FDCC Insights
DEFENSE LAWYERS. DEFENSE LEADERS.
A Journal for Defense and Corporate Counsel

JUNE 2017

THE AMERICAN LAW INSTITUTE'S NEW LAW OF LIABILITY INSURANCE RESTATEMENT

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On May 23, 2017, the members of the American Law Institute ("ALI") assembled in the basement of the Ritz-Carlton Hotel in Washington, D.C. for what was forecast as the final debate and vote on the *Restatement of Law, Liability Insurance* ("RLLI"). This Restatement, which would have followed in the wake of storied works of scholarship such as the Restatements of Contracts, Torts and Conflicts of Law, has been in the works since 2010 and had already been the subject of discussion at several earlier ALI Annual Meetings. At the last minute, however, the ALI deferred a final vote until May 2018. What happened, and what does this debate portend for the future of the RLLI?

In the weeks leading up to the scheduled May 23, 2017 vote, a firestorm of protest erupted from the defense community which was led by prominent members of the insurance defense bar, state insurance regulators, trade industry associations, individual insurers, and outside defense counsel. Numerous letters were submitted to the Executive Director of the ALI protesting that this proposed Restatement was not, in fact, a "restatement" of the law and ignored established common law principles with respect to the interpretation and application of liability insurance policies. The Comments urged the ALI to give further consideration before approving the RLLI.

While a final vote on the RLLI has been put off for a year, it is by no means certain that this delay will yield substantive changes by the Reporters. The Reporters have scheduled another meeting with the project's Advisers group (scheduled for September 7, 2017) and will likely circulate a revised draft later this summer. Any substantive changes, if any, will also require further review and approval by the ALI Council this fall. There will also be an opportunity for a final floor debate when the RLLI project is brought back for a vote at the 2018 Annual Meeting in Washington, D.C.

With all that as prologue, what is this Restatement of Law, Liability Insurance, and why has it become so controversial? Despite the fact that the RLLI Project has been ongoing for seven years and now nears completion and approval, many insurance lawyers are unaware of and/or have significant misconceptions about the RLLI's provisions. This article provides an overview of the RLLI's provisions.

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The American Law Institute is a Philadelphia-based organization of practicing lawyers, legal scholars, and judges who are devoted to maintaining and advancing the law. Founded in 1923 by prominent judges and scholars including Benjamin N. Cardozo and Learned Hand, the ALI's stated mission is "…to promote the clarification and simplification of the law and its better adaptation to social needs, to secure the better adminis-

tration of justice and to encourage and carry on scholarly and scientific legal work." *See* The American Law Institute, available at www.ali.org/about-ali/creation. Over the past century, the ALI has had a profound impact on American law through model statutes such as the Uniform Commercial Code and the Model Penal Code, as well as various Restatements of the Law in areas as diverse as torts, conflicts of law, and the law of lawyering.

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ALI Restatements proceed through a slow iterative process. First, Reporters (experts in the field of law being considered) circulate memoranda and a Preliminary Draft. This initial draft is reviewed by the Advisers (a small group of judges, lawyers, and law professors with special knowledge on the subject) and the Members' Consultative Group (members of the ALI who have a particular interest in the subject), and these groups provide feedback to the Reporters. With this input, the Reporters produce a Council Draft which is submitted to and reviewed by the ALI Council (a small group of senior members that vet all proposed text) which can refer the draft for further consideration or approve it. If approved, the draft is revised and presented as a Tentative Draft to the full membership for final approval at the ALI's annual meeting. *See* www.ali.org/about-ali/how-institute-works and www.ali.org/projects/project-life-cycle/.

In 2010, the ALI embarked on an analysis of legal issues presented by liability insurance disputes. This project was originally envisioned as a "Principles of the Law" Project. Unlike the ALI's more familiar "Restatement" projects, Principles projects are geared more toward regulators and legislatures and set forth "best practices" that the Reporters feel should be adopted, whether they currently reflect the way that most courts address such issues or not. In short, *Principles* set forth the law as it should be, whereas *Restatements*, for the most part, codify the law as it is.

Four years into the project, however, the new executive director of the ALI decided that the project should be converted into a Restatement project. "As a Restatement, the project aim[ed] to provide clear formulations of common law and its statutory elements or variation and reflect the law as it presently stands or might appropriately be stated by a court." *See* www.thealiadviser.org/liability-insurance/. As a result, and despite the fact that Chapters One and Two had already been approved by the full ALI membership, the Reporters were obliged to pull back and reassess Chapters One and Two at the end of 2014 to eliminate aspirational provisions that were not rooted in the common law or that were otherwise inappropriate for inclusion in a Restatement.

The RLLI contains four chapters. Chapter One addresses basic principles of insurance contract interpretation, the doctrines of waiver and estoppel, and the effect of misrepresentations made by policyholders during the application process. Chapter Two focuses on the obligation of a liability insurer to defend (or pay defense costs), as well as the duties of the insurer and the insured with respect to settlement and cooperation issues. Chapter Three addresses the scope of insured risks and topics such as trigger, allocation, and issues related to exclusions and conditions. Chapter Four covers remedies, bad faith, and enforceability. *See* www.thealiadviser.org/liabilty-insurance/.

A. Chapter One: Basic Liability Insurance Contract Principles

Following an introductory definitional section, Chapter One consists of three topics: (1) Interpretation (Sections 2 through 4); (2) Waiver and Estoppel (Sections 5 and 6); and (3) Misrepresentations (Section 7 through 11).

Section 3 is perhaps the most controversial part of the RLLI. Instead of adopting "plain meaning" as a fixed rule, Section 3, by inclusion of an express exception to the "plain meaning" rule, proposes a "*presumption* of plain meaning" rule that can be refuted by extrinsic evidence of contractual intent. Furthermore, even if a policy term is unambiguous on its face, the plain meaning can be overcome if a judge "determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence."

As indicated above, ALI Restatements are generally meant to embrace majority rules unless they are outmoded or impractical to apply. Therefore, it is surprising that the project's Reporters have chosen to abandon the "plain meaning" rule of contract interpretation, which is the acknowledged standard for interpreting insurance policies in nearly every state, for a novel "presumption of plain meaning" rule.

Section 4 is another section that seems to contradict well-accepted principles of insurance contract construction and interpretation. When standard-form policy language is involved, most states recognize that a finding of ambiguity automatically results in coverage -- the "tie goes to the insured." Many states also adhere to the rule that, as to boilerplate or standard-form policy language, an insurer's preferred interpretation must be the only reasonable interpretation. Thus, even if an insurer's proposed interpretation is demonstrably reasonable, ambiguity (and coverage) will be found so long as the in-

sured's proposed interpretation is also reasonable. Comment j. to Section 4 indicates that the RLLI rejects the standard "tie breaker" rule followed in many jurisdictions and, instead, declares that coverage should be found only if a court is otherwise unable to determine the meaning of an insurance policy term "using all other permissible sources of meaning, including extrinsic evidence."

In Comment b. to Section 4, the Reporters explore the relationship between *contra proferentem* ("interpretation against the draftsman") and the doctrine of "reasonable expectations." The Reporters comment that the reasonable expectations doctrine is not actually a rule of interpretation, but rather "…a rule regarding the enforceability of terms that are inconsistent with the reasonable expectations of the insured." The Reporters posit that, while policies should be interpreted in accordance with the reasonable expectations of coverage, coverage may not be found based on the reasonable expectations doctrine where to do so would confound the actual language of the policy.

In short, these two Sections jettison the certainty and protection of the "plain meaning" rule for an uncertain new regime of contract interpretation that seems more likely to generate ambiguity and delay than facilitate the resolution of coverage disputes

Sections 3 and 4 are also troubling in their one-sided aspect. Although the black letter rules seem to promote an approach that permits an evenhanded search for the true meaning and intent of the parties, the Comments and Reporters Notes to these sections, in fact, make clear that the rules are heavily weighted towards policyholders. Policyholders are free to present a wide range of extrinsic evidence in support of their proposed interpretation, including evidence of a policy's drafting history; regulatory filings with state insurance departments; other versions of the policy available on the market; and expert testimony regarding custom and practice in the insurance industry, the history, purpose, and functions of policy terms and forms of insurance coverage. By contrast, insurers may only present extrinsic evidence that the insured would or should have known at the time of contracting!

In short, these two Sections jettison the certainty and protection of the "plain meaning" rule for an uncertain new regime of contract interpretation that seems more likely to generate ambiguity and delay than facilitate the resolution of coverage disputes. It is perhaps appropriate to question whether the leeway that the ALI has historically accorded itself to diverge from the majority approach adhered to by common law courts is appropriate in the field of insurance. This is the first Restatement that is directed solely towards a single industry. The insurance industry, almost uniquely, depends on predictability of results in deciding how to price and market its insurance products. Significant changes to well-settled principles governing the interpretation and application of insurance products disrupt that process and complicate the ability of actuaries to predict premium and lawsuits based upon past experience.

Sections 5 and 6 set forth the general rules governing application of the doctrines of waiver and estoppel to insurance coverage disputes. For the most part, the principles enunciated in these two sections follow the common law in most jurisdictions, both with regard to the distinction between waiver and estoppel and the general principle that an insurer cannot "waive into coverage." However, Section 6 does state that an insurer's post-loss conduct can estop it from disputing coverage if the insured reasonably relied on such post-loss conduct to his/her detriment.

The analysis of misrepresentation issues (the third topic addressed in Chapter One) was one of the most contentious issues during the *Principles* phase of this project. In particular, insurers objected to **Section 7** because it offered a "fraud" standard of proof and to **Section 11** which included a requirement that insurers accept coverage, albeit at the cost of additional premium to the insured, in cases of "innocent misrepresentation." Both of these provisions were eliminated in the 2105 Council Draft, along with any distinction between negligent and intentional misrepresentations. As revised, Sections 7 and 8 generally track the rules in most states with respect to intent, materiality, and reliance.

B. Chapter Two: Management of Potentially Insured Liability Claims

Chapter Two (Sections 10 through 30) is also divided into three topics: (1) Defense; (2) Settlement; and (3) Cooperation. According to the Reporters, these three Topics have "engendered much confusion in the case law," and there is a "real opportunity to clarify and improve the law...." The Reporters assert that Chapter Two is an attempt to "clarify and unify existing law" and that it largely sets forth rules already applicable in most jurisdictions. Indeed, the *Principles* project version of Chapter Two was less controversial than Chapter One. As a result, there were fewer changes to Chapter Two in the Council Drafts issued in 2015 after the RLLI became a *Restatement* project.

Sections 10 through 23 analyze the right and duty of insurers to defend.

Text in **Section 12** that would have declared insurers vicariously liable for the conduct of defense counsel was shed in the metamorphosis of the RLLI from a *Principles* project to a *Restatement* project. However, insurers may still be liable for the acts of their employees, an issue that may arguably create

liability for the conduct of staff counsel. Insurers may also be liable for negligence in the selection or supervision of defense counsel or failure to insure that defense counsel has adequate malpractice insurance.

Section 12(2) was a flashpoint for controversy in the weeks leading up to the May 23, 2017 vote. The Defense Research Institute ("DRI") and other leading defense lawyers complained that the proposed language would impose liability where none exists at the common law and, therefore, would impair the ability of defense lawyers to represent policyholders at the behest of liability insurers.

Section 13 sets forth the standard for determining when an insurer has a duty to defend. It largely adopts a "four corners plus" standard, wherein the analysis of the duty to defend obligation is measured by the facts alleged in the underlying complaint as well as extrinsic facts that bear on the issue of coverage. Insurer advocates have criticized Section 13(1) as creating a duty to defend based on (a) the mere possibility that pleadings may be amended in the future to add a covered claim or (b) consideration of facts about which a "reasonable insurer" should be aware, even if those facts are not actually known to the insurer. Section 13(3) permits insurers to decline to defend an insured based on extrinsic facts, but only in four very narrow factual circumstances (i.e., whether the claimant indisputably does not qualify as an insured under the policy).

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Section 16 addresses the circumstances in which an insured may insist on its own defense counsel and, for the most part, adopts the California *Cumis* standard. (The term "Cumis counsel" is derived from *San Diego Fed. Credit Union v. Cumis Ins. Society. Inc.* 162 Cal.App.3d 358, 364 (Ca.Ct.App. 1984)(*Cumis*). In response to *Cumis*, the California Legislature enacted Civil Code Section 2860 which"'clarifies and limits'" *Cumis*. Generally, the benefits of dual representation give way to the need for independent *Cumis* counsel for the insured where an insurer reserves its rights to deny indemnification on specific coverage issues, and the reservation creates a conflict of interest between the insurer and its insured that precludes dual representation because of the attorney's ethical obligations to refrain from representing conflicting interests.)

Section 17 states that an insurer's determination of the hourly rate for independent counsel may not be determined based solely on what the insurer pays to its panel counsel. An early version of Section 17 included a provision requiring the insurer to front the full amount charged subject to a right to sue defense counsel at the conclusion of the litigation to recoup excessive fees; however this provision was eliminated.

Section 18 provides that an insurer may terminate its duty to defend its insured by entering into a settlement with the underlying claimant to dismiss the covered claims, but only with the insured's express consent.

Section 19 provides that "an insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action." As originally drafted, this section provided that an insurer that failed to defend lost the right "to contest coverage for the claim." However, after vehement opposition by insurer advocates, the Reporters amended the section and inserted compromise language stating that an insurer should only lose the right to raise defenses to indemnify if its failure to defend lacked a "reasonable basis." Although this compromise language is similar to the bad faith standard used in states such as California, the Reporters have gone to great lengths to state that Section 19 is not a bad faith standard.

Section 20 states that, if multiple insurers have a duty to defend, the insured may target a single insurer to handle his/her defense. Unlike the Illinois "targeted tender" approach, however, the insurer that undertakes the defense is entitled to contribution from other insurers that shared a similar obligation.

Section 21 states that insurers may not retroactively recoup their costs of defense absent explicit policy language allowing such recovery. The Reporters are struggling to reconcile the language of Section 21 with Section 35 of the *Restatement (Third) of Restitution and Unjust Enrichment*, which allows for equitable restitution under analogous circumstances.

Section 24 addresses settlement when either (a) a liability insurer has the authority to settle a claim against the policyholder, or (b) the policy grants the insurer a right to consent to a settlement negotiated by the policyholder. Section 24 provides that the insurer owes a duty to the policyholder to make reasonable decisions, but stipulates that this "reasonable decision" duty pertains only to claims that potentially exceed policy limits. The term "reasonable settlement decision" was defined in the initial draft of the RLLI as "[a decision] that would be made by a reasonable person who bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending a claim." Subsequently, the Reporters determined that defense costs were not relevant to the "rea-

sonable settlement decision" analysis and, in later drafts of the RLLI, eliminated defense costs from the definition. Subsection (3) of Section 24 provides that the insurer's "reasonable decision" duty extends to accepting reasonable settlement demands made by plaintiffs with a proviso that the insurer's liability is "never greater than policy limits." Additionally, the insurer's duty includes the "duty to contribute its policy limits . . . if that settlement exceeds those policy limits."

The duty to cooperate requires the insured to render "reasonable assistance," with reasonableness assessed based on the complexity of the claim, the insurer's ability to obtain information from other sources, the extent to which the insurer needs the policyholder's cooperation, etc.

While the amelioration of the standards of liability have been welcomed by insurer advocates, concerns remain that insurers will face increased liability for failing to accept a "reasonable" settlement offer even where their efforts to settle have otherwise been reasonable. Additionally, although the Reporters have undertaken to distinguish failure to settle claims from bad faith litigation, the inclusion of "procedural factors" as a basis for imposing liability muddies the waters and certainly introduces bad faith evidentiary elements into failure to settle litigation. Finally, while the revised text of Section 24 omits prior language imposing an affirmative duty to make settlement offers, the echoes of this earlier language continue to resonate in the Comments to this Section.

Section 26 addresses situations in which there are claimants whose claims exceed the policy limits. This scenario raises difficult questions of timing and entitlement to insurance proceeds, particularly when an insurer has not paid defense costs as they are incurred. Courts have struggled to identify appropriate rules to govern such situations. Does the insurer faced with this situation act in bad faith if it pays its full limit to settle some, but not all, of the claims? Alternatively, if the insurer is unable to settle all of the claims, does the insurer nonetheless have a duty to settle as many claims as it can? The answer, according to Section 26, is interpleader. The Reporters state that an insurer has a duty to make "a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure." The insurer may satisfy this duty by "joining all affected claimants in the underlying action and tendering its policy limits to the court" with a motion to allocate the limits "among the claimants on the basis of the relative value of their claims." If a claimant rejects a portion of the policy limits offered in full satisfaction of his/her claim, the insurer's duty to defend remains in effect until the claim is settled, the claim is finally adjudicated, or a court finds that the insurer does not have a duty to defend.

Section 27 provides that an insurer that fails to make a reasonable settlement decision is liable for the entire amount of the judgment against the insured, not just the amount within its policy limits. Furthermore, the insurer also may be liable for "any other reasonably foreseeable harms." If there is an excess judgment, the insurer's liability exposure encompasses possible liability for the insured's emotional distress. This rule applies only if there is an excess judgment. Comment e. to Section 27 states that an insurer that fails to effectuate a reasonable settlement is liable for all damages flowing from that failure, even if the resulting excess judgment may include elements, such as punitive damages, that would not otherwise have been covered. This is contrary to the view of cases such as *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999) and *Lira v. Shelter Ins. Co.*, 913 P.2d 514 (Colo. 1996)(California and Colorado courts held that an insured may not shift to its insurance company, and ultimately to the public, the payment of punitive damages awarded in the third party lawsuit against the insured as a result of the insured's intentional, morally blameworthy behavior against the third party. To allow such recovery would (1) violate the public policy against permitting liability for intentional wrongdoing to be offset or reduced by the negligence of another; (2) defeat the purposes of punitive damages, which are to punish and deter the wrongdoer; and (3) violate the public policy against indemnification for punitive damages.)

Section 28 recognizes that an excess insurer may pursue a right of equitable subrogation against a primary insurer for failing to effectuate a reasonable settlement. This appears to reflect the emerging majority view on this issue, although this view is not yet one that is universally accepted.

Section 29 provides that an insured has a duty to cooperate with his/her insurer as follows:

(i) the investigation and settlement of a claim for which the insured seeks coverage;

(ii) the insurer's defense of a claim, "when applicable"; and

(iii) situations in which the insurer associates in the defense.

As the Comments note, the duty to cooperate "serves to align the incentives of insurer and insured," and helps to insure that the insured has the incentive to aid the insurer in its defense and management of the claim. The duty to cooperate requires the insured to render "reasonable assistance," with reasonableness assessed based on the complexity of the claim, the insurer's ability to obtain information from other sources, the

extent to which the insurer needs the policyholder's cooperation, etc. Comment c. to Section 29 explicitly states that the duty to cooperate is not intended to "become a trap for the insured," and an insurer "may not unilaterally withdraw from the defense of a claim based on non-cooperation." Instead, an insurer must follow the procedure set forth for reserving rights and pursuing a declaratory judgment action in such situations. Similarly, Comment d. to Section 29 states that the duty to cooperate does not obligate the insured to comply with unreasonable requests from his/her insurer.

Section 30 states that, where an insured has failed to cooperate with his/her insurer, the insurer may avoid coverage only if the insured's action resulted in prejudice to the insurer. In early drafts, the RLLI included language which stipulated that a delay must have substantially prejudiced the outcome of the case; however, this language was deleted in the Proposed Final Daft. Further, if an insurer can show that its policyholder colluded with the claimant, the insurer is excused from coverage unless the insured proves that the collusion "if undetected, would not have caused substantial prejudice to the insurer in the outcome of the claim."

Section 39 analyzes the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate "occurrence" limits and adopts the majority "cause" approach.

C. Chapter Three: General Principles Regarding the Risks Insured

Chapter Three (Sections 31 through 45) represents a comprehensive effort to analyze and apply the building blocks of all liability insurance policies, including (1) the scope of coverage; (2) conditions to coverage; and (3) terms affecting the amount that an insurer must pay.

Section 32 states that exclusions are to be read narrowly. Exclusions requiring proof of intent will generally be interpreted as requiring proof of subjective intent. However, Comment d. to this section confirms that insurers may draft around this requirement (which is commonly seen in homeowners form exclusions). Comment d. also points out that subjective intent must be proved by objective evidence and may sometimes be inferred as a matter of law, as in cases of sexual assault.

Section 33 describes the role that "trigger" clauses play in liability insurance, whether in the context of "occurrence" based policies or "claims-made" policies. Comment f. to this section adopts the "injury in fact" approach as the default solution, and acknowledges that this approach may implicate multiple years of coverage depending on the causal circumstances of loss (i.e., "long-tail claims" where the injury is caused by a continuing or repeated harm that occurs over one or more years). Comment g. to Section 33 assigns the burden of proof in such cases to insureds. The burden appears to be light, and an insured may be able to compel coverage based on mere evidence of exposure, subject to each insurer's ability to show that no harm actually occurred in its policy period.

Section 34 defines a "condition" as an event that "unless excused, must occur, or must not occur, before performance under the policy becomes due." Whether a term is a "condition" does not depend on where it is placed in a policy. Subsection (3) of Section 34 provides that a failure to satisfy a condition will generally defeat coverage only if it results in prejudice to the insurer. Although earlier language requiring "substantial prejudice" was removed, Comment e. confirms the Reporters' view that the prejudice must be "material."

Section 35 addresses instances where coverage is contingent on the insurer giving advance consent, as is the case with indemnity payments and, in some types of policies, defense costs. Section 35 provides that the insurer need not give its assent, as long as consent is sought within the time required and a reasonable insurer would have consented.

Having articulated a general "prejudice requirement" for notice conditions in Section 34, the Reporters carve out an exception for "claims-made" policies in **Section 36** because notice conditions play a different role in the context of "claims made" coverage. Section 36 does insist, however, that policyholders be given a "reasonable" amount of time within which to report claims that are received toward the end of the policy period.

Section 37 distinguishes between the assignment of a specific claim and the assignment of rights under a policy. As to the former, insureds are free to assign individual claims. However, an insured may only enter into an assignment of rights as part of a merger or other corporate transaction that also transfers financial responsibility, the policy has already expired, and the transfer does not materially increase the risk insured by the carrier. Comment c. to this Section confirms that these assignments of rights extend only to liabilities that were already insured under the policy, and successor entities may not obtain coverage for pre-merger liabilities.

Section 39 analyzes the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate "occurrence" limits and adopts the majority "cause" approach. Importantly, this Section also provides that "cause" is based on the source of the insured's liability, not the process or processes that are the physical cause of the underlying injuries.

For these "long-tail" cases, an insurer's coverage obligations are pro-rated on a "time on the risk" basis by dividing the years of an insurer's coverage by the years of overall duration of the underlying injury or damage. The RLLI recognizes the division of authority on the issue, but the Reporters concluded that "pro rata by years" is the most consistent, simplest, and fairest solution to this problem.

Section 40 addresses two issues of consequence to excess insurers: (1) what event triggers an excess insurer's duties; and (2) whether insurers must "drop down" following the insolvency of a primary insurer. Section 40(1) provides that an excess insurer's duties are not triggered until the underlying limits are exhausted. Section 40(2) adopts the *Zeig* rule that allows the underlying limits to be exhausted through a combination of sums paid by the underlying insurers and the policyholder. *See Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928) (often cited for the general rule that exhaustion may occur by way of a settlement for less than a policy's limits). Comment d. explains that this is only a default rule, and an excess insurer can draft around the *Zeig* rule by adopting language that states (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."

Section 41 states that, in most cases, "when more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy." Insurers may internally allocate their obligations through the use of "other insurance" clauses or similar terms; however, competing "other insurance" clauses cannot conflict with each other and operate to eliminate coverage altogether.

Although Section 41 adopts "joint and several" liability as the default rule where two policies insure the same risk, **Section 42** carves out an exception for "continuing or repeated harm" that causes injury in successive policies. For these "long-tail" cases, an insurer's coverage obligations are pro-rated on a "time on the risk" basis by dividing the years of an insurer's coverage by the years of overall duration of the underlying injury or damage. The RLLI recognizes the division of authority on the issue, but the Reporters concluded that "pro rata by years" is the most consistent, simplest, and fairest solution to this problem.

Before the May 2016 Annual Meeting, policyholders filed a motion that sought restoration of the original "all sums" approach. However, time ran out before the motion was argued. Policyholders filed a revised motion before the May 2017 Annual Meeting in which they argued that policyholders should not be held responsible for orphan shares allocable to years when insurance was "unavailable." As a practical matter, the changes proposed in the revised motion mainly impact asbestos disputes, as that is the one area where coverage was nearly universally unavailable after the mid-1980s. Although similar arguments have been raised in the context of environmental coverage disputes, most courts have found that coverage was, in fact, available through other markets even if it was excluded by most commercial general liability insurers after 1985. At the May 2017 Annual Meeting, policyholder advocates withdrew the motion and, instead, urged the Reporters to treat it as a comment in crafting the final text of Section 42.

Section 43 permits one insurer that has paid more than its fair share of a judgment or settlement to recover from another insurer that has not paid its fair share as long as the second insurer has not, in the interim, entered into a settlement agreement and obtained a release from the insured. This right of contribution only applies to indemnity claims and does not apply in situations where a carrier settles out early for a small amount.

Section 46 (formerly Section 34) was among the more controversial provisions at the ALI's May 2016 Annual Meeting. As originally drafted, this Section declared that it is not against public policy for insurers to pay to defend cases involving aggravated fault, as where an insured acted with intent to cause injury, or for insurers to pay judgments or settlements in aggravated fault cases. Insofar as the law forbids insurers from indemnifying cases of aggravated fault, this Section (as originally drafted) proposed that insurers pay such losses in the first instance, but have the right to pursue reimbursement from their policyholders. In the face of harsh criticism from insurer advocates, the Reporters revised this Section prior to the 2016 Annual Meeting and eliminated the proposed "claw back" provision after counsel pointed out that it was inconsistent with other sections of the RLLI that prohibit recoupment. The Reporters ultimately agreed to re-write this Section so that coverage for punitive damages is not allowed if "contrary to public policy."

D. Chapter Four: Remedies, Enforceability and Bad Faith

In the months leading up to the release of Chapter Four in September 2016, there was great uncertainty and anticipation about the approach the Reporters would take in addressing bad faith law and related issues. Given the ambitious innovations with which Professors Baker and Logue experimented while the RLLI was a *Principles* project and the broad scope of the RLLI project as a whole, insurers feared (with some justice) that Chapter Four would seek to transform the terrain upon which bad faith claims would be litigated in the years to come by incorporating broad and controversial rules. In light of this backdrop, the discussion of bad faith in Chapter Four is anti-climactic, consisting of only Section 50 (bad faith) and Section 51 (bad faith damages). The brevity of analysis may reflect *Restatement* fatigue on the part of the Reporters after seven years of labor on this project. Another explanation is that the Reporters may have sensed that an in-depth analysis was unnecessary because some of the more complex issues presented by extra-contractual liability claims are not susceptible to a *Restatement*. Clearly, many of the issues that practitioners and courts consider as involving "bad faith" were not viewed in the same manner by the Reporters. Accordingly, these issues are dealt with elsewhere in Chapter 2 ("Management of Potentially Insured Liability Claims") and Chapter 3 ("General Principals Regarding the Risks Insured"). In particular, the issue of whether and when insurers may be liable for failing to settle within policy limits is separately dealt with in Chapter Three, Section 24. Similarly, the manner in which insurers should act when there are more claims than policy limits is addressed in Chapter 3, Section 26.

Policyholder advocates have criticized the Reporters for setting the bar too high and requiring proof of both an objective element and a subjective element in order to recover in a bad faith action against an insurer.

Similarly, other topics that often engender bad faith disputes are addressed as "non-bad faith" topics and discussed in the claims management sections of Chapter Two, including whether insurers can be sued for the misfeasance of appointed defense counsel (Section 12); the insured's right to independent counsel (Section 16); and the consequences of wrongfully failing to defend (Section 19).

Section 50 defines when insurers may be liable for "bad faith" and provides:

> An insurer is subject to liability to the insured for insurance bad faith when it fails to perform its duties 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 obligtion to perform.

In Comment a., the Reporters acknowledge that the proposed rule contains both an objective and a subjective element. The objective element is the familiar requirement that insurers have a "fairly debatable" basis for their coverage position. Instead of merely relying on this element, however, the Reporters have also required that the insurer act "with knowledge or reckless disregard" of a lack of a good faith basis for its position. This subjective "reckless disregard" element may be based on (1) the insurer's lack of investigation of the relevant facts; (2) the insurer's failure to conduct the necessary state-specific legal research to evaluate the coverage position; or (3) some other circumstance that placed the insurer on notice that it had not done what was necessary to evaluate whether it had a reasonable basis for its coverage position.

Policyholder advocates have criticized the Reporters for setting the bar too high and requiring proof of both an objective element and a subjective element in order to recover in a bad faith action against an insurer. In response, the Reporters defend their position in Comment a. to Section 50, which sets forth three reasons for the decision not to adopt a purely objective standard. First, the Reporters felt that the objective element was already embodied in other insurance law rules requiring that the insurer act reasonably. *See* Sections 19, 24 and 27. Second, the Reporters maintain that the insured's right to attorney's fees, as set forth in Sections 49 and 50, already enables the insured to recover attorney's fees when his/her right to a defense is denied or threatened, without regard to whether the insurer's failure to provide a defense is in bad faith. Finally, the Reporters note that many of the cases in which courts have adopted a purely objective standard involve types of conduct that the RLLI treats as not involving bad faith (such as the insurer's failure to settle or defend).

Section 51 enumerates the damages that an insured may recover if successful in a bad faith claim against his/her liability insurer. Recoverable damages include (1) attorney's fees and other costs incurred by the insured in the legal action establishing the insurer's breach; (2) any other loss to the insured proximately caused by the insurer's bad faith conduct; and (3) if the insurer's conduct meets the applicable state-law standard, punitive damages.

Section 52, which addressed the circumstances in which punitive damages could be awarded against insurers, has been withdrawn. This withdrawal was presumably because the Reporters concluded that the standard for punitive damages was properly addressed in other Restatements and did not require unique treatment in the context of liability insurance.

E. CONCLUSION

As indicated above, all of the sections of the RLLI have now been approved; however, the RLLI project is not yet approved as a whole. In the coming year, the RLLI will be considered as a whole, and both the Advisers and the Members' Consultative Group will provide additional input.

In the final analysis, it seems likely that most of what is now in this RLLI will still be there when it is brought back before the ALI for a final vote in May 2018. Even so, there will be intense efforts to persuade the ALI and the Reporters to revise some of the more troublesome features in this Restatement (e.g. Sections 3, 4, 12(2), 13(3), and 24) before a new draft is published later this summer. Acting against these efforts of reform and further revision the RLLI, there is a strong desire on the part of ALI's leadership to push the RLLI across the finish line after seven years of effort and to move on to other projects. *See* Teitman, Ryan, "Insurance expert Tom Baker discusses progress on ALI's Restatement of Law Liability Insurance," The ALI Adviser (June 6, 2017), available at http://www.thealiadviser.org/liability-insurance/insurance-expert-tom-baker-discusses-progress-on-alis-restatement-of-law-liability-insurance/.