

**ALI's Restatement of the Law Liability Insurance:
Regulatory Considerations**

I. Executive Summary

(i) Background

The American Law Institute (“ALI”) is preparing to issue a Restatement of the Law, Liability Insurance that has the potential to disrupt the liability insurance system to the detriment of policyholders and insurers alike. The proposed Restatement sets forth a revision of insurance law that dramatically departs from the law with respect to eight (8) topics described below. If adopted by courts, the draft Restatement (“Draft”) could have a significant and dramatic adverse impact on policyholders by restricting access to reasonable and affordable coverage. Market disruption and turmoil is possible in the form of an uncertain and unpredictable pricing and reserving environment, increased claim handling costs and litigation, inflated settlements, increased premiums, and the potential for market exits by insurers and reinsurers as well as carrier insolvencies. Regulators will have the unenviable and unnecessary, if not impossible, task of trying to protect the consumer and assess the financial stability of insurers in this new world, unnecessarily and unjustifiably created by the Draft.

Although addressed to courts, the Draft appears to ignore decades of jurisprudence on key issues and supplants the roles of state regulators and legislators by giving little to no consideration to the executive and legislative branches of government that perform critical insurance functions. The Draft changes longstanding and fundamental precepts in key areas that form the foundation for policy coverages, rates, reserving, claim handling and reinsurance. Insurers are recast as quasi-governmental financial guarantors under the Draft’s proposed rules which are designed to force insurers to defend and pay for all claims. While the objectives of promoting access to compensation for injured parties and protecting policyholders are important, they should not be at the expense of insurers by turning them into financial guarantors. Absent corrections, adoption of the Draft will likely result in the cost of insurance becoming more unaffordable to many, leaving people and companies uninsured or underinsured.

ALI Background:

The ALI was founded in 1923 by a group of “prominent judges, lawyers and academics” to address uncertainty and complexity in court case across the country, known as the common law. Its mission is to “to promote the clarification and simplification of the law and its better adaptation to social needs, to secure the better administration of justice, and to encourage and carry on scholarly and scientific legal work.”

The ALI publishes Restatements of the Law, model statutes, and Principles of the Law that are enormously influential in the courts, having been cited in published cases over 201,000 times. Restatements are designed to contain clear formulations of common law and reflect the law as it currently stands or might appropriately be stated by a court. Principles, on the other hand, are aspirational, promoting changes that academics identify.

Liability Insurance Principles & Restatement Projects:

The Liability Insurance project began in 2010 as a *Principles project*, an aspirational project on what academics thought insurance law should be. As such, it was not confined, like a Restatement, to stating what the law is or what the emerging trend in the law is as supported by a majority of jurisdictions. Between 2011 and 2014, there were multiple drafts and revisions and significant segments of the Principles project that were approved by and supported by the membership, under the standards applicable to a Principles project.

In August of 2014, the ALI transmogrified the Principles to a Restatement project, the first time in ALI's history that a project was changed from a Principles to a Restatement. Most importantly, the project thus should have abandoned the aspirational standard and instead moved to the Restatement standard requiring clear formulations of common law as it currently stands or could be appropriately stated by a court. Despite the vastly different standards for Restatements and Principles, the timeline for completion did not change. Instead of *adapting* the Principles to a different set of standards, the Restatement essentially *adopted* the Principles as if they were the majority law rather than merely aspirational. Thus, this white paper discusses what we understand the law is, rather than what it could or should be.

The proposed Restatement of Liability Insurance Law ("Draft") appears to ignore the regulator's integral role in maintaining an efficient, accessible and competitive market, while ensuring that insurance consumers are adequately protected. In an attempt to transform the insurer to financial guarantor, the Draft diminishes fundamental contractual protections, and if adopted by the courts, could result in increased losses and expenses and underwriting uncertainty and unpredictability. The market instability that could result impacts primary areas of concern for the regulator, including market competition, the adequacy of claim reserves and filed rates, insurer solvency, the availability of insurance, policy forms and claim handling practices.

A number of the Draft's provisions depart from established case law precedent and can disrupt the market by creating new liabilities for the insurer, including: the duty "to make reasonable settlement decisions" (imposing quasi-strict liability for the insurer for any judgment in excess of policy limits, including punitive damages assessed against the insured that are otherwise excluded under the policy), an expanded duty to defend, presumed coverage for intentionally harmful conduct, revised rules of policy construction allowing unambiguous policy terms to be disregarded, limiting the insurer's ability to rescind coverage following misrepresentations by the insured, alleviating the insured's duty to cooperate and various default rules.

Notwithstanding the Draft's presumed goal of providing additional protection for the tort claimant and insurance consumer, the highlighted Draft rules could have the opposite effect by creating significant market disruption, while usurping the role of the regulator. Specifically, the Draft rules could lead to a decrease in the availability and quality of insurance, significant premium increases, more restrictive coverage terms and conditions and greater leverage for the remaining insurers in a less competitive market. Therefore, we recommend that the highlighted rules be re-evaluated to avoid the potential market disruption and negative consequences for both the insurer, insurance consumer and the regulators.

(ii) *Summary of Regulatory Considerations*

A. Effect on the Markets

If adopted by the courts, the Draft can disrupt the insurance market by eliminating fundamental rights of the insurer, including the protection of negotiated policy limits, the right to refuse unreasonable settlement demands, the right to exclude coverage for punitive damages and the right to rely upon

unambiguous negotiated policy language. Insurer losses may increase dramatically, by requiring settlement of weak claims and payment of excessive demands to avoid extra contractual liability, while incurring increased claim handling expenses through the likely proliferation of encouraged coverage litigation. The anticipated Draft induced losses, expenses and underwriting uncertainty may cause widespread disruption in the insurance market.

B. Market Competition

The anticipated Draft induced losses, expenses and underwriting uncertainty may have a significant anti-competitive effect on the insurance markets by forcing insurers to tighten terms and conditions or exit the market, to the detriment of all potential insureds.

C. Reserves

It is unlikely that insurers will be adequately reserved or that policies will be priced to account for the new Draft liabilities. The combination of potentially inadequate premiums and claim reserves increases the risk of insurer insolvencies or other potential claim paying impairment.

D. Reinsurance

The Draft may force the ceding insurer to pay unreasonable settlement demands or damages that are excluded (punitive damages assessed against the insured). Reinsurers can challenge their obligation to fund unreasonable settlements or excluded damages, threatening the accessibility of this essential source of capital.

E. Rates

Current rate structures may be found inadequate in response to the new liabilities created by the Draft. Inadequate rates may result in increased risk of insolvencies, claim paying impairment and market exits.

F. Forms

The Draft's underlying premise for modifying policy rules of construction is wrong. Specifically, that policy forms are contracts of adhesion with inadequate protections in place for the insurance consumer.

G. Claim Handling Procedures

The Draft imposes overreaching and unnecessary quasi-strict liability on the insurer for any judgment in excess of policy limits, despite well-established regulatory, statutory and common law protections against unfair claim handling practices.

(iii) *Summary of Specific ALI Restatement Topics That May Create Market Disruptions*

1. Failure to Settle

Section 24 of the Draft subjects the insurer to excess damages beyond policy limits for failure to "make reasonable settlement decisions." By requiring the insurer to settle weak claims or risk of extra-contractual damages, Section 24 transforms a traditional "bad faith" analysis into a quasi-strict liability standard, obviating the most fundamental protection for the insurer: the negotiated policy limits.

Specifically, Section 24 diverges from established case law by: (i) potentially requiring settlement of claims with a minimal chance of success, while disregarding traditional factors that are considered when assessing the insurer's decision to refuse a settlement offer; (ii) overruling the majority rule that bad faith on the part of the insurer is required for damages in excess of the policy limits and (iii) holding the insurer liable for extra contractual damages even when the insurer acted reasonably and in good faith. Moreover, Section 27 of the Draft (in conjunction with Section 24) holds the insurer responsible for punitive damages (assessed against the insured) that are part of a judgment in excess of the policy limits following a refusal to settle, even where the insurer excludes punitive damages under the policy, if such damages were "foreseeable." Consequently, the insurer may be forced to accept unreasonable settlement demands, including paying for excluded matters, to avoid the extra-contractual damages risk created by the Draft.

2. Settlement Obligations Effect on Reinsurance

Sections 24 and 27 of the Draft can collectively force the insurer to settle defensible claims or claims for uncovered liabilities. Subsequently, the reinsurer can refuse to cover unreasonable settlements, or settlements based, in part, upon liabilities that are affirmatively excluded.

3. Duty to Defend

Section 13 of the Draft expands the insurer's duty to defend beyond case law precedent that either limits the insurer's duty to defend to the actual pleadings or information beyond the pleadings that the insurer has actual knowledge of, by requiring the insurer to defend any claim if the insurer *should know* of information that would require the insurer to defend.

4. Intentional Acts Coverage

Section 47 highlights the Draft's efforts to make the insurer a financial guarantor by presuming that coverage is permissible for intentionally harmful conduct, unless barred by legislation or judicially declared policy. The Draft is focused upon the availability of funds for victims, inappropriately interjecting a third party's perspective into a two-party contract.

5. Rules of Construction-Plain Meaning

Section 3 of the Draft allows the insured to disregard unambiguous terms, by allowing the insured to offer extrinsic evidence in the absence of any ambiguity to reconcile the insured's expectations for coverage. This rule contradicts the majority view: the language of an insurance policy will be given its plain meaning unless an ambiguity exists and extrinsic evidence is not permitted absent ambiguity.

6. Insurer's Ability to Rescind

Section 8 of the Draft does not allow the insurer to rescind coverage, following insured misconduct, unless the insurer can demonstrate that it would have issued the policy on "substantially different terms." However, case law only requires that the insurer demonstrate that it would not have issued the policy with the *same* terms and conditions.

7. Duty to Cooperate

Section 30 of the Draft allows the insured to refuse to cooperate with the insurer, including collusion with the plaintiff under certain circumstances, unless the insurer can demonstrate that failure to cooperate prejudiced the insurer. However, prejudice is described as being outcome determinative. This standard contradicts case law holding that the insurer is prejudiced if the insured's failure to cooperate

impairs the insurer's ability to assess coverage, raise coverage defenses or effects other contractual rights, for example, the insurer's subrogation rights.

8. Implied-in-Law Terms and Restrictions

Section 46 of the Draft allows the parties to rewrite the insurance contract through implied-in-law terms and restrictions, which can be based upon common law. This approach diverges from the more narrow traditional view, allowing for implied-in-law terms if based upon legislation or judicially declared public policy.

II. **Overview of Regulatory Considerations**

Congress has given the state legislatures broad powers to regulate the insurance industry. The state legislatures have in turn delegated this broad authority to state agencies or insurance commissioners¹ and the McCarran-Ferguson Act is primarily responsible for insurance regulation remaining with the states.² Most states have statutorily empowered insurance boards, commissioners or similar officials to regulate and supervise the transaction of insurance business within the state in order to protect the public interest. "The insurance commissioner is accorded broad discretion to adopt rules and regulations as necessary to promote the public welfare,"³ including: proprietary of reserves, approving policy forms and rates and oversight of insurers' claims procedures.⁴

The state insurance commissioner has specific powers, including the granting, renewal and revocation of licenses, the maintenance of reserves, the establishment of rates..."⁵ Commissioners exert control through the admission and licensing process and insurers who fail to comply with regulatory requirements are subject to losing their authority to sell insurance through the suspension or revocation of their license or certificate of authority and Commissioners may also exact fines for regulatory violations that serve as a further financial inducement toward compliance.⁶ "In every jurisdiction, insurance regulators also have the authority to directly enforce claim practices standards through penalties for violations of the standards and through cease and desist orders."⁷ Contrary to the Draft's fundamental premise that insureds are unprotected against potentially abusive insurer practices, "these measures give regulators considerable leverage in forcing insurers to comply with insurance laws and regulations."⁸ For example, in New York the Superintendent may refuse to issue or renew a domestic insurer's license to do business in the state if, in his/her judgment, the refusal would "best promote the interests of the people of this state."⁹ While the Draft must be adopted by the courts to have any impact, the courts, like the ALI should not interfere with or undermine executive/legislative authority.

A. Effect on the Markets

If adopted by the courts, the Draft could disrupt the insurance market by eliminating fundamental rights of the insurer, including the protection of negotiated policy limits, the right to refuse unreasonable settlement demands, the right to exclude coverage for punitive damages and the right to rely upon unambiguous negotiated policy language. The Draft appears to usurp the role of the state regulators and

¹ Steven Plitt et al., *1 Couch on Insurance* (3d ed. 1995) § 2:6 p. 39.

² McCarran-Ferguson Act, 15 U.S.C. § 1101 (1976).

³ Plitt et al., *supra*, § 2:18 at 83.

⁴ New Appleman on Insurance Law Library Edition § 1.04 (2016 LexisNexis).

⁵ Plitt et al., *supra* § 2:8, at 47.

⁶ Robert Klein, *A Regulator's Introduction to the Insurance Industry*, 121 (2005)

⁷ Jay M. Feinman, *The Regulation of Insurance Claim Practices*, 5 U.C. Irvine L. Rev, 1319, 1337 (2015).

⁸ Klein, *supra* at 121.

⁹ N.Y. Ins. Law § 1102(d) (McKinney 2003).

well-developed state case law. As a result of the ALI's Restatement initiative, insurer losses may increase dramatically, by requiring settlement of weak claims and payment of excessive demands to avoid extra contractual liability, while incurring increased claim handling expenses through the likely proliferation of encouraged coverage litigation. The anticipated losses, expenses and underwriting uncertainty resulting from adoption of the Draft could cause widespread disruption in the insurance market. This potential effect is augmented when the insurer is forced to pay additional losses today under policies issued prior to the adoption of the Draft rules that were not underwritten to account for the new liabilities imposed under the Draft. The inherent lag time to catch up to those new losses via increased premiums, higher reserves and modified terms and conditions can stress the insurer's financial condition. A consequence could be movement towards claims made policies or new products with wasting defense and indemnity limits with the right to terminate at exhaustion.

A troubling theme throughout the Draft is the notion of insurer as financial guarantor, notwithstanding the terms, conditions and limitations of the operative insurance contract. For example, as discussed more fully below, the collective effect of Sections 24 and 27 is to marginalize the negotiated limits protection. The Draft mimics a quasi-enforcement handbook, with the Reporters as private attorneys general. The Draft fails to recognize the diligence and protections at the regulator level to assure the availability of insurance coverage for legitimate claims. As described more fully below, that regulator oversight includes monitoring insurer solvency and claim reserve issues, market competition, the availability of insurance, policy language and claim handling practices.

B. Market Competition

An important regulatory function is the monitoring of competition, including market concentration, entries and exits, market growth, the availability of insurance and profitability.¹⁰ One of the primary purposes of regulation is to promote an efficient market and to determine the underlying cause of market problems to determine the appropriate regulatory response.¹¹ However, any market disruption described herein will not be the result of naturally occurring market forces. Rather, the disruption would be the direct result of the adoption of new Draft rules.

The effect of such adoption in the primary carrier market extends to the excess and reinsurance markets. Under the Draft rules, the excess layer's underlying limits protection and the reinsurer's primary policy protection may be diminished as the primary carrier's exposure is likely to be significantly increased. Therefore, excess carriers may be forced to charge significantly higher premiums (reflecting a percentage of the primary policy's premium), may reduce capacity or could exit the market entirely if the perceived risk of the new Draft rules outweighs the excess premium benefit. Reinsurers could also be forced to significantly increase their rates to account for these new exposures and could also exit unprofitable markets. Further constraints on consumer choice and decreased bargaining power for the insureds could result, threatening the Regulator's goal of maintaining efficient and competitive insurance markets and contrary to the ALI's goal of protecting the insured. Thus, the Draft rules may have a significant anti-competitive effect on the insurance markets, to the detriment of all potential insureds.

C. Reserves

The historic mission of state regulation has been to safeguard the solvency of insurers so the insurer is able to fulfill its promise to pay claims.¹² Legislatures delegate their power to regulate insurers to regulatory authorities, including required surplus and reserves that must be maintained by the

¹⁰ Klein, *supra* at 186.

¹¹ Klein, *supra* at 107-08.

¹² Thomas, *supra* at § 1.04.

insurers.¹³ Therefore, a primary regulatory function is to address inadequate reserves and “if regulators believe that an insurer is shorting its reserves, they may require the insurer to increase its reserves or take other action.”¹⁴ Under New York Insurance Law 4117 (e), “Whenever in the judgment of the superintendent, the loss and loss experience reserves of any property/casualty insurance company doing business in this state calculated in accordance with the foregoing provisions are inadequate or excessive, he may prescribe any other bases which will produce adequate and reasonable reserves.”^{15 16}

Under-reserving means equity is overstated, allowing the insurer to write more business than it can actually support. Worse, claim reserves are a large part of estimated historical losses and thus used in future rate making; so under-reserving causes rate inadequacy, compounding the effect and thus exacerbating the probability of insolvency. Deficiencies in case reserves may cause the insurance company to use surplus to pay for claims in the future. Reductions in surplus may adversely affect the ability to write additional premium due to the insurance company not meeting premium-to-surplus ratios required by regulators. If reserve deficiency is not recognized over the long term, it could cause an insurance company to experience financial problems or even result in bankruptcy.¹⁷ Insurers have incentive to avoid reserve increases allowing insurers to transfer non-working capital into their operating accounts. Insurers may raise reserves voluntarily or may not be positioned to do so, forcing regulators to act or risk market insolvencies and other potential impairment of the insurer’s ability to pay claims.

The Draft rules may create new loss trends, consistent with the Draft’s view that the insurer should serve as a financial guarantor. Additionally, as described below, under the new Draft rules it is less likely that reinsurance will be accessible. The combination of potentially inadequate premiums, claim reserves and reinsurance increases the risk of carrier insolvency or other potential claim paying impairment.

Regulators will be charged with digesting the broad impact of the groundbreaking Draft changes on the adequacy of reserves. Because the Draft is re-writing insurance law, (including diminishing the historical protection of the negotiated policy limits, creating settlement premiums, requiring coverage for otherwise excluded liabilities (for example, punitive damages), presuming coverage for intentionally harmful conduct and allowing unambiguous policy terms to be challenged via extrinsic evidence), it will be very difficult to determine adequate reserve levels because there will be no historical basis to assess the anticipated loss experience.¹⁸ The lack of incentive and uncertainty regarding voluntary reserve raises to account for the new Draft exposures, coupled with the difficulty for the regulator in mandating adjustments (based upon a lack of historical data)¹⁹, may lead to under-reserving and increased risk of

¹³ Plitt et al., *supra* § 2:2 at 13.

¹⁴ Klein, *supra* at 145-46.

¹⁵ N.Y. Ins. Law § 4117(e) (McKinney 2008).

¹⁶ See also *Notrica v. State Comp. Ins. Fund*, 70 Cal. App. 4th 911, 923, 83 Cal. Rptr. 2d 89, 98 (Cal. Ct. App. 1999) (“the [implied] covenant of good faith and fair dealing requires an insurer to conduct its claims resolution and reserve allocation processes with good faith regard to the [insured’s] interests.”) (quoting *Security Officers Service, Inc. v. State Compensation Ins. Fund*, 17 Cal. App. 4th 887, 896, 21 Cal. Rptr. 2d 653 (Cal. Ct. App. 1993); *In re Stewart*, 244 N. E.2d 690, 694 (N.Y. 1968) (“The question of sufficiency of reserves of an insurance company to cover all losses insured is not solely a question of statutory interpretation, but rather a factual determination to be arrived at by actuarial calculations; accordingly, a hearing is necessitated at which the parties can introduce evidence in support of their respective contentions).

¹⁷ Michael Murdock, The CLM, *Impact of Reserve Redundancy and Deficiency on Results* (2012), <http://claims-management.theclm.org/home/article/Impact-of-Reserve-Redundancy-and-Deficiency-on-Results>.

¹⁸ See *Delta Holdings, Inc. v. National Distillers and Chemical Corp.*, 945 F.2d 1226, 1230 (2d Cir. 1991) (“Many of the judgment calls needed to implement the loss development or loss ratio methods rely upon historical data as to loss reporting patterns.”).

¹⁹ Plitt et al., *supra* § 2:29 at 125-27.

insolvencies or other claim paying impairment because, in the absence of a showing to the contrary, “it may be presumed that a company doing business within the state maintains a sufficient reserve to satisfy the local statute.”²⁰

D. Reinsurance

The availability of reinsurance is essential to a competitive and efficient market, allowing the ceding insurers to allocate their assumed risk. Adoption of the Draft may force the ceding insurer to pay unreasonable settlement demands, damages that might be otherwise excluded (punitive damages) and to pay extra contractual damages *absent* bad faith. These new liabilities could have a material impact on the availability of reinsurance. Specifically, reinsurers can challenge their obligation to fund the unreasonable settlements created under Sections 24 and 27. The reinsurer will also refuse coverage for damages under Section 27 for punitive awards assessed against the policyholder that are otherwise excluded, or for extra-contractual damages pursuant to Section 24 and 27, (unless otherwise endorsed as part of the Reinsurance Agreement.) Reinsurers may be disinclined to offer extra-contractual damages coverage under the quasi-strict liability imposed upon the ceding insurer under Sections 24 and 27.²¹ Ultimately, the ceding insurer may be less likely to access reinsurance, creating further market anxiety.

If the reinsurers are compelled to contribute towards inflated or uncovered Draft driven settlements, there could be irreparable damage to the reinsurer relationship because the ceding insurer’s claims department may lose credibility with the reinsurer. If the Draft created losses mount, reinsurers will likely exit the market. The remaining reinsurers will likely increase their premiums and may tighten terms and conditions (for example, eliminating the extra-contractual damages coverage endorsement due to the quasi-strict liability imposed upon the ceding insurer under Sections 24 and 27²², or expressly excluding coverage for punitive damages given the effect of the Draft rules). Therefore, ceding insurers may be less likely to access this essential source of capital, which allows the insurer to increase its writing capacity and diversify its risk if there is an overconcentration in any particular market. This critical risk management tool bolsters the insurer’s claim paying ability, inuring to the benefit of all insurance consumers. The anticipated losses due to the new Draft rules and the potential unavailability of reinsurance could increase the insolvency risk at the ceding insurer level and impede the ceding insurer’s ability to write new risks. The new liabilities coincide with increasing loss trends, creating a greater need for reinsurance. Verisk Analytics has reported that the combined ratio for private U.S. property and casualty (P&C) insurers deteriorated further in 2015, a trend that might also stimulate increased demand for reinsurance capacity.²³ The combined ratio for U.S. P&C insurance companies ended 2015 at 97.8%, representing continued deterioration from the 97% reported in 2014 and 96.2% in 2013, as a range of persistent market pressures continue to challenge the profitability of global insurers and reinsurers. As a result of an increased LAE in 2015, which still exceeded premium growth despite net written premiums for the year growing to \$514 billion in 2015, and rising combined ratios, P&C insurers could have utilized a greater portion of reinsurance protection.²⁴ Therefore, diminished access to that protection could have a significant impact in the current loss environment.

²⁰ *Id.* at 127.

²¹ Restatement of Liability Insurance §§ 24, 27

²² *Id.*

²³ Press Release, Verisk Analytics, Premium Growth Slows and Combined Ratio Creeps Up for Property/Casualty Insurers in 2015 (May 16, 2016) available at <http://www.verisk.com/press-releases/2016/may/premium-growth-slows-and-combined-ratio-creeps-up-for-property-casualty-insurers-in-2015.html>

²⁴ *Id.*

E. Rates

The power of the state to regulate and control the business of insurance includes the power to regulate insurance rates. This power is exercised to promote the public welfare by regulating rates so that...the rates are not excessive, inadequate (detrimental to the solvency of insureds)...and the availability and reliability of insurance are improved.”²⁵ Premium reflects the cost for the insured for a specific policy and the insurers base the premiums charged on rates that are filed with the relevant state insurance department.

Rates are generally subject to filing with state regulators prior to use. Actuaries set the insurance rate based upon specific variables, while underwriters decide which variables apply to a specific insurance applicant. An efficient market requires that rates charged must cover losses and expenses and earn some profit. The primary purpose of ratemaking is to determine the lowest premium that meets the required objectives and identifying every characteristic that can reliably predict future losses. Even if the underwriting is competent, assigning proper variables to insurance applicants if the rate is based on variables that do not reliably predict future losses, the insurance company may suffer significant losses. Current rate structures may be found inadequate in response to the new liabilities created by the Draft rules. Inadequate rates may result in significant market disruption due to the increased risk of insolvencies, claim paying impairment and market exits. As the projected new losses are recognized, the insurers who do not exit the market could be forced to dramatically increase rates/premiums. Regulators will be tasked with assessing these dramatic increases because these new liabilities and expenses will become a significant variable to be considered in predicting future losses.²⁶ In determining rates, procedural due process requires the regulatory authority must act reasonably upon proper evidence,²⁷ and “acting upon proper evidence means there must be facts in the record from which it can be determined that the regulator had a rational basis for his decision. That decision must be based on current data, but the Draft rules create groundbreaking liability for insurers. Therefore, it will be exceedingly difficult for the regulators to effectively evaluate any proposed increases.

If the regulators attempt to cap the rate increases, insurers are unlikely to discount rates that are already perceived to be inadequate due to the new rules and may decline to offer coverage outright. The rate challenges created by the Draft rules could lead to an unstable and less competitive market and the resulting increased premiums may force many consumers to self-insure or underinsure.

F. Forms

As a general matter, commissioners are required to approve policy forms to assure that they are in conformity with all applicable statutes.²⁸ Insurers must generally obtain separate consent from the regulator in each state in which they are licensed to do business, including amendatory endorsements that are required to be added to the issued policies that protect the insured against potential gaps in coverage. Compliance with policy form and rate regulation is generally enforced through periodic market conduct exams and “Market conduct examiners ensure that the rates and policy forms used by insurers have been filed with the insurance dep’t in compliance with state laws and regulation.”²⁹

²⁵ 68 New York Jur. 2d *Insurance* § 44 (2010).

²⁶ Plitt et al., *supra* § 2:12 at 61.

²⁷ *Id.* § 2:12 at 61-63

²⁸ *Clarendon Nat. Ins. Co.*, 892 F. Supp. 815, 819, 36 U.S.P.Q.2d 1769 (W.D. La. 1995); *Joslin v. Mitchell*, 584 S.E.2d 913, 919 (W. Va. 2003); *B & S Underwriters, Inc. v. Sec. of Am. Life Ins. Co. v. Com. Ins. Dept.*, 372 A.2d 54, 58 (Pa. 1977).

²⁹ Klein, *supra* at 183.

Contrary to the Draft's flawed premise that all insurance policies are contracts of adhesion and indecipherable to the insureds, "It is quite common for policies to have many riders or endorsements to effect compliance in all states" and "the tendency in regulation is to compel "plain English" policies."³⁰ "State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected."³¹

Section 46 Comment (e) acknowledges that

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. If the insured demonstrates that the result of 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...³²

Notwithstanding, the Draft then seemingly disregards the level of regulatory oversight regarding policy forms that are admitted for use in a particular state. As a result, the Draft's underlying assumption for the Draft rules is wrong: that all insurance policies are contracts of adhesion and that due to unequal bargaining power and a complete lack of protection for the insured, the field needs to be tilted further in favor of insureds. That flawed assumption presumably led to Draft rules allowing the insured to challenge unambiguous policy language via extensive evidence in an effort to reconcile the insured's expectations.³³ From the Draft's perspective, primary regulatory functions such as the general oversight, file/use form approval process, mandatory state amendatories and market conduct examinations appear to be meaningless. As a result, the Draft rules attempt to displace the Regulator's function, disregarding unambiguous policy language and creating further market uncertainty by diminishing the insurer's ability to rely upon the negotiated policy language, as well as inviting coverage litigation regarding the "true meaning" of otherwise unambiguous terms. Moreover, given the regulator's active role, there is no reason for Draft default rules.

G. Claim Handling Procedures

The Draft imposes quasi-strict liability on the insurer regarding any judgment in excess of policy limits under sections 24 and 27³⁴ despite well-established regulatory, statutory and common law protections against unfair claim handling practices. These overreaching and unnecessary liabilities disregard well developed case law regarding the implied duty of good faith/fair dealing, bad faith liability excess of policy limits and regulatory enforcement via unfair claim handling statutes, market conduct examinations and the assessment of consumer complaints.^{35 36}

³⁰ Cf. N.Y. Ins. Law § 3101 (McKinney 1984) ("Simplified policies of insurance providing broad coverage...")

³¹ National Association of Insurance Commissioners and the Center for Insurance Policy and Research, *State Insurance Regulation*, 4 (2011).

³² Restatement of the Law of Liab. Ins. § 46 cmt. E.

³³ *Id.* § 3.

³⁴ Restatement of Liability Insurance §§ 24, 27.

³⁵ N.Y. Ins. § 2601 (a)(4)&(5) (McKinney 2015).

Market conduct exams are also utilized by state regulators to ensure that the insurer is not engaged in abusive claim handling practices and is otherwise compliant with various market conduct laws and regulations.³⁷ Generally, examiners check to see that claims covered under a policy are paid within a reasonable period of time and conform with promised coverage as stated in the policy form³⁸ and insurers are frequently fined for regulatory violations to ensure that claims are paid according to the provisions of the insurance contracts.³⁹ Additionally, department analysts respond to consumer complaints, determining whether a complaint has merit or indicates a potential violation of state laws or regulations.⁴⁰

The potentially draconian effect of Sections 24 and 27 can create significantly inflated settlements while the insurer's claim handling expenses dramatically increase, as insureds are encouraged to challenge the meaning of otherwise unambiguous terms with extrinsic evidence under Section 3. The anticipated Draft generated losses and uncertainty could force insurers to exit the market, leading to greater leverage for the remaining insurers, which may make consumers more vulnerable. Therefore, the Draft's apparent goal of getting all claims paid with the insurer as financial guarantor may lead to market instability, to the consumer's ultimate detriment, as insurers are forced to pay inflated settlements and unjustified claims and have to abandon prudent claims handling and valuation processes under threat of Sections 24 and 27.

III. Specific Draft Topics That Will Create Market Disruptions

A. Failure to Settle

The proposed Draft mandate regarding the insurer's duty to settle can create significant market disruption by subjecting the insurer to excess damages beyond policy limits for failure to "make reasonable settlement decisions." As discussed below, the standards applied by the Draft transform a traditional "bad faith" analysis into a quasi-strict liability standard, obviating the most fundamental protection for the insurer: the negotiated policy limits. Consequently, the insurer may be forced to accept unreasonable settlement demands to avoid the extra-contractual damages risk created by the Draft rules. Without the certainty of the negotiated policy limits and the losses created by inflated settlements, insurers may be forced to dramatically tighten their underwriting practices, to the detriment of the consumer.

Sec 24 provides:

§ 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 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.

³⁶ See also, *Roldan v. Allstate Ins. Co.*, 149 A.D.2d 20, 43 (N.Y. App. Div. 1989) ("We conclude that the allegations that an insurance company is engaging in a persistent course of conduct involving fraud or unfair claims practices may more properly be evaluated and, if proved, be redressed by the Superintendent of Insurance, who is charged by law with the regulation of this industry, rather than by private litigants.").

³⁷ Klein, *supra* at 183.

³⁸ *Id.*

³⁹ *Id.* at 174

⁴⁰ *Id.* at 182.

- (2) A reasonable settlement decision is one that would be made by a reasonable insurer who 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.⁴¹

Under the Draft, a violation of Section 24 triggers damages under Section 27:

§ 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 the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits, as well as any other foreseeable harm caused by the insurer's breach of the duty.⁴²

1. *The Draft's duty to make reasonable settlement decisions is unnecessary and overreaching and may result in significant market losses and uncertainty*
 - (a) *Implied duty of good faith remedies*

The Draft creates a new legal obligation regarding the insurer's duty to settle when substantial protections against unfair claim practices are already in place, including well-developed case law regarding the insurer's implied duty of good faith and fair dealing inherent in every insurance contract. Specifically, in the settlement context: "In the vast majority of the cases passing upon the question, the courts have held that a liability insurer, having assumed control of the right of settlement of 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."^{43 44}

Although the Draft conflates negligence and bad faith in the settlement context, the majority rule for failure to settle claims and reported cases involve bad faith allegations.⁴⁵ Notwithstanding, Sections 24 and 27 allow the policyholder to disregard whatever bad faith statutory or common law requirements must be proven to exist in a particular jurisdiction. Sections 24 and 27 also ignore the market reality that there are a significant number of claims with legitimate coverage defenses and the insurer has a duty to its shareholders and policyholders to pay covered claims only. Ultimately, the parties to the insurance contract may be deprived of litigating liability and the insurer is deprived of enforcing the contract.

⁴¹ Restatement of the Law of Liab. Ins. Insurance § 24.

⁴² *Id.* at § 27.

⁴³ *Bollinger v. Nuss*, 449 P.2d 502, 508 (Kan. 1969).

⁴⁴ *See also Jones v. Secura Ins. Co.*, 638 N.W. 2d 575, 586 (Wis. 2002) (holding that "an insurer is liable for any damages which are the proximate result of the insurer's bad faith."); *Birth Center v. St Paul Cos. Inc.* 787 A.2d 376, 407-08 (Pa. 2001) (holding state Bad Faith Statute did not prohibit compensatory damages when insurer's bad faith actions were the proximate cause of the injury); *Crisci v. Security Ins.* 426 P.2d 173, 178 (Cal. 1976) (If an insurer is found to have violated its implied covenant of good faith and fair dealing, it may be liable for compensatory damages for all detriment proximately caused by the breach).

⁴⁵ *See* 3-23 APPELMAN ON INSURANCE LAW § 23.02[2][a]-[c] (commenting that majority view adopts bad faith standard while minority view adopts negligence standard).

(b) *Statutory and regulatory protection*

As described above, insurers are statutorily prohibited from engaging in unfair insurance practices in most states.⁴⁶ The statutory prohibitions are enforced by the State Insurance Commissioners and specifically address the insurer's settlement practices.⁴⁷ It is worth highlighting that these statutory provisions refer to the insurer's duty to settle when liability "has become reasonably clear," as opposed to Section 24 ("a *potential* for a judgment in excess of the applicable policy limit"), as discussed fully below.⁴⁸

Additionally, insurers are subject to regular market conduct examinations, which include evaluation of the insurer's claim handling process, as well as consumer complaint divisions regarding claim handling generally.

(c) *Market forces*

The Draft also discounts market forces that deter insurers from failing to consent to reasonable settlement opportunities. The insurer's claim paying reputation is paramount for commercial insureds. Subsequently, the insurance brokerage community is particularly attuned to each insurer's claim paying reputation. For example, large insurance brokers provide annual rankings of insurer claim departments. Additionally, insurers are keenly aware that their claim practices and reputation are critical to their ability to maintain existing business and to write new business and some include the annual amounts paid in claims (in specific lines of business) as part of their marketing materials. The market reality is that insurers who regularly engage in unreasonable settlement practices cannot survive. Additionally, the ALI proposal ignores the market reality wherein many commercial policies allow the insured to control the settlement negotiations, with the insurer's consent, which consent "shall not be unreasonably withheld." Therefore, contractual protection against unreasonable settlement posturing is already provided under many commercial policies and the Draft offers no evidence that these competitive market forces fail to protect consumers from unfair settlement practices, thereby justifying the need for the new rules under Sections 24 and 27.

2. *Departure from existing law*

(a) *Extra-contractual damages for failure to settle a claim with a minimal chance of success*

Section 24 black letter is substantially modified by comments. For example, comment (a) provides that the insurer has a duty to protect the insured from "unreasonable exposure to a judgment in excess of the limits of the liability insurance policy" which is a very different duty from the duty to make "reasonable settlement decisions." The Draft rules significantly depart from existing case law regarding the insurer's duty to settle and the availability of extra-contractual damages by applying a quasi-strict liability standard to the insurer's decision whether to accept a settlement offer, completely disregarding the *likelihood* of an excess judgment at the time the offer was refused. Specifically, Section 24 mandates that the insurer has a duty to the insured if there is a mere "*potential* for a judgment in excess of the

⁴⁶ See e.g. FLA. STAT. ANN. §§ 626.951—626.9541, 626.9641 (2016); NEB. REV. STAT. §§ 44-1522—44-15443 (2016); N.H. REV. STAT. ANN. §§ 417:1—417:25 (2016); PA. ST. 40 P.S. §§ 1171.1—1171.15 (West 2016).

⁴⁷ See e.g. *Roldan v Allstate Ins Co* 149 A.D. 2d 20, 41-42 (N.Y. App. Div. 1989) (discussing controlling state law for breach of good faith). Failure to comply with those statutory provisions can result in penalties and the potential suspension of the insurer's license to provide insurance in that state.

⁴⁸ See Restatement of the Law of Liab. Ins. Insurance § 24.

applicable policy limit.” Illustration (1) highlights Draft’s problematic approach.⁴⁹ Notably, the insurer can be found liable by a “trier of fact” for the judgment beyond limits because it failed to settle when the plaintiff had a mere thirty (30%) percent chance of success at trial because the Draft reduces the insurer’s duty to settle to a simple formula: probability of liability times potential damages.⁵⁰ This simplistic approach can lead to absurd results. For example, if the potential damages are sufficiently high, insurers would be forced to settle a claim with a five (5%) percent chance of success, or be liable for a potential excess judgment. Another inherent flaw in the Draft’s approach is that the analysis is applied retroactively from the excess judgment award. Therefore, even though the determination as to whether to settle is conceptually made “at the time of settlement,” the excess judgment will undoubtedly taint the determination as to whether the decision was reasonable at the time. Specifically, good faith defenses at the time will likely be discounted in hindsight following the excess award and the risk will appear to be higher than it was when the decision not to settle was made.⁵¹

The proposed Draft standard contradicts well-settled case law that requires the insurer to accept a demand within policy limits when there is a great risk of recovery beyond the policy limits.⁵² Other jurisdictions utilize similar tests focused on the claimant’s probability of success, such as the “substantial or significant likelihood of an excess verdict” test,⁵³ or by determining whether the risk of unfavorable results was disproportionate to the chance of a favorable outcome.⁵⁴ Some jurisdictions require the insurer to settle if there is a reasonable probability of a finding of liability against the insured.⁵⁵ Some courts have ruled that there is no duty to settle if insurer honestly believes it has a good chance of winning the suit.⁵⁶

In contrast to the foregoing precedent, Sections 24 and 27 create extra-contractual liability for the insurer for failing to settle even when the plaintiff’s probability for success is negligible.

⁴⁹ Restatement on the Law of Liability Insurance § 24 cmt. (d) illus. 1.

⁵⁰ *Id.*

⁵¹ See *Covill v. Phillips*, 452 F. Supp. 224, 237-38 (D. Kan. 1978).

⁵² See *Archdale v. American Intern. Specialty Lines Ins. Co.*, 154 Cal. App. 4th 449, 470-71, Cal. Rptr. 3d 632, 650-51 Ct. App. (2007) (finding that the likelihood of a recovery in excess of the policy limits for breach of good faith was authorized under state law); *Hamilton v. Maryland Cas. Co.*, 41 P. 3d 128, 27 Cal. 4th 718, 724-25 (Cal. 2002) (finding an insurer must take into account the insured’s interest if a great risk of recovery beyond the policy limits exists).

⁵³ See *Allstate Ins. Co. v. Herron*, 634 F.3d 1101, 1109 (9th Cir. 2011) (applying Alaska law, the court found “the covenant of good faith and fair dealing places a duty on an insurer to tender maximum policy limits to settle a plaintiff’s demand when there is a substantial likelihood of an excess verdict against the insured.”) (quoting *Jackson v. Am. Equity Ins. Co.*, 90 P.3d 136, 142 (Alaska 2004)); *Rupp v. Transcon. Ins. Co.*, 627 F. Supp. 2d 1304, 1324 (D. Utah 2008) (applying Utah law, the court found that the insurer has a duty to accept a reasonable settlement offers within policy limits if there is a significant likelihood of a judgment in excess of the policy.),

⁵⁴ See, *United States Fire Ins. Co. v. Royal Ins. Co.*, 759 F.2d 306, 310 (3d Cir 1985); *DiBlasi v. Aetna Life and Cas. Ins. Co.*, 147 A.D.2d 93, 98-99 (N.Y. 1989).

⁵⁵ See *Chandler v. American Fire and Cas. Co.*, 879 N.E.2d 396, 400 (Ill. 2007) (the duty to settle arises when there is a reasonable probability of recovery in excess of the policy limits).

⁵⁶ See *Southern Healthcare Services, Inc. v. Lloyd’s of London*, 110 So. 3d 735, 751 (Miss. 2013) (while the insurer has a duty to make an honest evaluation of the claim, if the insurer honestly believes the claim is without merit there is no duty to accept a settlement offer); *Cowden v. Aetna Cas. & Sur. Co.*, 134 A.2d 223, 228 (Pa. 1957) (It means that when there is little possibility of a verdict or settlement within the limits of the policy, the decision to expose the insured to personal pecuniary loss must be based on a bona fide belief by the insurer, predicated upon all of the circumstances of the case, that it has a good possibility of winning the suit.).

(b) *Failure to consider relevant factors in “applying the reasonableness standard”*

Despite the passing reference in Section 24(d) to the consideration of other “evidence,”⁵⁷ as described above, the insurer’s duty to settle is reduced to a rigid equation. Section (d) provides that the insurer should “take into account the realistically possible outcomes of a trial and to the extent possible, to weigh those outcomes according to their likelihood,”⁵⁸ but Illustration (1) under section (d) highlights the practical application of the Draft’s approach.⁵⁹ Despite hollow references to “evidence supporting the conclusion,” the “reasonable settlement offer” (\$45,000), is reduced to multiplying the liability probability (30%) times the damages calculation (\$150,000).⁶⁰

Under the Draft, regarding the insurer’s duty to settle, a “negligence” standard may be applied. Contrary to the Draft’s approach, even if a “negligence” standard is applied, courts logically consider various factors in determining whether the insurer had a duty to settle because each settlement negotiation is unique and the insurer’s obligation to settle can only be assessed within the context of those particular facts. Even in a minority rule “negligence” jurisdiction, the test is whether the insurer exercised due care in refusing the settlement offer, a far cry from the insurer being strictly liable for refusing an “unreasonable settlement decision” when the Draft formula is applied. As highlighted by illustration (1), a “reasonable settlement decision” includes *any* combination of liability times potential damages.⁶¹ Therefore, even a claim with virtually no chance of success should be settled if the potential damages number is significant. Moreover, although Illustration (1) pinpoints a specific “likely” damages number,⁶² a potential damages *range* is more realistic and the insurer will have to assume that the higher range of the potential damages would apply to the Draft’s rigid formula.

The new Draft rule would overrule long established case law in the majority of jurisdictions that apply a traditional “bad faith” analysis.⁶³ Under New York law, establishing a claim of bad faith against the insurer requires the insured to establish that the insurer’s conduct was in gross disregard of the insurer’s interest.^{64 65} Michigan, following the “bad faith” standard, defines bad faith as the arbitrary,

⁵⁷ Restatement of the Law of Liab. Ins. Insurance § 24

⁵⁸ *Id.* § 24 cmt.d.

⁵⁹ *Id.* § 24 cmt. d illus. 1.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ See *Benkert v. Med. Protective Co.*, 842 F.2d 144, 149 (6th Cir 1988) (“Good-faith denials, offers of compromise, or other honest errors of judgment are not sufficient to establish bad faith”); *Bar Plan Mut. Ins. Co. v. Chesterfield Mgmt. Assocs.*, 407 S.W.3d 621 (Mo. Ct. App. E.D. 2013) (“[N]o action will lie against the insurer for the amount of the judgment recovered against the insured in excess of the policy limits, unless the insurer is guilty of fraud or bad faith in refusing to settle a claim within the limits of the policy”) (quoting *Zumwalt v. Utils. Ins. Co.*, 228 S.W.2d 750, 753 (Mo. 1950.); *Eskind v. Marcel*, 951 So. 2d 289, 293 (La. 2006) (“in the absence of bad faith, [an insurer] is generally free to settle or to litigate at its own discretion, without liability to its insured for a judgment in excess of the policy limits) *Mowry v. Badger State Mut. Cas. Co.* 385 N.W.2d 171, 180 (Wis. 1986) (determining whether the insurer’s choice to litigate rather than settle constitutes a breach “involves more than a mere finding of negligence on the part of the insurer”).

⁶⁴ *Tokio Marine v. Macready*, 803 F. Supp. 2d 193, 204 (E.D. N.Y. 2011).

⁶⁵ See also *Awrey v. Progressive Cas. Ins. Co.*, 728 F.2d 352, 357 (6th Cir. 1984) (claim of negligence against insurer not sufficient to show a dishonest purpose or moral obliquity and, thus, was insufficient as a matter of law to show bad faith); *Ortega-Maldonado v. Allstate Ins. Co.*, 519 F. Supp. 2d 981, 991 (D. Minn. 2007) (applying Minnesota law) (“In order to find that an insurer acted in bad faith, the insured must show that he made a demand of his insurance company to accept an offer within the policy limits, and that the insurance company’s refusal to accept the offer was arbitrary”); *CBLPath, Inc. v. Lexington Ins. Co.*, 73 A.3d 829, 830 (N.Y. App. Div. 2010) (“bad faith must be for conduct that is clearly more than ordinary negligence, i.e., more than merely poor judgment”); *Johnson v. Tennessee Farmers Mut. Ins. Co.*, 205 S.W.3d 365 (Tenn. 2006) (Mere

reckless, indifferent, or intentional disregard of the insured's interest to which an insurer owes a duty.⁶⁶ Virginia utilizes the "bad faith" standard as well when determining an insurer's liability for failure to settle within policy limits.⁶⁷ Specifically, an insured must prove by clear and convincing evidence that the insurer acted in furtherance of its own interest with intentional disregard of the financial interest of the insured.⁶⁸

Even in the minority rule jurisdictions, the insurer would not be liable unless it failed to exercise due care in considering the settlement offer. However, unlike the Draft's formulaic approach, the insurer may refuse to settle a claim that has little chance of success or reject an offer if the totality of circumstances, including the many factors considered by the courts (as discussed below), indicate that the insurer's refusal to settle was reasonable. The Draft may embolden plaintiffs' to make excessive demands and create a strong incentive for insurers to pay unreasonable demands, regardless if there is only a remote possibility of an adverse judgment against the insured, or risk exposure beyond the policy limits. Given the latitude afforded the insured under the Draft's formulaic proposal, particularly with a likely *range* of potential damages including punitive and other consequential damages, it is conceivable that any demand within policy limits would trigger payment under the "reasonable settlement decision" duty. Therefore, the insurer would be liable for the excess verdict, regardless of how improbable such a verdict was at the time the offer was refused.

In general, the question of an insurer's good or bad faith "is to be tested against the background of the totality of the circumstances in which the insurer's disputed actions occurred"⁶⁹ and "the reasonableness of a settlement offer cannot be evaluated in a vacuum...."⁷⁰

Express Inc. v. Home Indemnity provides an illustration of the extensive list of factors that courts consider regarding an insurer's decision to settle, including: (1) Was there a full investigation of the facts of the case; (2) Was there an incompetent or dishonest evaluation of the underlying case; (3) Did the insurer properly analyze the strength of the insured's position in the underlying case from both the liability and damages standpoint; (4) Did the insurer place its interest ahead of the interest of the insured; (5) Was the refusal related in any way to the existence of reinsurance; (6) Did the insurer establish appropriate reserves to settle the case; (7) Did the insurer fail to respond to settlement offers; delay responding to settlement offers; or, fail to explore settlement possibilities when it would have been prudent to do so; (8) Did an opportunity exist to settle the case within policy limits; (9) Did the insured request settlement within the policy limits; (10) Did the insurer fail to keep the insured advised of relevant facts and developments; (11) Was the amount of risk to the insured disproportionately large compared to the risk to the insurer; (12) Did the insurer heed or listen to its own counsel's advice; (13) Did the insurer act in an arbitrary and flexible manner indifferent to the consequences to the insured; (14) Did the insurer properly react to adverse developments; (15) Was the insured negligent in failing to settle the case; (16) Did the insurer request a third party to contribute to the settlement before it offered its own policy limits; (17) Was the insurer defending the insured under a reservation of rights; and, (18) Any other factors exist tending to establish or disprove bad faith or negligence on the part of the insurer?⁷¹

negligence is not sufficient to impose liability for failure to settle on an insurer") (citing *S. Fire & Cas. Co. v. Norris*, 250 A.D.2d 785, 792 (Tenn. 1952)).

⁶⁶ *Commercial Union Ins. Co. v. Liberty Mut. Ins. Co.*, 393 N.W.2d 161, 164 (Mich. 1986).

⁶⁷ *State Farm Mut. Auto. Ins. Co. v. Floyd*, 366 S.E.2d 93 (Va. 1988).

⁶⁸ *Id.* at 97-98.

⁶⁹ *Walbrook Ins. Co.*, 5 Cal. App. 4th at 1455-1456.

⁷⁰ *Camelot by the Bay Condo. Owners' Assn. v. Scottsdale Ins. Co.*, 32 Cal. Rptr. 2d 354, 363-64, 27 Cal. App. 4th 33, 51 (Cal. Ct. App. 1994).

⁷¹ *Carrier Express, Inc. v. Home Indem. Co.*, 860 F. Supp. 1465, 1479-80 (N.D. Ala. 1994).

There are many other factors considered in assessing the insurer's duty to settle, including similar cases in the relevant jurisdiction, failure to properly investigate, defense counsel's settlement evaluation, the insurer's good faith belief that the insured was not liable, the probability of liability, the insurer adjuster's evaluation, the strength of potential witnesses and any other factors that may establish or negate bad faith on the insurer's part.⁷² Illustration (2) suggests that the insurance adjuster's informed and good faith decision to reject a settlement offer may be factors to be considered by the trier of fact in determining whether the insurer breached its duty under Section 24. However, more importantly, Illustration (2) confirms that even if the adjuster's settlement valuation was informed and in good faith, the insurer can still be liable under Section 24 for damages beyond the policy limits based upon the Draft's rigid equation described in Illustration (1).

Section 24 Comment (e) highlights the Draft's uneven application, to the insurer's detriment.⁷³ Comment (e) provides:

it is appropriate for the trier of fact 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, and 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 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.

⁷² See *Haugh v Allstate Ins. Co.*, 322 F.3d 227, 238 (3d Cir. 2003) (history of cases in the jurisdiction); *Brown v. Guarantee Ins. Co.*, 319 P.2d 69, 75 (Cal. Dist. Ct. App. 1957) (failure to properly investigate circumstances, fault of insured in inducing rejection of compromise offered by misleading insurer as to facts) (citing annotation); *Christian Builders, Inc. v. Cincinnati Ins. Co.*, 501 F. Supp. 2d 1224, 1232 (D. Minn. 2007) (where insurer relied on much lower settlement evaluation of competent and experienced defense attorney); *Capitol Indem. Corp. v. St. Paul Fire & Marine Ins. Co.*, 357 F. Supp. 399, 414 (W.D. Wis. 1972) (applying Minnesota law) (whether insurer in good faith believed that insured was not liable); *Jessen v. O'Daniel*, 210 F. Supp. 317, 326-27 (D. Mont. 1962) (whether the facts in the case indicate that a defendant's verdict on the issue of liability is doubtful. No one factor is decisive, but all must be considered in determining whether the insurer acted in good faith); *Smith v. Safeco Ins. Co.*, 50 P.3d 277, 281 (Wash. Ct. App. 2002) (the resulting "climate for settlement"), rev'd on other grounds, 78 P.3d 1274 (Wash. 2003); *O'Neill v. Gallant Ins. Co.*, 769 N.E.2d 100, 106 (Ill. App. Ct. 2002) (whether the insurer ignored the advice of the insurer's own adjusters); *Smith v. General Accident Ins. Co.*, 697 N.E.2d 168, 171 (N.Y. 1998) (any other evidence which tends to establish or negate the insurer's bad faith in refusing to settle); *Employers National Ins. Co. v. General Accident Ins. Co.*, 857 F. Supp. 549, 553 (S.D. Tex. 1994) (reliance on the advice of counsel that the settlement value of a claim against an insured does not exceed the insurer's policy); *Shamblin v. Nationwide Mut. Ins. Co.*, 396 S.E.2d 766, 776 (W.Va. 1990) (whether the insurer had a reasonable basis to conclude that there was a genuine and substantial issue as to liability of its insured); *Rova Farms Resort, Inc. v. Investors Ins. Co. of America*, 323 A.2d 495, 503-04 (N.J. 1974) (the view of the carrier or its attorney as to liability; a good faith evaluation; and the relative appearance, persuasiveness, and likely appeal of the claimant, the insured and the witness at trial.); *Gen. Accident Fire & Life Assurance Corp. v. Little*, 443 P.2d 690, 694 (Ariz. 1968) (any other factors tending to establish or negate bad faith on the insurer's part).

⁷³ Restatement of the Law of Liab. Ins. Insurance § 24 cmt. e.

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.... 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, the insurer may be subject to liability for bad-faith breach.⁷⁴

Thus, the Draft suggests that procedural factors are only used against the insurer "in a close case by allowing the jury to draw a negative inference."⁷⁵ Notwithstanding the reference in (d) that the "reasonableness of settlement offer may take into account other facts,"⁷⁶ the application of the Draft proposal as described Illustrations (1) and (2) proves that statement false.⁷⁷

Finally, there is little, if any, burden on the insured in making a claim for failure to settle under the Draft rules. The insured can merely back out the offer and adjust the probability of liability and the damages range "at the time of the offer" to arrive at the offer number, contrary to case law precedent. *See, Cowden*, 134 A.2d at 229 (bad faith in a third-party failure to settle case must be proven by clear and convincing evidence). "Failure to settle" litigation will likely increase as the insured is encouraged to litigate if there is an excess award, given the insurer's quasi-strict liability for refusing an offer within the policy limits. The Draft can incentivize plaintiffs to make excessive demands as a result of the new excess limits risk to the insurer and prompt insureds to underinsure because it is unlikely that the insured will be capped at the policy limit in the event of an excess judgment. The anticipated end result is inflated, unreasonable settlements that will significantly increase market losses and premiums across the board, negatively impacting the insurance purchaser. Additionally, due to the lack of limits protection, smaller premium/lower limit policies may exit the market because the newly created extra contractual risk outweighs the premium benefit.

(c) *Offer in excess of policy limits*

Comment (h) in Section 24 provides that, with respect to offers in excess of policy limits, the insurer may satisfy its duty by offering policy limits if a "reasonable insurer that bore the risk of the entire liability" would settle for an amount in excess of policy limits.⁷⁸ Section 24 is fundamentally flawed because the remote likelihood of success of the plaintiff's claim is not a defense to refusing an offer and that flawed underlying premise extends to offers beyond limits. Additionally, Section 24(h) conveniently disregards a refusal to settle due to legitimate coverage defenses.

Reporter's note (h),⁷⁹ acknowledges "According to some commentators, ..., 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"⁸⁰ Some courts reason that the insurer is under no obligation to respond

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.* § 24 cmt. d.

⁷⁷ *Id.* § 24 cmt. d illus. 1.

⁷⁸ Restatement of the Law of Liab. Ins. § 24 Reporter's note (h).

⁷⁹ *Id.*

⁸⁰ *See* Robert H. Jerry II & Douglas S. Richmond, Understanding Insurance Law, 874 (4th ed. 2007).

to an offer beyond the limits because “[I]t is apparent . . . (1) the legal rules relating to bad faith come into effect only when a conflict of interest develops between the carrier and its insured; (2) a conflict of interest only develops when an offer to settle an excess claim is made within policy limits or when a settlement offer is made in excess of policy limits and the assured is willing and able to pay the excess,”⁸¹ while other courts require that the insurer knew that settlement within policy limits could feasibly be negotiated and “in the absence of such evidence, or evidence the insurer by its conduct has actively foreclosed the possibility of settlement, there is no opportunity to settle that an insurer may be taxed with ignoring.”⁸² Other courts require a demand within policy limits in order to trigger the insurer’s duty to settle.⁸³

The Draft’s suggestion regarding the insurer’s obligation to respond to demands beyond limits might encourage the plaintiff to make excessively high demands because under Sections 24 and 27 the insurer must consider tendering the limits, or risk a potential excess judgment, regardless of the claim’s probability of success. Again, the insurer is potentially forced to overpay settlements. The proposal also disregards established law in many jurisdictions wherein the insurer is not required to respond to an offer beyond the limits. Thus, this section illustrates another unnecessary duty imposed upon the insurer that could further disrupt the market.

3. *Punitive Damages*

Section 27 provides for the damages for a breach of Section 24 (Duty to Make Reasonable Settlement Decisions) which include “the full amount of damages assessed against the insured in the underlying legal action, without regard to those policy limits, as well as any other foreseeable harm caused by the insurer’s breach of the duty,” “including punitive damages awarded at the underlying trial (against the policyholder)” which concludes “this rule is unproblematic in a jurisdiction in which punitive damages are insurable.”⁸⁴

Illustration 6 confirms the absurd application under Section 27. Even where the “insurance policy with a \$1 million limit of liability excludes punitive damages from coverage,” because 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... [if] the insurer 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).”⁸⁵

Punitive damages cannot be “reasonably foreseeable at the time of contracting” to an insurer that excluded punitive damages from coverage. Additionally, courts have rejected attempts by insureds to obtain coverage for an underlying punitive damages award through a failure to settle claim absent bad faith, and as described above, bad faith is not required for Section 24 liability.

Transferring the insured’s underlying punitive damages risk to the insurer to failing to settle also violates the public policy of not allowing liability for intentional wrongdoing to be offset or reduced by the negligence of another.⁸⁶ “Thus, allowing [insured] to shift to [insurer] its responsibility to pay the

⁸¹ *Merritt*, 110 Cal. Rptr. at 523-24.

⁸² *Reid*, 220 Cal. App. 4th at 272 (internal quotations omitted).

⁸³ *Haddick ex rel. Griffith v. Valor Insurance*, 763 N.E. 2d 299, 304-05 (Ill. 2001); *Texas Farmers Ins. Co.*, 881 S.W.2d at 314.

⁸⁴ Restatement of the Law of Liab. Ins. § 27 cmt. d.

⁸⁵ *Id.* § 27 cmt d. illus.

⁸⁶ See *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999) (“Here, the Colorado jury’s award of punitive damages in the third party action against the insured was based on the insured’s own intentional,

punitive damages in the third party action would violate the public policy against reducing or offsetting liability for intentional wrongdoing by the negligence of another.”^{87 88} “The punitive damages awarded against an insured in a civil suit are not a proper element of the compensatory damages recoverable in a suit against an insurer for a bad-faith refusal to settle.”⁸⁹ “Such a [punitive damages] recovery would improperly focus on the insurer’s allegedly wrongful act in refusing to settle and would minimize the insured’s own blameworthy conduct...Regardless of how egregious the insurer’s conduct has been, ...any award of punitive damages that might ensue is still directly attributable to the insured’s immoral and blameworthy behavior.”⁹⁰

Courts have applied a much different standard for punitive damages award for failure to settle than is provided under Sec 27, which simply compliments the quasi-strict liability standard under Section 24.⁹¹ Although standards vary, in order to justify an award of punitive damages the insurer’s breach of the duty of good faith and fair dealing must be shown to have been particularly outrageous.^{92 93}

morally blameworthy behavior.... By contrast, the action that the insured [] then brought against its insurance company, was based on [insurer’s] alleged negligent failure to settle the third party lawsuit against the insured Such a cause of action is based not on a bad faith breach of the insurance contract but on the failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.” (internal quotations omitted) ; *Johansen v. California State Auto. Inter-Ins. Bureau*, 538 P.2d 744, 15 Cal. 3d 9, 16 n.5 (Cal. 1975); Restatement (Second) of Torts § 481 (1965); W. Page Keeton et al., *Prosser & Keeton on Torts*, § 65, p. 462; and § 67, pp. 477-78 (5th ed. 1984).

⁸⁷ *PPG Indus. Inc. v. Transamerica Ins. Co.*, 975 P.2d 652, 20 Cal. 4th 310, 316-17 (Cal. 1999).

⁸⁸ *See also Wolfe v. Allstate Property & Cas. Ins. Co.*, 790 F.3d 487, 493 (3d Cir. 2015) (“shifting punitive damages to insurers would result in insurers pricing up policies to factor in [insureds] who behave egregiously.”); *Lira v. Shelter Ins. Co.*, 913 P.2d 514, 516 (Colo. 1996) (holding that “in an action by an insured against his insurer for bad faith failure to settle, the insured may not collect as compensatory damages the punitive damages awarded against him in the underlying lawsuit.”); *Esmond v. Liscio*, 224 A.2d 793, 799 (Pa. Super. Ct. 1966), (holding that “public policy does not permit a tortfeasor [in certain circumstances] to shift the burden of punitive damages to his insurer”).

⁸⁹ *Soto v. State Farm Ins. Co.*, 635 N.E.2d 1222, 1225 (N.Y. 1994).

⁹⁰ *Id.*

⁹¹ *See Amadeo v. Principal Mut. Life Ins. Co.*, 290 F.3d 1152, 1164 (9th Cir. 2002) (Under California law, punitive damages are available on an insured’s bad faith claim against an insurer “if in addition to proving a breach of the implied covenant of good faith and fair dealing proximately causing actual damages, the insured proves by clear and convincing evidence that the insurance company itself engaged in conduct that is oppressive, fraudulent, or malicious”) (quoting *PPG Indus.*, 975 P.2d at 658); *Mitchell v. State Farm Fire and Cas. Co.*, 799 F. Supp. 2d 680, 695 (N.D. Miss. 2011) (punitive damages requires insured to prove that there was no arguable or legitimate reason to deny coverage and the insurer acted willfully, 384maliciously, or with gross and reckless disregard for the insured’s rights) (applying Mississippi law); *Medical Protective Co. v. Pang*, 606 F. Supp. 2d 1049, 1064 (D. Ariz. 2008) (“the insured may recover punitive damages when, ‘and only when, the facts establish that [the insurer’s] conduct was aggravated, outrageous, malicious, or fraudulent.’”) (quoting *Lange v. Penn Mut. Life Ins. Co.*, 843 F.2d 1175, 1183 (9th Cir. 1988)); *Eccobay Sportswear, Inc. v. Providence Washington Ins. Co.*, 585 F. Supp. 1343, 1344 (S.D.N.Y. 1984) (“New York courts routinely dismiss claims for punitive damages against insurers when there has been no allegation or showing that the carrier... had engaged in a fraudulent scheme evincing such a ‘high degree of moral turpitude and ... such wanton dishonesty as to imply a criminal indifference to civil obligations.’”) (quoting *Leidesdorf v. Fireman’s Fund Ins. Co.*, 470 F. Supp. 82, 85 (S.D.N.Y. 1979) (internal quotations omitted)); *Stewart v. Truck Ins. Exch.*, 17 Cal. App. 4th 468, 483 21 Cal. Rptr. 2d 338 (Cal. Ct. App. 1993) (“Evidence that an insurer has violated its duty of good faith and fair dealing does not thereby establish that it has acted with the requisite malice to justify an award of punitive damages. In order to establish that an insurer’s conduct has gone sufficiently beyond mere bad faith to warrant a punitive damage award, it must be shown by clear and convincing evidence that the insurer has acted maliciously.”) (quoting *Mock v. Michigan Millers Mut. Ins. Co.*, 4 Cal. Appl 4th 306, 328 (Cal. Ct. App. 1992) (italics omitted).

⁹² *See Bush*, 425 F.2d at 396; *Bailey*, 322 F. Supp. at 393, affirmed, 439 F.2d 763 (5th Cir. 1971); *Ins. Corp. of America v. Webster*, 906 S.W.2d 77, 79 (Tex. App. 1995).

Depending on the jurisdiction, the plaintiff's proof must demonstrate that the insurer's conduct under examination, in some combination, met the following criteria:

- The insurer's conduct was an extreme deviation from acceptable standards; and/or
- The insurer's actions were oppressive, fraudulent, wanton, malicious, or outrageous; and/or
- The insurer acted with an understanding of and a reckless or conscious disregard for the likely consequences; and/or
- The insurer's actions were carried out with an extremely harmful state of mind with the manifest intent to deliberately or willfully injure another.⁹⁴

Section 27 provides for coverage for punitive damages if "foreseeable", even when excluded. Additionally, the punitive damages are awarded against the insurer for a breach of the Section 24 failure to settle, a far cry from the "bad faith" requirement as described in the cases above.⁹⁵ Therefore, insurers are now potentially liable for punitive damages, even when excluded, that are the result of the insured's underlying egregious conduct merely as a result of the failure to settle under the quasi-liability standard in Section 24. Mandating the risk transfer to the insurer for the insured's underlying bad conduct creates a moral hazard and defeats the deterrent effect of the punitive award.

(A) it frustrates the purpose of the punitive award, which is to punish the defendant and deter others; (b) imposing liability for punitive damages on the actual wrongdoer is the only way to advance the compelling interest of enhancing public safety, particularly with respect to manufacturers of defective products; (c) the pass along to an insurer permits the tortfeasor to escape punishment, and the burden is ultimately transferred to the premium-paying public; and (d) the punitive award serves no useful public purpose; it simply becomes a windfall for the plaintiff, who has already been made whole by the compensatory damage award.)⁹⁶

Section 46 (comment c) recognizes that punitive damages coverage should not be available in states with a "judicially declared public policy" against insuring punitive damages.⁹⁷ However, "an alleged public policy may be the basis of a judicial decision only in the 'clearest cases,'⁹⁸ and there is no guidance as to what qualifies as a "judicially declared public policy." Further complicating the potential application of this provision is the fact that many insurance policies do not contain an express choice of law provision. By way of example, some policies provide that with respect to determining the availability of insurance for punitive damages, "the most favorable jurisdiction" will apply. Despite the late addition of Section 46, which presumably was an attempt by the Draft to mitigate the potentially draconian results under Section 27 regarding punitive damages coverage, Section 46 does nothing to protect insurers that is not already in place — specifically, that an insurer does not have to pay losses that are otherwise

⁹³ Cf. *American Mut. Ins. Co.*, 338 A.2d at 309 (holding that insurer could not be liable for third-party bad faith when insured never demanded the insurer to settle the claim against him); *Miller*, 519 N.E.2d at 858 (holding that insurer does not have duty to initiate settlement negotiations when plaintiff had not previously instituted negotiations).

⁹⁴ *George J. Couch et al.*, 15A *Couch on Insurance* (2d ed. 1983) § 58:11.

⁹⁵ Restatement of the Law of Liab. Ins. § 27.

⁹⁶ Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes*, §14.02 (b) (17th ed. 2014). See also *Payne v. Jones*, 711 F.3d 85, 94 (2d Cir. 2013); *Fairfield v. Stephens Martin*, 246 S.W.3d 653 (Tex. 2008).

⁹⁷ Restatement of the Law of Liab. Ins. § 46

⁹⁸ *Fed. Ins. Co. v. Cont'l. Cas. Co.*, No. 2:05 cv 305, 2006 WL 3386625, at *22 (W.D. Pa. November 22, 2006) (citing *Hall v. Amica Mut. Ins. Co.*, 648 A.2d 755, 761 (Pa. 1994)).

uninsurable under applicable law. Ultimately, the insurer is pressured to pay unreasonable settlement demands to avoid potentially funding a “foreseeable” punitive damages award, even where affirmatively excluded.

4. *Sections 24 and 27 effect on reinsurance*

The availability of reinsurance is critical to facilitating and maintaining a competitive insurance market by allowing the ceding insurer to allocate its assumed risk among the participating reinsurers. Because Sections 24 and 27 may create unreasonable settlement values, including payment for excluded liabilities,⁹⁹ the ceding insurer’s ability to procure the applicable reinsurance for those settlements is jeopardized.

(a) *Reasonable Settlement*

“Reasonableness” is a factual issue.^{100 101}

As described above, Sections 24 and 27 significantly depart from case law precedent in various ways, imposing extra-contractual damages for failure to settle even if: (i) the probability of success for the claim is extremely low; (ii) the insurer acted reasonably and in good faith (iii) other relevant factors support a decision not to settle and (iv) punitive damages are affirmatively excluded but the excess judgment includes a punitives component, if “foreseeable.” “The reasonableness of the settlement consists of two components which are interrelated. The fact finder must look at the amount paid in settlement of the claim in light of the risk of exposure. The risk of exposure is the probable amount of a judgment if the original plaintiff were to prevail at trial, balanced against the possibility that the original defendant would have prevailed.”¹⁰² “The only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim’s injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer.”¹⁰³ Section 24, as applied, appears to reject the probability of success analysis, potentially forcing the ceding insurer to settle defensible claims or risk excess damages beyond the policy limit.

The reinsurer can also challenge the ceding insurer’s settlement decision if other relevant factors indicate that the settlement was unreasonable, because Sections 24 and 27, as applied, may not permit the consideration of relevant factors. Rather, the analysis is reduced to the Draft’s convenient equation. In *Alton M. Johnson Co.*, the court noted that, in considering the issue of reasonableness “the decisionmaker receives not only the customary evidence on liability and damages but also other evidence, such as expert opinion of trial lawyers evaluating the ‘customary’ evidence.”¹⁰⁴ This ‘other evidence’ may include verdicts in comparable cases, the likelihood of favorable or unfavorable rulings on legal defenses and evidentiary issues if the tort action had been tried, and other factors of forensic significance.”¹⁰⁵

⁹⁹ Restatement on the Law of Liability §§ 24 & 27

¹⁰⁰ *J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*, No. 31295, slip op., 13 (N.Y. Sup. Ct. 2016) (“the Court cannot determine at this juncture whether the settlements entered into were reasonable, which is a fact laden inquiry, ill-suited for summary disposition.”)

¹⁰¹ See also *Samson v. Transamerica Ins. Co.*, 30 Cal. 3d 220, 243 (Cal. 1981) (“It is true that the reasonableness of a rejected settlement offer is often an issue of fact to be determined by a jury.”) (citing *Critz v. Farmers Ins. Group*, 230 Cal. App. 2d 788, 796-797 (Cal. Ct. App. 3d Dist.).

¹⁰² *Valloric v. Dravo Corp.*, 357 S.E.2d 207, 214 (W. Va. 1987) (citations omitted)).

¹⁰³ *Johansen*, 538 P.2d at 748.

¹⁰⁴ *Alton M. Johnson Co. v. M.A.I. Co.*, 463 N.W.2d 277, 279 (Minn. 1990)

¹⁰⁵ *Alton M. Johnson Co. v. M.A.I. Co.*, 463 N.W.2d 277 (Minn. 1990)

Section 27 also encourages settlement of any claim with a punitive damages claim, if “foreseeable,” even if the insurer’s policy excludes coverage for punitive damages. The reinsurer can logically challenge the reasonableness of a settlement that is based, in part, upon an exposure that is affirmatively excluded. With respect to which party has the applicable burden regarding the reasonableness of a settlement, there are differing views. However, the reinsurer can make a strong argument that the ceding insurer should bear that burden, as the party in possession of the relevant information regarding the settlement, as well as the party controlling or associating in the defense of the claim.

(b) *Effect on reinsurer’s obligation*

(i) *Follow the fortunes and follow the settlements doctrines*

The “follow the fortunes” and “follow the settlements” doctrines preclude reinsurers from challenging cedents’ (the insurance company that transfers part or all of its risks from its insurance policy to the reinsurer) payments of claims and settlements that are reasonable and made in good faith. This doctrine requires reinsurers to reimburse the reinsured (or cedent) for payment of the settled claims as long as the payments were made reasonably and in good faith.¹⁰⁶ Some courts have held that the duty to “follow the settlements” can be implied in the reinsurance agreement,¹⁰⁷ while other courts have rejected this approach.¹⁰⁸ A reinsurer may not be obligated by the reinsured’s settlement decisions if there is no “follow the settlements” clause contained in the reinsurance agreement.¹⁰⁹ Where the reinsurer was not required to “follow the settlements,” the cedent bears the burden of establishing that the underlying claim was covered by the reinsured certificate of insurance.^{110 111}

In sum, if the reinsurer is “following the fortunes” of the ceding insurer’s claim payments, those payments must be reasonable and in good faith or the reinsurer can challenge the payment. Moreover, if the reinsurer is not “following the fortunes” of the ceding insurer, the ceding insurer will need to prove that the underlying settlement was reasonable and otherwise covered.

(ii) *Duty of utmost good faith to the reinsurer*

A ceding insurer owes its reinsurer a duty of utmost good faith.¹¹² The duty of utmost good faith requires the cedent to act honestly and to follow all “proper and businesslike steps” when settling claims.^{113 114} The settlement pressures applied to the ceding insurer under Sections 24 and 27 may make

¹⁰⁶ *Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268, 280 (2nd Cir. 1992).

¹⁰⁷ *Aetna Cas. & Sur. Co. v. Home Ins. Co.*, 882 F. Supp. 1328 (S.D.N.Y. 1995).

¹⁰⁸ *American Marine Ins. Group v. Neptunia Ins. Co.*, 775 F. Supp. 703 (S.D.N.Y. 1991), *aff’d*, 961 F.2d 372 (2d Cir. 1992).

¹⁰⁹ *Employer Reins. Corp. v. Laurier Indem. Co.*, No. 8:03-cv-1650-T-17MSS, 2006 WL 1679366, at *17-18 (M.D. Fla. June 25, 2007).

¹¹⁰ *Am. Motorists Ins. Co. v. Am. Re-Ins. Co.*, 2007 WL 4197427, at *5 (N.D. Cal. 2007).

¹¹¹ *See also Duber Indus. v. Allendale Mut. Ins. Co.*, Civ. 69, 133 (Sup. Ct. No. C. 232 595) (Cal. Ct. App. 2d Dist. Feb 16 1984) (where a reinsurance treaty contains no “excess of policy limits” clause and the reinsurer has not participated in or directed the conduct of the insurer in settlement negotiations, the reinsurer has no liability to the insured based on the insurer’s failure to conduct settlement negotiations in good faith).

¹¹² *See Reliastar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874 (8th Cir 2002); *Ins. Co. of the State of Pa. v. Argonaut*, 2013 WL 4005109, at *13 (S.D.N.Y. Aug 6, 2013).

¹¹³ *Am. Marine Ins.*, 775 F. Supp. at 708.

¹¹⁴ *See also Ins. Co. of Africa v. Scor (U.K.) Reins. Co.*, [1985] 1 L.L.Rep. 312, 330 (A.C.), 1985 WL 311007, slip op. at 12, 17. (1984).

it difficult for the ceding insurer to demonstrate that it has acted with the utmost good faith towards its reinsurer.

(iii) *Coverage defenses for the reinsurer created by Sections 24 and 27*

Sections 24 and 27 require the ceding insurer to settle against the risk of uncovered matters (for example, punitive damages that are excluded) but the reinsurer is not obligated to pay for losses that are not covered under the underlying policy.¹¹⁵ Specifically “[w]here bulk settlements directly or indirectly include elements of punitive damages, serious coverage questions may be raised by reinsurers.^{116 117} A reinsurer is only required to reimburse the reinsured for the type of loss covered by the policy; ceding insurer’s settlement must be made using a reasonable interpretation of its own policy.¹¹⁸

Ex Gratia Payments: An ex gratia payment is one that is “made by one who recognizes no legal obligation to pay but who makes payment to avoid greater expenses as in the case of a settlement by an insurance company to avoid costs of a suit.”¹¹⁹ The Draft rules could create ex-gratia payments by pressuring the ceding insurer to pay settlement amounts for potentially uncovered liabilities to avoid excess judgment exposure or to avoid coverage litigation costs encouraged by the Draft regarding policy interpretation.

Excess damages beyond limits: the potentially inflated settlements are the direct result of the threat of liability for excess judgments, which are not covered by reinsurance (unless specifically added by endorsement). A reinsurer is not liable for any extra contractual liabilities of the ceding insurer where no treaty provision expressly providing for bad faith conduct exists and contractually reinsurance treaties do not cover a scenario where liability is imposed upon the reinsurer for the reinsured’s bad faith or negligent failure to settle a liability claim within policy coverage when there has been a reasonable opportunity to settle.¹²⁰ “Reinsurance companies are not generally held liable beyond the limits of liability contained in the agreement.”¹²¹

Reasonableness of the settlement: Sections 24 and 27 collectively pressure the ceding insurer to settle claims that are not covered or have only a remote chance of success.¹²² Therefore, the ceding insurer may be forced to pay unreasonable settlements, allowing the reinsurer to avoid its obligations because in order to trigger the deference due under follow-the-fortunes, a settlement must be reasonable.¹²³

¹¹⁵ *Am. Ins. Co. v. North Am. Co. for Prop. and Cas. Ins.*, 697 F.2d 79, 81 (2d Cir 1982); *Ins. Co. of N. Am. v. United States Fire Ins.*, 322 N.Y.S.2d 520, 523 (N.Y. Sup. Ct. 1971).

¹¹⁶ Barry R. Ostrager & Thomas R. Newman, Handbook on Insurance Coverage Disputes, 1369 (2012) (citing *Reliance Ins. Co. v. Gen. Reins. Corp.*, 506 F. Supp. 1042 (E.D. Pa. 1980)).

¹¹⁷ See also *Am. Ins. Co.*, 697 F.2d at 81 (reinsurer properly denied reinsurance coverage for its ceding insurer’s settlement of a claim because the settlement was intended primarily to dispose of a punitive damage award that was not covered under the terms of the ceding insurer’s policy).

¹¹⁸ *Bellafonte Reins. Co. v. Aetna Cas. And Sur. Co.*, 903 F.2d 910, 913 (2d Cir. 1990).

¹¹⁹ Black’s Law Dictionary 514 (5th ed. 1979).

¹²⁰ *Employers Reins. Corp. v. Am. Fid. and Cas. Co.* 196 F. Supp. 553 (W.D. Mo. 1959).

¹²¹ *Am. Ins. Co. v. N. Am. Co. for Prop. & Cas. Ins.*, 697 F.2d 79 (2d Cir. 1982).

¹²² Restatement of the Law of Liab. Ins. §§ 24 & 27.

¹²³ See *Am. Employers Ins. Co. v. Swiss Reins. Am. Corp.*, 413 F.3d 129, 136-37 (1st Cir. 2005)); *Hartford Accident and Indem.*, 98 F. Supp.2d 251, 259 (D. Conn. 2000) (summary judgment denied based on issues of fact as to whether the cedent unreasonably settled and allocated an underlying environmental claim in order to maximize its reinsurance recovery); *Int’l Surplus Lines Ins. Co. v. Certain Underwriters & Underwriting Syndicates at Lloyd’s of London*, 868 F. Supp. 917 (S.D. Ohio 1994); *Travelers v. Gerling Global*, 419 F.3d, 190 (2d Cir 2005)

The Draft can threaten the availability of reinsurance by creating unreasonable settlements, if the ceding insurer is (i) strongly incentivized to settle claims with little chance of success under the rigid Section 24 formula; (ii) forced to settle against “foreseeable” punitive damages assessed against the policyholder that are excluded under the policy (iii) coerced to overpay settlements as a result of the potential for excess limit losses which are not covered by the reinsurance (unless specifically endorsed) (iv) forced to settle pursuant to the rigid Draft formula, disregarding relevant factors that indicate that settlement is not appropriate (for example, the dismissal of similar claims in the relevant jurisdiction) and (v) dissuaded from making counter offers, weakening its negotiating position and unnecessarily increasing the claim’s settlement value.

B. Duty to Defend

1. *Determination of Duty*

Section 13 Comment (b) of the Draft provides: “if the insurer knows or *reasonably should know* of information that, under existing pleading rules, could reasonably be expected to be added as an obligation, and that, if so added, would require the insurer to defend, then the insurer has a duty to defend the action.”¹²⁴

The rule that the insurer’s duty to defend is determined by the allegations contained within the “four corners of the complaint” is followed in many jurisdictions.¹²⁵ Courts following the “four corners of the complaint” rule typically refuse to look beyond the pleadings to determine whether an insurer has a duty to defend (lower court erroneously considered evidence outside four corners of the complaint to determine defense obligations).¹²⁶

(a) *Extrinsic Evidence*

The Draft departs from jurisdictions that consider facts beyond the pleadings when considering the insurer’s duty to defend because the Draft requires the insurer to defend if it “should reasonably know” of information that would trigger a duty to defend.¹²⁷ Reporter’s note (b) highlights the distinction: “the insurer must defend ... if the insurer *possesses* extrinsic information...”¹²⁸ Courts

(“Follow the settlements requires the reinsurer to reimburse the reinsured for payment of a settled claim as long as the settlement was made reasonably and in good faith.”) (Internal quotations omitted).

¹²⁴ *Id.* § 13 cmt. b (emphasis added).

¹²⁵ *Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co.*, 589 Pa. 317, 331, 908 A.2d 888 (Pa. 2006). See also *Admiral Ins. Co. v. Ford*, 607 F.3d 420, 424-25 (5th Cir. 2010) (applying Texas law); *Emhart Indus., Inc. v. Century Indem. Co.*, 559 F.3d 57, 65-69 (1st Cir. 2009); *Indian Harbor Ins. Co. v. Valley Forge Ins. Group*, 535 F.3d 359, 363 (5th Cir. 2008); *Fireman’s Fund Ins. Co. v. Univ. of Georgia Athletic Association, Inc.*, 288 Ga. App. 355, 356 (Ga. App. 2007); *H.L. Libby Corp. v. Fireman’s Fund Ins. Co.*, No. 03-601 (W.D. Pa. July 24, 2006).

¹²⁶ *Kvaerner Metals*, 589 Pa. at 317. See also *Sony Computer Entm’t Am., Inc. v. Am. Home Assur. Co.*, 532 F.3d 1007, 1020 (9th Cir. 2008) (insured “may not speculate about unpled third party claims to manufacture coverage”) (quoting *Hurley Constr. Co. v. State Farm Fire & Cas. Co.*, 10 Cal. App. 4th 533, 538-39 (Cal. Ct. App. 1992)); *Employers Mut. Cas. Co. v. Indus. Rubber Products, Inc.*, Civ. No. 04-3839, at *7 (D. Minn. Feb. 23, 2006) (duty to defend is based on claims in underlying complaint; extrinsic evidence is not considered); *General Star Indem. Co. v. Schools Excess Liab. Fund*, 888 F. Supp. 1022, 1029 (N.D. Cal. 1995) (under California law “although insurance contracts often have special features, ordinary rules of contract interpretation still apply.”). In turn, insurers are not forced to “speculate beyond the written words of the complaint in order to imagine a claim that a plaintiff might be making.” *State Farm Fire & Cas. Co. v. Easy PC Sols., LLC*, No. 2014AP2657, 2015 WL 8215533, ¶ 8 (Wis. Ct. App. Dec. 9, 2015).

¹²⁷ Restatement of the Law of Liab. Ins. § 13 cmt. b.

¹²⁸ *Id.* § 13 Reporter’s note b.

applying the expanded extrinsic information test require that the insurer has “actual knowledge” of information that would trigger a duty to defend, but there is no obligation based upon what an insurer should have known.¹²⁹ Some courts limit the use of extrinsic information based upon the policy language, with the duty to defend determined by the contractual terms. If the policy terms make the duty to defend dependent on the allegations against the insured, then extrinsic evidence is irrelevant to a determination of whether a duty to defend exists.¹³⁰

The Draft duty to defend imposes an elusive framework that will be difficult to apply or to predict. The insurer would be at risk for bad faith claims if it fails to defend unpled, hypothetical claims that it should have “reasonably known.” Like other Draft provisions, this proposed burden may invite significant coverage litigation causing the underwriters to adjust their pricing and terms and conditions accordingly.

C. Intentional Acts Coverage

Section 47(2) highlights the Draft’s efforts to make the insurer a financial guarantor. The relevant provision provides “*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.*”¹³¹ Comment (d) notes that there is no “blanket, public-policy objection in insurance law” regarding civil liability arising out of a criminal act and dismisses the potential moral hazard created by such coverage because “criminal penalties are an effective deterrent.”¹³² Comment (f) regarding insurability for “morally offensive acts” reasons that disallowing coverage for such types of conduct as sexual molestation is problematic because the victim is less likely to be able to obtain redress for those wrongs.¹³³ Comment (g) addressing insurability for “intentional harm” also stresses the need to compensate victims through the bad actor’s insurance.¹³⁴ Comment (h) (also addressing insurability for “intentional harm”) alludes to the “final adjudication” exclusions for misconduct that are common in many policies, as further evidence that acts that are undertaken with the intent to harm should be covered.¹³⁵

Comment (d)’s dismissal of the moral hazard concern under this provision is unconvincing.¹³⁶ Section 47(2) would cover losses that result due to an insured’s fraudulent activity. *Id.* § 47(2). Therefore, an individual can defraud others with impunity. As a practical matter, once a person has insurance, he will take more risks than before because he bears less of the cost of his conduct.”¹³⁷ Under Section 47(2), those “risks” include criminal and fraudulent activity and morally offensive crimes. The moral hazard is unavoidable because the insured is rewarded for the misconduct through the insurance proceeds or has little incentive not to engage in the misconduct because he/she will suffer no pecuniary liability. Comments (f) and (g) highlight the Draft’s goal of transforming the insurer’s role to that of a financial guarantor for the benefit of potential plaintiffs.¹³⁸ Comment (h) misunderstands the intent of the “final adjudication” exclusion with respect to insured misconduct.¹³⁹ The “final adjudication” language

¹²⁹ *Fitzpatrick v American Honda* (NY Ct of Appeals); *Scottsdale Ins Co vs MV Transport*, P3d (Cal 2005).

¹³⁰ *Fire Ins. Exch. v. Estate of Therikelsen*, 27 P.3d 555, 560 (Utah 2001).

¹³¹ Restatement of the Law of Liab. Ins. § 47(2).

¹³² *Id.* at § 47 cmt. d (emphasis added).

¹³³ *Id.* § 47 cmt. f.

¹³⁴ *Id.* § 47 cmt. g.

¹³⁵ *Id.* § 47 cmt. h.

¹³⁶ *Id.* § 47 cmt. d.

¹³⁷ *W. Cas. & Sur. Co. v. W. World Ins. Co.*, 769 F.2d 381, 385 (7th Cir. 1985).

¹³⁸ Restatement of the Law of Liab. Ins. § 47 cmts. f & g.

¹³⁹ *Id.* § 47 cmt. h.

gives the insured the benefit of the doubt, covering “alleged” conduct until or unless such conduct is proven. The Draft proposes something entirely different: coverage for the insured even if the misconduct *has been proven*.¹⁴⁰

Coverage for intentionally harmful acts also contradicts case law precedent. The New York Court of Appeals mandated “*two situations* in which a countervailing public policy will override the freedom to contract, First, an insurer may not indemnify an insured for a punitive damages award, and a policy provision purporting to provide such coverage is unenforceable. Second, as a matter of public policy, an insured may not seek coverage when it engages in conduct with the intent to cause injury”^{141 142}

Some states have codified the fortuity requirement: section 1101 (a)(1) of the New York Insurance Law defines an “Insurance Contract” as “[A]ny agreement or other transaction whereby one party, the “insurer,” is obligated to confer benefit of pecuniary value upon another party, the “insured” or “beneficiary” dependent upon the happening of a fortuitous event...”¹⁴³ and Section 533 of the California Insurance Code provides “an insurer is not liable for a loss caused by the willful act of the insured”¹⁴⁴ A “willful act” under section 533 includes “a deliberate, liability producing act that the individual, before acting, expected to cause harm.”¹⁴⁵

The Draft’s coverage for intended harm would have significant consequences for liability policies, which are not underwritten to cover intentional misconduct. For example, coverage for intentional misconduct under an environmental policy would create a significant moral hazard and it is difficult to overstate the magnitude of the potential losses.¹⁴⁶ Courts may infer an intent to harm where hazardous waste was intentionally dumped into the environment.¹⁴⁷ No defense or indemnity was owed by the insurer under comprehensive general liability policies for global warming-related claims where the underlying complaint did not allege an “occurrence.”¹⁴⁸ Finally, the Draft’s reasoning that disallowing coverage for intentionally harmful acts is problematic from a victim’s perspective fundamentally alters the contractual nature of the insurance contract. It is a contract between the insurer and the insured. Insureds may not perceive a need to insure against behaviors that they see zero risk that they will engage in and not wish to pay premium to insure those who do engage in such reprehensible conduct. Introducing a victim’s perspective interjects a third party into a two party contract.

¹⁴⁰ *Id.* § 47 cmt. h.

¹⁴¹ *J.P. Morgan Sec. v. Vigilant Ins. Co.*, 992 N.E.2d 1076, 1081 (N.Y. 2013) (emphasis added) (internal citations and quotation marks omitted).

¹⁴² See also, *Bohrer v. Church Mut. Ins. Co.*, 965 P.2d 1258, at 1262 (Colo. 1998) (“[I]t is contrary to public policy to insure against liability arising directly against the insured from intentional or willful wrongs, including the results and penalties of the insured’s own criminal acts”); *Perreault v. Maine Bonding & Cas. Co.*, 568 A.2d 1100, 1102 (Me. 1990) (denial of coverage “in accord with the general rule that insurance to indemnify an insured against his or her own violation of criminal statutes is against public policy and, therefore, void.”) (quoting *Altena v. United Fire & Cas. Co.*, 422 N.W.2d 485, 490 (Iowa 1988); *Everglades Marina, Inc. v. Am. E. Dev. Corp.*, 374 So. 2d 517, 519 (Fla. 1979).

¹⁴³ N.Y. INS. LAW, § 1101 (a)(1)

¹⁴⁴ CAL. INS. CODE § 533.

¹⁴⁵ *California Amplifier v. RLI Ins Co.*, 94 Cal App 4th 102, Cal. Ct. App. (2d Dist. 2001) (quoting *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, at 743 (Cal. Ct. App. 1st Dist. 1993)).

¹⁴⁶ See *Ins. Co. of N. Am v. ASARCO Inc.*, No. A-5557-96T1, slip op., at 55-63 (NJ. Super. Ct. App. Div. July 13, 1999) (no coverage under accident-based policy for pollution liability when insured knew the nature of chemicals it was handling and knew “that they were being continuously discharged in the environment, and...they were doing at least some harm.”).

¹⁴⁷ *Travelers Ins. Co. v. Waltham*, 883 F.2d 1092, 1099 (1st Cir. 1989).

¹⁴⁸ *AES Corp. v Steadfast Ins. Co.*, 725 S.E.2d 532, 536 (Va. 2012).

D. Draft Rules of Construction-Plain Meaning

Section (3) paragraph (2) provides

An insurance policy term is interpreted according to its plain meaning, if any, unless extrinsic evidence shows that a reasonable person in the policyholder's position could give the term a different meaning. That different meaning must be more reasonable than the plain meaning in light of the extrinsic evidence, and it must be a meaning to which the language of the term is reasonably susceptible."¹⁴⁹

This proposed departure from the majority approach appears to be another attempt by the Draft to diminish the relevance of the insurance contract.

The Draft allows the insured to disregard unambiguous terms, if the insured's understanding of the term is "more reasonable than the plain meaning."¹⁵⁰ The Draft acknowledges that "there are more jurisdictions with some version of a plain meaning rule."¹⁵¹ Notwithstanding the Draft's strained reasoning (there can be a "more reasonable" meaning than the accepted "plain meaning" of the term),¹⁵² to avoid a proliferation of litigation and to enforce the intent of the contracting parties, as evidenced in the written contract, courts "may not disregard clear provisions which the insurers inserted in [an insurance policy] and the insured accepted."¹⁵³ ¹⁵⁴ Clear and unambiguous terms in an insurance policy are to be taken and understood in their plain, ordinary and popular sense.¹⁵⁵ Courts may not by construction add or excise terms, nor distort the meaning of those used and thereby make a new contract for the parties under the guise of interpreting the writing.¹⁵⁶ "Courts "should act with extreme reluctance to interpret an agreement as implying something which the parties have specifically not included."¹⁵⁷

1. *Ambiguity and extrinsic evidence*

An ambiguity exists when a word or phrase is reasonably susceptible to more than one construction,¹⁵⁸ and there must be two reasonable interpretations in order for a court to find an ambiguity.¹⁵⁹ Moreover, "[i]n interpreting insurance contracts, courts are not at liberty to raise doubts where there are none or to make a new contract between the insured and insurer."¹⁶⁰ ¹⁶¹ Nor does the

¹⁴⁹ Restatement of the Law of Liab. Ins. § 3(2).

¹⁵⁰ *Id.*

¹⁵¹ *Id.* § 3 cmt. a.

¹⁵² *id.* § 3,

¹⁵³ *Caporino v. Travelers Ins. Co.* 62 N.Y.2d 234, 239 (2d Cir. 1984) (citations omitted).

¹⁵⁴ *See also, Foreman v Cont'l Cas. Co.*, 770 F.2d 487 (5th Cir 1985).

¹⁵⁵ *First Ins. Funding v. Fed. Ins. Co.*, 284 F.3d 799, 804 (7th Cir. 2002); *In re Enron Corp. SEC Derivative and ERISA Litig.*, 391 F. Supp. 2d 541 (S.D. Tex. 2005).

¹⁵⁶ *Vermont Teddy Bear Co., Inc. v. 538 Madison Realty Co.*, 1 N.Y. 3d 470, 475 (N.Y. 2004); *In re Reliance Ins. Co.*, 55 A.D.3d 43, 46 (N.Y. 2008).

¹⁵⁷ *Vermont Teddy Bear Co., Inc.*, 1 N.Y. 3d at 475.

¹⁵⁸ *Morgan Stanley v. New England Ins. Co.*, 225 F.3d 270, 274 (2d Cir. 2000)

¹⁵⁹ *Sher v. Lafayette Ins. Co.*, 988 So. 2d 186, 194 (La. 2008).

¹⁶⁰ *Id.* at 196 (citations omitted).

¹⁶¹ *See also Liberty v. Lone Star*, 290 Conn. 767, 796 (Conn. 2009) (the parties' differing interpretations of a policy term does not give rise to an ambiguity); *Polarome International, Inc. v. Greenwich Ins. Co.*, 404 N.J. Super. 241, 961 A.2d 29 (N.J. Super. App. Div. 2008), *cert. denied*, 199 N.J. 133, 790 A.2d 1050 (N.J. 2009).

absence of a definition for a term make the term ambiguous.¹⁶² Counter to the precedent summarized above, the new rules can create ambiguity where none exists, through the use of extrinsic evidence.

With respect to the use of extrinsic evidence, the Draft notes that “Extrinsic evidence is admissible to show the meaning of a policy term that is unambiguous on its face, but the language of the term must be susceptible to the alternative interpretation”¹⁶³ The Draft’s analysis is confusing because “unambiguous on its face” implies that the term should *not* be “susceptible to alternative interpretation.” The Draft further reasons that “the objective [of the use of extrinsic evidence] is not to determine whether the term has another reasonable interpretation and hence is ambiguous, but rather to determine whether there is another more reasonable meaning. *Id.* “Regardless of how the Draft tries to creatively frame the analysis, the Draft’s approach contradicts the widely followed “plain meaning” rule, as it permits extrinsic evidence to argue that the “plain meaning” is distinct from the true meaning. *Id.* § 3 reporter’s note. The Draft posits that “This evidence [extrinsic] informs the court’s interpretation of the term; it does not contradict that term,” when the extrinsic evidence is being offered with the sole purpose of contradicting the plain meaning.¹⁶⁴ Ultimately, the Draft’s approach can disrupt the fundamental premise of contract law: the understanding between the parties should be reflected in the agreement itself, not outside. Moreover, each term must be given full force and effect¹⁶⁵ contradicting the Draft’s assertion “that insurance policies frequently contain what might be considered redundancies or surplusage.”¹⁶⁶

By allowing the insured to offer extrinsic evidence in the absence of any ambiguity, the Draft’s rule regarding the use of extrinsic evidence contradicts the majority view: Generally, the language of an insurance policy will be given its plain meaning unless an ambiguity exists.¹⁶⁷ Parol Evidence rule generally precludes extrinsic evidence of the meaning of an insurance contract unless the policy is language is found to be ambiguous.¹⁶⁸

2. *The Draft’s flawed premise regarding unequal bargaining power*

The Draft’s suggested approach in disregarding the unambiguous policy language is presumably guided by the Draft’s view regarding the insured’s lack of bargaining power with respect to the policy language. The Draft asserts that “Even in the commercial insurance market, the vast majority of insurance policies are standard-form contracts.”¹⁶⁹ This academic perspective is detached from the market reality. Specifically, commercial policies are often heavily negotiated and manuscripted based

¹⁶² *Millsbaugh v. Ross*, 645 N.E. 2d 14, 16 (Ind. Ct. App. 1994); *In Re Katrina Canal Breaches Litig.*, 495 F.3d 191, 210 (5th Cir. 2007); *Consol. Edison v. United Coastal*, 216 A.D.2d 137, (N.Y. App. Div. 1995) (Courts should not find the language ambiguous based on the interpretation urged by one party, where that interpretation would push the contract language beyond its reasonableness and plain meaning) (citations omitted).

¹⁶³ Restatement of the Law of Liab. Ins. § 3 cmt. A.

¹⁶⁴ *Id.* § 3 cmt. g.

¹⁶⁵ *See, Westminster Secs. Corp. v. Petrocom Energy*, 456 Fed. Appx. 42, 43, 2012 WL 147917, at *1 (2d Cir. 2012) (“The rules of contract construction require us to adopt an interpretation which gives meaning to every provision of the contract”) (quoting *Panecasio v. Unisource Worldwide, Inc.*, 532 F.3d 101, 111 (2d Cir. 2008); *XL Specialty Ins. v. Level Global Inv’rs*, 874 F. Supp. 2d 263 (S.D.N.Y. 2012) (finding that the rules of contract construction require an interpretation which gives meaning to every provision of the contract); *MBIA Ins. Corp. v. Patriarch Partners*, 842 F. Supp. 2d 682, 706 (S.D.N.Y. 2012) (“an interpretation ‘that has the effect of rendering at least one clause superfluous or meaningless is not preferred and will be avoided if possible.’”) (quotation omitted).

¹⁶⁶ Restatement of the Law of Liab. Ins. § 3 cmt. h.

¹⁶⁷ *Plastics Eng’r Co. v. Liberty Mutual Ins. Co.*, 759 N.W.2d 613, 620 (Wis. 2009); *Leonard v. Exec. Risk Indem.*, 545 F.3d 661, 668 (8th Cir. 2008)

¹⁶⁸ *Chicago Ins. Co. v City of Council Bluffs*, 713 F.3d 963 (8th Cir. 2013); *AstenJohnson v. Columbia Cas. Co.*, 562 F.3d 213, 220 (3d Cir. 2009); *Merrimack Mutual Fire Ins. Co. v. Dufault*, 958 A.2d 620, 624-25 (R.I. 2008)

¹⁶⁹ Restatement of the Law of Liab. Ins. § 2 cmt. d.

upon the expert advice of the insurance broker and/or consultant and outside counsel. Market competition also plays a critical role, as the proposed policies are compared against one another by the insured's experts to determine which insurer provides the broadest coverage and to identify shortfalls in any existing policies.¹⁷⁰ An insurance contract between parties of equal bargaining power should be interpreted as an ordinary contract.¹⁷¹

Moreover, the policy forms that are issued have to be approved by the relevant state insurance authority which identifies any material gaps in coverage in the insurer's filed forms. The result is the addition of mandatory "state amendatory" endorsements that address potential gaps in coverage and other issues that are critical to the insured's protection (See Exhibit A). Therefore, in addition to the protection afforded through expert advisors and competitive market forces, the insured is also protected by the relevant regulatory authorities that review and approve the policy forms filed for use.

3. *Reasonable expectations doctrine*

The Draft seeks to impose an unqualified "reasonable expectations" standard that is not supported by case law precedent. The Draft's analysis considers "the policyholder as a member of a relevant class of insurance purchasers, with greater or lesser experience...Accordingly,...the court should employ a tailored objective standard--that of a reasonable person in the policyholder's position.... This 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."¹⁷² Therefore, the Draft further complicates the analysis, with different rules applied to different classes of insureds. Draft disclaimers notwithstanding, the Draft is moving towards a subjective standard that will be challenging to apply on a case by case basis. At a minimum, the Draft moves further away from any consistent application, as unambiguous language can be disregarded and the meaning can be different depending upon the insured's level of sophistication. Moreover, as described in the cases above, the insured's broker, coverage agent or outside counsel's expert knowledge should impute to the insured for purposes of determining the insured's level of sophistication and relevant negotiating power.

Cases assessing the "reasonable expectations" doctrine have rejected the concept outright or applied the doctrine to resolve ambiguous language or to protect the insured against terms that are "buried in fine print,"¹⁷³ unlike the Draft's unqualified application. The application of the reasonable expectations doctrine is typically limited to cases in which the policy is ambiguous and the mutual intent of the parties

¹⁷⁰ See, *Ethicon Inc. v Aetna Cas. and Sur Co.*, 737 F. Supp. 1320, 1327 (S.D.N.Y. 1990) ("A number of courts have recognized that a business insured often has "the market power to negotiate with its insurers on an even field.").

¹⁷¹ See *Penford Corp. v. National Union Fire Ins.* 662 F.3d 497, 505 (8th Cir. 2011) (finding contra proferentem rule inapplicable in light of equal bargaining power of parties and nature of drafting process); *Am. Wrecking Corp. v Burlington Ins. Co.*, 946 A.2d 1084, 1088 (N.J. App. Div 2008) ("our review must take into account that we are dealing with policies 'covering commercial risks procured through a broker, and thus involving parties on both sides of the bargaining table who were sophisticated with regard to insurance") (quoting *Werner Indus., Inc. v. First State Ins. Co.*, 112 N.J. 30, 38 (N.J. 1998)).

¹⁷² Restatement of the Law of Liab. Ins. § 3 cmt. g.

¹⁷³ See *Derrickson v. Am. Nat'l Fire Ins. Co.*, 538 A.2d 1113, 1114 (Del. 1988) ("there is no "authority[] for a court to apply rules of construction which require an insurance contract to be construed in favor of the insured, or attempt to discern the reasonable expectations of the purchaser."); *W.W.W. Assoc. v. Ginancontieri*, 77 N.Y. 2d 157, 162 (N.Y. 1990) ("Evidence outside the four corners of the document as to what was really intended but unstated or misstated is generally inadmissible to add to or vary the writing") (citations omitted).

cannot be determined.¹⁷⁴ The reasonable expectations doctrine is considered only when interpreting ambiguous policies.¹⁷⁵

4. *The “fine print” limitation to the reasonable expectations doctrine*

Courts applying the “fine print” version of the doctrine refuse to enforce unambiguous contract terms that conflict with the insured’s reasonable expectations if those terms are “buried” in “fine print”. The Delaware Supreme Court held that the insured’s reasonable expectations will trump policy terms where “the policy contains a hidden trap or pitfall, or if the fine print...take[s] away that which has been given by the large print.”^{176 177}

5. *The Draft rules are unwarranted as protections are already in place for the insured*

In rejecting the insured’s “reasonable expectations” argument, the *Allen* court reasoned “It is not clear why estoppel, waiver, unconscionability, breach of the implied duty of good faith and fair dealing, and the rule that ambiguous language is to be resolved against the drafter, for example, are insufficient to protect against overreaching insurers when applied on a case-by-case basis.” ... “The Court notes the existence of the state Insurance Code, which permits the state Insurance Department to promulgate rules regulating insurance. As part of this rulemaking and enforcement scheme: Preprinted policies for household insurance, such as the Prudential policy at issue in this case, must be filed with the commissioner. The commissioner may disapprove a preprinted policy at any time if it is found to be “inequitable, encourages misrepresentation.” Thus, the validity of preprinted insurance contracts is premised on executive approval”... “[o]ur prior case law demonstrates our tradition of deferring to the legislature on questions of general policy when considering the validity of insurance policies.” “Taken as a whole, [prior] cases show our unwillingness to alter fundamentally the terms of insurance policies in the

¹⁷⁴ See *W3i Mobile v. Westchester*, 632 F.3d 432, 438 (8th Cir. 2011) (under Minnesota law reasonable expectations doctrine is limited to resolving ambiguities and is not a license for rewriting policy terms); *Noble Energy v. Bituminous Cas. Co.*, 529 F.3d 642, 648 (5th Cir. 2008) (“under Texas law, the reasonable expectations on the insured are not to be considered when the policy language is unambiguous”) (*Qualcomm Inc. v. Certain Underwriters at Lloyd’s, London*, 161 Cal. App. 4th 184, 193, Cal. Ct. App., 4th Dist. 2008) ([a]n expectation of coverage cannot create an ambiguity; it is merely an interpretive tool used to resolve an ambiguity once it is found); *150 Broadway N.Y. Assoc., L.P. v. Bodner*, 14 A.D.3d 1, 4 (N.Y. App. Div. 2004) (“[i]t is a court’s task to enforce a clear and complete written agreement according to the plain meaning of its terms without looking to extrinsic evidence to create ambiguities not present on the face of the document.”) (citations omitted); *Farmers Ins. Exch. v. Young*, 832 P. 2d 376, 379 (Nev. 1992) (expectations analysis only applicable when contested policy language is ambiguous or otherwise problematic).

¹⁷⁵ *Carley v. Lumber-man’s Mut. Cas. Co.*, 521 A.2d 1053, 1057-58 (Conn. App. Ct.1987); *Eli Lilly and Co. v. Home Ins. Co.*, 482 N.E.2d 467, 470 (Ind. 1985); *Allstate Ins. Co. v. Elwell*, 513 A.2d 269, 271 (Me. 1986); *Lutshy v. Blue Cross Hosp. Serv., Inc.*, 695 S.W.2d 870, 875 (Mo. 1985); *State Farm Mut. Auto. Ins. Co. v. Desfosses*, 536 A.2d 205, 208 (N.H. 1987); *Fox v. 18-05 215 Street Owners, Inc.*, 535 N.Y.S.2d 386, 387 (N.Y.App. Div. 1988); *Standard Venetian Blind Co. v Am. Empire Ins. Co.*, 469 A.2d 563, 567 (Pa.1983).

¹⁷⁶ *Hallowell v. State Farm Ins. Co.*, 443 A.2d 925, 927-28 (Del. 1982). See also *Stoms v. Federated Service Ins. Co.*, 125 A.3d 1102, 1109 (Del. 2015).

¹⁷⁷ See also *Aetna Cas. & Surety Co. v Velasco*, 240 Cal. Rptr. 290, 292-93 (Cal. Ct. App. 2d 1987) (ordered not to be officially published) (“exclusion was “relatively unambiguous,” but “buried in a lengthy form contract” and “the agent failed to mention any exclusions to [the insured]” therefore the court read the exclusion out of the policy); *Gordinier v Aetna Cas. & Surety Co.*, 742 P.2d 277, 84 (Ariz.1987) (finding that the average customer checking his rights under the policy could readily understand them because the contested limitation was inconspicuous and scattered over the policy to a degree where the insured might not even notice that his spouse had not been designated a named insured).

absence of legislative direction . . . Today, we again affirm the principle of deferring to legislative policy in considering the facial validity of an insurance provision.”¹⁷⁸

Although the Draft distinguishes between a term that is “unambiguous ‘on its face’ when applied to the claim in question”¹⁷⁹ and a term that “has more than one meaning to which the language of the term is reasonably susceptible when applied to the claim,”¹⁸⁰ the unambiguous terms can still be disregarded through extrinsic evidence and the insured’s reasonable expectations.¹⁸¹ This approach contradicts the Draft’s goal of providing consistency, as universally accepted meanings can be disregarded in favor of insured expectations, which will vary further under the Draft proposal based upon that insured’s level of sophistication. This approach will likely result in a spike in coverage litigation, wherein insureds can dispute the “true meaning” of unambiguous terms and essentially re-write the negotiated insurance contract. The insurer’s claim handling expenses could increase dramatically, causing premiums to increase significantly. The negotiated language may not be enforceable, creating widespread underwriting uncertainty, consistent with the Draft’s apparent goal of moving away from the fundamental contractual relationship between insurer and insured towards the insurer as financial guarantor. The Draft would permit the rewriting of the contract by a court, limited solely by the insured’s expectations. There is no more justification to rewrite an insurance policy than any other contract and the Draft interferes with the parties’ fundamental freedom to contract. The Draft imposes duties on the insurer in addition to those stipulated in the insurance policy, breaking from traditional contract law wherein the contracting parties’ duties are determined by the written contract.

E. Insurer’s Ability to Rescind

Section 8 provides that a misrepresentation by or on behalf of an insured during the application or renewal of an insurance policy is material only if, in the absence of the misrepresentation, a reasonable insurer in the insurer’s position would not have issued the policy or would have issued the policy under substantially different terms.¹⁸²

Section 8 reflects another Draft rule that would impose a new legal standard for insurers, requiring the insurer to prove that it would have issued a policy on “substantially different terms” in the event that the insured makes misrepresentations during the insurance application or renewal process.¹⁸³ What qualifies as “substantially different terms” remains unanswered. The Draft diverges from case law precedent regarding the insurer’s burden following a misrepresentation by the insured in the underwriting process.

1. *Presumed Materiality*

The general rule is that a material misrepresentation or omission made in an application for insurance will void the insurer’s obligations under the policy.¹⁸⁴

¹⁷⁸ *Allen v. Prudential Prop. and Cas. Ins. Co.*, 839 P.2d 798, 805 (Utah 1992).

¹⁷⁹ Restatement of the Law of Liab. Ins. § 3 cmt. a.

¹⁸⁰ *Id.* § 3 cmt. d.

¹⁸¹ *Id.* § 3 cmt. f.

¹⁸² *Id.* § 8.

¹⁸³ *Id.*

¹⁸⁴ See *Cont’l Cas. Co. v. Law Offices of Melbourne Mills, Jr. PLLC*, 676 F.3d 534, 541 (6th Cir. 2012); *Cedar Hill Hardware and Constr. Supply, Inc. v. Ins. Corp. of Hannover*, 563 F.3d 329, 356 (8th Cir. 2009); *Carroll v. Metro. Ins. & Annuity Co.*, 166 F.3d 802, 804 (5th Cir. 1999); and *Christiania General Ins. Corp. of New York*, 979 F.2d at 279 (“Of course, materiality must be assessed as of time contract was entered into.”) (citing *Cohen v. Cont’l Life Ins. Co.*, 69 N.Y. 300, 307 (N.Y. 1877)).

Some courts have reasoned that when an insurer specifically requests information in an insurance application, that information is material as a matter of law.¹⁸⁵ The obvious rationale for this result is the equitable notion that in making underwriting decisions and in setting premiums for the risks it underwrites the insurer has the right to obtain information from applicants and to rely upon it as true and to govern its actions according to that reliance.^{186 187}

Some courts have also mandated that certain information is presumed to be material as a matter of law. For example, concealment of a serious disease in a life insurance application, failure to disclose the insured's true financial condition or circumstances that could lead to litigation in a "directors and officers" insurance application and where the insured would know that concealed facts would be a material concern to the insurer.¹⁸⁸

2. *Substantially different terms is not the legal standard*

The prevailing view holds that a misrepresentation or omission is deemed "material" if it affects the insurer's decision to enter into the contract, its evaluation of the degree or character of the risk, or premium calculation.¹⁸⁹

An insurer may void coverage if the insured makes material misrepresentations in obtaining it.¹⁹⁰ In fact, the rule voiding coverage for misrepresentations is black-letter insurance law. "If a party to the contract is deprived of some important piece of information that would affect that party's willingness to contract, and the other party may be considered responsible for this state of affairs, the party so deprived of information should not have to live up to the terms of the contract."¹⁹¹ Proof of materiality is generally offered through common-sense, self-evident testimony of underwriters who explain why something affects the underwriting process, but no particular type of evidence is required.¹⁹²

¹⁸⁵ See *New Hampshire Ins. Co. v. C'est Moi, Inc.*, 519 F.3d 639, 939 (9th Cir. 2008) ("[t]he fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law.") *cert. denied*, 129 S. Ct. 639 (U.S. 2008); *Cass Bank & Trust Co. v. National Indem. Co.*, 326 F.2d 308, 309-10 (8th Cir. 1964) (enforcing policy provision that the policy is voidable if insured concealed or misrepresented any material fact.); *Allied Prop. and Cas. Ins. Co. v. Good*, 938 N.E.2d 227, 234 (Ind. App. 2010) (applicants' false statements on a policy application rendered the policy void *ab initio*).

¹⁸⁶ *Modisette v. Foundation Reserve Ins. Co.*, 427 P.2d 21, 25 (N.M. 1967) ("The insurer has the right to set up its own standards, to avail itself of its own experience and the experience of others, to secure information from the applicant, and to rely upon the information furnished as true and to govern its actions accordingly") (citing *Chamberlain v. National Life & Accid. Ins. Co.*, 76 S.W.2d 628 (Ky. Ct. App. 1934)).

¹⁸⁷ See also *In re Payroll Express Corp.*, 216 B.R. 344, 357 (S.D.N.Y. 1997), (information requested is presumed to be material because the insurer determines what information is critical to its assessment of the risk and asks questions that will elicit such information. Anyone completing the application is put on notice that the insurer considers the facts requested to be material) *aff'd*, 186 F.3d 196 (2d Cir. 1999), *cert. denied*, 529 U.S. 1019 (2000).

¹⁸⁸ *Am. Int'l Specialty Ins. Co. v. Towers Financial Corp.*, 1997 WL 906427, at *8 (S.D.N.Y. Sept. 12, 1997); *Ris v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 86 CIV. 9718 (RO), 1989 WL 76199, at *2 (S.D.N.Y. July 6, 1989) (citing *Cohen v. Mutual Benefit Life Ins. Co.*, 638 F. Supp. 695, 697 (E.D.N.Y. 1986)); *Jaunich v. Nat'l Union Fire Ins. Co.*, 647 F. Supp. 209, 211 (N.D. Cal. 1986) (applying California law).

¹⁸⁹ *Cedar Hill Hardware & Constr. Supply, Inc.*, 563 F.3d at 339; *Carroll*, 166 F.3d at 804; *Mut. Benefit Life Ins. Co. v. JMR Elecs. Corp.*, 848 F.2d 30, 32-33 (2d Cir. 1988).

¹⁹⁰ *Curanovic v. New York Cent. Mut. Fire Ins. Co.*, 762 N.Y.S.2d 148, 150 (N.Y. App. Div. 2003); *accord* N.Y. INS. LAW §3105 (2006).

¹⁹¹ 6 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance*, § 81:1, at 81-9 (3d ed. 2005).

¹⁹² *Old Line Life Ins. Co. v. Superior Court of Alameda County*, 229 Cal. App. 3d 1602, 1603-04 (Cal. Ct. App. 1991); *Imperial Cas. & Indem. Co. v. Sogomonian*, 198 Cal. App. 3d 169, 179-81 (Cal. Ct. App. 1988); *Holz*

- (a) *The insurer is only required to demonstrate that it would not have issued the policy with the same terms and conditions*

A misrepresentation is material if knowledge of the true facts might have caused the insurer to decline to issue the policy on the *same terms* or for the *same premium*.¹⁹³ The analysis is based upon a “reasonable person” standard and considers the insurer’s underwriting practices based upon the underwriter’s testimony.¹⁹⁴ Also, the evidence is viewed from the insurer’s perspective, i.e., would the insurer at issue have issued *the same coverage on the same terms and at the same price* if the requested information was accurately provided by the insured.¹⁹⁵

When an insured misrepresents facts that affect the insurer’s decision The effects can go beyond a single policy or insured; by causing higher risks to be categorized inappropriately as lower risks, an insured’s misrepresentations can upset risk pools and drive up costs for all insureds. The rule against misrepresentations permits insurers to rely on statements that applicants make when seeking coverage. Absent such reliance, insurers would be forced to incur the burden, delay and expense of making their own investigations into facts that are within the applicant’s knowledge and control.¹⁹⁶

The new standard imposed by the Draft allows the insured to misrepresent facts that could lead to higher premiums or more restrictive coverage terms, with the insurer bearing the burden of proving that it would have only offered the policy under “substantially different terms.”¹⁹⁷ The insurer’s ability to rely upon the accuracy of the underwriting information/application is threatened, likely leading to tighter underwriting standards and less insurance applications accepted for coverage. Losses may increase due to inadequately priced/underwritten policies ---policies that would have been issued on different terms, but not necessarily rising to the elusive “substantially different” standard required by the Draft.¹⁹⁸

F. Duty to Cooperate

Section 30, “Consequences of the Breach of the Duty to Cooperate, acknowledges in Comment b: *The standard for prejudice* that most courts do “not require that the insurer demonstrate that the insured’s lack of cooperation would have allowed it to defeat the legal action,” but, nevertheless, concludes:

Rubber Co., Inc. v. Am. Star Ins. Co., 14 Cal. 3d 45, 61 (Cal. 1975) (“Materiality is determined by the probable and reasonable effect that truthful disclosure would have had upon the insurer in determining the advantages of the proposed contract.”); *Old Line Life*, 229 Cal. App. 3d at 1604-06 (materiality was established where the evidence indicated that the insurer would have charged higher premiums); *Wilson v. Western National Life Ins. Co.*, 235 Cal. App. 3d 981, 995 (Cal. Ct. App. 1991); *Williamson & Vollmer Engineering, Inc. v. Sequoia Ins. Co.*, 64 Cal. App. 3d 261, 272 (Cal. Ct. App. 1976) (“An underwriter testified that if the true circumstances had been disclosed the policy would only have issued with an endorsement excluding liability for any services under the contract in question.”).

¹⁹³ *Christiania Gen’l Ins. Corp.*, 979 F.2d at 278; N.Y. Ins. Law §3105(b). See also, e.g., *Aetna Cas. & Sur. Co. v. Retail Local 906*, 921 F. Supp. 122, 131 (E.D.N.Y. 1996) (“Thus, the insurer need not prove that it would not have issued any policy at all, but that the *policy in question would not have been issued.*”) (citations omitted), *aff’d*, 106 F.3d 34 (2d Cir. 1997).

¹⁹⁴ E.g. *Falcon Crest Diamonds, Inc. v. Dixon*, 655 N.Y.S.2d 232, 236-37 (N.Y. Sup. Ct. 1996) (underwriter’s affidavit regarding significance of application questions demonstrated materiality).

¹⁹⁵ *Geer v. Union Mut. Life Ins. Co.*, 273 N.Y. 261, 266-67 (N.Y. 1937); *Old Line Life*, 229 Cal. App. 3d at 1604-06; *Imperial Cas.*, 198 Cal. App. 3d at 177-82; *Williamson*, 64 Cal. App. 3d at 272 (material if the undisclosed or misrepresented information would have led the insurer not to issue the policy, or to issue the policy on different terms or for a different premium).

¹⁹⁶ See, e.g., *Skinner v. Norman*, 59 N.E. 309, 310 (N.Y. 1901) (“The company may rely on the presumption that the insured has stated all the material facts, and as a rule, is not bound to make inquiries.”).

¹⁹⁷ Restatement of the Law of Liab. Ins. § 8.

¹⁹⁸ *Id.*

“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...*”¹⁹⁹

1. “Outcome” test in comment (b) is not supported by case law

A minority of jurisdictions do not require the insurer to demonstrate that it was prejudiced as a result of the insurer’s failure to cooperate.²⁰⁰ With respect to states requiring prejudice, the insurer is not required to demonstrate that the failure to cooperate prejudiced the insurer in the “outcome of the claim.” Rather, courts focus on whether the failure to cooperate impaired the insurer’s rights under the insurance contract.²⁰¹

2. Comment (b) only speaks to “full or partial defense to liability” neglecting any coverage considerations

As highlighted in the *Northwest Prosthetic*²⁰² and *Prince George’s County*²⁰³, insurers will be deemed to have been prejudiced if the insured’s failure to cooperate impairs the insurer’s ability to assess coverage or raise coverage defenses. However, Section 30 completely ignores this essential aspect of the insured/insurer relationship and the detrimental effect on the market if insureds are permitted to stonewall the insurer’s investigation and coverage determination process.

¹⁹⁹ Restatement of the Law of Liab. Ins. § 30 cmt. b.

²⁰⁰ *E.g. Atl. Mut. Ins. Co. v. Struve*, 210 A.D.2d 112, 114 (N.Y. App. Div. 1994), *appeal denied*, 85 N.Y.2d 803, 648 N.E.2d 793, 624 N.Y.S.2d 373 (1995).

²⁰¹ See *Allstate Ins. Co. v. Occidental Int’l, Inc.*, 140 F.3d 1, 5 (1st Cir. 1998); *Northwest Prosthetic & Orthotic Clinic, Inc. v. Centennial Ins. Co.*, 997 P.2d 972, 976 (2000) (“The loss of a meaningful opportunity to investigate a debatable claim before it is settled is, by itself, a sufficiently concrete detriment to establish actual prejudice.”); *Am. Access Cas. Co. v. Alassouli*, 31 N.E.3d 803, 814 (Ill. App. Ct. 2015) (“An insurer must demonstrate that ‘it was actually hampered’ in its investigation or defense by the insured’s violation of the cooperation clause.”) (citing *M.F.A. Mut. Ins. Co. v. Cheek*, 66 Ill. 2d 492, 499 (Ill. 1977); *Tran v. State Farm Fire and Cas. Co.*, 961 P.2d 358, 366-67 (Wash. 1998) (summary judgment appropriate where the insured’s breach of a notice cooperation clause prevented the insurer from conducting a meaningful investigation of a claim or presenting a viable defense to a claim); *Unigard Ins. Co. v. Leven*, 97 Wn. App 417, 435 P.2d 1155 (1999); *Prince George’s County v. Local Gov’t Ins.Trust*, 388 Md. 162, 189 (Md. 2005) (The court rejected the proposition that [insurer] was required to prove prejudice other than the denial of its contractual rights [to investigate, evaluate coverage, choose defense counsel and attempt to settle] ... ‘We do not perceive that Article 48A, § 482 of the Maryland Code requires the insurance carrier to assume the burden of proving a negative. It is impossible for the carrier to demonstrate to the court what witnesses it might have discovered, what defense it might have made, and what disposition it might have reached in settlement if it had received notice before the verdict was rendered in this case.’) (citing *Washington v. Federal Kemper Ins.*, 60 Md. App. 288, 482 A.2d 503 (Md. Ct. Spec. App. 1984)); *Ward v. Custom Glass & Frame, Inc.*, 663 N.E.2d 734, 736 (Ohio Ct. App. 1995) (“the totality of the circumstances” will be considered when evaluating whether an insured’s breach of the insurance contract by failing to comply with the obligations of the cooperation clause is material); Richard L. Suter, *Insurer Prejudice: Analysis of an Expanding Doctrine of Insurance Coverage Law*, 46 ME. L. Rev. 221, 222-225 (1994) (“Generally speaking, courts have found prejudice from the insured’s breach of a cooperation clause where the purposes of the cooperation requirement have been defeated. For instance, if the insurer is unable to properly investigate a claim, to prepare an adequate defense or to pursue a subrogation action, the insurer may be deemed prejudiced by the insured’s acts and/or omissions in violation of the applicable cooperation clause.”)

²⁰² *Northwest Prosthetic*, 997 P.2d 972. See fn. 241.

²⁰³ *Prince George’s County*, 997 P.2d 972. See fn. 241.

3. *Comment (b) neglects prejudice recognized as a result of collusion between the plaintiff and the insured*

An insured's breach of an insurance policy's cooperation clause nullifies the insurer's coverage obligations... the insurer satisfied its burden of proof ... by showing that [the insured] actively colluded with [the plaintiff].²⁰⁴ ²⁰⁵ Cooperation provisions in an insurance contract are designed to "protect [] the insurer's right to a fair adjudication of the insured's liability [and to] prevent [] collusion between the injured person and the insured," and are necessary for the protection of the insurer.²⁰⁶ Not only does Section 30 discount collusive behavior as a breach of the duty to cooperate, Section 30 permits collusion under certain circumstances.

4. *Comment (b) neglects prejudice resulting from a breach of the subrogation clause*

Insurance policies typically contain a subrogation clause, which provides:

In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

The subrogation clause provides basic protection for the insurer in the event that the insurer pays on behalf of the insured and the insured was entitled to contribution from a third party. The insured's basic cooperation obligation under the subrogation clause is a fundamental aspect of the insured/insurer relationship.²⁰⁷ The cooperation clause is considered a condition precedent to coverage.²⁰⁸ Accordingly, when the insured deliberately fails to cooperate with its insurer in the investigation of a covered claim as required by the policy, the condition will remain unsatisfied, and the insurer may disclaim coverage.²⁰⁹ However, under the Draft, the insured is no longer obligated to honor this basic insurance principal because failure to do so may not be outcome determinative.²¹⁰

One of the regulator's primary functions is to fight fraud and to encourage good conduct. Section 30 permits the insured to conceal bad coverage facts and to even collude with the plaintiff under certain circumstances, allowing the parties to set the insurer up for excess of limits claims under Sections 24 and 27.²¹¹ The insurer is dissuaded from mitigating the insured's failure to cooperate because under Section 30, the failure to cooperate is not a defense unless outcome determinative.²¹² The lack of protection for

²⁰⁴ *Charter Oak Fire Ins. Co. v. Interstate Mechanical, Inc.*, 958 F. Supp. 2d 1188, (D. Or. 2013), vacated on other grounds 2014 WL 9849553 (D. Or. 2014).

²⁰⁵ See also, *M.F.A. Mutual Ins. Co.*, 66 Ill. 2d at 496 (cooperation clause prevents collusion between the insured and injured and enables an insurer to prepare its defense to a claim); *Holt v. Utica Mutual Ins. Co.*, 759 P.2d 623, 627 (Ariz. 1988)

²⁰⁶ *Holt*, 759 P.2d at 629.

²⁰⁷ *Paxton Nat'l Ins. Co. v. Brickajlik*, 522 A.2d 531, 532 (Pa. 1987) ("Both lower courts correctly agreed that [insured's] refusal to sign the complaint constituted a breach of both the subrogation and cooperation clauses.").

²⁰⁸ *Wilson v. Farmers Ins. Group*, 655 N.W.2d 414, 416 (N.D. 2003); *Am. Transit Insurance Co. v. Sartor*, 3 N.Y.3d 71, 78, 781 N.Y.S.2d 630, 634 (N.Y. 2004).

²⁰⁹ *New York Central Mut. Fire Ins. Co. v. Salomon*, 11 A.D.3d 315, 316 (N.Y. App. Div. 2004); *Lentini Bros. Moving & Storage Co. v. New York Prop. Ins. Underwriting Ass'n.*, 53 N.Y.2d 835, 836, 440 N.Y.S.2d. 174 (N.Y. 1981); *Mosley v. Allstate Ins. Co.*, 996 P.2d 513, 517 (Or. Ct. App. 2000).

²¹⁰ Restatement of the Law of Liab. Ins. § 30 cmt. b.

²¹¹ See *id.*

²¹² *Id.*

the insurer under Section 30, including the insurer's inability to subrogate on behalf of the insured, will make it difficult for the insurer to appropriately investigate claims and to associate in or effectively manage the defense of claims and allows the insured to collude with the plaintiff to create bad faith liability.

G. Implied-in-Law Terms and Restrictions

Section 46 (1) is another provision under the Draft that allows the parties to rewrite the negotiated policy under various circumstances and is another instance wherein the Draft diminishes the role of the regulator.

1. *"Sources of positive law" as a means to rewrite insurance policies*

The Restatement (Second) of Contracts § 178 (1981) mandates that a policy term is only unenforceable due to specific legislation or clear public policy considerations,²¹³ whereas Comment *a.* provides that "authoritative source[s] of positive law" can also provide implied-in-law terms or restrictions²¹⁴ notwithstanding the fact that courts are understandably loathe to rewrite insurance policies.²¹⁵

2. *Common law as basis for implied-in-law terms and restrictions will create further uncertainty*

"Authoritative sources of positive law" include statutes, regulations, and the common law."²¹⁶ The "common law" addition creates unnecessary uncertainty for the contracting parties. Either of those parties to the contract can simply argue that a particular case supports their position for the inclusion of an implied in law term or the voiding of an existing term, including precedent that was unforeseeable or unknowable to the parties at the time of contracting. Therefore, consistent with other Draft rules, Section 46 allows policy language to be re-written after the fact, beyond the traditional legislative or public policy considerations.

²¹³ The Restatement (Second) of Contracts § 178 (1981)

²¹⁴ Restatement of the Law of Liab. Ins. § 46 cmt. a.

²¹⁵ See *Westminster Sec. Corp.*, 456 Fed. Appx. at 43 ("The rules of contract construction requires us to adopt an interpretation which gives meaning to every provision of the contract."); *Level Global*, 874 F. Supp.2d at 280 ("An insurance contract is interpreted to give effect to the intent of the parties as expressed in the clear language of the contract.") (citing *Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marine Ins. Co.*, 472 F.3d 33, 42 (2d Cir. 2006)); *Simpson v. American Auto. Ins. Co.*, 327 S.W.2d 519, 528 (Mo. Ct. App. 1959) (quoting *Forir v. Toman*, 202 S.W.2d 32, 34 (Mo. 1947)) ("Courts are without authority to rewrite contracts, even insurance contracts."); *Angus v. Western Heritage Ins. Co.*, 48 S.W.3d 728, 731 (Tenn.Ct.App. 2000) ("We are not at liberty to rewrite an insurance policy simply because we do not favor its terms or because its provisions produce harsh results. In the absence of fraud, overreaching, or unconscionability, the courts must give effect to an insurance policy if its language is clear and its intent certain."); *In re Merrill Lynch Trust Co. FSB*, 235 S.W.3d 185, 191 (Tex. 2007); *Blasing v. Zurich Am. Ins. Co.*, 850 N.W.2d 138, 142 (Wis. 2014) (refusing to rewrite the insurance policy to avoid an absurd result); *MBIA Ins. Corp.*, 842 F. Supp. 2d at 706 ("A contract interpretation 'that has the effect of rendering at least one clause superfluous or meaningless is not preferred and will be avoided if possible.'") (citing *LaSalle Bank Nat. Ass'n v. Nomura* 195, 206 (2d Cir. 2005)); *Trishan Air, Inc. v. Federal Ins. Co.*, 635 F.3d 422, 431 (9th Cir. 2011) (court is bound to enforce the language as written, and is not at liberty to rewrite the insurance contract).

²¹⁶ Restatement of the Law of Liab. Ins. § 46 cmt. a.

3. *Section 46 neglects the regulator's function and potentially impacts the parties' freedom to contract*

With respect to unenforceability based upon applicable statutes or regulations, comment (a) acknowledges that “typically the applicable statutes and regulations are part of the state insurance code or regulations.” Moreover, one of the regulator’s primary functions is to ensure that proposed policy forms do not violate any existing statute or regulation. Regulators regularly address these issues by requiring the addition of “state amendatories” to address any inconsistencies with state law. Therefore, terms or conditions that are in violation of applicable state law should not be approved for use in the filed forms. Subsequently, Section 46 is yet another example of the Draft creating unnecessary and elusive legal requirements (implied in law terms based upon common law) that can have significant ramifications for both the insured and the insurer, while marginalizing the regulator’s role. The ambiguity created by the “authoritative source of positive law” trigger for disregarding policy language will likely encourage more coverage litigation, because plaintiffs will undoubtedly argue that any court decision alluding to vague public policy concerns qualifies (for example, courts are split on whether there is a public policy prohibition regarding the insurability of contractual liability), creating more uncertainty for the insurance market and the parties who rely upon the negotiated policy language, extending well-beyond precedent regarding the court’s ability to rewrite the insurance contract due to “public policy” considerations. Therefore Section 46 will add to the uncertainty created by other Draft rules creating further market disruption by moving further away from the parties’ freedom to contract and the negotiated contract itself.

IV. Conclusion

Contrary to the Draft’s presumption regarding the vulnerability of the insurance consumer, comprehensive regulatory oversight, extensive insurance laws and regulations, well-developed case law and competitive market forces are already in place to protect the consumer. Therefore, the highlighted Draft rules are unnecessary and overreaching. Those rules also depart from case law and attempt to displace the role of the regulator.

If the Draft rules are adopted by the courts, there could be a material and lasting impact in the insurance market because fundamental insurer protections such as negotiated limits, the right to rely upon unambiguous policy language and the ability to enforce exclusions (punitive damages) are diminished, with the insurer as guarantor. In sum, the insurer loses the ability to enforce the negotiated contract. The Draft rules, if adopted, could significantly increase insurer losses and expenses and historical rates and claim reserving practices may be found inadequate. That combination could threaten the solvency and claim paying ability of participating insurers and the anticipated losses, underwriting uncertainty and loss of fundamental contractual protections could lead to insurers exiting the market. The result could be a less competitive market where the remaining insurers would have greater leverage.

The potential cumulative effect of the Draft could materially detriment the insurance consumer because the less competitive and more cautious market will likely tighten underwriting terms and conditions and decrease available limits in response to the increased losses, elimination of contractual protections, the inability to enforce the contract and underwriting uncertainty. Premiums will likely increase significantly. The end result will be more uninsured and underinsured consumers.

While the regulator is focused on promoting good conduct to produce a fair and efficient market, the Draft incentivizes bad conduct. Examples include permitting collusion between the plaintiff and the policyholder under certain circumstances in Section 32, a presumption of coverage for intentionally harmful conduct under Section 47 unless otherwise prohibited under Section 46, protection for the insured for failing to cooperate with the insurer under Section 30 and coverage for punitive damages that are assessed against the policyholder even when excluded in the policy under Section 27. The impact of the

Draft may extend well beyond the insurance market to the economy generally, as insurance is a necessity to most business operations and the availability, affordability and quality of insurance can impact those businesses. The Draft may have intended to benefit the insurance consumer, but it is likely that the highlighted overreaching and unnecessary Draft rules, if adopted by the courts, will ultimately harm the insurance consumer due to the overall market impact as described above.

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