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Examining the Restatement of the Law, Liability Insurance

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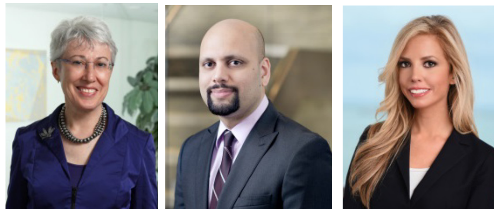

In late May 2017, the American Law Institute met to approve its new Restatement of the Law, Liability Insurance. This is the first Restatement to address the law of insurance coverage. While not law itself and not binding authority on courts, Restatements aim to "provide clean formulations of common law and its statutory elements" and seek to "reflect the law as it presently stands or might appropriately be stated by a court." The Restatement is thus relevant to corporate policyholders and their risk managers because many courts consider Restatements to be persuasive, and may look to them in formulating their decisions in coverage disputes particularly in those jurisdictions that lack extensive case law on common insurance coverage issues. In addition, risk managers should be aware of the Restatement rules because many are specifically called "default rules," meaning that policyholders (and insurers) may contract around these rules.

Not surprisingly, many of the issues discussed in the Restatement have been hotly contested by insurers with the reporters ultimately opting to state the majority rule on the vast majority of issues. In a few instances, however, the Restatement may state, after the Institute's extensive dialectical process, what the ALI considers the "better rule" and thus seeks to move the law on key issues in a way that aligns the law and the incentives underlying insurance and claims-handling. Below, we analyze sections of the Proposed Final Draft of the Restatement that have generated the most debate. Those sections address policy interpretation principles, the standard for determining an insurer's duty to defend, the insurer's "duty to settle," and the allocation of liability in long-tail claims.

Principles of Policy Interpretation**:** Section three adopts the plain meaning rule for interpretation of "standard-form" policy terms, stating: "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 would 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."

As noted in the comments, "a meaning that is plain to a judge examining an insurance policy may differ from the meaning that is plain in the circumstances in which such policies are sold."

While insurers support the plain meaning rule in Section 3(1), they reject the "extrinsic evidence exception" in Section 3(2) because, according to one motion, it "ignores the majority rule and dominant trend in the law, and expands the reasonable expectations doctrine," which in comments the Restatement declines to follow. Insurers also argue that this rule will encourage litigation and thus increase the costs of

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resolving claims. In an April 2017 law review article, the Reporters explain that the Section 3 approach is consistent with the contextual approach of the Restatement (Second) of Contracts and, in fact, gives more weight to plain meaning than the Contracts Restatement does. While we might favor an approach that coincides with that of the Contracts Restatement, we believe that this formulation is a reasonable approach, consistent with the practical approach taken by most courts.

Another fervently debated issue was Section 4's rule on interpretation of ambiguous policy terms. In many jurisdictions, like Florida, absent contrary policy language, ambiguous policy terms are to be construed against the drafter—the insurer—and in favor of coverage for the insured. Thus, Section 4 largely accords with the law in most jurisdictions and deems a policy term ambiguous "if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the claim in question, without reference to extrinsic evidence regarding the meaning of the terms."

Insurers also challenged this provision, but the "ambiguity rule" is a clear majority rule not just for insurance policies, but for contracts in general, as shown in the Contracts Restatement. Nonetheless, insurers or policyholders may contract around the "ambiguity rule" and resulting presumption, and in fact, frequently do as demonstrated by the Bermuda Form's provision expressly forbidding such an interpretation and instead requiring unclear or ambiguous policy terms to be resolved "in the manner most consistent with the relevant provisions, exclusions and conditions (without regard to authorship of language, without any presumption or arbitrary interpretation of construction in favor of the insured or the company or reference to the 'reasonable expectations' of either thereof…)."

***Potentiality Standard for Insurers' Duty to Defend*:** Section 13 also caused quite a stir at the annual meeting, which may not be surprising as the duty to defend is one of the most common areas of dispute between insurers and insureds. At the ALI's 2016 annual meeting, insurers asked for this section to include exceptions where "objective facts" show that coverage cannot apply. In 2017, the complaint was that the exceptions were too narrow. That section first defines the applicable standard as the traditional "potential for coverage" standard included in the "four corner/eight corners" rule adopted in most jurisdictions. *See, e.g., GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church*, ("Under the eight-corners or complaint-allegation rule, an insurer's duty to defend is determined by the third-party plaintiff's pleadings, considered in light of the policy provisions, without regard to the truth or falsity of those allegations."). Once the duty to defend applies, "[t]he insurer must defend until its duty to defend is terminated under § 18 by declaratory judgment or otherwise," unless facts as to which there is no genuine dispute establish that:

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

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

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer's performance is excluded under the rule stated in § 36(s); or

(d) There is no duty to defend because the insurance policy has been properly cancelled.

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The comments recognize the conflict between the insurer's desire to limit its defense exposure based on facts known to it, but outside of the complaint; and the insured's expectation of a defense based on the allegations of the complaint—a document over which it has no control. The comments explain the public-policy concerns with the proposal that insurers be able to consider "an all-the-facts-and-circumstances approach" that extends well beyond the exceptions stated in Section 13(3) and would eliminate the common rule that the insurer must pursue a declaratory-judgment action before rejecting its duty to defend. That approach creates inherent uncertainty for insureds who would be forced to finance their own defense and then file a breach of contract action against the insurer to seek reimbursement.

Insurer's Duty to Settle: Section 24 recasts this duty as the insurer's duty to make reasonable settlement decisions when an insurer controls the defense of an action against an insured or the policy requires the insurer's consent to settlement payable by the insurer. 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" and "includes the duty to make its policy limits available to the insured for the settlement of a covered [claim] that exceeds those policy limits if a reasonable insurer would do so in the circumstances." Under Section 27, an insurer that breaches this duty is liable for "the full amount of damages assessed against the insured in the underlying action, without regard to the policy limits, as well as any other foreseeable harm caused" by the breach. The comments explain that this standard "align[s] the interests of insurer and insured in cases that expose the insured to damages in excess of policy limits." The comments also provide that insurers have the affirmative duty to make a settlement offer when an excess judgment is a possibility.

Some challenges to Section 24 conceded that the "framework" in the black letter "broadly reflects current law." However, insurers challenged the comments, arguing that they go farther than the black-letter law, suggesting, for example, that an insurer may have an obligation to make a reasonable settlement offer even in the absence of a settlement offer by the plaintiff, if "a reasonable insurer that bore the sole financial responsibility for the full amount of the judgment would do so." In addition, they argue that the comments "give allegations actual value," even if the settlement expectation of the claimant is unreasonable. They also argue that damages should apply only if the breach of this duty causes an excess judgement to be entered against the policyholder. Finally, they objected that Section 24 provides for coverage of an award of punitive damages against the policyholder even in those states where such coverage is void as against public policy.

There is room for debate on the standard for this duty. While some jurisdictions require the insurer to initiate settlement negotiations where its insured faces likely excess liability, many do not. *Compare* the Florida case of *Goheagan v. Am. Vehicle Ins. Co.*, in which the court explained that "[w]here liability is clear, and injuries so serious that a judgment in excess of the policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations" with the California appellate case of *Reid v. Mercury Ins. Co.*, explaining that nothing in California law supports the proposition that bad-faith liability for failure to settle may attach if an insurer fails to initiate settlement discussions, or offer its policy limits, as soon as an insured's liability in excess of policy limits has become clear. Nor will this court make such a rule of law." However, this standard and the foreseeability standard for damages assessed for the breach of this duty is straight out of "Contracts 101."

Allocation of Long-Tail Liability: Section 42 addresses liability for long-tail harm claims, such as environmental disasters or asbestos claims. Courts around the country have adopted one of two general approaches for allocating liabilities for indivisible harm for such claims: "all sums" allocation and

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variations of “pro rata” allocation. Under the “all sums” theory, the insured may recover the full limits from any of the triggered policies. In contrast, under the “pro rata” approach, the court will allocate the insured’s indemnity liability across triggered years from the first year in which the harm occurred until the last—including, under the pro rata theory adopted in some states, years in which the insured, for one reason or another, may be uninsured.

Rejecting the “all sums” theory, Section 42 of the Restatement adopted a specific pro-rata rule, known as “time on the risk” allocation. Policyholder representatives challenged this approach as the original draft had proposed all-sums allocation and, as the comments point out, only a slim majority of courts around the country have adopted the pro-rata approach (and even fewer use the pro rata/time-on-the-risk rule). Indeed, many jurisdictions have adopted the all-sums approach, including California, Delaware, District of Columbia, Illinois, Missouri, Ohio, Pennsylvania, Texas, Washington and Wisconsin. Policyholder representatives commented that, if (as is true) the Restatement is adopting proration because of fairness (and not based on strict contract interpretation), then in fairness, the comments also should encourage courts to follow the “unavailability exception,” which refuses to extend off the pro-rata allocation period to those years when the policyholder could not purchase relevant insurance in the marketplace. *See, e.g., R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indem. Co.* (formally adopting unavailability exception in dispute over coverage for insured industrial talc producer in long-tail asbestos claims).

During this next year, the ALI will continue to entertain comments on the approach that the Restatement should follow on the important issues of insurance coverage law that courts routinely face. Initiated in 2010, the Restatement is the result of the ALI’s traditionally rigorous drafting process and, thus, has included extensive analysis and comment by lawyers representing both policyholders and insurers, judges, law professors, in-house counsel and others. However, with final approval looming this year, insurance industry representatives submitted at least 18 motions, some to defer or even cancel the project and others to revise even provisions already approved in past ALI meetings. Faced with many motions, some even on provisions previously given tentative approval, the ALI leadership opted to defer a final vote on the project in an effort to “dial back the temperature.” The ALI membership, however, after its traditional debate, did overwhelmingly reject each of the insurer motions presented at this year’s meeting and tentatively approved the complete project. Now, the plan is to present the Restatement for a final vote at the ALI’s next annual meeting in May 2018.

While many critics question whether the ALI should issue such a Restatement, supporters argue that the Restatement will—as other (sometimes controversial) Restatements have—help guide courts in interpreting and applying the law to these often difficult disputes. For now, risk managers may want to consider commenting on sections of interest and can look to the Proposed Final Draft as guidance on what the law may be when they are faced with a possible coverage dispute.

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