ChemCo continues monitoring the site. In Year 10, ChemCo enters into a corrective-action plan with the U.S. EPA and the corresponding state agency and provides notice to Insurer of the potential liability. Insurer agrees to defend pursuant to a detailed reservation of rights on multiple grounds, including the known-loss doctrine. Insurer then brings a declaratory-judgment action seeking to terminate the duty to defend. Because ChemCo knew, prior to the policy period, that its liability for remediation costs in excess of its SIR was substantially certain, Insurer prevails on its known-loss defense in the proceeding, terminating its duty to defend.

2. Same facts as Illustration 1, except that when ChemCo renews its policy with Insurer in Year 5, ChemCo reasonably estimates the cost of remediation will be less than the \$1 million SIR. This estimate proves wrong and the remediation costs exceed the retention. Insurer does not prevail in the declaratory-judgment action based on the known-loss doctrine because remediation costs in excess of the SIR were not substantially certain at the time of renewal.

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3. ChemCo purchases property in Year 1. Early in Year 5, ChemCo receives a letter from the EPA notifying it that hazardous chemicals have been discovered on the property and demanding that ChemCo enter immediately into a program of remediation. At the time, it is substantially certain that property damage is continuing on the property and that ChemCo will incur defense costs in connection with the EPA demand letter. ChemCo subsequently renews its CGL policy with Insurer without informing Insurer of the EPA's demand letter or the likelihood of incurring costs to defend against a remediation action. The policy has a policy limit of \$5 million. Because there is no self-insured retention, the policy provides first-dollar coverage for defense costs. After the policy has been renewed, ChemCo provides notice to Insurer of the EPA letter and requests a defense under all its policies with Insurer. Insurer agrees to defend pursuant to a detailed reservation of rights on multiple grounds, including the application of the known-loss doctrine to the renewal policy issued subsequent to the EPA's demand letter. Insurer brings a declaratory-judgment action seeking to terminate the duty to defend. Because ChemCo was substantially certain, prior to the beginning of the policy period, that it was facing a liability action that would trigger the insurer's defense duties under the policy, Insurer prevails on its known-loss defense in the proceeding, terminating all of its obligations with regard to the EPA action under the renewal policy.

d. A subjective standard. The known-liability standard is subjective: the known-loss doctrine avoids coverage only if the policyholder knows, prior to the policy period, that it is substantially certain to incur covered defense costs in, or be held liable in, a legal action, absent a settlement of that action. The subjective standard best fits the anti-fraud purpose of the known-loss doctrine. As with all subjective standards, this knowledge is capable of proof using circumstantial or other objective evidence, as well as direct evidence of subjective knowledge.

e. Known defense costs. In considering whether to adopt and how to apply the known-liability rule, courts have focused on the certainty of the insured's liability in the legal action in question and do not appear to have focused separately on defense costs. Thus, courts have not squarely addressed the circumstance in which a policyholder believes, prior to the policy period, that it is substantially certain to face a legal action that will result in defense costs that would be covered by the policy (if the known-liability rule does not apply), and the

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policyholder also believes that it will successfully defend the action, such that there will be no liability. Because of the central importance given to liability insurers' defense obligations in this Restatement, it would be incongruous for the known-liability rule to ignore defense costs. See, e.g., §§ 13-19 (rules regarding defense duties) ~~and 48(3) (including attorneys' fees as damages when insurer breaches the duty to defend)~~. Accordingly, subsection (2)(a) states that, unless the insurance policy provides to the contrary, the known-liability default rule applies to exclude coverage for a legal action when the policyholder is substantially certain, prior to the policy period, that a person insured under the policy will incur otherwise covered defense costs.

f. Relationship to misrepresentation and concealment doctrine. The known-loss doctrine provides an additional incentive beyond that supplied by misrepresentation and concealment doctrine for policyholders to disclose known liabilities to their insurers. In contrast to misrepresentation and concealment law, the known-loss doctrine does not require the insurer to prove materiality or reliance. In practice, however, the same result would be reached under both sets of doctrine in most cases, especially if the insurer asked a question in the application process that obligated the policyholder to disclose any known liabilities. Indeed, there are few cases in which the known-loss doctrine provides the sole basis for a decision denying coverage under a liability insurance policy. In most cases, the court's decision is also based on concealment or fraud.

g. Not a doctrine of legal insurability. The known-loss doctrine obligates policyholders to disclose known liabilities if they want to obtain insurance coverage for those liabilities. The rule does not limit insurers' freedom to provide insurance of the liabilities so disclosed. Whether a known liability is insurable is a decision for the insurer to make in its discretion.

REPORTERS' NOTE

a. History and rationale for the known-loss doctrine. For cases discussing the history and rationale of the known-loss doctrine, see, e.g., *State v. Hydrite Chem. Co.*, 695 N.W.2d ~~816, 825~~[816](#) (Wis. [Ct. App.](#) 2005); *see* *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d 403, 415 (R.I. 2001) (endorsing the view that the known-loss doctrine "is designed to prevent fraud when coverage is sought to be misused to insure a certainty rather than a fortuity") (quoting 3 ERIC MILLS HOLMES, *HOLMES'S APPLEMAN ON INSURANCE* § 16.4 (2d ed. 1998)); *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 737 (Minn. 1997) ("In this state, 'known loss' is a fraud-based defense.") (citations omitted). For examples of courts' reliance on the fortuity rationale, see *Gen. Housewares Corp. v. Nat'l Sur. [CompCorp.](#)*, 741 N.E.2d 408, 414-415 (Ind.

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Ct. App. 2000) (citing the definition of “insurance” in *Black’s Law Dictionary* 721 (5th ed. 1979), which states that insurance is “applicable only to some contingency or act to occur in [the] future,” to show that the known-loss doctrine is “inherent to the very concept of insurance.”); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, 1210 (Ill. 1992) (resting the known-loss doctrine on the premise that “[b]y its very nature, insurance is fundamentally based on *contingent risks* which may or may not occur.”) (emphasis in original).

For examples of cases in which the known-loss doctrine serves as the sole ground for decision, see *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d ~~1204, 1211~~ 1204 (Ill. 1992); *SCA Servs., Inc. v. Transp. Ins. Co.*, 419-646 N.E.2d 394 (Mass. ~~528~~ (1995)); *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d ~~65, 85-86~~ 65 (Wis. 2004). For examples of cases that reject the known-loss doctrine, see *City of Johnstown, N.Y. v. Bankers Standard Ins. Co.*, 877 F.2d 1146, 1153 (2d Cir. 1989) (predicting that the New York courts would reject the doctrine because it “might well swallow up the more narrow doctrines regarding (1) concealment and misrepresentation, and (2) damages that are ‘expected’ or ‘intended’ by the insured.”); *Owens-Corning Fiberglas Corp. v. Am. Centennial Ins. Co.*, 660 N.E.2d 770, 777-778 (Ohio Ct. C.P. 1995) (explaining that the court is “unwilling to recognize” the doctrine, in part because “the defense that only fortuitous losses are insurable is already provided for in the policy, which states that only an ‘occurrence’ which is neither ‘expected or intended’ will be covered.”).

b. The fortuity principle. The insurance codes of New Mexico and West Virginia provide representative examples of how statutory definitions of insurance incorporate the concept of fortuity: The former defines “insurance” as “a contract whereby one undertakes to pay or indemnify another as to loss from certain specified *contingencies or perils*, or to pay or grant a specified amount or determinable benefit in connection with ascertainable *risk contingencies*, or to act as surety,” N.M. Stat. Ann. § 59A-1-5 (West) (emphasis added), and the latter states that “[i]nsurance is a contract whereby one undertakes to indemnify another or to pay a specified amount upon determinable *contingencies*.” W. Va. Code Ann. § 33-1-1 (West) (emphasis added). Courts occasionally interpret such statutes to mean that insurance policies do not cover known losses. See, e.g., *Interstate Fire & Cas. Co. v. Abernathy*, 93 So. 3d 352, 358 (Fla. Dist. Ct. App. 2012) (deriving from a statutory definition of insurance that “Florida’s insurance laws embody the fortuity and known loss principles, precluding coverage for losses that have already taken place.”); *Henry Modell & Co. v. Gen. Ins. Co. of Trieste & Venice*, ~~597 N.Y.S.2d 75, 75~~ (193 A.D.2d 412, 412 (N.Y. App. Div. 1993) (citing a statutory definition of insurance for the rule that known losses were not covered by an insurance policy); *City of Corvallis v. Hartford Acc. & Indem. Co.*, No. ~~CIV-89-294-JU~~, 1991 WL 523876, at *8 (D. Or. May 30, 1991) (asserting that the known-loss doctrine is “implicit in Oregon’s definition of insurance”). Significantly, courts have not used the fortuity elements of statutory definitions of insurance as grounds to eliminate coverage for known losses when both parties intended for such coverage to exist.

c. Rationale for the known-liability standard. The *known-liability* standard for determining the application of the known-loss doctrine has been adopted by more courts than the *known-harm* standard. See *State v. Hydrite Chem. Co.*, 695 N.W.2d 816, ~~825~~ 828 (Wis. Ct. App.

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2005) (stating that what this Restatement calls the *known-liability* standard is “apparently the majority view”); *Rohm & Haas Co. v. Cont’l Cas. Co.*, 781 A.2d 1172, 1182 (Pa. 2001) (Castille, J., dissenting) (calling it “the prevailing standard among those courts recognizing known loss”). The courts that have adopted the known-liability standard recognize its fidelity to the fortuity principle. As one district court explained:

[T]he occurrence of the event (here, the leak of [pollutants from the insured’s underground storage tanks]) does not destroy the requisite element of statistical uncertainty in the third party liability context, as *the relevant events remain to be determined*, including: is there any harm to off-site locations; will claims be filed at all; what number of claims will be filed; what sums of money will the claims demand.

UTI Corp. v. Fireman’s Fund Ins. Co., 896 F. Supp. 362, 376 (D.N.J. 1995) (emphasis added). Similarly, in applying the known-liability standard, the Second Circuit stated:

Though NGC was aware, prior to the inception of many of the policies, that its products risked asbestosis and cancer diseases and had received a large number of claims, it was highly uncertain . . . as to the prospective number of injuries, the number of claims, the likelihood of successful claims, and the amount of ultimate losses it would be called upon to pay. NGC was fully entitled to replace the uncertainty of its exposure with the precision of insurance premiums and leave it to the insurers’ underwriters to determine the appropriate premiums.

Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1215 (2d Cir. 1995), [\(applying N.Y. & Tex. law\)](#), modified on denial of reh’g, 85 F.3d 49 (2d Cir. 1996) (citations omitted). For other courts adopting the known-liability standard for applying the known-loss doctrine, see *Pittston Co. Ultramar Am. Ltd. v. Allianz Ins. Co.*, 124 F.3d 508, 518 (3d Cir. 1997) [\(applying N.J. law\)](#) (“~~we~~We think the better rule, and the one likely to be adopted by the New Jersey Supreme Court, is that the known loss doctrine will bar coverage only when the legal liability of the insured is a certainty.”); *UTI Corp. v. Fireman’s Fund Ins. Co.*, 896 F. Supp. ~~362, 376~~362 (D.N.J. 1995); *General Gen. Housewares Corp. v. National Surety Nat’l Sur. Corp.*, 741 N.E.2d 408, 414 [\(Ind. Ct. App. 2000\)](#) (the known-loss doctrine bars coverage only for “substantially certain” liabilities); *CPC Int’l, Inc. v. Hartford Acc. & Indem. Co.*, 720 A.2d ~~408, 422~~408 (N.J. Super. Ct. App. Div. 1998); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, ~~1210~~1212 (Ill. 1992) (“the known loss doctrine may be invoked if the insurers demonstrate that OMC knew or had reason to know, at the time it purchased the CGL policy, that there was a substantial probability that loss or liability would ensue due to the PCB contamination for which it is seeking coverage. The question is not whether OMC knew it was discharging a pollutant into the environment, as the insurers and their amici argue. Rather, the relevant question is whether OMC knew or had reason to know that a probable loss or liability would occur due to the PCB contamination alleged in the underlying complaints.”); *Westchester Fire Ins. Co. v. G. Heileman Brewing Company, Inc., 2000 Co.*, ~~747 N.E.2d 955, 966~~ (Ill. App. ~~LEXIS 990 (1st Dist. Dec. 22, 2000)~~Ct. 2001) (adopting standard of “substantial probability that

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loss or liability would result from the conduct for which it seeks coverage ~~is sought~~.”); SCA Servs., Inc. v. Transp. Ins. Co., ~~419-646 N.E.2d 394, 398~~ (Mass. ~~528-~~(1995) (“However, SCA’s knowledge goes beyond simply knowing that there was environmental contamination and that its landfill was the probable source of this contamination. SCA knew that the residents of Wilsonville were damaged by the operation of the site. Therefore, the nuisance for which SCA sought personal injury coverage was not only a known but an adjudicated fact at the time SCA purchased the insurance and thus was uninsurable.”); Ins. Co. of N. Am. v. Kayser-Roth Corp., 770 A.2d 403, 415 (R.I. 2001) (internal citations omitted) (loss is still insurable “when there is uncertainty about the imposition of liability and no legal obligation to pay yet established”); Atchison, Topeka & Santa Fe ~~Railway~~Ry. Co. v. Stonewall Ins. Co., 71 P.3d 1097, 1136 (Kan. 2003) (affirming trial-court ruling that “The[the inquiry was whether Santa Fe knew when it purchased liability policies that there was a substantial probability it would suffer a known loss exceeding its self-insured retention. The district court concluded that Santa Fe did not have such knowledge for the policy years at issue,” with the relevant “loss” being “liability,” not the underlying harm); Columbus Farmers Mkt., LLC v. Farm Family Cas. Ins. Co., No. ~~CIV-A~~ 05-2087, 2006 WL 3761987, at *11 (D.N.J. Dec. 21, 2006) (although the policyholder had been subject to raids on its premises and Recording Industry Association of America (“RIAA”) investigations into its activities prior to the policy period, the court held that such notice did not preclude coverage for a law suit filed by RIAA members because the policyholder “could not have concluded to any ‘certainty’ that they would be liable” due to uncertainty in the applicable law); Stonehenge Eng’g Corp. v. ~~Employers~~Emp’rs Ins. of Wausau, 201 F.3d 296, 301 (4th Cir. 2000) (when prior to the inception of the policy period, the policyholder received an inspection report revealing construction defects and a letter threatening legal action, and had been named as a defendant in a law suit prior to the policy period, the court held that such notice did not preclude coverage because the evidence existing at the time the policies commenced made liability uncertain); Peck v. Pub. Serv. Mut. Ins. Co., 363 F. Supp. 2d 137, 146 & 147 n.~~76~~ (D. Conn. 2005) (when the policyholder had been named as a defendant in the underlying law suit prior to the policy period, the court held that coverage was not precluded under the known-loss doctrine because the policyholder was only aware of “potential likely losses,” explicitly disagreeing with case law “from other jurisdictions suggesting that the known loss doctrine applies to a loss for which suit had been filed prior to the effective date of the policy”). Cf. Montrose Chem. Corp. of Cal. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995) (en banc) (requiring that the insured be certain about both liability and damages in order for the insurer to avoid coverage under California’s known-loss statute, which limits the insurability of a liability and does not simply impose an obligation to disclose a liability).

The Supreme Court of Hawai‘i held that the known-loss doctrine does not bar liability-insurance coverage even when the adjudication of third-party claims against the insured had already begun prior to the policy period unless “the insured’s liability as alleged in the lawsuit or claim is a certainty” when the policy period began. Sentinel Ins. Co. Ltd. v. First Ins. Co. of Hawai‘i, Ltd., 875 P.2d 894, 920 (Haw. 1994), as amended on reconsideration (June 24,

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1994). The known-loss doctrine did not bar coverage, it continued, “if the insured’s liability is *in any degree contingent*.” *Id.* (emphasis added) (citations omitted). Likewise, the Fourth Circuit held that the known-loss doctrine did not bar coverage for an insured who was already being sued when the policy period began, because, at that time, it had “sufficiently viable defenses” against the third-party claims being adjudicated “so as to prevent the conclusion that [the insured] had knowledge that entry of a judgment against it was substantially certain to occur.” *Stonehenge Eng’g Corp. v. Employers Emp’rs Ins. of Wausau*, 201 F.3d 296, 303 (4th Cir. 2000).

It is sometimes argued that, under the known-liability standard, the known-loss doctrine applies whenever the insured is made aware of a serious legal dispute, as when it receives a demand letter or notice of a lawsuit prior to the inception of the policy period, irrespective of the substantial probability that the insurer will have to make payouts for defense costs or indemnification. There is little support for this interpretation of the known-loss doctrine in the case law, however. Many of the cases typically cited to support this proposition are not in fact known-loss-doctrine cases; rather, they are cases involving the interpretation of the “occurrence” or “accident” language found in many liability insurance policies. See, e.g., *Western Cas. & Sur. Co. v. Hays*, 781 P.2d 38 (Ariz. Ct. App. 1989) (finding no coverage because insured’s prior knowledge of dispute resulted in claim falling outside policy’s definition of “occurrence”); *United States of America U.S. v. Conservation Chemical Chem. Co.*, 653 F. Supp. 152 (W.D. Mo. 1986) (same); *Chemical Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 788 F. Supp. 846 (D.N.J. 1992), *aff’d in part, rev’d in part*, 89 F.3d 976 (3d Cir. 1996) (same); and *City of Okanogan v. Cities Ins. Assoc. Ass’n of Washington Wash.*, 865 P.2d 576 (Wash. Ct. App. 1994) (same). Moreover, in the cases that do appear to apply the known-loss doctrine to deny coverage in cases involving an insured’s having received notice of a lawsuit prior to the policy’s inception, it is not clear either that the relevant liability insurance policies contained substantial self-insured retentions or, if they did, that the courts took that fact into account in rendering their decisions. See, e.g., *Outboard Marine Corp. v. Liberty Mutual Mut. Ins. Co.*, 607 N.E.2d 1204 (Ill. 1992) (no coverage for environmental liabilities arising out of its discharge of PCBs after the insured was put on notice of the claim prior to beginning of policy period); *Westchester Fire Ins. Co. v. G. Heileman Brewing Company, Inc.*, ~~2000 Ill. App. LEXIS 990 (1st Dist. Dec. 22, 2000) (no coverage~~ 747 N.E.2d 955 (Ill. App. Ct. 2001) (no right to indemnification where lawsuit had been filed against the insured prior to beginning of policy period). Under the rule adopted in this Section, if the policy in question is a first-dollar policy (with no SIR) and a lawsuit is filed against the insured prior to the beginning of the new policy period, failure to notify the insurer would likely trigger the known-loss doctrine under the new policy, assuming that the insured was substantially certain that it would incur defense or liability costs attributable to harm that would occur in the new policy period. See Illustration 3.

For examples of the known-harm standard, under which coverage is said to be barred for claims arising out of harm to third parties that was known to the insured prior to the policy period, see *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 10 F. Supp. 2d 771, 790 (E.D. Mich. 1998) (ruling that “the crucial issue” in determining whether the known-loss doctrine bars coverage “is

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whether [the insured] was aware, at a minimum, of an immediate threat of the contamination for which it was ultimately held responsible and for which it now seeks coverage; not [the insured’s] awareness of its legal liability for that contamination.”); *Two Pesos, Inc. v. Gulf Ins. Co.*, 901 S.W.2d 495, 502 (Tex. App. 1995) (holding that coverage of an insured’s liability arising out of its infringement of a third party’s trade dress was precluded because, inter alia, the insured knew about the infringement before obtaining the policy); ~~*American Am. Family Mutual Insurance Company v. American Mut. Ins. Co. v. Am. Girl, Inc.*~~, 673 N.W.2d 65, 85-86 (Wis. 2004) (“Here, the fact that [property damage] was occurring on the 94DC was known as early as March of 1995, and the extent of the damage was substantially known by the time of the meeting in January or February, 1997. The policies of these remaining insurers post-date this period. Accordingly, the known loss doctrine precludes coverage under these policies.”).

Illustration 1 is based on *State v. Hydrite Chem. Co.*, 695 N.W.2d ~~816, 825~~816 (Wis. Ct. App. 2005). For further support of the requirement that the insured be substantially certain that the liability will reach the level of coverage at issue, see *UTI Corp. v. Fireman’s Fund Ins. Co.*, 896 F. Supp. ~~362, 376~~362 (D.N.J. 1995), and *Gould, Inc. v. Arkwright Mut. Ins. Co.*, 907 F. Supp. ~~103, 109~~103 (M.D. Pa. 1995).

d. A subjective standard. Among courts that have considered the question, the majority rule is that the known-liability standard is subjective. See *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 10 F. Supp. 2d 771, 789 (E.D. Mich. 1998) (adopting the subjective standard because the known-loss doctrine’s function is to prevent fraud and noting that the subjective standard has the advantage of “protect[ing] against the misuse of hindsight to avoid indemnification coverage.”); *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d ~~403, 415~~403 (R.I. 2001); *Stonehenge Eng’g Corp. v. Employers Emp’rs Ins. of Wausau*, 201 F.3d ~~296, 303~~296 (4th Cir. 2000); *Gen. Housewares Corp. v. Nat’l Sur. Corp.*, 741 N.E.2d ~~408, 417~~408 (Ind. Ct. App. 2000); *Pub. Util. Dist. No. 1 of Klickitat Cty Cnty. v. Int’l Ins. Co.*, 881 P.2d ~~1020, 1030~~1020 (Wash. 1994); *Gould, Inc. v. Arkwright Mut. Ins. Co.*, 907 F. Supp. ~~103, 109~~103 (M.D. Pa. 1995). But see *Sentinel Ins. Co., Ltd. v. First Ins. Co. of Hawai’i, Ltd.*, 875 P.2d 894, 919 (Haw. 1994), as amended on reconsideration (June 24, 1994) (holding that the known-loss doctrine bars coverage for liability that the insured “was or should have been aware of before coverage began”).

f. Relationship to misrepresentation and concealment doctrine. Because the known-loss doctrine includes neither a materiality nor a reliance requirement, there are plausible circumstances under which it could bar coverage that would not be barred under the misrepresentation or concealment doctrines. See Kenneth S. Abraham, *Peril and Fortuity in Property and Liability Insurance*, 36 TORT & INS. L.J. 777, 795-796 (2001). This is because “[t]he relevance of information about known losses undoubtedly varies, depending on the potential size of the known loss, . . . [and] the frequency and severity of other losses that the insured can be expected to suffer during the policy period, among other factors.” *Id.* For examples of the very few cases that apply the known-loss doctrine as the sole basis for denying coverage under a liability insurance policy, see the Reporters’ Note to Comment *a* of this Section. For an illustration of the known-loss doctrine’s overlap with the doctrines against fraud

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and concealment, see, e.g., *Rohm & Haas Co. v. Cont'l Cas. Co.*, 781 A.2d 1172, 1181 (Pa. 2001) (Nigro, J., concurring) (because “the evidence clearly supported the jury’s verdict with respect to [the insurer]’s defense of fraud,” there is “no need for the majority to address the merits of [the insurer]’s additional defenses of known loss and late notice”).

g. Not a doctrine of legal insurability. See *Gen. Housewares Corp. v. Nat’l Sur. Comp.*, 741 N.E.2d 408, 414-415 (Ind. Ct. App. 2000) (reversing summary judgment in insurer’s favor because there was a genuine issue of material fact as to whether the insurer as well as the insured knew about the insured’s liabilities before the policy was issued, which would have rendered the known-loss doctrine inapplicable); *Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 71 P.3d 1097, 1137 (Kan. 2003) (upholding a trial court’s ruling that an insurer’s knowledge precluded its avoiding coverage based on the known-loss doctrine, because, “[g]iven the underlying basis of the doctrine, and the right of the parties to agree to cover existing losses, it has been recognized that the known loss doctrine does not apply if the insurer also knew of the circumstances on which it bases the defense.”) (citations and internal quotations omitted); see also *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, 1210 (Ill. 1992) (“[T]he insurer has no duty to defend or indemnify the insured with respect to the known loss *ab initio*, unless the parties intended the known loss to be covered.”) (emphasis added).

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Liability Insurance

TOPIC 2
REMEDIES

§ 47. Remedies Potentially Available

The remedies that may be available, ~~depending on the circumstances,~~ in an action determining the rights of parties under a liability insurance policy include:

- (1) An award of damages under § 48;
- (2) A declaration of the rights of the parties;
- (3) Court costs or attorneys' fees to a prevailing party when provided by ~~legislation~~ state law or the policy;
- ~~(4) When the insured substantially prevails in a declaratory judgment action brought by an insurer seeking to terminate the insurer's duty to defend under the policy, an award of a sum of money to the insured for the reasonable attorneys' fees and other costs incurred in that action;~~ (5) If so provided in the liability insurance policy or otherwise agreed by the parties, an award of a sum of money due to the insurer as recoupment of the costs of defense or settlement;
- (6) Collection and disbursement of interpleaded policy proceeds;
- (7) Payment or return of premiums;
- (8) Indemnification of the insurer by the insured when state law permits recovery from highly culpable insureds; and
- (9) Prejudgment interest.

Comment:

a. Damages for breach and other remedies. This Section lists the potential remedies available in a liability insurance coverage action. Section 48 contains rules regarding the damages to be paid to the insured for breach of a liability insurance policy. Insurance bad-faith actions are addressed in §§ 49-50. This list of remedies is comprehensive but not exhaustive; there may be special circumstances in which justice may require a court to award an equitable or other remedy not listed.

b. An order declaring the rights of the parties. Particularly when a liability insurer is defending under a reservation of rights, the court's order declaring the rights of the parties can be

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the most important remedy granted in a liability insurance coverage action. If the court determines that the liability action is not covered, that declaration terminates the insurer's duty to defend under § 18.

c. Liability insurance law exceptions to the American rule regarding attorneys' fees. This Section follows the law of each state with respect to the award of attorneys' fees to the prevailing party. Under the traditional "American Rule," each party to a legal dispute is responsible for bearing its own attorneys' fees, ~~but~~ However, in the insurance law context, there is substantial authority ~~and strong reasoning in favor of an exception in the liability insurance context. This Restatement recognizes a liability insurance exception to the American rule in three circumstances, while acknowledging that there may be controlling legislation in some jurisdictions that provides for attorneys' fees in insurance coverage litigation more broadly or narrowly. First, the rule in subsection (4) entitles the insured to recover its attorneys' fees when that insured prevails in a declaratory judgment action brought by an insurer seeking to terminate its defense duties. Second, the rule in § 48 entitles the insured to recover its attorneys' fees when it prevails in an action establishing that the insurer breached its defense duties. These first two rules reflect the importance of the defense coverage provided by traditional liability insurance policies. Third, the rule in § 50 entitles the insured to recover its attorneys' fees in other circumstances if the insurer breached in bad faith. The rule followed in this Restatement regarding attorneys' fees in insurance bad faith cases is the overwhelming majority~~ in favor of exceptions to this rule. Courts in all but a very few states award attorneys' fees to a prevailing insured when the insurer breaches in bad faith. ~~The characterization of the other two attorneys' fee rules followed in this Restatement depends on the authority used to form a basis for the characterization. See § 50.~~ Courts in about half the states award attorneys' fees to an insured ~~in one or both of these two exceptional circumstances, but most often they do so on the basis of legislation. Nevertheless,~~ that prevails in an ordinary insurance coverage action, without requiring a finding of bad faith. Most often, the source of the legal rule authorizing courts to award fees in liability insurance coverage actions is statutory, but there are many states in which ~~these exceptions result from a common-law rule or a judicial gloss on a statute that would otherwise be narrower in its application~~ the liability insurance exceptions to the American Rule are common-law rules. Moreover, in some cases, the legislation authorizing the fee shifting was enacted to clarify a common-law rule, and in other cases courts have transformed a discretionary

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~~statute into an automatic fee shifting rule in liability insurance cases. Accordingly, although a majority of courts that have addressed the issue solely based on the common law have held to the contrary, there is ample authority both common law and statutory supporting a special, common-law liability insurance exception to the American rule when an insurer breaches the duty to defend or the insurer initiates a declaratory judgment action seeking to terminate its duty to defend.~~

Outside of the bad-faith context, the justifications for altering the American rule are strongest in the case of a breach of the duty to defend. Liability insurance defense coverage provides the access to civil justice for defendants that corresponds to the access to civil justice that contingent-fee arrangements make possible for plaintiffs. Without an insurer-funded defense lawyer, many if not most consumers and small businesses would be deprived of an adequate defense, causing harm that may well be irreparable even if there is the possibility of reimbursement through filing a breach-of-contract action. An insured with adequate and readily available assets to pay for its defense has nevertheless lost the bargained-for expertise of the insurer in managing the litigation as well as the timely insurer-funded defense. For all insureds, however, the loss of a timely insurer-funded defense means that they must litigate two cases on their own and at their own expense—one against the underlying plaintiff and one against their insurer—when they should not have had to fund the litigation of even one case. For that reason, the insured’s costs of litigating both actions are understood by the courts of some jurisdictions to be among the damages owed for breach of the duty to defend or pay defense costs on an ongoing basis. Those courts reason that, otherwise, the insurer would be able to unilaterally convert a duty-to-defend policy into a policy that provides coverage for only a portion of the costs of defense (the costs of defense minus the insured’s costs of litigating coverage) long after the fact.

~~d. *Attorneys’ fees to an insured who prevails in a declaratory judgment proceeding initiated by the insurer.* Courts award fees to insureds who prevail in a declaratory judgment proceeding initiated by the insurer, in essence, because of the nature of liability insurance policies. Specifically, policyholders purchase a liability insurance policy that includes the duty to defend or pay defense costs in order to receive a timely and effective legal defense, paid for by the insurer, so that the insured does not have to bear that defense burden. When an insurer brings a declaratory judgment action seeking to terminate its defense of a legal action, the insured is then forced to hire a lawyer to preserve the defense that the liability insurance policy was~~

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~~purchased to provide. Having to hire a lawyer to preserve the right to have one's legal fees covered significantly frustrates a central purpose of the liability insurance policy. In that context, the insured's attorneys' fees can be understood to be part of the costs of the insured's defense of the underlying claim. Indeed, some courts have held that the insurer's duty to defend extends to a defense of a declaratory judgment action brought by the insurer seeking to terminate the defense. Once an insurer files the declaratory judgment action, the insured cannot as a practical matter continue to receive a defense of the underlying legal action unless it hires a lawyer and then prevails in that declaratory judgment action. Although courts in many states hold to the contrary, courts in nearly half of the states award attorneys' fees to an insured who prevails in a declaratory judgment proceeding initiated by the insurer, typically on an automatic basis, but sometimes as a matter of judicial discretion.~~ *e. Recoupment.* Although the default rule is that the insurer is not entitled to recoupment of the costs of defense or settlement of an uncovered action, the default nature of the rule means that the parties can agree to the contrary, either in the liability insurance policy or in a separate agreement. See § 21 regarding recoupment of the costs of defense and § 25(2) regarding recoupment of the costs of settlement. Indeed, many liability insurance policies contain provisions addressing circumstances in which an insured may be obligated to reimburse the insurer for the costs of defense. When the parties have altered the default rule against recoupment, an insurer that prevails in a liability insurance action may be entitled to an order directing the insured to pay a sum of money to the insurer, provided that the insurer reserved the right to do so in the notice required by § 15.

f. Interpleaded policy proceeds. Especially when there are multiple potential tort claimants and it is likely that the damages will exceed the available liability insurance coverage, a liability insurer may file an interpleader action seeking adjudication regarding how the limits should be shared among the potential claimants. If policy proceeds have been paid into the court pursuant to such an action, the potential remedies may include distribution of the assets deposited with the court.

g. Payment or return of premiums. The circumstances in which the remedies may include the payment or return of premiums include an action in which an insurer rescinds the policy based upon a misrepresentation, in which case the policyholder is entitled to a return of premiums, and an action in which an insurer seeks payment of retrospective premiums based upon losses suffered by the policyholder.

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hg. Indemnification rights against the insured. The general rule is that an insurer may not seek subrogation or indemnification from its own insured. The two most widely accepted purposes for this anti-indemnification rule are, first, to prevent the insurer from using the right of indemnification to, in effect, avoid providing coverage to the insured and, second, to avoid conflicts of interest between insurer and insured. Some courts have recognized an exception to this rule in the case of highly culpable conduct, as an alternative to declaring the insurance coverage contrary to public policy. This alternative has the potential to more closely tailor the liability insurance rule to the underlying deterrence and retribution objectives than a general prohibition of insurance coverage for such liabilities. If the insured has the financial capacity, the insurer's right to indemnification will place the financial responsibility on the insured. If the insured does not have the financial capacity, the availability of the insurance will make it possible for the underlying tort action to proceed.

ih. Prejudgment interest. Under the general contract-law rule, a party is entitled to prejudgment interest in a breach-of-contract claim if the breach “consists of a failure to pay a definite sum in money or to render a performance with fixed or ascertainable monetary value.” Restatement Second, Contracts § 354(1). There has been a clear long-term trend to holding more and different kinds of damages to have been ascertainable, thus liberalizing the award of prejudgment interest, and some jurisdictions have abandoned the ascertainability standard. Courts awarding prejudgment interest against insurers in coverage cases have relied on policy language, state statutes, or public policy generally. Courts typically award prejudgment interest to an insured who prevails in a liability insurance coverage matter. The amount owed for breach of the duty to indemnify is obviously ascertainable when it is based on a judgment in the underlying case. It is also ascertainable when it is based on a settlement that is determined to be reasonable in amount and, similarly, when it is based on the payment of defense costs that are determined to be reasonable in amount. While there is little guidance from the courts regarding the payment of prejudgment interest in cases in which an insurer is required to pay only the reasonable amount of an unreasonable settlement or unreasonable defense fees, or when the insured is awarded consequential damages, the general contract-law rule states that “interest may be allowed as justice requires on the amount that would have been just compensation had it been paid when performance was due.” Restatement Second, Contracts § 354(2).

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REPORTERS' NOTE

b. An order declaring the rights of the parties. See *Olson v. Farrar*, 809 N.W.2d 1, 8 (Wis. 2012) (“If the allegations in the complaint, construed liberally, appear to give rise to coverage, insurers are required to provide a defense *until the final resolution of the coverage question by a court.*”) (emphasis added); see also *Am. & Foreign Ins. Co. v. Jerry’s Sport Ctr., Inc.*, 2 A.3d 526, 542 (Pa. 2010) (“If the insurer is successful in the declaratory judgment action, it is relieved of the continuing obligation to defend.”).

c. Liability insurance law exceptions to the American rule regarding attorneys’ fees. ~~For authority regarding insureds’ rights to recover attorneys’ fees when the insurer brings an action seeking to terminate the duty to defend, see Reporters’ Note to Comment *d* below. For authority regarding insureds’ rights to recover attorneys’ fees when the insurer breaches the duty to defend, see § 48, Reporters’ Note to Comment *d*.~~ For authority regarding insureds’ rights to recover attorneys’ fees when the insurer breaches in bad faith, see § 50, Reporters’ Note to Comment *b*. For ~~examples of courts awarding~~ legislation providing for an automatic award of attorneys’ fees to an insurer that prevails in insurance coverage litigation, see *O.K. Lumber Co. v. Providence Wash. Ins. Co.*, 759 P.2d 523, 528 (Alaska 1988) (affirming fee award to insurer under Alaska’s general two-way fee-shifting rule); *Mortensen v. Stewart Title Guar. Co.*, 235 P.3d 387, 397 (Idaho 2010) (awarding insurer attorneys’ fees under Idaho Code Ann. § 41-1839, which authorizes court to award fees to an insurer when the court “finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation”)- ~~See also Okla. Stat.~~ insured who prevails in a liability insurance coverage action, see Alaska R. Civ. P. 82 (broader rule that always awards attorneys’ fees to any prevailing party unless otherwise provided by law or agreed to by the parties); Ark. Code Ann. § 23-79-209 (“[T]he company shall also be liable to pay the holder of the policy all reasonable attorney’s fees for the defense or prosecution of the suit.”); Fla. Stat. Ann. § 627.428 (awarding attorneys’ fees when judgment is entered against an insurer); Haw. Rev. Stat. Ann § 431: 10-242 (“Where an insurer has contested its liability under a policy and is ordered by the courts to pay benefits under the policy, the policyholder, the beneficiary under a policy, or the person who has acquired the rights of the policyholder or beneficiary under the policy shall be awarded reasonable attorney’s fees and the costs of suit, in addition to the benefits under the policy”); Me. Rev. Stat. Ann. tit. 24-A, § 2436-B (in an action “to determine an insurer’s contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney’s fees”); Neb. Rev. Stat. § 44-359 (“In all cases when the beneficiary or other person entitled thereto brings an action upon any type of insurance policy, except workers’ compensation insurance, or upon any certificate issued by a fraternal benefit society, against any company, person, or association doing business in this state, the court, upon rendering judgment against such company, person, or association, shall allow the plaintiff a reasonable sum as an attorney’s fee in addition to the amount of his or her recovery, to be taxed as part of the costs.”); *State Farm Mut. Auto Ins. Co. v. Selders*, 202 N.W.2d 625, 626 (Neb. 1972) (extending statute to declaratory actions brought by insurer as well); N.H. Rev. Stat. Ann. § 491:22-b (“In any action

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to determine coverage of an insurance policy pursuant to RSA 491:22, if the insured prevails in such action, he shall receive court costs and reasonable attorneys' fees from the insurer.”); Okla. St. Ann. tit. 36, § 3629(B) (allowing the prevailing party ~~in an insurance coverage matter~~ to recover attorneys' fees, not limited to insured).

~~*d. Attorneys*~~ For legislation authorizing courts to award attorneys' fees to an insured who prevails in a ~~declaratory judgment proceeding initiated by the insurer. According to the count reflected in this Note, there~~ liability insurance coverage action, see Ariz. Rev. Stat. Ann. § 12-341.01 (allowing the court to award attorneys' fees to a prevailing party in a breach-of-contract action); Lennar Corp. v. Auto-Owners Ins. Co., 151 P.3d 538, 553 (Ariz. Ct. App. 2007) (awarding attorneys' fees to insured under § 12-341.01 in declaratory-judgment action brought by insurer seeking to terminate the duty to defend); Missouri Rev. Stat. 527.100 (permitting attorney-fee shifting in declaratory-judgment actions); Allstate Ins. Co. v. Sullivan, 643 S.W.2d 21, 24 (Mo. Ct. App. 1982) (citation omitted) (insurer's action in bringing declaratory-judgment suit found not to be “in any way frivolous or unjustified,” yet, “justice and equity warranted” allowing attorneys' fees); N.D. Cent. Code Ann. § 32-23-08; Ohio Rev. Code Ann. 2721.09 (“whenever necessary or proper, a court of record may grant further relief based on a declaratory judgment or decree previously granted under this chapter”); N.J. Ct. R. Ann. 4:42-9 (“No fee for legal services shall be allowed in the taxed costs or otherwise, except . . . (6) In an action upon a liability or indemnity policy of insurance, in favor of a successful claimant.”); Passaic Valley Sewerage Comm'rs v. St. Paul Fire & Marine Ins. Co., 21 A.3d 1151, 1164 (N.J. 2011) (“The award of counsel fees, however, is not mandatory, but rather the trial judge has broad discretion as to when, where, and under what circumstances counsel fees may be proper and the amount to be awarded.”) (internal quotation omitted); Este Oils Co. v. Federated Ins. Co., 724 N.E.2d 854, 859 (Ohio Ct. App. 1999) (citation omitted) (“In a declaratory judgment action, the trial court has the authority under R.C. 2721.09 to assess attorney fees, which would clearly include fees expended by an insured in pursuing its right to coverage. This is so regardless of the conduct of the insurer.”); Tex. Civ. Prac. & Rem. Code Ann. § 37.009 (“In any proceeding under this chapter [declaratory-judgment actions], the court may award costs and reasonable and necessary attorney's fees as are equitable and just”); Allstate Ins. Co. v. Hallman, 159 S.W.3d 640, 642 (Tex. 2005) (trial court has discretion to award attorneys' fees to insured in declaratory-judgment action brought by insurer defending under a reservation of rights even if the underlying action is concluded with no liability for insured); and Wis. Stat. Ann. § 806.04(10) (“In any proceeding under this section the court may make such award of costs as may seem equitable and just”); Elliott v. Donahue, 485 N.W.2d 403, 409 (Wis. 1992) (interpreting the Wisconsin statute as allowing fee shifting when the insurer breaches the duty to defend).

There are 23 states that award attorneys' fees to an insured that prevails in a declaratory-judgment action brought by the insurer seeking to avoid the duty to defend: nine states by common law (Maine later codified); seven states automatically by ~~statute~~ the statutes cited above; and seven states by statute that grants the court discretion to award fees in these

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circumstances, [cited above](#). The Massachusetts Supreme Judicial Court has explained the justification for [a common-law rule](#) awarding attorneys’ fees to an insured who prevails in a declaratory-judgment action initiated by the insurer as follows:

... It is immaterial whether the insurer proceeds in good faith or in bad faith to avoid the duty to defend under a liability insurance policy because “[t]o impose upon the insured the cost of compelling his insurer to honor its contractual obligation is effectively to deny him the benefit of his bargain.” “The entitlement of an insured to attorneys’ fees and costs incurred in establishing contested coverage depends exclusively on whether that coverage is ultimately determined to exist. It does not depend on whether the denial of coverage by the insurer was reasonable or unreasonable, justified or unjustified, a close question of fact or a matter not even subject to legitimate dispute. *The focus is exclusively on the bottom line*” (emphasis added).

The existence of a breach of the terms of the policy is irrelevant because “a special relationship exists between the insured and the insurer under a liability insurance policy, [wherein] . . . insureds obtain liability insurance to avoid the prospect of being burdened by significant legal expenses.” “The intent of an insured in acquiring liability insurance is to transfer to the insurer the responsibility for defending the insured against any claim which may fall within the coverage of the policy.” In this respect, liability insurance is “‘litigation insurance’ as well.” Thus, as the Appeals Court noted, “[i]t should not matter whether (as in *Gamache*) the insurer announces withdrawal from the third-party action and sues for a declaration, or (as in the present case) brings a declaratory action and provisionally maintains defense of the third-party action pending instruction by the declaration. In either case the insured deserves reimbursement for his reasonable outlay ‘in successfully establishing the insurer’s duty to defend under the policy.’”

The [insureds] were forced to defend Hanover’s action and incur legal fees to establish Hanover’s duty to defend. If they failed to defend that action, they would have risked being defaulted and they would have incurred attorney’s fees they otherwise would not have incurred for the defense of the [underlying legal action]. Instead, they were successful in establishing that Hanover’s duty to defend extended beyond its payment of the policy limits. They are entitled to recover their attorney’s fees for that effort.

Hanover Ins. Co. v. Golden, 766 N.E.2d 838, 840-841 (Mass. 2002) (citations omitted)-~~(common-law rule)~~. For additional [common-law](#) authority, see ~~Alaska R. Civ. P. 82 (broader rule that always awards attorneys’ fees to any prevailing party unless otherwise provided by law or agreed to by the parties); Ark. Code Ann. § 23-79-209 (broader insurance law rule: “[T]he~~

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~~company shall also be liable to pay the holder of the policy all reasonable attorney’s fees for the defense or prosecution of the suit.”); Fla. Stat. Ann. § 627.428 (broader insurance law rule: awarding attorneys’ fees when judgment is entered against an insurer); Haw. Rev. Stat. Ann. § 431:10-242 (broader insurance law rule: “Where an insurer has contested its liability under a policy and is ordered by the courts to pay benefits under the policy, the policyholder, the beneficiary under a policy, or the person who has acquired the rights of the policyholder or beneficiary under the policy shall be awarded reasonable attorney’s fees and the costs of suit, in addition to the benefits under the policy”); Farm Bureau Mut. Ins. Co. v. Kurtenbach By and Through Kurtenbach, 961 P.2d 53, 64 (Kan. 1998) (common-law rule: [citations omitted](#)) (“where an insurer denies coverage and the duty to defend and brings a declaratory judgment action against the insured to determine that issue, the insured may recover his or her attorney fees incurred in the defense of the declaratory judgment action if it is determined as a result of that action that there is coverage. The same rule is applicable where an insurer agrees to assume the duty to defend under a reservation of rights. . . .”); Union Mut. Fire. Ins. Co. v. Inhabitants of the Town of Topsham, 441 A.2d 1012, 1018-1019 (Me. 1982) (common-law rule subsequently codified in Me. Rev. Stat. Ann. tit. 24-A, § 2436-B (in an action “to determine an insurer’s contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney’s fees”)); Bausch & Lomb Inc. v. Utica Mut. Ins. Co., 735 A.2d 1081, 1095 (Md. 1999) (common-law rule: “Where an action is brought to enforce an insurer’s obligations under the third party liability provisions of a policy, and it is determined that there is coverage under the policy, the insurer is liable for the prevailing party’s attorneys’ fees.”); [Montana](#) [Mont.](#) Mountain W. Farm Bureau Mut. Ins. Co. v. Brewer, 69 P.3d 652, 660 (Mont. 2003) (common-law rule: “Accordingly, we hold that an insured is entitled to recover attorney fees, pursuant to the insurance exception to the American Rule, when the insurer forces the insured to assume the burden of legal action to obtain the full benefit of the insurance contract, regardless of whether the insurer’s duty to defend is at issue.”); [Neb.](#) [Rev. Stat.](#) § 44-359 (broader insurance law rule: “In all cases when the beneficiary or other person entitled thereto brings an action upon any type of insurance policy, except workers’ compensation insurance, or upon any certificate issued by a fraternal benefit society, against any company, person, or association doing business in this state, the court, upon rendering judgment against such company, person, or association, shall allow the plaintiff a reasonable sum as an attorney’s fee in addition to the amount of his or her recovery, to be taxed as part of the costs”); [State Farm Mut. Auto Ins. Co. v. Selders](#), 202 N.W.2d 625, 626 (Neb. 1972) (extending statute to declaratory actions brought by insurer as well); [N.H.](#) [Rev. Stat. Ann.](#) § 491:22-b (broader insurance law rule: “In any action to determine coverage of an insurance policy pursuant to RSA 491:22, if the insured prevails in such action, he shall receive court costs and reasonable attorneys’ fees from the insurer.”); U.S. Underwriters, Ins. Co. v. City Club Hotel, LLC, 822 N.E.2d 777 (N.Y. 2004) (common-law rule: [quotations omitted](#)) (“[A]n insured who is cast in a defensive posture by the legal steps an insurer takes in an effort to free itself from its policy obligations, and who prevails on the merits, may recover attorneys’ fees incurred in defending~~

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against the insurer’s action.”); ~~Okla. St. Ann. tit. 36, § 3629(B) (broader insurance law rule: allowing the prevailing party to recover attorneys’ fees, not limited to insured);~~ Hegler v. Gulf Ins. Co., 243 S.E.2d 443, 444 (S.C. 1978) (quotations omitted) (~~common-law rule:~~ “[T]he legal fees incurred by appellant[insured], in successfully asserting his rights against respondent[insurer’s] attempt in the declaratory judgment action to avoid its obligation to defend, were damages arising directly as a result of the breach of the contract.”); Olympic S.S. Co. v. Centennial Ins. Co., 811 P.2d 673, 681 (Wash. 1991) (holding on the basis of a common-law rule that an insured can recoup any attorneys’ fees it incurs because an insurer wrongfully refuses to pay or defend, regardless of who files the lawsuit); Aetna Cas. & Sur. Co. v. Pitrolo, 342 S.E.2d 156, syllabus 2159-160 (W. Va. 1986) (~~common-law rule:~~ “Where a declaratory judgment action is filed to determine whether an insurer has a duty to defend its insured under its policy, if the insurer is found to have such a duty, its insured is entitled to recover reasonable attorney’s fees arising from the declaratory judgment litigation.”).

There are also 23 states that award attorneys’ fees to an insured when the insurer breaches the duty to defend: 10 states by common-law rule (Maine was later codified); seven states in every case by the statutes cited above; two states in every case because of a judicial gloss on a statute that grants the courts discretion, as cited below; and four states under a statute that grants the courts discretion and is widely used, also as cited below. The Massachusetts Supreme Judicial Court articulated the justification for the common-law rule allowing an insured who prevails in an action to recover attorneys’ fees in the case of a breach of the duty to defend as follows:

The intent of an insured in acquiring liability insurance is to transfer to the insurer the responsibility for defending the insured against any claim which may fall within the coverage of the policy. The position advanced by the defendant would enable an insurer that wrongfully refused to defend to deprive its insured of the principal benefit of its contractual bargain, and for which the insured paid premiums. Even if the insured were eventually compensated for its defense of the third party action, it would remain permanently uncompensated for the costs associated with the declaratory judgment action it was forced to initiate because of the insurer’s violation of its duty to defend.

~~For authority granting trial-court discretion to~~ Rubenstein v. Royal Ins. Co. of America, 708 N.E.2d 639, 642 (Mass. 1999). For additional common-law authority permitting a prevailing insured to recover attorneys’ fees when the insurer breaches defense duties, see Farm Bureau Mut. Ins. Co. v. Kurtenbach By and Through Kurtenbach, 961 P.2d 53, 64 (Kan. 1998) (“where an insurer denies coverage and the duty to defend and brings a declaratory judgment action against the insured to determine that issue, the insured may recover his or her attorney fees incurred in the defense of the declaratory judgment action if it is determined as a result of that action that there is coverage.”); Union Mut. Fire Ins. Co. v. Inhabitants of the Town of Topsham, 441 A.2d 1012, 1018-1019 (Me. 1982).

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(common-law rule subsequently codified in Me. Rev. Stat. Ann. tit. 24-A, § 2436-B (in an action “to determine an insurer’s contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney’s fees.”)); Bausch & Lomb Inc. v. Utica Mut. Ins. Co., 735 A.2d 1081, 1095 (Md. 1999) (“Where an action is brought to enforce an insurer’s obligations under the third party liability provisions of a policy, and it is determined that there is coverage under the policy, the insurer is liable for the prevailing party’s attorneys’ fees.”); Morrison v. Swenson, 142 N.W.2d 640, 647 (Minn. 1966) (“Legal fees incurred in the declaratory judgment action were damages arising directly as the result of the breach.”) (Superseded by statute on a different matter as stated in *Graff v. Robert M. Swendra Agency, Inc.*, 800 N.W.2d 112 (Minn. 2011); *Montana Mountain W. Farm Bureau Mut. Ins. Co. v. Brewer*, 69 P.3d 652, 660 (Mont. 2003) (“Accordingly, we hold that an insured is entitled to recover attorney fees, pursuant to the insurance exception to the American Rule, when the insurer forces the insured to assume the burden of legal action to obtain the full benefit of the insurance contract, regardless of whether the insurer’s duty to defend is at issue.”); *Blount v. Kennard*, 612 N.E.2d 1268, 1271 (Ohio 1992) (“When an insurer refuses to defend its insured as required by the policy, the insured may recover from the insurer attorney fees which the insured incurs in the action brought to enforce the duty to defend and in the defense of the claims for which the duty to defend exists.”); *Hegler v. Gulf Ins. Co.*, 243 S.E.2d 443, 444 (S.C. 1978) (“The legal fees incurred by appellant, in successfully asserting his rights against respondent’s attempt in the declaratory judgment action to avoid its obligation to defend, were damages arising directly as a result of the breach of the contract.”); *Berenyi, Inc. v. Landmark Am. Ins. Co.*, No. 2:09-CV-01556-PMD, 2010 WL 233861 (D.S.C. 2010) (applying rule in *Hegler* to circumstance in which insurer denied a defense and insured brought an action seeking a declaration that the insurer was obligated to defend); *Olympic S.S. Co. v. Centennial Ins. Co.*, 811 P.2d 673, 681 (Wash. 1991) (holding that an insured can recoup any attorneys’ fees it incurs because an insurer wrongfully refuses to pay or defend, regardless of who files the lawsuit); *Aetna Cas. & Sur. Co. v. Pitrolo*, 342 S.E.2d 156, 160 (W. Va. 1986) (including attorneys’ fees in the subsequent declaratory-judgment action as part of the damages for breach). For contrary authority, see, e.g., the cases cited in the Reporters’ Note to Comment *d*.

For authority holding that courts should always award attorneys’ fees to a prevailing insured ~~in a declaratory judgment action, see Ariz. Rev. Stat. Ann.~~ when the insurer has breached the duty to defend, despite the facially discretionary nature of the authorizing legislation, see *State Farm Fire & Cas. Co. v. Sigman*, 508 N.W.2d 323, 326-327 (N.D. 1993) (holding that, although N.D. Cent. Code Ann. § 32-23-08 gives courts discretion whenever necessary and proper in any kind of case to award attorneys’ fees, it is always necessary and proper that insurer pays fees to an insured who prevails in an action challenging an insurer’s denial of a defense); *Tex. Civ. Prac. & Rem. Code Ann. § 38.001* (allowing recovery of reasonable attorney’s fees if the claim is for “an oral or written contract”); *Elliott Appraisers, LLC v. JM Ins. Servs., LLC*, No. H-10-2231, 2011 WL 722186, at *4 (S.D. Tex. Feb. 22, 2011) (awarding attorneys’ fees under § 38.001 for a breach of the duty to defend and stating that such an award is “mandatory”).

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~~For legislation granting trial-court discretion to award attorneys' fees to a prevailing insured, see, e.g., Ariz. Rev. Stat. Ann. § 12-341.01 (allowing the court to award attorneys' fees to a prevailing party in a breach-of-contract action); Lennar Corp. v. Auto-Owners Ins. Co., 151 P.3d 538, 553 (Ariz. Ct. App. 2007) (awarding attorneys' fees to insured under § 12-341.01 in declaratory judgment action brought by insurer seeking to terminate the duty to defend applying § 12-341.01 to insurance-contract disputes and allowing insurer to recover); Missouri Rev. Stat. 527.100 (permitting attorney-fee shifting in declaratory-judgment actions); Allstate Ins. Co. v. Sullivan, 643 S.W.2d 21, 24 (Mo. Ct. App. 1982) (citation omitted) (insurer's action in bringing declaratory-judgment suit found not to be "in any way frivolous or unjustified," yet, "justice and equity warranted" allowing attorneys' attorney fees); N.D. Cent. Code Ann. § 32-23-08; Ohio Rev. Code Ann. 2721.09 ("whenever necessary or proper, a court of record may grant further relief based on a declaratory judgment or decree previously granted under this chapter"); N.J. Ct. R. Ann. 4:42-9 ("No fee for legal services shall be allowed in the taxed costs or otherwise, except . . . (6) In an action upon a liability or indemnity policy of insurance, in favor of a successful claimant."); Passaic Valley Sewerage Comm'rs v. St. Paul Fire & Marine Ins. Co., 21 A.3d 1151, 1164 (N.J. 2011) ("The award of counsel fees, however, is not mandatory, but rather the trial judge has broad discretion as to when, where, and under what circumstances counsel fees may be proper and the amount to be awarded.") (internal quotation omitted); Este Oils Co. v. Federated Ins. Co., 724 N.E.2d 854, 859 (Ohio Ct. App. 1999) (citation omitted) ("In a declaratory judgment action, the trial court has the authority under R.C. 2721.09 to assess attorney fees, which would clearly include fees expended by an insured in pursuing its right to coverage. This is so regardless of the conduct of the insurer"); Tex. Civ. Prac. & Rem. Code Ann. § 37.009 ("In any proceeding under this chapter [declaratory judgment actions], the court may award costs and reasonable and necessary attorney's fees as are equitable and just"); Allstate Ins. Co. v. Hallman, 159 S.W.3d 640, 642 (Tex. 2005) (trial court has discretion to award attorneys' fees to insured in declaratory judgment action brought by insurer defending under a reservation of rights even if the underlying action is concluded with no liability for insured); and Wis. Stat. Ann. § 806.04(10) ("In any proceeding under this section the court may make such award of costs as may seem equitable and just."); Elliott v. Donahue, 485 N.W.2d 403, 409 (Wis. 1992) (interpreting the Wisconsin statute as allowing fee shifting when the insurer breaches the duty to defend).~~

For contrary authority, see, e.g., Griffin Dewatering Corp. v. Northern Ins. Co. of N.Y., 97 Cal. Rptr. 3d 568, 605 (Cal. Ct. App. 2009) ("When an insurance company acts reasonably, though incorrectly, only contract damages are available. And *Brandt* fees are clearly tort damages."); Allstate Ins. Co. v. Huizar, 52 P.3d 816, 821-822 (Colo. 2002) (citation and footnote omitted) ("Colorado does recognize several exceptions to the general rule that attorney fees are not recoverable by the prevailing party in the absence of an express statute, court rule, or private contract to the contrary, but we have previously made clear that the creation of a new exception is 'a function better addressed by the legislative than the judicial branch of government.'"); Gibson v. Southern General Gen. Ins. Co., 406 S.E.2d 121, 124 (Ga. Ct. App. 1991) ("Absent a

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showing of bad faith, fraud or litigiousness, the expenses of an insured incurred in the defense of a legitimate request for a declaration of rights through the use of a declaratory action are not recoverable from an insurance company.”); Idaho Code Ann. § 41-1839 (West) (“(4) Notwithstanding any other provision of statute to the contrary, this section and section 12-123, Idaho Code, shall provide the exclusive remedy for the award of statutory attorney’s fees in all actions or arbitrations between insureds and insurers involving disputes arising under policies of insurance. Provided, attorney’s fees may be awarded by the court when it finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation.”); Liberty Mut. Ins. Co. v. OSI Industries~~Indus.~~, Inc., 831 N.E.2d 192, 205 (Ind. Ct. App. 2005) (holding attorneys’ fees could not be awarded even in declaratory action determining breach of duty to defend); ~~Am. Standard Ins. Co. v. Le, 551 N.W.2d 923, 927 (Minn. 1996)~~ (“~~The insured is not entitled to recover attorney fees incurred in maintaining or defending a declaratory action to determine the question of coverage unless the insurer has breached the insurance contract in some respect—usually by wrongfully refusing to defend the insured.~~”) (note that Minnesota common law does award fees for breach of the duty to defend); McGraw v. Gwinner, 578 P.2d 1250, 1253 (Or. 1978) (“We adhere to the proposition that in order to secure attorney fees pursuant to ORS 743.114, the insured must recover a money judgment against the insurer; it is not sufficient that the insured establish coverage which may in turn lead to a subsequent recovery of money.”); Insurance Co. of North America v. Kayser-Roth Corp., 770 A.2d 403, 419 (R.I. 2001) (holding that unless there was a showing of bad faith, attorneys’ fees could not be awarded in a case where insurer brought declaratory-judgment action against insured to determine coverage); Saleh v. Farmers Ins. ~~Exchange~~Exch., 133 P.3d 428, 435 (Utah 2006) (“It is settled law that in order to recover attorney fees for breach of contract, they must be authorized by a statute or a contract provision, or there must have been bad faith.”); and Concord Gen. Mut. Ins. Co. v. Woods, 824 A.2d 572, 579 (Vt. 2003) (“In the absence of a finding of bad faith on the part of the insurance company, or outrageous conduct creating the ‘dominating reasons of justice’ we have held to be necessary to justify a departure from the American Rule, ~~see DJ Painting, 172 Vt. at 246, 776 A.2d at 419-420 (internal quotations omitted), the Woods...~~ the [Insured] are not entitled to attorneys’ fees incurred in defending against the declaratory judgment action.”) (internal citations omitted). Cf. CUNA Mut. Ins. Soc’y v. Norman, 375 S.E.2d 724, 727 (Va. 1989) (holding attorneys’ fees could not be awarded when the insurer acted reasonably in denying coverage).

For examples of courts awarding attorneys’ fees to an insurer that prevails in insurance-coverage litigation, see O.K. Lumber Co. v. Providence Wash. Ins. Co., 759 P.2d 523, 528 (Alaska 1988) (affirming fee award to insurer under Alaska’s general two-way fee-shifting rule); Mortensen v. Stewart Title Guar. Co., 235 P.3d 387, 397 (Idaho 2010) (awarding insurer attorneys’ fees under Idaho Code Ann. § 41-1839, which authorizes court to award fees to an insurer when the court finds, from the facts presented to it, “that a case was brought, pursued or defended frivolously, unreasonably or without foundation”) (internal quotation omitted).

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ed. Recoupment. See, e.g., *St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 457 F.3d ~~766~~, ~~773~~ 766 (8th Cir. 2006). There, an insurer sent its insured a letter in which it offered to give up its right to veto the insured's choice of counsel in exchange for a right to recoupment. *Id.* at 773. The court found that the insured accepted the insurer's offer by performance so as to "create a bilateral agreement." *Id.* The court held that, pursuant to that agreement, the insurer had a right to recoup the costs it incurred while defending a claim that was ultimately found to be uncovered by the policy. *Id.* For authority and discussion related to the default rule for recoupment, see § 21, Reporters' Note to Comment *a*, and § 25, Reporters' Note to Comment *c*.

fe. Interpleaded policy proceeds. See, e.g., *Phoenix Ins. Co. v. Small*, 307 F.R.D. 426, 429 (E.D. Pa. 2015) (discussing earlier order that tortfeasor and his insurer interplead the applicable policy proceeds); *Lawhorne v. Employers Emp'rs Ins. Co. of Wausau*, 680 A.2d 518, 521 (Md. 1996) (discussing trial court's order directing insurer to deposit funds with court and directing court clerk to disburse funds to claimants per their agreed shares); *Canal Ins. Co. v. Pizer*, 901 P.2d 1192, 1196 (Ariz. Ct. App. 1995) (discussing the deposit of interpleaded funds into court's interest-bearing account).

gf. Payment or return of premiums. See, e.g., *TIG Ins. Co. v. Reliable Research Co.*, 334 F.3d 630, 633 (7th Cir. 2003) (noting that district court ordered refund of premium by carrier that prevailed in action rescinding policy); *Nat'l Fire & Marine Ins. Co. v. Robin James ConstConstr., Inc.*, 478 F. Supp. 2d 660, 662 (D. Del. 2007) (holding that policyholder owed retrospective premiums).

hg. Indemnification rights against the insured. On the purpose of the general anti-subrogation rule, see, e.g., *ELRAC, Inc. v. Ward*, 748 N.E.2d 1, 9 (N.Y. 2001) ([citations omitted](#)) ("The purpose of this [anti-subrogation] rule is to prevent an insurer from using the right of subrogation to avoid paying coverage that is due under the policy. Additionally, the antesubrogation rule limits the instances in which an insurer and its insured have adverse interests, which might undercut an insurer's incentive to provide a vigorous defense to its insured."); accord *Chubb Ins. Co. v. DeChambre*, 808 N.E.2d 37, 42-43 (Ill. App. Ct. 2004) (citing 16 COUCH ON INSURANCE 3D § 224.3, at 18-19). See also 13-~~161~~ NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 161.01(2)(b) ([Lexis 2017](#)) ("The first concern is to make sure an insurer does not pass off to its insured ultimate liability for a loss or claim, for which the insured has purchased insurance from the insurer The second public policy concern . . . is to avoid a conflict of interest."). For examples of courts permitting subrogation against the insured, see, e.g., *Ambassador Ins. Co. v. Montes*, 388 A.2d ~~603~~, 603 (N.J. 1978) (permitting liability insurance in an arson-death case, but allowing the insurer to obtain indemnification against the insured); *Continental Cont'l Cas. Co. v. Kinsey*, 499 N.W.2d 574 (N.D. 1993) (requiring insurer to pay punitive damages assessed against the insured but permitting the insurer to seek indemnification against the insured).

ih. Prejudgment interest. See generally [2](#) ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSURED § 9:22 (6th ed.

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~~2013~~2017) (the availability of prejudgment interest in insurance disputes follows the general contract-law rule, and generally prejudgment interest is available from the time that payment was due as long as the amount due was ascertainable) and § 9:23 (“In the case of a liability policy, the debt is due on the date the insured makes a payment that the carrier was obligated to make.”); 1-7 BENEDICT M. LENHART, ANNA P. ENGH, MICHAEL GREENBERG & JARRETT A. WILLIAMS, 1-7 NEW APPLEMAN ON INSURANCE LAW LIBRARY ED. § 7.06(5)(d) (Lexis 2017) (“Whether by policy language, statute, or public policy, the insured often may also recover prejudgment interest on the amounts owed.”). See, e.g., School Dist. No. 1, Multnomah ~~County~~Cnty. v. Mission Ins. Co., 650 P.2d 929, 943 (Or. Ct. App. 1982) (holding that interest was due (a) “from the date on which payments were made to the private counsel hired to defend the [insured]” and (b) with regard to monies owed pursuant to the duty to indemnify, from “the dates on which the settlement payments were made by the [insured]”). On the general trend, see, e.g., 1 DAN B. DOBBS & CAPRICE L. ROBERTS, LAW OF REMEDIES § 3.6(21) at 339-341 (23d ed. ~~1993~~2018); DOUGLAS LAYCOCK, MODERN AMERICAN REMEDIES 197-200 (4th ed. 2010).

§ 48. Damages for Breach of a Liability Insurance Policy

The damages that an insured may recover for breach of a liability insurance policy include:

(1) In the case of a policy that provides defense coverage, all reasonable costs of the defense of a potentially covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(2) All amounts required to indemnify the insured for a covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

~~(3) In the case of a breach of the duty to defend or to pay defense costs on an ongoing basis, the reasonable attorneys’ fees and other costs incurred in the legal action establishing the insurer’s breach, which sums are not subject to any limit, deductible, or self-insured retention of the policy;~~ (4) In the case of a breach of the duty to make reasonable settlement decisions, the damages stated in § 27; and

(~~5~~4) Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of

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contracting as a probable result of a breach, which sums are not subject to any limit of the policy.

Comment:

a. Relationship to contract-law damages rules. In general, the remedies available for breach of a liability insurance policy are governed by contract-law rules, ~~including, for example, the rules regarding mitigation.~~ The exceptions included in this Restatement are: the rules in § 47 ~~and this Section~~ regarding the insured's attorneys' fees in the liability insurance coverage action; the inclusion of emotional distress as a compensable element of damages for breach of the duty to make reasonable settlement decisions under § 27 when such distress is foreseeable; and the rules in § 50 regarding remedies for liability insurance bad faith.

b. Costs of defending a potentially covered legal action. When an insurer has breached the duty to defend or pay defense costs, the damages include the costs of defense of the underlying legal action. While insurers are obligated only to pay reasonable defense costs, what is reasonable in the case of a breach of defense duties is judged from the perspective of an insured forced to defend a liability action without the timely assistance of its insurer. In that circumstance, the negotiated rates that liability insurers pay their regular defense counsel are unlikely to provide a useful guide to what is reasonable. Defense counsel can agree to defer collecting from the insured all or part of the fees until after the conclusion of the insurance-coverage action without undermining the insurer's obligation to pay those fees if the insured prevails in that action.

c. Amounts to indemnify the insured for a covered legal action. The amounts to indemnify the insured for a covered action include the amount of any judgment entered in the action and the reasonable amount of any settlement that the insured was entitled to make, in both cases subject to any applicable policy limit. This means that the insurer is obligated to pay the reasonable portion of an unreasonable settlement and, in the case of a settlement for both covered and uncovered counts, the amount reasonably apportioned to the covered count(s). Typically, an insured is authorized to make settlements without the consent of the insurer only if the insurer breaches its defense duties as stated in § 19, the insurer is defending under a reservation of rights and the insured follows the procedure stated in § 25(3), or the insurer has breached the duty to make reasonable settlement decisions under § 24. The policy limit serves as a cap on the amount that the insurer is obligated to pay, except if the insurer has breached the duty to make reasonable

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settlement decisions stated in § 24. If the insurer has breached that duty, the insurer is subject to liability for additional damages under § 27.

~~d. *Attorneys' fees.* This Section includes attorneys' fees as an element of damages for breach of the duty to defend or pay defense costs because, otherwise, a breach of these duties would deprive the insured of the benefits of the defense coverage. Liability insurance defense coverage provides the access to civil justice for defendants that corresponds to the access to civil justice that contingent fee arrangements make possible for plaintiffs. Without an insurer funded defense lawyer, many if not most consumers and small businesses would be deprived of an adequate defense. Other defendants with access to greater resources would not be as defenseless, but when such defendants choose to purchase insurance that promises to provide them with a defense, as opposed to the after-the-fact reimbursement of their own defense costs, they are deserving of the benefits of that protection. An insured without the resources and sophistication to fund and manage its defense will be harmed in obvious ways by a breach of the duty to defend, causing harm that may well be irreparable even if there is the possibility of reimbursement through filing a breach of contract action. An insured with adequate and readily available assets to pay for its defense has nevertheless lost the bargained for expertise of the insurer in managing the litigation as well as the timely insurer funded defense.~~

~~For all insureds, however, the loss of a timely insurer funded defense means that they must litigate two cases on their own and at their own expense—one against the underlying plaintiff and one against their insurer—when they should not have had to fund the litigation of even one case. For that reason, the insured's costs of litigating both actions are properly understood to be among the damages owed for breach of the duty to defend or pay defense costs on an ongoing basis. Otherwise, the insurer would be able to unilaterally convert a duty to defend policy into a policy that provides coverage for only a portion of the costs of defense (the costs of defense minus the insured's costs of litigating coverage) long after the fact. Although courts in a bare majority of states hold to the contrary, courts in nearly half the states award attorneys' fees to a prevailing insured when the insurer has breached the duty to defend or pay defense costs on an ongoing basis, and a large number do so on the basis of a common-law liability insurance exception to the American Rule. Conceptually, the insured's attorneys' fees in the coverage action are a form of consequential damages and, thus, are not subject to any policy limit. See Comment e.~~

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~~When an insurer provides a defense under reservation of rights and defers litigating its coverage defenses until after the completion of the underlying liability action, the insurer has not compelled the insured to engage in litigation to obtain the promised defense coverage. Thus, if the insured prevails in the subsequent coverage litigation, the damages do not include the insured's attorneys' fees in the coverage action unless the insurer acted in bad faith. See § 50.e.~~ *Other loss.* This Section follows the ordinary contract-law rules regarding consequential damages, recognizing that the nature and extent of loss that is likely to be foreseeable by liability insurers at the time of contracting is quite extensive, particularly for breach of the duty to defend, because of liability insurers' expertise in understanding and assessing the potential liabilities of their prospective insureds. Damages caused by the insurer's own breach were not caused by the tort or other wrong for which the insured is covered, and they are not part of the cost of defending the tort claim against the insured; they are outside the scope of the policy limits.

[e. Attorneys fee shifting for breach of the duty to defend. Nearly half the states follow the legal rule that authorizes fee shifting when an insurer prevails in an action for breach of the duty to defend. See § 47\(3\) \(providing for "attorneys' fees to a prevailing party when provided by state law"\) and Comment e \(providing justification for fee shifting when an insurer breaches the duty to defend\).](#)

REPORTERS' NOTE

a. Relationship to contract-law damages rules. For cases holding that, in general (and subject to any special liability-insurance-law rules), the damages for breach of a liability insurance policy are governed by contract-law rules, see, e.g., *Montana Petroleum Tank Release Comp. Bd. v. Crumleys, Inc.*, 174 P.3d 948, 960-961 (Mont. 2008) (determining the damages arising out of a liability insurer's breach pursuant to the principle that "[u]nder Montana law, an insured is entitled to all damages which result from a breach of contract by the insurer.") (internal quotation marks and citations omitted). Restatement Second of Contracts § 350 (AM. LAW INST. 1981) states the general rule for mitigation of damages as follows: "damages are not recoverable for loss that the injured party could have avoided without undue risk, burden or humiliation," subject to an exception "to the extent that [the injured party] has made reasonable but unsuccessful efforts to avoid loss." For a case illustrating the application of mitigation doctrine to damages for breach of a liability insurance policy, see, e.g., *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 686 A.2d 152, 156 (Del. 1996) ([citation omitted](#)) ("Public policy clearly favors imposing upon insureds a duty to mitigate damages. In the absence of such a rule, insureds could sit back and allow environmental damage to accumulate until they are compelled to mitigate damages through litigation.").

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b. Costs of defending a potentially covered legal action. For examples of defense costs being awarded as damages for an insurer’s breach of its duty to defend, see *Mesmer v. Maryland Auto. Ins. Fund*, 725 A.2d 1053, 1058 (Md. 1999) (allowing recovery for the “costs of defending the underlying tort suit”); *Greer v. NwNorthwestern Nat’l Ins. Co.*, 743 P.2d 1244, 1250 (Wash. 1987) (ruling that the damages for an insurer’s breach of its duty to defend its insured include “the amount of expenses, including reasonable attorney fees, the insured incurred in defending the underlying action.”) (citations omitted); *Gedeon v. State Farm Mut. Auto. Ins. Co.*, 188 A.2d 320, 322 (Pa. 1963) (“[T]he recovery for breach of the covenant to defend will ordinarily be the cost of hiring substitute counsel and other costs of the defense. ~~The~~This recovery may be in addition to any other obtained against the insurer.”); *Hogan v. Midland Nat’l Ins. Co.*, 476 P.2d 825, 831 (Cal. 1970) (“[U]pon the wrongful refusal of an insurer to defend an action against its insured[,] . . . the insurer is liable for the total amount of the fees [even if] some of the damages recovered in the action against the insured were outside the coverage of the policy.”) (citing *Mannheimer Bros. v. Kansas Casualty & Surety Co.*, 184 N.W. 189, 190 (Minn. 1921); *Prince v. Universal Underwriters Ins. Co.*, 143 N.W.2d 708, 717 (N.D. 1966); *Globe Navigation Co. v. Maryland Casualty Co.*, 81 P. 826, 828 (Wash. 1905)).

c. Amounts to indemnify the insured for a covered legal action. For cases requiring an insurer to pay only the reasonable amount of an unreasonable settlement, see, e.g., *Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co.*, 799 P.2d 1113, 1117-1118 (N.M. 1990) (holding that an insurer that breached its duty to defend and waived its right to participate in settlement negotiations would be held liable only for the amount of the settlement deemed reasonable upon remand); *State Farm Fire & Cas. Co. v. Farmers Alliance Mut. Ins. Co.*, 96 P.3d 1179, 1184-1185 (N.M. Ct. App. 2004) (holding that “the primary insurer . . . is bound by the settlement reached between” an additional insurer and the plaintiff, but that in reimbursing the other insurer that settled the claim, the primary insurer was only responsible for “\$250,000, out of the total \$375,000 settlement, because a reasonable settlement should not have exceeded ~~\$250,000~~250,000.”); *Zurich Ins. Co. v. Killer Music, Inc.*, 998 F.2d 674, 680 (9th Cir. 1993) (applying California law) (remanding an action in which an insurer was found to have breached its duty to defend “for a determination of the damages attributable to a reasonable settlement”).

For cases requiring a reasonable allocation between covered and uncovered counts, see, e.g., *EmployersEmp’rs Mut. Liab. Ins. Co. of Wis. v. Hendrix*, 199 F.2d 53, 59 (4th Cir. 1952) (“[A]n insurer is not excused from defending suits against the policy holder by the joinder in the same suits of causes of action covered by the policy with . . . other causes of action beyond its scope; but the insurer is not liable for damages recovered upon or paid in compromise of the latter causes of action.”); see also *Enserch Corp. v. Shand Morahan & Co.*, 952 F.2d 1485, 1494 (5th Cir. 1992), as clarified on denial of reh’g (Mar. 9, 1992) (remanding an action “for findings to make the necessary apportionment between damages for which the insurers owe, and those for which they do not owe,” which was a matter of distinguishing between “damages covered and those not covered by the policies.”). In *Enserch*, the Fifth Circuit explained that it “cannot allow an insured to settle allegations against it . . . for its policy limits and then seek full

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indemnification from its insurer when some of that settled liability may be for acts clearly excluded by that policy.” Id. This same principle of apportionment between covered and uncovered damages for purposes of determining the extent of an insurer’s obligation to indemnify its insureds also applies to damages imposed by judgments, in addition to those reached in settlements. See *Willcox v. Am. Home Assur. Co.*, 900 F. Supp. 850, 856 (S.D. Tex. 1995) (“The damages recited in either a judgment or a settlement of the underlying lawsuit must be apportioned between claims covered by the policy and those that are not.”) (citing *Enserch*, 952 F.2d at 1494); see also, e.g., *Hogan v. Midland Nat’l Ins. Co.*, 476 P.2d ~~825, 831-833~~825 (Cal. 1970).

For examples of the policy limit serving as a cap on the damages for an insurer’s wrongful refusal to provide coverage, see *Greer v. ~~Nw.~~Northwestern Nat’l Ins. Co.*, 743 P.2d 1244, ~~1250~~1251 (Wash. 1987) (reversing a lower court’s award of damages above a policy limit because allowing such damages undermined the “goal of placing the parties in as good a position as they would have occupied but for the breach”); see also *State Farm Mut. Auto. Ins. Co. v. Paynter*, 593 P.2d ~~948, 954~~948 (Ariz. Ct. App. 1979). For examples of damages above the policy limit being allowed because an insurer breached its duty to make reasonable settlement decisions, see *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 202 (Cal. 1958) (allowing damages for such a breach in an amount equal to the entire judgment against the insured, which was above the policy limit, because doing so would “not give the insured any additional advantage but merely place him in the same position as if the contract had been performed.”); see also *Landie v. Century Indem. Co.*, 390 S.W.2d ~~558, 566~~558 (Mo. Ct. App. 1965).

~~d. *Attorneys’ fees.* According to the count reflected in this Note, 23 states award attorneys’ fees to an insured when the insurer breaches the duty to defend: 10 states by common-law rule (Maine was later codified); seven states in every case by statute; two states in every case because of a judicial gloss on a statute that grants the courts discretion; and four states under a statute that grants the courts discretion and is widely used. The Massachusetts Supreme Judicial Court articulated the justification for allowing an insured who prevails in a declaratory judgment action to recover attorneys’ fees in the case of a breach of the duty to defend as follows: *Other loss.* See, e.g., *Bainbridge, Inc. v. Travelers Cas. Co. of Conn.*, 159 P.3d 748, 756 (Colo. App. 2006), as modified on denial of reh’g (Nov. 30, 2006) (“[An] insured may recover consequential damages for [a] breach which, if based on contract principles, include those damages that arose naturally from the breach and were reasonably foreseeable at the time of contract.”) (citations omitted). Cf. *Bi-Econ. Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, 886 N.E.2d 127, 132 (N.Y. 2008) (consequential damages allowed for breach of business-interruption policy).~~

~~The intent of an insured in acquiring liability insurance is to transfer to the insurer the responsibility for defending the insured against any claim which may fall within the coverage of the policy. The position advanced by the defendant would enable an insurer that wrongfully refused to defend to deprive its insured of the~~

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~~principal benefit of its contractual bargain, and for which the insured paid premiums. Even if the insured were eventually compensated for its defense of the third party action, it would remain permanently uncompensated for the costs associated with the declaratory judgment action it was forced to initiate because of the insurer's violation of its duty to defend.~~

~~Rubenstein v. Royal Ins. Co. of America, 708 N.E.2d 639, 642 (Mass. 1999) (common law rule). For additional authority permitting a prevailing insured to recover attorneys' fees when the insurer breaches defense duties, see Alaska R. Civ. P. 82 (broader rule that always awards attorneys' fees to any prevailing party unless otherwise provided by law or agreed to by the parties); Ark. Code Ann. § 23-79-209 (broader insurance law rule: "[T]he company shall also be liable to pay the holder of the policy all reasonable attorney's fees for the defense or prosecution of the suit."); Fla. Stat. Ann. § 627.428 (broader insurance law rule: awarding attorneys' fees when judgment is entered against an insurer); Haw. Rev. Stat. Ann. § 431:10-242 (broader insurance law rule: "Where an insurer has contested its liability under a policy and is ordered by the courts to pay benefits under the policy, the policyholder, the beneficiary under a policy, or the person who has acquired the rights of the policyholder or beneficiary under the policy shall be awarded reasonable attorney's fees and the costs of suit, in addition to the benefits under the policy"); Farm Bureau Mut. Ins. Co. v. Kurtenbach By and Through Kurtenbach, 961 P.2d 53, 64 (Kan. 1998) (common law rule: "where an insurer denies coverage and the duty to defend and brings a declaratory judgment action against the insured to determine that issue, the insured may recover his or her attorney fees incurred in the defense of the declaratory judgment action if it is determined as a result of that action that there is coverage. The same rule is applicable where an insurer agrees to assume the duty to defend under a reservation of rights. . . ."); Union Mut. Fire Ins. Co. v. Inhabitants of the Town of Topsham, 441 A.2d 1012, 1018-1019 (Me. 1982) (common law rule subsequently codified in Me. Rev. Stat. Ann. tit. 24-A, § 2436-B (in an action "to determine an insurer's contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney's fees")); Bausch & Lomb Inc. v. Utica Mut. Ins. Co., 735 A.2d 1081, 1095 (Md. 1999) (common law rule: "Where an action is brought to enforce an insurer's obligations under the third party liability provisions of a policy, and it is determined that there is coverage under the policy, the insurer is liable for the prevailing party's attorneys' fees"); Morrison v. Swenson, 142 N.W.2d 640, 647 (Minn. 1966) (common law rule: "Legal fees incurred in the declaratory judgment action were damages arising directly as the result of the breach"); Montana Mountain W. Farm Bureau Mut. Ins. Co. v. Brewer, 69 P.3d 652, 660 (Mont. 2003) (common law rule: "Accordingly, we hold that an insured is entitled to recover attorney fees, pursuant to the insurance exception to the American Rule, when the insurer forces the insured to assume the burden of legal action to obtain the full benefit of the insurance contract, regardless of whether the insurer's duty to defend is at issue."); Neb. Rev. Stat. § 44-359 (broader insurance law rule: "In all cases when the beneficiary or other person entitled thereto brings an action upon any type of insurance policy, except workers' compensation insurance, or upon any~~

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~~certificate issued by a fraternal benefit society, against any company, person, or association doing business in this state, the court, upon rendering judgment against such company, person, or association, shall allow the plaintiff a reasonable sum as an attorney's fee in addition to the amount of his or her recovery, to be taxed as part of the costs"); State Farm Mut. Auto Ins. Co. v. Selders, 202 N.W.2d 625, 626 (Neb. 1972) (extending statute to actions brought by insurer as well); N.H. Rev. Stat. Ann. § 491:22-b (broader insurance law rule: "In any action to determine coverage of an insurance policy pursuant to RSA 491:22, if the insured prevails in such action, he shall receive court costs and reasonable attorneys' fees from the insurer."); State Farm Fire & Cas. Co. v. Sigman, 508 N.W.2d 323, 326-327 (N.D. 1993) (holding that, although N.D. Cent. Code Ann. § 32-23-08 gives courts discretion whenever necessary and proper in any kind of case to award attorneys' fees, it is always necessary and proper that insurer pays fees to an insured who prevails in an action challenging an insurer's denial of a defense); Blount v. Kennard, 612 N.E.2d 1268, 1271 (Ohio 1992) (common law rule: "When an insurer refuses to defend its insured as required by the policy, the insured may recover from the insurer attorney fees which the insured incurs in the action brought to enforce the duty to defend and in the defense of the claims for which the duty to defend exists."); Okla. St. Ann. tit. 36, § 3629(B) (broader insurance law rule: allowing the prevailing party to recover attorneys' fees, not limited to insured); Hegler v. Gulf Ins. Co., 243 S.E.2d 443, 444 (S.C. 1978) (common law rule: "[T]he legal fees incurred by appellant, in successfully asserting his rights against respondent's attempt in the declaratory judgment action to avoid its obligation to defend, were damages arising directly as a result of the breach of the contract."); Berenyi, Inc. v. Landmark American Ins. Co., 2010 WL 233861 (D.S.C. 2010) (applying rule in *Hegler* to circumstance in which insurer denied a defense and insured brought an action seeking a declaration that the insurer was obligated to defend); Tex. Civ. Prac. & Rem. Code Ann. § 37.009 ("In any proceeding under this chapter [declaratory judgment actions], the court may award costs and reasonable and necessary attorney's fees as are equitable and just."); Tex. Civ. Prac. & Rem. Code Ann. § 38.001 (allowing recovery of reasonable attorney's fees if the claim is for "an oral or written contract"); Elliott Appraisers, LLC v. JM Ins. Servs., LLC, No. CIV.A. H 10-2231, 2011 WL 722186, at *4 (S.D. Tex. Feb. 22, 2011) (awarding attorneys' fees under § 38.001 for a breach of the duty to defend and stating that such an award is "mandatory"); Olympic S.S. Co. v. Centennial Ins. Co., 811 P.2d 673, 681 (Wash. 1991) (common law rule: holding that an insured can recoup any attorneys' fees it incurs because an insurer wrongfully refuses to pay or defend, regardless of who files the lawsuit); Aetna Cas. & Sur. Co. v. Pitrolo, 342 S.E.2d 156, 160 (W. Va. 1986) (common law rule: including attorneys' fees in the subsequent declaratory judgment action as part of the damages for breach).~~

~~For authority granting trial court discretion to award attorneys' fees to a prevailing insured, see, e.g., Ariz. Rev. Stat. Ann. § 12-341.01 (allowing the court to award attorneys' fees to a prevailing party in a breach of contract action); Lennar Corp. v. Auto Owners Ins. Co., 151 P.3d 538, 553 (Ariz. Ct. App. 2007) (applying § 12-341.01 to insurance contract disputes and allowing insurer to recover); Missouri Rev. Stat. 527.100 (permitting attorney fee shifting in~~

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~~declaratory judgment actions); Allstate Ins. Co. v. Sullivan, 643 S.W.2d 21, 24 (Mo. Ct. App. 1982) (citation omitted) (insurer’s action in bringing declaratory judgment suit found not to be ‘in any way frivolous or unjustified,’ yet, justice and equity warranted allowing attorney fees”); N.J. Ct. R. Ann. 4:42-9 (“No fee for legal services shall be allowed in the taxed costs or otherwise, except . . . (6) In an action upon a liability or indemnity policy of insurance, in favor of a successful claimant.”); Passaic Valley Sewerage Comm’rs v. St. Paul Fire & Marine Ins. Co., 21 A.3d 1151, 1164 (N.J. 2011) (“The award of counsel fees, however, is not mandatory, but rather the trial judge has broad discretion as to when, where, and under what circumstances counsel fees may be proper and the amount to be awarded.”) (internal quotation omitted); Wis. Stat. Ann. § 806.04(10) (“In any proceeding under this section the court may make such award of costs as may seem equitable and just”); Elliott v. Donahue, 485 N.W.2d 403, 409 (Wis. 1992) (interpreting the Wisconsin statute as allowing fee shifting when the insurer breaches the duty to defend). For contrary authority, see, e.g., Griffin Dewatering Corp. v. Northern Ins. Co., 97 Cal. Rptr. 3d 568, 605 (Cal. Ct. App. 2009) (“When an insurance company acts reasonably, though incorrectly, only contract damages are available. And Brandt fees are clearly tort damages.”); Idaho Code Ann. § 41-1839 (West) (“(4) Notwithstanding any other provision of statute to the contrary, this section and section 12-123, Idaho Code, shall provide the exclusive remedy for the award of statutory attorney’s fees in all actions or arbitrations between insureds and insurers involving disputes arising under policies of insurance. Provided, attorney’s fees may be awarded by the court when it finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation.”); Liberty Mut. Ins. Co. v. OSI Industries, Inc., 831 N.E.2d 192, 205 (Ind. Ct. App. 2005) (holding attorneys’ fees could not be awarded even in declaratory action determining breach of duty to defend); Miller v. Allstate Ins. Co., 631 So. 2d 789, 795 (Miss. 1994); Saleh v. Farmers Ins. Exchange, 133 P.3d 428, 435 (Utah 2006) (“It is settled law that in order to recover attorney fees for breach of contract, they must be authorized by a statute or a contract provision, or there must have been bad faith.”); CUNA Mut. Ins. Soc’y v. Norman, 375 S.E.2d 724, 727 (Va. 1989) (holding attorneys’ fees could not be awarded when the insurer acted reasonably in denying coverage).~~

~~e. Other loss. See, e.g., Bainbridge, Inc. v. Travelers Cas. Co. of Conn., 159 P.3d 748, 756 (Colo. App. 2006), as modified on denial of reh’g (Nov. 30, 2006) (“[An] insured may recover consequential damages for [a] breach which, if based on contract principles, include those damages that arose naturally from the breach and were reasonably foreseeable at the time of contract.”) (citations omitted). Cf. Bi Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y., 886 N.E.2d 127, 132 (N.Y. 2008) (consequential damages allowed for breach of business interruption policy).~~

§ 49. Liability for Insurance Bad Faith

An insurer is subject to liability to the insured for insurance bad faith when it fails to perform under a liability insurance policy:

(a) Without a reasonable basis for its conduct; and

(b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

Comment:

a. The tort of insurance bad faith. Most states classify insurance bad faith as a tort-law cause of action. This tort-law classification has important consequences for the damages that are potentially available. First, there is an important difference in the timing of when a harm caused by the breach must be foreseeable for the harm to be compensable under contract- and tort-law rules. Under the contract-law approach followed in § 48, a consequential harm must have been foreseeable at the time of contracting in order to be compensable; while under the tort-law approach, the extent of the harm that is compensable is subject only to rules regarding proximate cause (or, as referred to in Chapter 6 of the Restatement Third, Torts: Liability for Physical and Emotional Harm, the scope of liability), and foreseeability is determined as of the time of the tort—the bad-faith breach—and not as of the making of the contract. See § 50 (following the tort-law approach to damages for insurance bad faith). The tort characterization can also open the door to compensatory damages for emotional distress and to punitive damages. Punitive damages are not recoverable in contract, but are recoverable, if other prerequisites are shown, for an independent tort committed in the course of negotiating, performing, or breaching the contract. See Restatement Second, Contracts § 355.

b. The standard for liability insurance bad faith. Much of the [relevant](#) law governing insurance bad faith has been developed in the first-party insurance context ~~because true liability insurance bad faith actions are uncommon~~. An action for breach of the duty to make reasonable settlement decisions that is framed as a “bad faith” action is not a liability insurance bad-faith action under the rules followed in this Restatement, unless the more demanding two-prong standard stated in this Section is met. See Comment *c* to this Section and § 24, Comment *a*. The relative dearth of true liability insurance bad-faith actions likely results from the fact that other liability insurance rules provide an incentive for insurers to behave

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reasonably. These rules include the duty to make reasonable settlement decisions and the inclusion of attorneys' fees as damages under the law of many states when the insurer breaches the duty to defend. Because there are fewer rules that create similar incentives in the first-party insurance context, insurance bad-faith actions have a larger role in first-party insurance.

Jurisdictions differ widely in the verbal formulations used to describe the legal standard for insurance bad faith. The rule followed in this Section requires both an objective and a subjective element. This Section follows that approach, rather than the purely objective approach, for three reasons. First, the purely objective approach is already embodied in the rule in § 24 regarding an insurer's duty to make reasonable settlement decisions and the rule in § 27 setting out the damages for breach of that duty. Second, the availability of attorneys' fees for the insured under ~~§ 47(4) and § 48(3)~~the law of many states means that insureds already are entitled to receive their attorneys' fees in many states when their rights to a defense are denied or threatened, without a finding of bad faith. Third, although a purely objective standard may be the majority rule for bad faith, the published opinions establishing a purely objective standard for bad faith most often address the contexts governed in this Restatement by the provisions just mentioned: §§ 24, 27, and 47(4), and 48(3). If a jurisdiction does require a finding of bad faith as a prerequisite to awarding the remedies provided in those Sections, the appropriate standard for bad faith in those contexts is the purely objective standard, but otherwise the stigma associated with a finding of liability insurance bad faith is appropriately limited to cases in which the insurer's culpability extends beyond negligence.

The objective element is most commonly stated as the lack of a "reasonable" or a "fairly debatable" basis for the failure to perform. What these and other similar expressions of the objective element have in common is that the insurer must have a sufficient basis for any refusal to perform. An insurer has a sufficient basis if it takes a legal position that a reasonable insurer might take, or acts as a reasonable insurer might act in the circumstances. Because a reasonable insurer is knowledgeable about and follows liability insurance law, a coverage position that lacks a fairly debatable basis in the law of the jurisdiction—a determination that ordinarily can be made by the court as a matter of law—would not be fairly debatable for purposes of assessing the objective element of insurance bad faith.

The subjective element is most commonly stated as "with knowledge or in reckless disregard of" the obligation to perform. This means that the insurer failed to perform (a) when it

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knew it was obligated to perform or (b) without regard to whether it had a reasonable basis for not performing, whether because of lack of investigation of the relevant facts, a failure to conduct the necessary state-specific legal research to evaluate the coverage position, or some other circumstance that placed the insurer on notice that it had not done what it needed to do in order to evaluate whether it had a reasonable basis for its position.

c. Liability insurance bad faith in the settlement context. Because the standard for liability insurance bad faith includes both a subjective and an objective element, it is more demanding than the purely objective standard for breach of the duty to make reasonable settlement decisions stated in § 24. An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for the damages stated in § 27, but it is not subject to additional liability for insurance bad faith unless it breached that duty “with knowledge or in reckless disregard of its obligation to perform.” For example, when an insurer adequately investigates a suit and appropriately trains its claims personnel, an honest mistake about the likelihood or size of an excess verdict would be very unlikely to satisfy the “with knowledge or in reckless disregard” standard in this Section even if the insurer is liable for the excess verdict under § 27. Similarly, when an insurer refuses to settle a suit in order to retain the right to contest coverage for the claim, it will be subject to liability under § 27 for breach of the duty to make reasonable settlement decisions if a reasonable insurer that accepted coverage would have settled the suit. See § 25(1) (“A reservation of the right to contest coverage does not relieve an insurer of the duty to make reasonable settlement decisions stated in § 24”). But, as long as the insurer had a fairly debatable basis for contesting coverage or did not act with knowledge or in reckless disregard of the absence of a fairly debatable basis, the insurer will not be subject to additional liability, beyond that available under §§ 24 and 27, for insurance bad faith. If the insured proves that the insurer’s conduct did meet the standard stated in this Section, the additional remedies that the insured will receive are the fees and other costs the insured’s attorneys incurred in establishing liability, any harm proximately caused by the bad-faith breach that was not already part of the damages for breach of the duty to make reasonable settlement decisions and, if the insurer’s conduct meets the applicable state-law standard, punitive damages. See § 50.

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Illustrations:

1. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of \$75,000 and no deductible. The claimant offers to settle for \$45,000, which is a reasonable settlement value of the case, based on the judgment that the plaintiff has a 30 percent chance of success and likely damages of \$150,000. The insurer rejects the offer because it concludes, based on discussion with defense counsel, that the chances of prevailing at trial are sufficiently strong that the risk is worth taking, even accepting the possibility that it will be held liable for failure to settle if the claimant prevails at trial. The case proceeds to trial and a verdict of \$175,000 is entered against the insured. The insurer is subject to liability under the rules in §§ 24 and 27 for the full amount of the verdict if the trier of fact concludes that a reasonable insurer would have accepted the settlement offer. The insurer is not subject to liability for insurance bad faith because the insurer reasonably determined that there was a strong possibility of success at trial, even accepting the potential liability for an excess verdict under § 27.

2. A claimant files a tort suit against the insured seeking damages of \$500,000. The insured has a duty-to-defend liability insurance policy that has policy limits of \$100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend under a reservation of rights. The insurer reasonably believes that it has a ground for contesting coverage that relieves it from any duty to indemnify the insured for the suit. As the case approaches trial, the claimant makes a settlement demand of \$80,000, which a reasonable insurer that covered the suit would have accepted. The insurer rejects the settlement demand. The suit then goes to trial, resulting in a \$500,000 verdict against the insured. If the coverage dispute is resolved in the insurer's favor, the insurer is not liable to the insured for any damages. If the coverage dispute is resolved in the insured's favor, the insurer is subject to liability under the rule in § 27 for the full amount of the verdict because it failed to accept the settlement offer, but the insurer is not subject to liability for insurance bad faith because it had a fairly debatable ground for contesting coverage.

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3. Following a fatal automobile accident, the estate of the decedent filed a suit against Driver, who was insured under a policy issued by Insurer with policy limits of \$25,000. Insurer agreed to defend. The estate offered to settle for the policy limits. Insurer refused. The case went to trial resulting in a verdict against Driver in the amount of \$135,000. Driver brought an action against Insurer for breach of the duty to make reasonable settlement decisions and for insurance bad faith. Evidence produced in discovery showed that Insurer’s investigator reported to her supervisor that Driver was at fault; the supervisor directed investigator to change her report so that it did not indicate that Driver was at fault; prior verdicts in death claims in the jurisdiction had all been greatly in excess of \$25,000; and supervisor was under pressure to meet claim-payment-reduction goals. Insurer is subject to liability under the rule in § 27 for the full amount of the verdict because it failed to make a reasonable settlement decision. In addition, a jury may find that Insurer is subject to liability for bad faith because it did not have a reasonable basis for the failure to settle, and it knew or recklessly disregarded its obligation to settle the claim.

d. Liability insurance bad faith in other contexts. Most of the relatively limited case law involving liability insurance bad faith arises in the context of a breach of the duty to defend or the duty to make reasonable settlement decisions. Nevertheless, there are a variety of other actions that can give rise to liability insurance bad faith. Drawing from published opinions, those actions can include but are not limited to: misrepresentations by the insurer of the coverage provided by the policy, improper destruction of evidence, obtaining from insurance defense counsel confidential information that the insurer could use to avoid coverage for the claim, negotiating with the claimant to plead the complaint so that the action falls outside of coverage, and overpaying on claims to accelerate exhaustion of policy limits.

REPORTERS’ NOTE

a. The tort of insurance bad faith. See Restatement Second, Torts § 917, Comment *d* (AM. LAW INST. 1979) (“The limitation in actions for breach of contract that the harm must be such as the contract breaker should reasonably foresee at the time of making the contract to be within the risk of occurrence as a result of his breach (see Restatement, Second, Contracts, Chapter 16 (Tent. Draft)), does not ordinarily apply to the extent of liability for a tort.”) In the majority of states, an insured may bring a bad-faith tort-law cause of action against its insurer.

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See, e.g., *Allstate Ins. Co. v. Miller*, 212 P.3d 318, 324 (Nev. 2009) (“A violation of the covenant [of good faith and fair dealing] gives rise to a bad-faith tort claim.”) (citing *United States Fidelity v. Peterson*, 540 P.2d 1070, 1071 (Nev. 1975)); *Goodson v. Am. Standard Ins. Co. of Wisconsin*, 89 P.3d 409, 414 (Colo. 2004) (explaining that since insurance contracts are “unlike ordinary bilateral contracts,” an insurer’s bad faith gives rise to a tort-law cause of action); *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1155 (Alaska 1989) (“Courts first recognized the tort of bad faith in third-party cases.”); *Anderson v. Cont’l Ins. Co.*, 271 N.W.2d 368, 374, 368 (Wis. 1978) (same); *Comunale v. Traders & General Ins. Co.*, 328 P.2d 198 (Cal. 1958) (recognizing a cause of action for the tort of insurance bad faith); see also *Kransco v. Am. Empire Surplus Lines Ins. Co.*, 2 P.3d 1, 8-9 (Cal. 2000) (holding an insurance company does not have a tort-law cause of action against its policyholder when the insured breaches its good-faith obligation under the policy). Very few jurisdictions do not recognize the tort and thereby limit insureds to bringing a contract action against their insurer. See, e.g., *Gebretsadike v. Travelers Home & Marine Ins. Co.*, 103 F. Supp. 3d 78, 83 (D.D.C. 2015) (internal quotations omitted) (“District of Columbia law does not recognize a tort of bad faith by insurance companies in the handling of policy claims.”); *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 934 P.2d 65, 89-90 (Kan. 1997) (stating Kansas does not recognize the tort of insurance bad faith; an insurer’s obligation under the contract is “to act in good faith and without negligence.”). On the application of tort-law-damages rules in a liability insurance bad-faith case, see, e.g., *Polito v. Cont’l Cas. Co.*, 689 F.2d 457, 461, 463 (3d Cir. 1982) (the tort of failing to settle in good faith “supports a claim for consequential damages.”); *Chavers v. Nat’l Sec. Fire & Cas. Co.*, 405 So. 2d 1, 5 (Ala. 1981) (insureds’ recovery of excess judgments is allowed when the insurer’s failure to settle a claim was “negligent[.],” but damages may also “include mental distress and economic loss” when the insurer’s failure to settle constituted the tort of bad faith).

b. The standard for liability insurance bad faith. In the liability insurance context, most courts have applied a purely objective standard for bad faith, but they have done so almost exclusively in contexts addressed by other rules in this Restatement: the duty to make reasonable settlement decisions addressed in § 24 and the award of attorneys’ fees to the insured for breach of the duty to defend. See, e.g., *Clearwater v. State Farm Mutual Automobile Ins. Co.*, 792 P.2d 719 (Ariz. 1990) (adopting an objective standard for “bad faith” in the context of what in this Restatement would be treated as a breach of the duty to make reasonable settlement decisions); *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973) (adopting an objective standard for “bad faith” in the context of what in this Restatement would be treated as a breach of the duty to make reasonable settlement decisions); *Cowden v. Aetna Casualty & Surety Co.*, 134 A.2d 223 (Pa. 1957) (adopting an objective standard for bad faith in the settlement context); *Kirk v. Mt. Airy Ins. Co.*, 951 P.2d 1124, 1125, 1124 (Wash. 1998) (adopting an objective standard for “bad faith” in the context of a breach of the duty to defend).

In the first-party insurance context, by contrast, the clear majority approach to determine whether an insurer acted in bad faith requires courts to evaluate the insurer’s conduct with both objective and subjective tests. See, e.g., *Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co.*, 277 P.3d

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789, 794-795 (Ariz. Ct. App. 2012) (“An insurer acts in bad faith when it unreasonably investigates, evaluates, or processes a claim (an ‘objective’ test), and either knows it is acting unreasonably or acts with such reckless disregard that such knowledge may be imputed to it (a ‘subjective’ test)”); *Anderson v. Continental Cont’l Ins. Co.*, 271 N.W.2d 368 (Wis. 1978) (same). Courts deciding liability insurance cases regularly apply this same first-party insurance bad-faith standard, requiring both subjective and objective elements of bad faith, when adjudicating bad-faith cases outside of the settlement context. See, e.g., *N. River Ins. Co. v. Bishop of Pueblo*, No. 06-cv-~~10971~~, [10971-WDM-CBS](#), 2008 WL ~~280842~~[280842](#), at *2 (D. Colo. Jan. 31, 2008) (under Colorado law, court denied motion to dismiss bad-faith claim arising out of refusal to defend because plaintiffs adequately pleaded “that [insurer’s] denial of coverage for the [insured’s] defense was unreasonable under the circumstances and that [insurer] knowingly or recklessly disregarded the validity of the claim.”); *Freidline v. Shelby Ins. Co.*, 774 N.E.2d ~~3737~~, [40](#) (Ind. 2002) ([citation omitted](#)) (for bad-faith breach of duty to defend “the plaintiff must establish, with clear and convincing evidence, that the insurer had knowledge that there was no legitimate basis for denying liability.”); *Nautilus Ins. Co. v. Hale*, No. 05-CV-186, 2007 WL ~~647565~~ (~~647565~~, at *6 (E.D. Ky. Feb. 27, 2007) ([applying](#) Kentucky law) ([citations omitted](#)) (in case alleging bad-faith denial of a defense, court stated, “To establish a bad faith claim the insured must prove ‘1) that the insurer was obligated to pay, 2) that the insurer lacked ‘a reasonable basis in law or fact for denying the claim,’ and 3) that the ‘insurer either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed.’”); *Gordon v. Nationwide Mut. Ins. Co.*, 285 N.E.2d ~~849~~[849](#), [850-851](#) (N.Y. 1972) (“More than an ‘arguable case’ of coverage responsibility must be shown before liability may be imposed for breach of an implied covenant to act in good faith in denying coverage”) (citations omitted); *Adamski v. Allstate Ins. Co.*, 738 A.2d 1033, 1036 (Pa. Super. Ct. 1999) (applying a two-part, objective and subjective, test for insurance bad faith); *Republic Ins. Co. v. Stoker*, 903 S.W.2d ~~338~~, [340](#)[338](#) (Tex. 1995) (same). For cases addressing what the Comments refer to as “true bad faith” in the settlement context, see, e.g., *Badillo v. Mid Century Ins. Co.*, 121 P.3d 1080, 1093-1094 (Okla. 2005) (“A central issue in any analysis to determine whether breach has occurred is gauging whether the insurer had a good faith belief in some justifiable reason for the actions it took or omitted to take that are claimed violative of the duty of good faith and fair dealing.”); *Campbell v. State Farm Mut. Auto. Ins. Co.*, 65 P.3d 1134 (Utah 2001).

Most courts define the objective prong of the test as the insurer lacking a “reasonable” or “fairly debatable” basis for its failure to perform. See, e.g., *Anderson v. Cont’l Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978) (adopting a two-prong test and defining the objective prong as the “absence of a reasonable basis for denying benefits of the policy”); *Reliance Ins. Co. v. Barile Excavating & Pipeline Co.*, 685 F. Supp. 839, 840 (M.D. Fla. 1988) (defining the objective prong as when “the insurance claim is determined not to be ‘fairly debatable.’”).

Courts define the subjective test as the insurer acting “with knowledge or in reckless disregard” of its obligation to perform under the policy. See, e.g., *Ruwe v. Farmers Mut. United Ins. Co.*, 469 N.W.2d 129, 133-135 (Neb. 1991) (first-party case) (explaining that an insured may

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meet the “knowledge or reckless disregard” standard by submitting proof of its insurer’s reckless indifference to facts such as a failure to investigate the covered loss); *Anderson v. Cont’l Ins. Co.*, 271 N.W.2d 368 (Wis. 1978) (same subjective test); *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790, 794 (Iowa 1988) (applying the *Anderson* test); *Pickett v. Lloyd’s*, 621 A.2d 445 (N.J. 1993) (same); *Travelers Ins. Co. v. Savio*, 706 P.2d ~~1258, 1274~~1258 (Colo. 1985) (same). But see *Nat’l Sec. Fire & Cas. Co. v. Bowen*, 417 So. 2d 179, 183 (Ala. 1982) (requiring an insurer’s actual knowledge that there was no lawful basis for its action). Cf. *Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 2424, 26 (N.Y. 1993) (first-party case) (holding that an insured must prove the insurer’s conduct constituted a “gross disregard” of the insured’s interests).

c. Liability insurance bad faith in the settlement context. See, e.g., *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973) (distinguishing *Comunale* and *Crisci* [v. Sec. Ins. Co. of New Haven, Conn.](#), 426 P.2d 173, 177 (Cal. 1967), cases in which an insurer was held liable for a failure to meet the duty to make reasonable settlement decisions, from the present bad-faith tort case). An insurer that rejects a reasonable settlement offer has not necessarily acted in bad faith. See, e.g., ~~*McDaniel v. GEICO General Ins. Co.*, 55 F. Supp. 3d 1244 (E.D. Cal. 2014) (“When there is a great risk of a recovery beyond the policy limits so that the most~~[Archdale v. Am. Int’l Specialty Lines Ins. Co.](#), 64 Cal. Rptr. 632, 647 (Cal. Ct. App. 2007) (internal citations omitted) (“An insurer’s liability for failing to accept a reasonable ~~manner of disposing of the claim is a settlement, a consideration of the insured’s interest requires the insurer to settle the claim~~ [Liability settlement offer](#) is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, [a duty included within the implied covenant of good faith and fair dealing.](#)”); *Davis v. Cincinnati Ins. Co.*, 288 S.E.2d 233, 237-238 (Ga. Ct. App. 1982) (affirming judgment against insurer for failure to make reasonable settlement decision because that claim does not require a showing of bad faith); ~~*Crisci v. Sec. Ins. Co. of New Haven, Conn.*, 426 P.2d 173, at 177~~ (Cal. 1967) (“Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.”); *Howard v. Am. Nat’l Fire Ins. Co.*, 115 Cal. Rptr. 3d 42, 69-71 (Cal. Ct. App. 2010) (evaluating independently whether insurer breached its duty to make reasonable settlement decisions and acted in bad faith; holding that insurer breached its duty to make a reasonable settlement decision and then holding insurer acted in bad faith because it did not make “an honest mistake or [a] bad judgment” but acted based on “an unfair and selective reading of . . . deposition testimony that distorted . . . [and] ignored powerful indications that a multimillion-dollar judgment was likely.”). Cf. *Mowry v. Badger State Mut. Casualty Cas. Co.*, ~~129 Wis. 2d 496, 517~~385 N.W.2d 171, 181 (Wis. 1986) (applying a true bad-faith standard to liability for an excess judgment and holding that, under that standard, an insurer that relies upon a fairly debatable coverage position as justification for not accepting a reasonable settlement offer is not acting in bad faith). See generally [14 STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 206:54](#) (3d ed. ~~2014~~2017) (explaining differences between standards for unreasonably refusing to accept a settlement, leading to liability for damages in excess of the policy limits, and for

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punitive damages, which requires, in addition, “malice, fraud or oppression”). See also ALLAN D. WINDT, 1 INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSURED §§ 5:12-5:13 (6th ed. ~~2013~~2017) (collecting cases) (“[A]n insurance company can breach its duty to settle without having acted in bad faith. The only prerequisite is that the company fails to settle a case that it would have settled had it treated the claim as if the company alone would be liable for the entire potential verdict. . . . There is, therefore, no theoretical justification for the bad faith requirement.”).

For cases regarding an insurer’s honest mistake, see, e.g., *Abernethy v. Utica Mut. Ins. Co.*, 373 F.2d 565, 568 (4th Cir. 1967) (applying North Carolina law) (“[A]n insurer may not be held liable for an honest mistake in judgment, even if unreasonable; it may be held liable only if it acts with wrongful or fraudulent purpose or with lack of good faith.”); *Henke v. Iowa Home Mut. Cas. Co.*, 97 N.W.2d 168, 173 (Iowa 1959) (“Bad faith requires more than a showing of inadvertence or honest mistake of judgment.”); *City of Wakefield v. Globe Indem. Co.*, 225 N.W. 643, 645 (Mich. 1929) ([citations omitted](#)) (“It is not bad faith if counsel for the insurer refuse settlement under the bona fide belief that they might defeat the action . . . A mistake of judgment is not bad faith.”); *Howard v. Am. Nat. Fire Ins. Co.*, 115 Cal. Rptr. 3d 42, 69-71 (Cal. Ct. App. 2010) (holding insurer acted in bad faith because it did not make an honest mistake). Illustration 3 is a simplified variation on the facts in *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003).

d. Liability insurance bad faith in other contexts. See, e.g., *Lloyd’s & Inst. of London Underwriting Cos. v. Fulton*, 2 P.3d 1199, 1209 (Alaska 2000) (insurer bad faith in failing to disclose a conflict of interest); *Parsons v. Continental National Am. Group*, 550 P.2d 94, 96 (Ariz. 1976) (insurer bad faith when defense counsel provided potentially coverage-defeating information to insurer); *Baios v. Clark*, 7 N.W.2d 255, 257 (Mich. 1943) (insurer bad faith in denying the existence of a policy); *Ellwein v. Hartford Accident & Indemnity Co.*, 15 P.3d 640 (Wash. 2001) (insurer bad faith in misappropriating insured’s expert), [overruled on other grounds by *Smith v. Safeco Ins. Co.*, 78 P.3d 1274 \(Wash. 2003\)](#); *Lockwood Int’l, B.V. v. Volm Bag Co.*, 273 F.3d 741 (7th Cir. 2001) (applying Wisconsin law) (insurer bad faith in negotiating directly with the claimant without disclosure to insured and paying the claimant to amend the complaint so that it did not include a potentially covered claim).

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§ 50. Remedies for Liability Insurance Bad Faith

The remedies for liability insurance bad faith include:

- (1) Compensatory damages, including the reasonable attorneys’ fees and other costs incurred by the insured in the legal action establishing the insurer’s breach of the liability insurance policy and any other loss to the insured proximately caused by the insurer’s bad-faith conduct;**
- (2) Other remedies as justice requires; and**
- (3) ~~If~~Punitive damages when the insurer’s conduct meets the applicable state-law standard, ~~punitive damages.~~**

Comment:

a. Compensatory damages for insurance bad faith. Except in an unusual circumstance in which the insurer’s bad-faith conduct does not constitute a breach of contract, an insured who prevails in a bad-faith case will also receive an award of damages for breach of the liability insurance policy. Subsection (1) identifies the additional compensatory damages that are available for liability insurance bad faith. These additional damages include: (a) any attorneys’ fees incurred by the insured in asserting its rights under the policy that were not already included in the damages for breach of the policy and (b) compensation for consequential harm that was not foreseeable at the time of the sale of the policy as a probable result of a breach but that does satisfy the less demanding tort-law requirement of proximate cause (referred to as “scope of liability” in Chapter 6 of the Restatement Third, Torts: Liability for Physical and Emotional Harm).

b. Attorneys’ fees. Almost every state has recognized the liability insurance bad-faith exception to the American rule, reasoning that the bad-faith nature of the insurer’s conduct eliminates the ordinary justifications for the rule. This is particularly appropriate in the liability insurance context, because the purpose of liability insurance is to protect the insured from litigation. In the case of an action that is solely directed at establishing liability insurance bad faith, the damages do not include the attorneys’ fees incurred in that action, but the damages do include any not-yet-compensated attorneys’ fees incurred in obtaining the benefits due under the liability insurance policy.

c. Other remedies as justice requires. The remedies for liability insurance bad faith generally are limited to the damages that the insured proves were caused by the insurer’s

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bad-faith breach (including attorneys' fees) and, if the applicable state-law standard is met, punitive damages. There are [some](#) circumstances, however, in which courts have held that an insurer is estopped by its bad-faith conduct from asserting a coverage defense that it would have been able to assert had it fulfilled its contractual obligations. These circumstances have included: refusing to defend in bad faith, using the insured's defense counsel to collect information to support a denial of coverage, and denying the existence of a liability insurance policy. The common thread [among these cases](#) is a strong claim of misconduct in circumstances in which it would otherwise be difficult for the insured to demonstrate significant compensatory damages, thereby undercutting the deterrent effect of a bad-faith finding.

The loss-of-coverage-defense remedy is particularly appropriate when an insurer refuses to defend in bad faith. Requiring the insurer to pay for a judgment or settlement entered in such a case reinforces the importance of the defense coverage provided by traditional liability insurance policies, which promise to pay for the defense of any potentially covered claim and, in most cases, also to select the defense lawyer and manage the defense. See Comment *d* to § 48. An insurer that could abandon the defense whenever it concluded that the coverage-relevant facts were in its favor, without any risk of having to pay a judgment or settlement of the action, would have an incentive to do so. Thus, this remedy is structurally related to the remedy for breach of the duty to make reasonable settlement decisions, which addresses a similar misalignment of incentives in the settlement context. Both ~~rules~~[remedies](#) align the insurer's incentives to be consistent with those of the insured, by providing a reason for the insurer to take into account all of the potential loss to the insured when making a crucial decision. The rule in § 27 encourages an insurer to evaluate a settlement offer as if it faced the full liability for the liability action, because the insurer will be liable under that rule for the full judgment entered in the action if a reasonable insurer would have accepted the offer. Similarly, requiring an insurer to provide coverage for a legal action that it refused in bad faith to defend encourages an insurer to evaluate the decision to defend as if it faced full liability for the action, because the insurer could be obligated to pay the judgment or settlement in the action if it refuses to defend in bad faith. This loss-of-coverage-defense remedy also draws support from ~~the rule in § 15, pursuant to which an insurer that defends without a reservation of rights loses its coverage defenses and from~~[\(a\)](#) the rule followed in a respectable minority of states, pursuant to which an insurer that breaches the duty to defend *always* loses its coverage defenses, without regard to whether the insurer acted in

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bad faith or whether the available compensatory damages ~~provides~~provide sufficient deterrence, and (b) the rule in § 15, pursuant to which an insurer that defends without a reservation of rights loses its coverage defenses.

d. Punitive damages. There are no special liability-insurance-law rules governing the standard for or the amount of punitive damages in an insurance bad-faith case. As with punitive damages generally, the purpose of awarding punitive damages for liability insurance bad faith is primarily to punish the insurer for its wrongful conduct and ~~also~~ to deter this insurer and other insurers from engaging in similar conduct in the future. Bad-faith conduct that has the potential to evade detection is particularly deserving of punishment on deterrence grounds, among other reasons, to provide a level playing field for insurers that do not engage in such conduct. Bad-faith conduct that denies the dignity of the people that the insurer promised to protect is deserving of punishment on retributive grounds.

The legal standard for awarding punitive damages is worded differently in almost every state. In many states, there is a statute that provides the legal standard for awarding punitive damages. With very few exceptions, every state requires proof of something more than the evidence required to prove an unreasonable failure to settle under § 24 of this Restatement. Such unreasonable settlement decisions are often called “bad faith” settlement decisions, even though they often do not involve subjective bad faith. But ~~where~~when an insurer is shown to have acted in true bad faith, meaning that the level of culpability extends beyond a merely unreasonable settlement decision, punitive damages are generally a jury question. Typically, this includes two distinct aspects: the mental state of the people acting for the insurer and the nature of the conduct. In most cases, the minimum necessary mental state is “reckless disregard.” The required degree of misconduct is often described with words like “outrageous” or “reprehensible.” That the insurer’s conduct has been repeated is relevant to show that it was deliberate, or a matter of policy, and not a one-off incident by a rogue employee. Tort-reform statutes in some states, and some courts as a matter of common-law development, require the insured to prove the insurer’s wrongful conduct by clear and convincing evidence.

Courts have awarded punitive damages in the liability insurance context when presented with adequate proof of: unreasonable delay, failing to investigate, failing to assist in presenting the claim, incorrectly denying the claim, breaching the duty to indemnify, and failing to settle, among other circumstances. An insurance company is not acting in bad faith when it employs a

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rigorous claims-handling process, but only when its actions evince a conscious or reckless disregard of a policyholder’s rights and a deliberate choice to promote the insurance company’s interests at the policyholder’s expense.

Courts generally apply an abuse-of-discretion or evidence-sufficient-to-support-the-verdict standard in reviewing the trier of fact’s decision that the bad-faith conduct warranted a punitive-damages award, and in common-law review of the amount of the award. Sometimes these standards are further specified by legislation or multifactor tests created by state courts in response to the United States Supreme Court’s decision in *Pacific Mutual Life Insurance v. Haslip*, which relied on such a list of factors in rejecting a claim that punitive damages were too standardless to satisfy due process.

The amount of punitive damages is subject to federal constitutional rules as well as state-law rules, and constitutional review of the amount of an award is *de novo*. The U.S. Supreme Court has directed both state and federal courts to apply a three-part test. Some states have aligned their common-law test with the Supreme Court’s constitutional test; many apply two different lists of factors to common-law and constitutional challenges, often in the same case, and occasionally with different results. The three elements, or “guideposts,” of the Supreme Court’s constitutional test are (1) the reprehensibility of the insurer’s conduct; (2) the ratio of the punitive damages to the compensatory damages or to the harm that the insurer’s wrongful conduct might have caused; and (3) a comparison to the civil and/or criminal penalties authorized or imposed in similar cases. The third guidepost has been difficult to administer, and the first two have been by far the more important. Although there are no liability-insurance-specific rules for any of these factors, the mass-market nature of liability insurance for consumers and small businesses means that bad-faith conduct embedded in an insurer’s manner of doing business will have impacts that extend well beyond any individual insured.

REPORTERS’ NOTE

a. Compensatory damages for insurance bad faith. An insured that prevails in a bad-faith case may recover damages that include compensation for consequential harm that was not foreseeable at the time of the sale of the policy, as long as the damages satisfy the requirement of proximate cause or scope of liability. See 1-1 NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 1.06, note 22 (2d ed. [2015/2017 update](#)) (collecting cases from Florida, New York, and Pennsylvania); *Goodson v. Am. Standard Ins. Co. of Wisconsin*, 89 P.3d 409, 415 (Colo. 2004) ([internal citations omitted](#)) (“An insured can recover damages for bad faith breach of

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insurance contract based on traditional tort principles. . . . Compensatory damages for economic and non-economic losses are available to make the insured whole and, where appropriate, punitive damages are available to punish the insurer and deter wrongful conduct by other insurers. . . . Non-economic losses recognized under the rubric of compensatory damages include emotional distress; pain and suffering; inconvenience; fear and anxiety; and impairment of the quality of life.”); *State Farm Mut. Auto. Ins. Co. v. Freyer*, 312 P.3d 403, ~~417~~[412](#) (Mont. 2013) (“[A]n insurer’s wrongful refusal to indemnify entitles its insured to recover consequential damages”; providing examples of consequential damages such as “administrative costs” and lost profits).

Consequential damages include emotional-distress damages. See, e.g., *Crisci v. SecuritySec. Ins. Co. of New Haven, Conn.*, 426 P.2d 173, 178 (Cal. 1967) (“it is settled in this state that mental suffering constitutes an aggravation of damages when it naturally ensues from the act complained of, and in this connection mental suffering includes nervousness, grief, anxiety, worry, shock, humiliation and indignity as well as physical pain.”). See also *Goodson v. Am. Standard Ins. Co. of Wisconsin*, 89 P.3d 409, 412 (Colo. 2004) (first-party case) (holding that insureds may recover damages for emotional distress without proving substantial property or economic loss); *Miller v. Hartford Life Ins. Co.*, 268 P.3d 418 (Haw. 2011) (same). Consequential damages also include harm to an insured’s business and/or reputation. See, e.g., *Magnum Foods, Inc. v. Cont’l Cas. Co.*, 36 F.3d 1491, 1507 (10th Cir. 1994) (reversing and remanding for a new trial so that insured could seek compensatory damages for harm to its business and reputation “proximately caused” by insurer’s bad faith); *Moore v. Am. Family Mut. Ins. Co.*, 576 F.3d 781, 789 (first-party case) (8th Cir. 2009) (finding that testimony that insured’s family “looked at her differently” and “she wondered what other members of the community thought about her” was sufficient for alleging emotional distress and loss of reputation).

b. Attorneys’ fees. For the proposition that attorneys’ fees generally are awarded to insureds in cases involving insurer bad faith, see STEVEN PLITT, ET AL., 14 COUCH ON INSURANCE § 205:96-97 (~~June 2016~~[December 2017](#)) (“To the extent that an insurer’s bad faith has caused an insured to engage counsel to defend against a claim that the policy requires the insurer defend against [or to engage counsel to obtain benefits provided by the policy], the fees incurred by the insured for such purposes are recoverable as damages in a later action based on the carrier’s bad faith.”) (collecting cases). Although the vast majority of jurisdictions permit recovery of attorneys’ fees when the insurer engages in a wrongful denial of coverage, the standards vary, and not all of these jurisdictions use the term “bad faith.” See, e.g., *Reynolds v. First Alabama Bank of Montgomery, N.A.*, 471 So. 2d 1238, 1243 (Ala. 1985) (“ . . . Alabama recognizes exceptions to the American Rule where fraud, willful negligence or malice has been practiced.”); *Brandt v. Superior Court*, 693 P.2d 796, ~~798~~[800](#) (Cal. 1985) (allowing recovery in bad-faith cases because they are “proximately caused by defendant’s breach of its duty to deal in good faith,” applying objective reasonableness standard) (internal citation omitted); Colo. Rev. Stat. Ann. § 13-17-101 (allowing fee shifting when an action is substantially frivolous,

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groundless, or vexatious), *Allstate Ins. Co. v. Huizar*, 52 P.3d 816, 821-822 (Colo. 2002) (applying statute to declaratory-judgment actions [and finding that the insured was not entitled to attorney fees.](#)); *ACMAT Corp. v. Greater N.Y. Mut. Ins. Co.*, 923 A.2d 697, 708 (Conn. 2007) (holding that Connecticut does not permit insureds to recover attorneys’ fees unless the “policyholder can prove that the insurer has engaged in bad faith conduct prior to or in the course of the litigation.”); *Tandycrafts, Inc. v. Initio Partners*, 562 A.2d 1162, 1164 (Del. 1989) (“Under the ‘equity’ exception a litigant may secure an award of counsel fees upon a showing of bad faith by an opposing party.”); *Nugent v. Unum Life Ins. Co. of Am.*, 752 F. Supp. 2d 46, 57 (D.D.C. 2010) (recognizing an exception to the general prohibition on fee shifting when a party has been “oppressive” or “vexatious”); Ga. Code Ann. § 33-4-6 (West) (granting attorneys’ fees when there has been a finding of bad faith); Idaho Code Ann. § 41-1839, *Allstate Ins. Co. v. Mocaby*, 990 P.2d 1204, 1213 (Idaho 1999) (holding that there was no fee shifting because the insurer “reasonably believed that the policy itself provided a basis for noncoverage”); 215 Ill. Comp. Stat. Ann. 5/155 (allowing fee shifting when the actions are “vexatious and unreasonable”); *Learman v. Auto Owners Ins. Co.*, 769 N.E.2d 1171, 1178 (Ind. Ct. App. 2002) (holding that whether attorneys’ fees are granted depends on whether there is bad faith); *Clark-Peterson Co. v. Indep. Ins. Associates, Ltd.*, 514 N.W.2d 912, 916 (Iowa 1994) (allowing fee shifting where the “insurance company has acted in ‘bad faith or fraudulently or was stubbornly litigious’”); *Clark-Peterson Co. Inc. v. Indep. Ins. Associates Assocs., Ltd.*, 514 N.W.2d 912, 916 (Iowa 1994) ([internal citations omitted](#)) (allowing fee shifting where the “insurance company has acted in ‘bad faith or fraudulently or was stubbornly litigious.’”); Ky. Rev. Stat. Ann. § 304.12-235 (West) (allowing attorneys’ fees in insurance disputes where insurer has not settled a claim within 30 days without a “reasonable foundation”); Louisiana Rev. Stat. 22:1892 (allowing attorneys’ fees if the denial is unreasonable or “without probable cause”); *Miller v. Allstate Ins. Co.*, 631 So. 2d 789, 795 (Miss. 1994) (denying attorneys’ fees because there was no showing of “a gross or willful wrong” sufficient to award punitive damages); Nev. Rev. Stat. Ann. § 18.010 (allowing fee shifting in all actions brought “without reasonable ground or to harass the prevailing party”), *Am. Excess Ins. Co. v. MGM Grand Hotels, Inc.*, 729 P.2d 1352, 1355 (Nev. 1986) (applying the statute to insurance-coverage disputes, but finding that the insurer had reasonable grounds for bringing a case of first impression); N.M. Stat. Ann. § 59A-16-30 (requires finding that insurer has “willfully engaged in the violation”); Nat’l R.R. [Passenger Corp. v. Arch Specialty Ins. Co.](#), 124 F. Supp. 3d 264, 280 (S.D.N.Y. 2015) (discussing recent line of New York cases permitting fee shifting in bad-faith cases); *Collins & Aikman Products Prods. Co. v. Hartford Acc. & Indem. Co.*, 481 S.E.2d 96, 98 (N.C. [Ct. App.](#) 1997) (stating in dicta that attorneys’ fees can be recovered in actions of bad faith); 42 Pa. Cons. Stat. Ann. § 8371 (“In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions: . . . (3) Assess court costs and attorney fees against the insurer.”); R.I. Gen. Laws Ann. § 9-1-33 (allowing an insured to bring an action against its insurer and recover attorneys’ fees if it proves bad faith); R.I. Gen. Laws Ann. § 9-1-45 (“The court may award a reasonable attorney’s

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fee to the prevailing party in any civil action arising from a breach of contract in which the court: (1) Finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party. . .”); S.D. Codified Laws § 58-12-3 (allowing attorneys’ fees whenever the insured brings an action against an insurer and proves the wrongful act was “vexatious or without reasonable cause”), *All Nation Ins. Co. v. Brown*, 344 N.W.2d 493, 494 (S.D. 1984) (interpreting the statute as also extending to cases where the insurer brings the declaratory judgment); Tenn. Code Ann. § 56-7-105 (West) (allowing for fee shifting to the policyholder when insurer fails to pay loss in bad faith); *Farmers Ins. Exch. v. Call*, 712 P.2d 231, 237 (Utah 1985) (requiring a finding that the “insurance company acted in bad faith or fraudulently or was stubbornly litigious” before fee shifting is permitted); Va. Code Ann. § 38.2-209 (allowing an insured who brings an action against his or her insurer and proves that the insurer did not act in good faith to recover attorneys’ fees); Wyo. Stat. Ann. § 26-15-124 (West) (allowing attorneys’ fee awards if the “refusal is unreasonable or without cause”).

The only jurisdiction that appears unequivocally to reject the liability insurance bad-faith exception to the American Rule is Michigan. See, e.g., *Shepard Marine ConstConstr. Co. v. Maryland Cas. Co.*, 250 N.W.2d 541, 543 ([Mich. Ct. App.](#) 1976) (“[T]he established rule in Michigan is that the insured may not be allowed attorney’s fees in excess of taxable costs for the declaratory action to enforce insurance coverage.”). Vermont appears not yet to have decided the issue. Compare *Concord Gen. Mut. Ins. Co. v. Woods*, 824 A.2d 572, 579 (Vt. 2003) (holding that attorneys’ fees could not be awarded because there was no bad faith), with *Monahan v. GMAC Mortgage Corp.*, 893 A.2d 298, 324 (Vt. 2005) (characterizing the language in *Concord Gen.* as dicta and declining to resolve whether attorneys’ fees could be awarded for bad faith). There are a few other jurisdictions with unusual or more demanding standards.

c. Other remedies as justice requires. For examples of cases in which a bad faith or similar finding led to a loss of coverage defenses, see, e.g., *Lloyd’s & Inst. of London Underwriting Cos. v. Fulton*, 2 P.3d 1199, 1209 (Alaska 2000) (holding that insurer was estopped from denying coverage when it breached marine-insurance duty of loyalty by failing to disclose a conflict of interest); *Parsons v. Continental National Cont’l Nat’l Am. Group Grp.*, 550 P.2d 94, 96 (Ariz. 1976) (insurer estopped from denying coverage when it used defense counsel to collect confidential information from the insured that it used to deny coverage); *Baios v. Clark*, 7 N.W.2d ~~255~~[255](#), [257](#) (Mich. 1943) (“Having in bad faith denied the existence of the policy, the Insurance Company was estopped from asserting or relying upon any limitation in the policy affecting the time within which suit should be brought.”). Cf. *Griggs v. Bertram*, 443 A.2d ~~163~~[163](#), [171](#) (N.J. 1982) (“where, after timely notice, adequate opportunity to investigate a claim, and the knowledge of a basis for denying or questioning insurance coverage, the insurance carrier fails for an unreasonable time to inform the insured of a potential disclaimer, it is estopped from later denying coverage under the insurance policy in the event a legal action is subsequently brought against its insured.”).

~~For cases supporting the loss of coverage defenses as a remedy for a bad faith refusal to defend, see, e.g., *Truck Ins. Exch. v. Vanport Homes*, 58 P.3d 276, 284 (Wash. 2002) (insurer~~

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~~forfeits coverage defense because of bad faith breach of the duty to defend); Mullen v. Glens Falls Ins. Co., 140 Cal. Rptr. 605, 610 (Cal. Ct. App. 5th Dist. 1977) (insurer that wrongly failed to defend under circumstances equivalent to those in Gray v. Zurich held responsible to pay judgment without regard to whether injuries were intentional) (discussed in John K. DiMugno & Pal E.B. Glad, California Insurance Law Handbook § 46:38 (2017) (describing the case as one in which “an insurer’s wrongful refusal to defend may render it liable for a judgment against the insured even though the insurer had no duty to indemnify against the judgment”). Cf. Allen v. Bryers, 512 S.W.3d 17 (Mo. 2016) (in case in which insurer “wrongfully refused” to defend a claim for which the complaint made clear that there was the potential for coverage, holding that the insurer “is bound by the result of the underlying litigation, including the findings related to coverage”). Note that the California Supreme Court has not addressed this issue, and there is dicta from other California intermediate courts disagreeing with the Mullen rule. See Amato v. Mercury Casualty Co., 61 Cal. Rptr. 2d 909, 914 (Cal. Ct. App. 2d Dist. 1997) (insurer that breached duty to defend in bad faith is liable for default judgment without regard to coverage because the breach caused the default judgment; dicta that Mullen goes too far because it did not require that the breach cause the uncovered judgment); Yap v. Industrial Indem. Co., 1993 WL 309598, at *4 (Cal. Ct. App. 1st Dist. 1993) (“To the extent that Mullen can be read for the proposition that the measure of damages for wrongful refusal to investigate and defend includes both the cost of the insured’s defense and the amount of any judgment or settlement he or she was required to pay, it is wrong”). Courts in Alaska have taken an approach that is similar to a bad faith rule, preventing the insurer from debating coverage when it has breached the duty to defend in a particularly unfair way. See Sauer v. Home Indem. Co., 841 P.2d 176, 183 (Alaska 1992) (“Where, as here, the insurance company does not communicate its decision to withdraw or explain the basis for its decision but simply denies coverage, it should be precluded from later arguing that coverage under the policy does not exist. . . . Thus, an insurance company which wrongfully refuses to defend is liable for the judgment which ensues even though the facts may ultimately demonstrate that no indemnity is due”).~~

~~For cases adopting~~Courts in a significant number of jurisdictions have adopted the broader rule regarding loss of rule that an insurer always loses its coverage defenses for a breach of when it breached the duty to defend, without regard to bad faith, ~~see~~ See Twin City Fire Ins. Co. v. City of Madison, Miss., 309 F.3d 901, 906 (5th Cir. 2002) (applying Mississippi law) (ruling on the basis of estoppel); Valley ~~Imp-Improvement~~ Ass’n, Inc. v. U.S. Fid. & Guar. Corp., 129 F.3d 1108, 1125 (10th Cir. 1997) (applying New Mexico law) (holding that an insurer that breaches the duty to defend “will not be heard to complain that the claims might not have been within coverage.”); Columbus Life Ins. Co. v. Arch Ins. Co., No. 3:14-CV-01659, 2016 WL 286592, 2865952, at *12 (N.D. Ind. May 17, 2016) (applying Ohio law) (relying on unpublished Ohio intermediate-appellate-court decision to conclude that Ohio follows the forfeiture of coverage rule: “*Stoller* indicates that Ohio courts would hold that an insurer is estopped from denying coverage where it wrongfully disclaims coverage and refuses to defend or participate in the settlement of an action brought against an insured.”); Missionaries of ~~Company~~ Co. of Mary,

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Inc. v. Aetna ~~Casualty~~Cas. & ~~Surety~~Sur. Co., 230 A.2d 21, 26 (Conn. 1967) (“The defendant having, in effect, waived the opportunity which was open to it to perform its contractual duty to defend under a reservation of its right to contest the obligation to indemnify the plaintiff, reason dictates that the defendant should reimburse the plaintiff for the full amount of the obligation reasonably incurred by it.”), limited in part by *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*, 67 A.3d ~~961~~961, 998 (Conn. 2013) (limiting the earlier *Missionaries* rule by holding that an insurer forfeits coverage defenses only for those causes of action “contained in the complaint or fairly discernible from the demand for defense, when considered independently” that it had a duty to defend, not for causes of action that it would not have had a duty to defend had they not been combined in the same action); *EmployersEmp’rs Ins. of Wausau v. Ehlco Liquidating Trust*, 708 N.E.2d 1122, 1135 (Ill. 1999) (“Once the insurer breaches its duty to defend . . . the estoppel doctrine has broad application and operates to bar the insurer from raising policy defenses to coverage, even those defenses that may have been successful had the insurer not breached its duty to defend.”); *Farmers Union Mut. Ins. Co. v. Staples*, 90 P.3d 381, 387 (Mont. 2004) (“the court should have ended the analysis and concluded that since FUMIC breached that duty, it was estopped from denying coverage and Staples was entitled to summary judgment.”); *Garcia v. Underwriters at Lloyd’s London*, 156 P.3d 712, 723 (N.M. Ct. App. 2007), *aff’d*, 182 P.3d 113 (N.M. 2008) (citation omitted) (deciding that “an insurer that fails to defend after a demand ‘suffers serious consequences’ including ‘loss of the right to claim that the insured breached policy provisions.’”); *Ames v. Cont’l Cas. Co.*, 340 S.E.2d 479, 485 (N.C. Ct. App. 1986) (“When an insurer without justification refuses to defend its insured, the insurer is estopped from denying coverage and is obligated to pay the amount of any reasonable settlement made in good faith by the insured of the action brought against him by the injured party.”); *Conanicut Marine Servs., Inc. v. InsuranceIns. Co. of N. Am.*, 511 A.2d 967, 971 (R.I. 1986) (holding that an insurer that breaches the duty to defend cannot later contest coverage); *Prof’s Office Bldgs., Inc. v. Royal Indem. Co.*, 427 N.W.2d 427 (Wis. Ct. App. 1988). ~~See also ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 861 (4th ed. 2007)~~Jerry and Richmond explain this broader loss of coverages rule as follows:

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

ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 826 (5th ed. 2012). See also Jeffrey W. Stempel, *Enhancing the Socially Instrumental Role of Insurance: The Opportunity and Challenge Presented by the ALI Restatement Position on Breach of the*

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Duty to Defend, 5 UC IRVINE L. REV. 587 (2015) (collecting authority and arguing in favor of the minority, [automatic](#) loss-of-coverage-defenses rule).

The majority rule is that an insurer that breaches the duty to defend may contest coverage. For examples of opinions so holding, see, e.g., *Servidone ConstConstr. Corp. v. SecuritySec. Ins. Co. of Hartford*, 477 N.E.2d ~~441, 443~~[441](#) (N.Y. 1985) (reaffirmed on stare decisis grounds in *K2 Investment Group, LLC v. AmericanAm. Guarantee & Liability Ins. Co.*, 22 N.Y.3d 578 (2014), a decision that reversed after rehearing an earlier Court of Appeals opinion in the same case that had adopted the forfeiture-of-coverage rule apparently in ignorance of the prior *Servidone* opinion); *Utica Nat. Ins. Co. of Texas v. Am. Indem. Co.*, 141 S.W.3d 198, 203 (Tex. 2004) (“Even if a liability insurer breaches its duty to defend, the party seeking indemnity still bears the burden to prove coverage if the insurer contests it.”).

The courts in the majority-rule states have generally not reached the question whether a different rule should apply in the case of a bad-faith breach. This means that there is little, if any authority, directly contradictory to the ~~rule that~~[bad-faith loss-of-coverages rule stated in Comment c, which unequivocally](#) applies [only](#) in Washington. ~~But see *Areneaux v. Amstar Corp.*, 66 So. 3d 438, 452 (La. 2011) (holding that forfeiture of coverage defenses is not an appropriate remedy for bad faith breach in Louisiana because there is a statute stating the remedies for bad faith breach)~~[See, e.g., *Truck Ins. Exch. v. Vanport Homes, Inc.*, 58 P.3d 276, 284 \(Wash. 2002\) \(insurer forfeits coverage defense because of bad-faith breach of the duty to defend\). The landmark case of *Gray v. Zurich* appeared to follow that rule, but subsequent California authority is equivocal. See *Mullen v. Glens Falls Ins. Co.*, 140 Cal. Rptr. 605, 610 \(Cal. Ct. App. 1977\) \(insurer that wrongly failed to defend under circumstances equivalent to those in *Gray v. Zurich* held responsible to pay judgment without regard to whether injuries were intentional\) \(discussed in John K. DiMugno & Pal E.B. Glad, *California Insurance Law Handbook* § 46:38 \(2017\) \(describing the case as one in which “an insurer’s wrongful refusal to defend may render it liable for a judgment against the insured even though the insurer had no duty to indemnify against the judgment”\)\); *Amato v. Mercury Cas. Co.*, 61 Cal. Rptr. 2d 909, 914 \(Cal. Ct. App. 1997\) \(insurer that breached duty to defend in bad faith is liable for default judgment without regard to coverage because the breach *caused* the default judgment; dicta that *Mullen* goes too far because it did not require that the breach cause the uncovered judgment\); *Yap v. Indus. Indem. Co.*, No. A056594, 1993 WL 309598, at *4 \(Cal. Ct. App. 1993\) \(“To the extent that *Mullen* can be read for the proposition that the measure of damages for wrongful refusal to investigate and defend includes both the cost of the insured’s defense and the amount of any judgment or settlement he or she was required to pay, it is wrong.”\).](#)

[Courts in Alaska and Missouri have taken an approach that is similar to a bad-faith rule, preventing the insurer from debating coverage when it has breached the duty to defend in a particularly unfair way. See *Sauer v. Home Indem. Co.*, 841 P.2d 176, 183-184 \(Alaska 1992\) \(“Where, as here, the insurer does not communicate its decision to withdraw or explain the basis for its decision but simply denies coverage, it should be precluded from later arguing that coverage under the policy does not exist. . . . Thus, an insurance company which wrongfully](#)

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refuses to defend is liable for the judgment which ensues even though the facts may ultimately demonstrate that no indemnity is due.”); Allen v. Bryers, 512 S.W.3d 17, 23 (Mo. 2016) (in case in which insurer “wrongfully refused” to defend a claim for which the complaint made clear that there was the potential for coverage, holding that the insurer “is bound by the result of the underlying tort action, including the findings related to coverage”).

d. Punitive damages. See *Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 19 (1991) (“[U]nder the law of most States punitive damages are imposed for purposes of retribution and deterrence.”); *Mitchell, Jr. v. Fortis Ins. Co.*, 686 N.E.2d 176, 188 (S.C. 2009) (“[An] award will adequately vindicate the twin purposes of punishment and deterrence that support the imposition of punitive damages.”). For cases supporting the proposition that to warrant the award of punitive damages, the defendant’s mental state must be at least “reckless,” see, e.g., *Liberty Mut. Fire Ins. Co. v. JT Walker Indus., Inc.*, 554 F. App’x 176, 189 (4th Cir. 2014) (applying South Carolina law) (“A court may award punitive damages in bad faith tort actions for conduct willful, wanton, or reckless in disregarding a plaintiff’s rights.”); *Sims v. Great Am. Life Ins. Co.*, 469 F.3d 870, 893-894 (10th Cir. 2006) (applying Oklahoma law) (“[An] insurer must ‘recklessly disregard’ or ‘intentionally and with malice breach[] its duty to deal fairly and act in good faith with its insured.’”) (citing Okla. Stat. tit. 23 § 9.1(B), (D) (2005); Badillo v. Mid Century Ins. Co., 121 P.3d 1080, 1106 (Okla. 2005)); *Ace v. Aetna Life Ins. Co.*, 139 F.3d 1241, 1241, 1246 (9th Cir. 1998) (applying Alaska law) (“[A] plaintiff must prove . . . that the wrongdoer’s conduct ‘was . . . [with] reckless indifference to the interests of another person.’”) (citing Alaska Stat. § 09.17.020; *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1158 (Alaska 1989)); *Uberti v. Lincoln Nat’l Life Ins. Co.*, 144 F. Supp. 2d 90, 107 (D. Conn. 2001) (“[W]here the insurer’s conduct is found to be malicious or outrageous, that is, done with bad motive or reckless disregard of, or indifference to, the plaintiff’s rights.”); *McLendon v. Wal-Mart Stores, Inc.*, 521 F. Supp. 2d 561, 565 (S.D. Miss. 2007) (stating the minimum mental state for punitive damages under Mississippi law is reckless disregard); *Forrest Constr., Inc. v. Cincinnati Ins. Co.*, 728 F. Supp. 2d 955, 967, 955 (M.D. Tenn. 2010) (same); *Goodson v. Am. Standard Ins. Co. of Wisconsin*, 89 P.3d 409, 415 (Colo. 2004) (“[T]he insurer either knowingly or recklessly disregarded the validity of the insured’s claim . . .”) (citing Colo. Rev. Stat. § 13-21-102 (“[W]illful and wanton conduct’ means conduct purposefully committed which the actor must have realized as dangerous, done heedlessly and recklessly, without regard to consequences, or of the rights and safety of others, particularly the plaintiff.”)); *Sloan v. State Farm Mut. Auto. Ins. Co.*, 85 P.3d 230, 232 (N.M. 2004) (“An insurer’s frivolous or unfounded refusal to pay is the equivalent of a reckless disregard for the interests of the insured . . . which has historically justified an award of punitive damages. To ensure the jury has found a culpable mental state before awarding punitive damages, we modify UJI 13–1718 to reflect that punitive damages may only be awarded when the insurer’s conduct was in reckless disregard for the interests of the plaintiff.”); *O’Neill v. Gallant Ins. Co.*, 769 N.E.2d 100, 109 (Ill. App. Ct. 2002) (“[W]here the insurer’s conduct exceeds mere negligence and, like here, demonstrates to a jury’s satisfaction that the refusal to

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settle within policy limits was engaged in with utter indifference and reckless disregard for its policyholder’s financial welfare, punitive damages can be awarded.”); *Majorowicz v. Allied Mut. Ins. Co.*, 569 N.W.2d 472, 479 (Wis. Ct. App. 1997) (“It is no longer necessary to show malice or vindictiveness in order to recover punitive damages; it is enough that the wrongdoer acted in wanton, willful, or reckless disregard . . .”); *Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254, 265 (Del. 1995) (“The penal aspect and public policy considerations which justify the imposition of punitive damages require that they be imposed only after a close examination of whether the defendant’s conduct is ‘outrageous,’ because of ‘evil motive’ or ‘reckless indifference to the rights of others.’”) (internal quotations omitted); see also Fla. Stat. Ann. § 624.155 (“No punitive damages shall be awarded under this section unless the acts giving rise to the violation . . . are . . . (b) In reckless disregard for the rights of any insured-”); Miss. Code Ann. § 11-1-65 (“ . . . which evidences a willful, wanton or reckless disregard for the safety of others.”).

For cases regarding the requirement that the insurer’s conduct must have been outrageous, see, e.g., *Ace v. Aetna Life Ins. Co.*, 139 F.3d 1241 (9th Cir. 1998) (applying Alaska law) (requiring the insurer’s conduct to be outrageous); *Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co.*, 277 P.3d 789 (Ariz. Ct. App. 2012) (same); see also *Trinity Evangelical Lutheran Church & Sch.-Freistadt v. Tower Ins. Co.*, 661 N.W.2d 789 (Wis. 2003) (stating the rule in Wisconsin that an insurer may be liable for punitive damages for “gross or outrageous conduct.”); *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141 (Cal. 1979) (first-party case) (insurer’s claim representative reduced insured to tears in the presence of his wife and child, also called insured a fraud, and incorrectly advised him on his bona fide claim, thereby showing outrageous conduct).

Examples of factual situations where courts have awarded punitive damages against an insurer include: (a) unreasonable delay, see, e.g., *Atchafalaya Marine, LLC v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 959 F. Supp. 2d 1313, 1329 (S.D. Ala. 2013) (finding clear and convincing evidence the insurance company acted with “unreasonable delay” constituting a reckless disregard for its insured’s rights); (b) failing to investigate, see, e.g., *Ace v. Aetna Life Ins. Co.*, 139 F.3d 1241 (9th Cir. 1998) (applying Alaska law) (listing failure to investigate as one of eight factors supporting an award of punitive damages); *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397 (Ohio 1994) (finding an award of punitive damages was justified when the record revealed a “one-sided inquiry” and the insurer breached its affirmative duty to conduct an adequate investigation); (c) failing to assist in presenting the claim, see, e.g., *Ace v. Aetna Life Ins. Co.*, 139 F.3d 1241 (9th Cir. 1998) (listing failure to assist in presenting the claim as one of eight factors supporting an award of punitive damages); (d) incorrectly denying the claim, *id.* (same); and (e) when it fails to uphold its settlement duties, see, e.g., *O’Neill v. Gallant Ins. Co.*, 769 N.E.2d 100, 109, 112-113 (Ill. App. Ct. 2002) (awarding punitive damages after finding an insurer “pursu[ed] a possible settlement of the claim in a way that kept its interests paramount, and it gambled its insured’s interest in a policy-limits settlement on a preposterous strategy designed to shift its responsibilities onto another insurance company,” evincing “utter indifference and

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reckless disregard for its policyholder’s financial welfare.”); ~~and~~ Neal v. Farmers Ins. Exch., 582 P.2d 980 (Cal. 1978) (same); and Campbell v. ~~Government Employees~~ Gov’t Emps. Ins. Co., 306 So. 2d 525, 532 (Fla. ~~1975~~ 1974) (insurer withheld information regarding settlement opportunities from insured, including offer from plaintiff posttrial to enter into a settlement pursuant to which it would agree not to execute against the insured in return for an assignment of the insured’s rights against the insurer). See also Coors v. Sec. Life of Denver Ins. Co., 112 P.3d ~~59~~ 59, 66 (Colo. 2005) (finding an internal company memo stating that the insurer’s actions “may turn out to be a very bad idea” and potentially viewed as “bad faith” supported a finding that the company acted unreasonably or in reckless disregard for the insured’s rights); Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 412 (Colo. 2004) (awarding punitive damages for failing to provide peace of mind when an insurer took over a year and a half to pay an obviously valid claim); Allied Processors, Inc. v. W. Nat’l Mut. Ins. Co., 629 N.W.2d 329 (Wis. Ct. App. 2001); and Newport v. USAA, 11 P.3d 190 (Okla. 2000).

For authority regarding the clear-and-convincing-evidence requirement, see, e.g., Minn. Stat. Ann. § 549.20 (“Punitive damages shall be allowed in civil actions only upon clear and convincing evidence”); Grossi v. Travelers Pers. Ins. Co., 79 A.3d 1141 (Pa. Super. Ct. 2013) (applying a clear-and-convincing-evidence burden when reviewing a punitive-damages award); Atchafalaya Marine, LLC v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA, 959 F. Supp. 2d 1313 (S.D. Ala. 2013) (citing Ala. Code ~~§ 6-11-20~~ (same); ~~Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789 (Ariz. 2012) (same); § 6-11-20~~ (same); Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789 (Ariz. Ct. App. 2012) (same); see also Tex. Civ. Prac. & Rem. Code Ann. § 41.003 (requiring, in addition to the clear-and-convincing-evidence burden, that the jury be instructed it must actually return a unanimous verdict). But see Colo. Rev. Stat. Ann. § 13-25-127(2); Coors v. Sec. Life of Denver Ins. Co., 112 P.3d 59 (Colo. 2005) (requiring proof beyond a reasonable doubt).

On constitutional limitations on the amount of punitive damages, see, e.g., State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. ~~408~~ 408, 429 (2003) (holding a punitive-damage award of \$145 million “was an irrational and arbitrary deprivation of the property of the defendant” thereby violating its due-process rights); Campbell v. State Farm Mut. Auto Ins. Co., 98 P.3d 409 (Utah 2004) (awarding \$9 million in punitive damages in the same case on remand); Deters v. USF Ins. Co., 797 N.W.2d 621 (Iowa Ct. App. 2011) (finding a \$1 million punitive-damages award constitutionally permissible where the potential harm was also approximately \$1 million; 1:1 ratio); Mitchell, Jr. v. Fortis Ins. Co., 686 S.E.2d 176, 184-185 (S.C. 2009) (aligning South Carolina’s eight-step test to match the Supreme Court’s three-part test, finding a ratio of 13.9:1 was grossly excessive and reducing the award to 9.2:1).

Courts usually afford triers of fact the abuse-of-discretion standard for determining whether the bad-faith conduct warranted a punitive-damages award and in common-law review of the amount of the award. But when the amount of an award is challenged as unconstitutional, courts are required to review the amount de novo. See Cooper Indus., Inc. v. Leatherman Tool Grp., Inc., 532 U.S. 424, 436 (2001). See also Kimble v. Land Concepts, Inc., 845 N.W.2d 395,

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[405396](#) (Wis. 2014) (“[O]nce the issue of punitive damages is properly before the jury, its decision to award punitive damages is accorded deference. The size of the award, however, is subject to de novo review to ensure it accords with the constitutional limits of due process.”); *Allstate Ins. Co. v. Dodson*, 376 S.W.3d 414, 432 (Ark. 2011) (applying de novo review to common-law challenge).

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Description	Liability Insurance - CD 4 - Ch 4 - formatted TF TB Edits further revised
Document 2 ID	file://S:\A L I\2018 Annual Meeting\Drafts\Liability Insurance PFD 2\files for comparisons\Liability Insurance PFD2 - Ch4 - formatted TF Edits.KL.TB.docx
Description	Liability Insurance PFD2 - Ch4 - formatted TF Edits.KL.TB
Rendering set	Standard

Legend:	
Insertion	
Deletion	
Moved from	
Moved to	
Style change	
Format change	
Moved deletion	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	421
Deletions	329
Moved from	73
Moved to	73
Style change	0

Format changed	0
Total changes	896