UNCOMMON LAW:

How Will the American Law Institute's New Liability Insurance Restatement Shape the Future of Coverage Disputes

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Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firm's complex insurance claims resolution group. For the past four decades, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He has also advised various medical malpractice insurers concerning professional liability claims and consults frequently on bad faith and ethics disputes. He has also served as an arbitrator in numerous insurance coverage matters and has testified as an expert in matters involving coverage and reinsurance issues arising out of such claims.

Mr. Aylward is a leading member of the defense bar, including roles as:

American Bar Association Section of Insurance Litigation
--Umbrella Issues Subcommittee Co-Chair (2009-present).
--CLE Co-chair (2004-2006).

American College of Coverage and Extra-Contractual Lawyers
--Founding Member (2012)
--Board of Directors (2012-18)
--President-Elect (2017-18)

Defense Research Institute
--Board of Directors (2000-2003)
--Insurance Law Committee Chair (2000-2002)
--Law Institute (2004-2015, Chair—2012-2014)

Federation of Defense and Corporate Counsel
--Reinsurance Excess Surplus Lines Committee Chair (2016-2017)
--Amicus Committee (2010 to present)

International Association of Defense Counsel
--Reinsurance, Excess and Surplus Lines Committee (2005-2007)
--Board of Editors, *Defense Counsel Journal* (2005-2015).

In 2002, he was honored by the Defense Research Institute as its Outstanding Committee Chair for his leadership of DRI's Insurance Law Committee. In 2006, he received DRI's G. Duffield Smith Award for Outstanding Publications for his article analyzing post-*Campbell* trends in punitive damages jurisprudence.

Mr. Aylward has lectured and written frequently on insurance issues and has contributed chapters to the *New Appleman* insurance treatise (2007 and 2010); the Law and Practice of Insurance Litigation (West 2005) and Emerging Issues in the CGL (National Underwriter 2008); the ABA's *Environmental Liability and Insurance* treatise (2012) and Thompson Reuters' 2015 *Reinsurance Desk Handbook*.

In 2014, he was elected to the American Law Institute and served from 2015 to 2018 as one of the several dozen Advisors to the Reporters on the ALI's *Restatement of the Law, Liability Insurance.*

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By
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I. Introduction

On May 22, 2018, the membership of the American Law Institute voted to give final approval to the *Restatement of Law, Liability Insurance.* Eight years in the making, the RLLI is the first Restatement devoted solely to a single industry. Perhaps due to that focus or the difficulty of finding consensus with respect to an area of the law that differs so markedly among the fifty states, the debate over the RLLI was quite contentious and resulted in an unprecedented amount of comments from outside interests in the last few years of the project.

In fact, this Restatement was originally supposed to have been approved a year earlier. In the weeks leading up to the scheduled vote on May 23, 2017, however, the ALI was deluged with objections and letters of concern from a broad spectrum of institutions and individuals who stood to be affected by its provisions. In the face of this firestorm of criticism, the ALI announced on May 22 that, while a debate would go forward on May 23, no final vote on this project would occur until the next Annual Meeting in May 2018. In the interim, the Reporters were asked to reconsider their existing text in light of the comments expressed by ALI members at the 2017 Annual Meeting and the criticisms leveled by outsiders in the weeks leading up to the meeting.

Now that the RLLI has received final approval, it remains to be seen how widely accepted this *Restatement* precepts will be and whether insurers and other groups that criticized many of its provisions over the past several year will come to terms with the Restatement as a whole or make use of certain provisions that are favorable to them while continuing to be critical of others that seem inconsistent with established law.

II. The American Law Institute Tackles Insurance Law

Founded in 1923 by eminent judges and scholars such as Benjamin Cardozo and Learned Hand, the ALI takes as its mission the goal of promoting "the clarification a simplification of the law and its better adaptation to social needs, to secure the better administrative of justice and to encourage and carrying out scholarly insights of legal work." Its membership includes hundreds of prominent state and federal appellate judges, leading legal scholars and practicing attorneys.

Over the past century, the ALI has had a profound impact on American law through model statutes such as the Uniform Commercial and Penal Codes as well as its various Restatements of the law in areas as diverse as torts, conflicts of law and the law of lawyering.

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

ALI projects proceed through a slow iterative process. First, ALI-appointed Reporters circulate Memoranda and Preliminary Drafts. These initial drafts are reviewed by appointed Advisors and the volunteer Members Consultative Group, ALI members who provide feedback to the Reporters. With this input, the Reporters produce so-called Tentative Drafts. When these drafts are approved, a so-called Council Draft is submitted to the ALI Council, a small group of senior members that vet all proposed sections before they are submitted to the full membership for final approval at the ALI's annual meetings in Washington, D.C.

Professors Thomas Baker and Kyle Logue of the Universities of Pennsylvania and Michigan agreed to serve as the Reporters for the Liability Insurance project and duly drafted several preliminary sections that were debated and approved by the American Law Institute at the annual meetings of its membership in Washington, D.C. in 2012 and 2013. In 2014, however, the new executive director of the ALI decided that it should be a Restatement. As a result, and despite the fact that Chapters One and Two had already by then been debated and approved by the full ALI membership, the Reporters were obliged to pull back Chapters One and Two at the end of 2014 and reassess these sections to eliminate aspirational provisions that were not rooted in the common law or that were otherwise inappropriate for inclusion in a Restatement.

The transition of this project to a Restatement did not eliminate the controversy concerning its provisions. Indeed, between 2015 and 2018, the Reporters advanced a number of proposals that were vigorously opposed by the insurance industry. Although many of these proposals were ultimately eliminated or scaled down by the time that the final text was approved in 2018, some remain in the final text:

- Section 3: Should the "plain meaning" rule be abandoned in favor of a rebuttable "presumption of plain meaning" allowing unambiguous policy provisions to be interpreted in favor of coverage based upon drafting history and other extrinsic evidence of meaning.

- Sections 7-9: Should insureds be excused for "innocent misrepresentations"?

- Section 12: Should insurers be automatically liable for the misconduct of defense counsel or for failing to ensure that defense counsel have reasonable amounts of malpractice insurance?

- Section 13: Under what circumstances may an insurer's duty to defend be negated by facts that are not alleged in the underlying complaint?

- Section 19: Is an insurer automatically estopped to dispute indemnity if it is found to have wrongfully refused to defend?

- Section 24: Do insurers have a duty to make settlement offers even if no demand has been made?

- Section 27: Do the damages recoverable against an insurer for failing to settle include a verdict for punitive damages that would otherwise not be covered?

- Section 38: Should the number of "occurrences" be determined based on the "cause" of the underlying claimants' injuries or the insured's legal liability?

- Section 41: Should long-tail losses be allocated on a "pro rata" or "all sums" basis? Should insureds bear responsibility for shares allocable to years in which insurance was "unavailable"?

- Section 46: Are losses uninsurable because the litigation pre-dates an insurer's issuance of its policy?

- Section 47-48: Are insureds that prevail in coverage litigation always entitled to be reimbursed for their DJ fees?

III. *The Restatement of the Law, Liability Insurance*

The *Restatement of Law, Liability Insurance* is divided into four chapters. Chapter One addresses basic principles of insurance contract interpretation; the doctrines of waiver and estoppel and the effect of misrepresentations made by policyholders during the application process. Chapter Two focuses on the obligation of a liability insurer to defend (or pay defense costs), as well as the duty to settle and cooperation issues. Chapter Three addresses the scope of insured risks and topics such as trigger, allocation, and issues related to exclusions and conditions, while Chapter Four covers remedies, bad faith, and enforceability.

A. Chapter One (Basic Liability Insurance Contract Principles)

Following an opening definitional section, Chapter One consists of three topics: (1) Interpretation (Sections 2-4); (2) Waiver and Estoppel (Sections 5-6) and (3) Misrepresentations (in Section 7-9).

--Topic 1: Interpretation

Section 3 was perhaps the most controversial section in the entire RLLI. Instead of adopting "plain meaning" as a fixed rule, the Reporters proposed a theory of their own creation whereby there would only be a *presumption* of plain meaning that could be refuted by extrinsic evidence of contractual intent. Furthermore, even if a policy term is unambiguous on its face, that plain meaning could have been overcome if a judge "determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence."

Comment d. in Preliminary Draft No. 1 (2014) stated that "plain-meaning" is assumed to be the understanding that "an ordinary reasonable person would have, if that person took the time to read all of the relevant parts of the policy in the context of the claims at issue." Section 3 diverged from the common law in its assessment of where courts can search for meaning. Whereas most courts have found that meaning derives from the policy wording itself, as late as 2017 the Reporters were insisting through Section 3 that even policy language that is plain on its face could be given a different meaning that favored coverage extrinsic evidence supported an interpretation that was different from what the text itself would suggest.

The Reporters explained at the time that their "presumption of plain-meaning" approach was a pragmatic compromise between the overly rigid "plain-meaning rule" and the overly flexible "contextual" approach to policy interpretation. Nevertheless, the "presumption" approach proved highly controversial given the near ubiquity of the "plain meaning rule."

In the weeks leading up to what was to have been the final vote on the RLLI in the Spring of 2017, the ALI was showered with letters of criticism from outside interests, including DRI; state insurance regulators from Illinois, Michigan, New York and South Dakota; several trade industry groups (American Insurance Association, National Association of Mutual Insurance Companies, National Conference of Insurance Legislators and the Property Casualty Insurance Industry Association) as well as commentary from several insurers and over a dozen law firms. Additionally, the general counsel of seven non-insurance corporations, including Brunswick, Eli Lilly, Johnson & Johnson, Novartis and Shell Oil, submitted a letter on May 19, 2017, expressing concern that the Reporters abandonment of "plain-meaning" would have consequences for contract law that went far beyond insurance contracts.

Faced with this avalanche of criticism, the ALI announced on the very eve of the May 23, 2017 vote that while it would allow the ALI membership to debate PFD No. 1 as originally agreed, but would delay the vote on final approval until the ALI's next annual meeting in May 2018. Meanwhile, the Reporters were instructed to reassess their earlier drafts in light of these comments and criticisms.

The revised text that the Reporters released in August 2017 disputed that U.S. courts were agreed on single "plain meaning" rule, observing about half used strict "plain-meaning", a third followed "latent ambiguity" and a "respectable minority" used a contextual approach. The Reporters also made a concerted effort in this draft to set forth case law support for their novel approach and to minimize the extent to which it diverged from strict "plain meaning." They explained that their proposed approach is a compromise between "strict plain meaning" and the "contextual" approach favored by the *Restatement of Contracts* that construes terms in accordance with the circumstances and context of the contract that because a determination of ambiguity is to be made without regard to extrinsic evidence, this section did not recognize the concept of "ambiguity in context."

While essentially adopting the "latent ambiguity" cases as the doctrinal basis for this "presumption" approach, the Reporters argued that their compromise was more favorable to insurers than the result in most "latent ambiguity" cases. As they noted, most courts that have recognized a latent ambiguity have automatically found coverage, whereas the Reporters'

proposal would only require coverage if the latent meaning is more reasonable than the patent meaning evident from the policy's text.

The Reporters also emphasized that extrinsic evidence may not be used to "manufacture" an alternative meaning. Rather, a plausible basis must already exist for arguing that an alternative meaning exists before courts should allow discovery of extrinsic evidence to determine the relative reasonableness of the proposed latent meaning.

The revised text of Section 3 survived a vigorous debate within the project's Adviser and Members Consultative Groups in the Fall of 2017 but fell afoul of the ALI Council in January 2018. Several members of the ALI Council were critical of Section 3 at their January 2018 and demanded further revisions. In the face of this criticism, the Reporters finally gave way and abandoned their "presumption of plain meaning" approach.

While the final text of Section 3 that was approved on May 22, 2018 purports to adopt a traditional "plain meaning" approach, it also stated for the first time that courts could consider "custom, trade and usage" evidence to interpret policies. As revised, Comment c., states that:

> Many courts that follow a strict plain-meaning rule also consider custom, practice, and usage when determining the plain-meaning of insurance policies entered into between parties who can reasonably be expected to have transacted with knowledge of that custom, practice, or usage. This is the better approach because informed insurance market participants conduct their business in light of custom, practice, and usage in the insurance market and in the trade of the business being insured.

A motion to delete Comment c. was defeated on a floor vote during the May 22 debate. The Reporters did, however, accept a suggestion by John Buchanan of Covington & Burling that the legal authority that they had deleted after abandoning the "presumption of plain meaning" approach be restored to the Reporters' Notes for Section 3 as reflecting the "spectrum" of views in this area. Under ALI rules, the Reporters' Notes reflect the private opinions of the Reporters and are not deemed to be a statement of the ALI's views.

Section 4 sets forth rules for determining whether policy language is ambiguous. In most states, when standard-form policy language is involved, a finding of ambiguity automatically results in coverage ("tie goes to the insured"). Thus, even if an insurer's proposed interpretation is reasonable, coverage will be found so long as the insured's proposed interpretation is also reasonable. As set forth in Comment c., the RLLI rejects this "tie breaker" approach to *contra proferentem* and allows insurers to present extrinsic evidence to show that the "coverage-promoting interpretation of the ambiguous term is unreasonable in the circumstances" because "a reasonable person in the policyholder's position would not give the term that interpretation."

Section 4 is not even handed in its approach to what sort of evidence insureds and insurers may present. As set forth in Comment h., whereas policyholders are free to present a wide-range of extrinsic evidence in support of their proposed interpretation, including evidence of a policy's drafting history; regulatory filings with state insurance departments; other versions

of the policy available on the market and expert testimony regarding custom and practice in the insurance industry, the history, purpose, and functions of policy terms and forms of insurance coverage, insurers may only present extrinsic evidence that the insured would or should have had knowledge of at the time of contracting.

Comment e. to Section 4 rejects any exception to these general rules for so-called "sophisticated policyholders." Comment h. does acknowledge, however, that a broader spectrum of evidence may be presented by insurers in cases where the insured is a large corporation advised by brokers and other insurance experts and thus would be expected to have a broader knowledge of various sources of policy meaning than a small business would likely have had access to.

Sections 5 and 6 set forth the general rules governing the application of the doctrines of waiver and estoppel to insurance coverage disputes. For the most part, the principles enunciated in these sections follow the common law in most jurisdictions both as regards the distinction between waiver and estoppel and the general principle that an insurer cannot "waive into coverage." Section 6 does state, however, that an insurer's post-loss conduct can estop it to dispute coverage if the insured reasonably relies on it to their detriment.

Misrepresentation is the subject of **Sections 7, 8 and 9.** The RLLI's analysis of misrepresentation issues was one of the most contentious issues during the *Principles* phase of this project (2010-14). In particular, insurers objected to Section 7's use of a "fraud" standard of proof as well as a requirement that insurers accept coverage, albeit at the cost of additional premium to the insured, in cases of "innocent misrepresentation." Both of these provisions were eliminated in the 2015 Council Draft, along with any distinction between negligent and intentional misrepresentations. Even as revised, however, certain provisions of Sections 7 and 8 do not track the rules in most states with respect to intent, materiality and reliance. For instance, Comment d. in Section 7 requires an insurer to demonstrate reliance if a misrepresentation is intentional. Likewise, Comment j. acknowledges that most states do not excuse "innocent misrepresentations" but states that courts should permit insureds to assert a "fairness objection" in these circumstances.

There was controversy during the May 22, 2018 floor debate with respect to Section 8's statement in Comment a. that a misrepresentation is "material" only if the insurer would have refused to issue the policy had it known the truth or would have issued the policy on "substantially different terms. " A motion by Allstate's Vanita Banks to delete the "substantially different terms" language was defeated on a floor vote after the Reporters' explained that it was needed to avoid insurers from rescinding a policy based on a trivial misstatement

B. Chapter Two: Management of Potentially Insured Liability Claims (Sections 10-30)

Chapter Two is divided into three topics: (1) defense; (2) settlement, and (3) cooperation. According to the Reporters, these three Topics have "engendered much confusion in the case law" and there is a "real opportunity to clarify and improve the law. . . . ." The Reporters go on to assert that Chapter Two is an attempt to "clarify and unify existing law" and that it largely sets forth rules that already apply in most jurisdictions. Indeed, the *Principles* version of Chapter

Two was generally less controversial than Chapter One and thus was changed less in drafts hat were issued after this became a *Restatement* project.

--Topic 1: Defense

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

Section 10 acknowledges the right of insurers to defend and states in Subsection (2) that insurers have the right to receive information from defense counsel. **Section 11** expands on this analysis, declaring that such disclosures do not result in a waiver of the attorney-client privilege with respect to the subject matter of such communications. Section 11(2) states, however, that insurers do not have the right to demand privileged information "if that information could be used to benefit the insurer at the expense of the insured."

Section 12 addresses when an insurer may be liable for its conduct of the insured's defense and was one of the most controversial sections of this Restatement. During the *Principles* phase of the project, this section declared that insurers should always be vicariously liable for the misconduct of defense counsel, in the apparent belief that imposing liability would cause insurers to more vigorously police the conduct of appointed defense counsel. In light of the absence of any common law support for this sweeping proposition, however, the Reporters abandoned this approach after 2014 but continued to impose liability for the negligent selection of counsel, as by failing to ensure that the firm had adequate malpractice coverage. Insurers could also still be liable for the acts of their employees, such as staff counsel.

Numerous ALI Advisers and outside bar associations, notably DRI, noted the impracticability of determining whether counsel had "adequate" E&O coverage as well as the lack of any case support for this proposition. In light of this criticism, this language was softened in the Revised Proposed Final Draft released by the Reporters on September 7, 2018. As revised, Comment c. now merely states that a court "could find" that an insurer was negligent for failing to ensure that defense counsel did not have adequate insurance but that this Restatement would not take a position on this topic owing to the lack of any case law to support this contention.

Concerns were expressed during the floor debate on Section 12 that the illustrations used by the Reporters, many of which involved an insurer's knowledge of substance abuse or other personal problems, were problematic or would place insurers in the position of intruding into the privacy of defense counsel. A motion to delete Subsection (1) by Brackett Denniston of Goodwin LLP and Harold Kim on the Chamber of Commerce was defeated. Nevertheless, the references to "substance abuse" have been eliminated Revised Proposed Final Draft released by the Reporters on September 7, 2018.

Section 13 proposes a "four corners plus" approach to the duty to defend that would require insurers to consider not only the facts alleged but also facts that become known through the insurer's investigation. However, extrinsic facts will only defeat a duty to defend that otherwise exists in five defined circumstances or any similar exception acknowledged by a state court, as where the issue concerns whether the claimant is an insured or the policy was cancelled before the accident. Insurer advocates argued during 2015-2017 that there is no case support for

codifying these specific situations as being the only instances where extrinsic facts might eliminate a duty to defend. Although the Reporters did initially agree to set forth a broader rule that created a general exception in all cases where the extrinsic facts showing a lack of coverage were undisputed, this language was abandoned by the Reporters in 2016 in favor of enumerating these specific examples instead.

Section 14 sets forth certain basic principles governing the insurer's right to defend, including the insurer's duty to defend the entire law suit, even if only some of the claims were covered. Subsection (1) also reinforces Section 11's statement that the insurer cannot compel defense counsel's duty to disclose confidential information that would harm the insured's interests. Subsection (2) affirms the insurer's right to conduct the defense with staff counsel unless independent counsel are required. Finally, Subsection (3) states that, unless the policy provides otherwise, defense costs do not count against limits.

Section 15 addresses reservation of rights letters. It requires the insurer to give timely notice to its insured of any coverage defense that it is aware of or to issue a supplemental letter when additional facts bring new defenses to its attention of which it was previously unaware. Such letters must identify the specific policy wordings at issue and explain the issue in language that is understandable to a reasonable person in the position of the insured. Subsection (4) does allow insurers to undertake the defense of a case pursuant to a generic reservation of rights letter if exigent circumstances prevent them from completing their investigation of a claim at the time. However, the insurer must act diligent to complete its investigation and issue a detailed RoR once the investigation is completed.

Section 16 addresses the circumstances in which an insured may insist on its own defense counsel. Section 16 adopts the California *Cumis* approach wherein independent counsel is only required if the insurer is raising a coverage defense that could affect how the case is defended to the prejudice of the insured.

Section 17 states that an insurer's determination of the hourly rate for independent counsel may not be determined solely based on what the insurer pays to its panel counsel. An earlier provision requiring the insurer to front the full amount charged subject to a right to sue defense counsel at the conclusion of the litigation to recoup excessive fees was eliminated in 2016.

Section 18 sets forth the specific circumstances that permit an insurer to terminate its defense, including a voluntary relinquishment by the insured; a final adjudication or settlement of the underlying claim or a successful coverage suit by the insurer. Comment c. makes clear, however, that an interlocutory order will not terminate the duty to defend and that the insurer must defend against any appeal that the plaintiff may bring from a lower court's dismissal of the claims against the insured. Subsection (5) provides that an insurer may terminate its defense duty by entering into a settlement with the underlying claimant to dismiss the covered claims, but only with the insured's express consent. Subsection (8) also states that an insurer may only terminate its duty to defend through coverage litigation if there has been a "final adjudication" that the insurer did not owe a defense.

Section 19 provides that "an insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action." Along with Sections 3 and 12, Section 19 was a flashpoint for insurer opposition to this Restatement. It originally provided that an insurer that failed to defend lost the right "to contest coverage for the claim." After vehement opposition by insurer advocates, the Reporters initially agree to scale back Section 19 so that insurers would only lose the right to raise defenses to indemnity if their failure to defend lacked a "reasonable basis." As there was no common law basis for even this compromise proposal, however, the final text of this section merely states that an insurer that fails to defend loses the right to exercise any control over how the insured's defense is conducted. Comment a. further states that the insurer is bound by the outcome of any case that it fails to defend and can only re-litigate the issue of the insured's liability or any resulting damages by showing fraud or collusion.

Section 20 states that if multiple insurers have a duty to defend, the insured may target a single insurer to handle its defense. This is very much a minority view, followed only in states like Illinois. Unlike the Illinois "targeted tender" approach, however, Section 20 provides that the insurer that the insured selects to defend is entitled to contribution from other insurers that shared a similar obligation.

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

Section 22 addresses so-called "defense cost indemnification policies" that require insurers to pay for an insured's defense but do not do so pursuant to any "duty to defend."

Section 23 discusses the insurer's right to associate in the insured's defense, including the right to receive reports from defense counsel (as limited by Sections 11 and 14) and to participate in "major decisions in the defense of the action that is consistent with the insurer's level of engagement with the defense of the action." "Level of engagement" appears to mean that an insured is not required to continue to follow up with its insurer if the insurer refuses to respond to earlier notices.

--Topic 2: Settlement

Section 24 concerns the obligation of insurers to make "reasonable settlement decisions." A "reasonable settlement decision" is "one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending a claim." Subsection (3) provides that this duty extends to accepting reasonable settlement demands made by plaintiffs with a proviso that the insurer's liability is "never greater than policy limits." The duty also includes the "duty to contribute its policy limits . . . if that settlement exceeds those policy limits."

Comment a. describes the rationale for these rules as follows:

> The objective is to encourage liability insurers to make efficient and equitable settlement decisions. In addition, because insureds are generally more risk adverse than insurers, this rule maximizes the joint well-being of the parties by shifting the risk of excess judgments from insureds to insurers.
>
> The purpose of the duty to make reasonable settlement decisions is to align the interest of insurer and insured in cases that expose the insured to damages in excess of the policy limits. Therefore, the duty is owed only with respect to cases that expose the insured to such damages.

It is interesting that the Reporters are treating the failure to make reasonable settlement decisions as a contractual issue and not "bad faith." Comment m. observes that the issue of whether an insurer has failed to make a reasonable settlement decision is not the same as whether an insurer has acted in bad faith or breached the implied duty of good faith and fair dealing as liability for failing to make a reasonable settlement decision does not require proof of bad intent. The issue is one of "reasonableness" and not a question of "good faith." Accordingly, a failure to settle is only bad faith if the insurer does so without a reasonable basis for its conduct or with reckless disregard to that lack, as required by Section 49 in Chapter 4 of the RLLI.

Comment b. observed that the Reporters use the term "duty to make reasonable settlement decisions" instead of the more common term "duty to settle," to emphasize their view that insurers do not have a duty to settle every claim but, rather, "to make reasonable settlement decisions." It emphasized that insurers "may reject unreasonable settlement demands," as defined in Section 27(2) of the black-letter rule. The reasonableness standard is "flexible," permitting the finder of fact "to take into account the whole range of reasonable settlement values." This range includes consideration of whether an insurer made reasonable offers and counteroffers.

Comment f. specifically distinguishes between an insurer's rejection of a reasonable settlement demand and its failure to make a reasonable offer at all:

> A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer's decision not to make a reasonable offer, or counter-offer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

Comment f. also makes plain that this difference rises from differences in proof of causation. When an insurer rejects a reasonable settlement demand leading to an excess judgment against the policyholder, causation is plain. It is less clear when an insurer fails to make any offer or counter-offer. This rule applies to both duty to defend and defense costs indemnification policies.

Comment f. proposes a "reasonableness" standard, not a "hard and fast rule" and that whether an insurer owes the duty to make an offer depends on the particular circumstances as where the facts known to the insurer make clear that the policy limits are significantly less than the reasonable settlement value of the underlying case given the severity of the claimant's damages and the likelihood of liability being found. The Reporters acknowledge, however, that there may be strategic value in not making an offer early on.

Comment g. acknowledges the argument that these rules may "hamper negotiation strategies by liability insurers in settlement discussions, to the detriment of policyholders as a whole." The Reporters stated, however, that "minimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions. Rather, the primary objective is to protect insureds from the conflict of interest inherent in the standard less-than-full-coverage case where the insurer has the sole settlement discretion." In any event, insurers remain free to reject settlement offers. "Rather, the rule simply imposes on insurers (and, thus, the insurance pool) the risk of being wrong in making that determination in individual cases."

There was vigorous debate within the ALI with respect to the circumstances in which liability would be imposed for failing to accept a "reasonable" offer of settlement. Prior to the 2016 Annual Meeting, Robert Cusamano of Crowell & Moring (former general counsel to ACE) submitted a lengthy letter to the Reporters urging them to delete language holding insurers liable for excess judgments in any case where they fail to accept a reasonable offer of settlement. As

Cusamano observed, Comment d. did not reflect the reality of how cases settle and would impose unrealistic and costly obligations on insurers:

> In tort actions, one can say that ranges of reasonable are often several hundred percent of each other or more. Indeed, in many cases where liability itself is questionable, or where the law is disputed, that ratio may rise to infinity as a perfectly reasonable defendant concludes that a given action has no merit at all. Once again, to force an outcome at the highest point in such a wide range is incompatible with the mandate to negotiate as if one "bears sole financial responsibility" for a potential judgment. And, once again, "reasonableness" is very much in the eye of the beholder and there are beholders (plaintiff, defendant, mediator, judge, jury and the main tort case, appellate bench, jury in the second case against the insurer for failure to settle) and they all have different cognitive apparatus, wants, needs and exigencies.

Cusamano criticized the treatment of this issue in Comment d. as representing "an existential change in the nature of settlement talks, and entail a dramatic, perhaps virtually total, shift in bargaining power among litigants" and as supplanting the existing framework of settlement negotiations "with a system that requires payment of any reasonable amount requested."

As Cusamano observed, "the current approach, while reflected in the black letter text of Section 24, certainly encourages a dialogue structure around policy limits and the duties of good faith, as it centers on the insurer's duty to act carefully and reasonably." By contrast, the new regime set forth in Comment d. "will center not on good faith, and will not even center on the insurer's course of conduct. Rather, it will center on predictions about how a later adjudicator will assess the reasonableness of a plaintiff's unilaterally selected settlement demand" based on valuation factors that are "hardly knowable and probably not even roughly predictable."

Adviser William Barker of Denton also proposed striking the final sentence of Comment d., which stated that an insurer is liable "even if the rejected settlement was at the high end of the reasonable range" and substituting in its place the following text:

> While reasonableness may be seen as a range, a reasonable person evaluating a demand will look towards the center of that range to evaluate the probable verdict value of the case, which would reflect the average result if the case were tried many times. Hypothetical verdicts at the high and low end of the range of reasonableness would average out.

While neither proposal was adopted at the 2016 ALI Annual Meeting, these criticisms clearly had an effect on the Restatement Reporters. In particular, in advance of the 2017 Annual Meeting, the Reporters softened Comment d. so that instead of being liable if they rejected "any" reasonable settlement demand, the liability of an insurer would only arise if the insurer rejected "a settlement offer that a reasonable insurer would accept …"

Furthermore, the Reporters adopted Cusamano's standard of a "reasonable insurer." Following the 2017 Annual Meeting, the Reporters added language to Comment d. to state that their conception of a "reasonable insurer" includes not only an average ordinary insurer but also "a more aspirational concept that protects against circumstances at which average conduct is objectively unreasonable." They have clarified, however, that the duty to make reasonable settlement decisions only extends to excess judgments that are otherwise covered by the policy, language that was lacking in earlier drafts.

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

Section 25 concerns the effect of an insurer's reservation of rights on its rights and duties with respect to settlements. Subsection (a) states that the insurer has no duty to settle non-covered claims. However, Subsection (b) also states that the insurer cannot recoup a settlement payment from its policyholder on the basis that the underlying claims were not covered in whole or in part.

Most of the controversy concerning Section 25 related to Subsection (3), which addressed the circumstances in which an insured may enter into a settlement over the objections of its insurer. The black letter rule requires the insured to alert the insurer to the proposed settlement and to give the insurer the opportunity to withdraw its reservation of rights. Finally, any such agreement must be one "that a reasonable person who bears the sole financial responsibility for the full amount of the potential covered judgment would make."

Prior to the May 22, 2018 floor debate, the RLLI Reporters accepted a proposal by Malcolm Wheeler of Wheeler Trigger to amend Sections 25(3) and 27 to require that insureds give full notice and information to insurers before being permitted to enter into settlements over the insurer's objection in cases where the insurer is defending under a reservation.

Section 26 addresses situations in which there are more claimants than policy limits. Such circumstances can present difficult questions of timing and entitlement to the policy proceeds, particularly when an insurer has not paid defense costs as they are incurred. Courts have struggled to identify appropriate rules to govern such situations. Does the insurer in such cases act in bad faith if it pays its full limit to settle some of the cases but not all? Alternatively, if the insurer is unable to settle all of the claims, does the insurer nonetheless have a duty to settle such claims as it can?

The answer, according to Section 26, is interpleader. Thus, the Reporters state that an insurer has a duty to make "a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure." The insurer may satisfy this duty by "joining all affected claimants

in the underlying action and tendering its policy limits to the court" with a motion to allocate the limits "among the claimants on the basis of the relative value of their claims."

If a claimant in such a situation rejects a portion of the policy limits offered in full satisfaction of its claim, the insurer's duty to defend remains in effect until the claim is settled, the claim is finally adjudicated, or a court finds that the insurer does not have a duty to defend.

Section 27 provides that an insurer that fails to make a reasonable settlement decision is liable for the entire amount of the judgment, not just the amount within its policy limits. Furthermore, the insurer may be liable for "any other reasonably foreseeable harms." If there is an excess judgment, this liability may include the insured's emotional distress. This rule applies only if there is an excess judgment, however.

Comment e. states that an insurer that fails to effectuate a reasonable settlement is liable for all damages flowing from that failure even if the resulting excess judgment may include elements, such as punitive damages, that would not otherwise have been covered. This is contrary to the view of cases such as *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999), and *Lira v. Shelter Insurance Co.*, 913 P.2d 514 (Colo. 1996). Despite this lack of common law authority for this aspect of Section 27, a motion by Victor Schwartz of Shook Hardy & Bacon to strike Comment e. was defeated at the 2018 Annual Meeting.

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

--Topic 3: Cooperation

Section 29 provides that policyholders have a duty to cooperate with their insurers in:

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

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

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

As the Comments note, the duty to cooperate "serves to align the incentives of insurer and insured," helping to ensure that the insured has the incentive to aid the insurer in its defense and management of the claim. The duty requires the insured to render "reasonable assistance," with reasonableness assessed depending on the complexity of the claim, the insurer's ability to obtain information from other sources, the extent to which the insurer needs the policyholder's cooperation, etc. Comment c. explicitly states that the duty to cooperate is not intended to "become a trap for the insured," and states that an insurer "may not unilaterally withdraw from the defense of a claim based on non-cooperation." Instead, an insurer must follow the procedure set forth for reserving rights and pursuing a declaratory judgment action in such situations. Similarly, Comment d. states that the duty to cooperate does not obligate the insured to comply with unreasonable requests.

Section 30 states that, where an insured has failed to cooperate with its insurer, the insurer may avoid coverage only if the insured's actions have substantially prejudiced the outcome of the case. Further, if the insurer can show that its policyholder colluded with the claimant, the insurer is excused from coverage unless the insured proves that the collusion "if undetected, would not have caused substantial prejudice to the insurer in the outcome of the claim." "Prejudice" is also defined by reference to the outcome of the case and does not take into account additional expense or difficulty that an insurer may suffer in defending the case due to the insured's tardiness.

C. Chapter Three: General Principles Regarding the Risks Insured (Sections 31-45)

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

--Topic 1: Coverage

Section 31 provides that meaning of a policy term does not depend on where it appears or what label is attached to it, although "insuring clauses" should be interpreted "broadly."

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

Section 33 describes the role that "trigger of coverage" clauses play, whether in the context of "occurrence"-based policies or "claims made" policies. Comment f. adopts the "injury in fact" approach as the default solution for long-tail claims, while acknowledging that "injury in fact" may implicate multiple years of coverage depending on the causal circumstances of loss. Comment g. assigns the burden of proof in such cases to insureds, although the burden appears to be light and an insured may be able to compel coverage based on mere evidence of injurious exposure, subject to each insurer's ability to show that no harm actually occurred in its policy period.

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

Having articulated a general requirement of prejudice for notice conditions in Section 34, the Reporters proceed to carve out an exception for "claims made" policies in **Section 35** in light of the different role that such terms play in "claims made" coverage. Section 35 does insist, however, that policyholders be given a "reasonable" amount of time within which to report

claims that are received at the end of the policy period if the policy otherwise lacks an Extended Reporting Period (ERP) endorsement.

--Topic 2: Application of Limits, Retentions and Deductibles

Section 36 distinguishes between the assignment of a specific claim and rights under a policy generally. As to the former, Section 36 states that insureds are free to assign individual claims. As to the latter, an insured may only enter into an assignment as part of a merger or other corporate transaction that also transfer financial responsibility, the policy has already expired and the transfer does not materially increase the risk insured by the carrier. Comment c. also confirms that these rights only extend to liabilities that were already insured under the policy; successor entities may not obtain coverage for pre-merger liabilities.

Section 37 defines the function and role of policy limits, including "per occurrence," "per claim" and aggregate limits.

Section 38 analyzes the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate "occurrence" limits and adopts the majority "cause" approach and have made the further important determination that "cause" is based on the source of the insured's liability and not the process or processes that are the physical cause of the underlying injuries.

Section 39 addresses two issues of consequence to excess insurers: (1) what event triggers an excess insurer's duties and (2) whether insurers must "drop down" following the insolvency of a primary insurer. Section 39(1) provides that an excess insurer's duties are not triggered until the underlying limits are exhausted, although Section 39(2) adopts the so-called *Zeig* rule that allows those limits to be exhausted through a combination of sums paid by the underlying insurers and the policyholder. Comment d. states that this is only a default rule and that an excess insurer can draft around the *Zeig* rule by adopting language stating that "liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits," or (2) "coverage under this policy shall attach only after the full amount of the underlying limits have been paid by the underlying insurers."

Section 40 states that, in most cases, "when more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy." Insurers may, however, internally allocate their obligations through the use of "other insurance" clauses or similar terms so long as they do not conflict with each other and do not operate to eliminate coverage altogether.

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

There was considerable debate following the 2016 Annual Meeting with respect to whether Section 41 should include an "unavailability" exception to "pro rata" liability. Under this proposed exception, the denominator for calculating each party's share of loss in asbestos cases would omit years after 1985, when asbestos exclusions became prevalent. By contrast, under a pure "pro rata" rule, the insured is responsible for all years when there is no coverage, without distinction as to exclusions, insolvency or a simple failure to purchase insurance. Following an intense debate within the ALI, the Reporters merely note in Comment h. that "some courts" have recognized an "unavailability" exception but do not endorse this approach.

Section 42 permits an insurer that has paid more than its share of a judgment or settlement to recover from another insurer that has not paid its fair share so long as the other insurer has not, in the interim, entered into a settlement and obtained a release from the insured. Note that this right of contribution only applies to indemnity claims and does not apply in the not uncommon situation where a carrier settles out early for a small amount.

Section 43 concerns the impact of earlier settlements on an insurer's indemnity duties. It provides that the judgment recovered against the non-settling insurer shall be reduced "by the amount paid for those losses by an insurers that settled with and were released by the insured respect to that legal action." Comment b. notes that this rule does not apply in long-tail cases where liability is allocated on a "pro rata" basis as, in such cases, "a settlement agreement has no bearing on the pro rata liability of insurers in other policy periods." Where liability is concurrent, however, Section 43 adopts the so-called *pro tanto* rule rather than the competing approach that gives the non-settling insurer a credit in proportion to the amount of liability that the settled insurers had. Section 43 does not discuss the practical problem of how credits should be apportioned in cases where multiple claims were involved and whether the judgment against the non-settling insurer overlaps with the settled claims.

D. Chapter Four: Enforceability and Remedies (Sections 44-49)

--Topic 1: Enforceability

Section 44 proposes that certain terms be "implied in law" even if they do not appear in the policy. Thus, subsection (1) states that a term that is required by statute will be deemed a part of the policy even if it does not appear in the text. Conversely, an express contractual term will be voided under Subsection (2) if it is prohibited by statute or "clearly outweighed in the circumstances" by public policy.

Section 45 was among the more controversial provisions at the 2016 ALI Annual Meeting. As originally drafted, it declared that it is not against public policy for insurers to pay to defend cases involving aggravated fault, as where an insured acted with intent to cause injury, nor are insurers precluded from paying judgments or settlements in such cases. Insofar as the law forbids insurers from indemnifying cases of aggravated fault, this Section proposed that insurers pay such losses in the first instance but be allowed to obtain reimbursement from their policyholders.

In the face of harsh criticism from insurer advocates, the Reporters walked back this construction of this Section prior to the 2016 Annual Meeting. The proposed "claw back"

provision was eliminated after counsel pointed out that it was inconsistent with other sections of the Restatement that prohibit recoupment. Finally, the Reporters agreed to re-write this Section so that coverage for punitive damages is not allowed if "contrary to public policy."

The final text of Section 45 that was approved at the 2018 ALI Annual Meeting allows policies to cover anti-social claims such as criminal proceedings unless prohibited by "legislation or judicially declared public policy" as is true in states such as California. On the other hand, the Reporters will not permit insurers to avoid coverage for such claims on the basis of public policy. According to Comment d. "moral hazard" is not a realistic or appropriate basis for precluding coverage on the basis of public policy. The Comments also argue that insurers already provide coverage for intentional acts, although these claims seem to conflate provisions found in certain D&O policy that do not mirror general liability insurance terms.

Section 46 addresses the so-called "known loss" doctrine. A "known liability" is defined as one that "a policyholders know that, absent a settlement, an adverse judgment establishing the liability in an amount that would reach the level of coverage provided under the policy is substantially certain."

Section 46 reflects something of a compromise between those courts have that ruled that losses are uninsurable if the policyholder is already aware that a loss is occurring and those such as California and Massachusetts that have found that even prior litigation may be insurable so long as the outcome of the claims is uncertain.

In short, Section 46 focuses on whether, prior to the issuance of a policy, an insured knows to a substantial certainty that it faces a liability that will affect its insurer. This would appear to be an absolute defense to coverage for primary insurers where a claim is already in suit. Excess insurers or primary insurers with large SIRs may only avail themselves of this defense if they can establish that the scope of the insured's defense costs will exceed the applicable SIR or is otherwise likely to penetrate the excess layer of coverage.

Section 46 is not limited to situations in which litigation is already pending. As policyholder advocates complained during ALI Adviser debates about this Section of the Restatement, Section 46 might arguably restrict coverage in cases such as environmental liability claims or other actions where the insured faced "strict liability." In such cases, the issue would be the degree of damages that the insured faced, rather than the possibility that it would face liability for some hypothetical judgment against it. In all of these cases, however, the issue is whether the insured is aware of some liability that is presently certain to trigger an obligation on the part of an insurer, whether for defense or indemnity.

Following the 2017 Annual Meeting, the Reporters added language to Section 46(a)(2) clarifying that insurers had no duty to defend law suits that were already pending before their policies were issued. As Comment e. to this August 2017 draft explained "unless the insurance policy provides to the contrary, the no-liability default rule applies to exclude coverage for a legal action when the policyholder is substantially certain, prior to the policy period, that a person insured under the policy will incur otherwise covered defense costs."

The August 2017 draft also deleted an earlier statement that the doctrine was inapplicable to claims made policies. This is a correct statement of the law although it must be said that "known loss" issues almost never appear in the context of "claims made policies, since these policies typically contain language that expressly limits coverage to claims that are first made during the policy period and exclude coverage for claims arising out of circumstances of which the insured was aware prior to the policy period. As before, this limitation did not apply to excess insurers or primary insurers with self-insured retentions.

In the course of the May 2018 Annual Meeting, however, the Reporters reversed course and accepted a "friendly" motion by policyholder advocate David Goodwin of Covington & Burling to delete language from the black letter rule addressing defense costs. Comment e. now merely states that this Restatement is not taking a position on whether insurers can apply the known liability doctrine to defense costs because courts have not "squarely addressed" this question. It is a pity that this rigorous "squarely addressed" standard was not also applied to some of the Reporters' proposals that largely lack common law support.

--Topic 2: Remedies

The concluding sections of the Restatement deal with fee awards and bad faith. In the months leading up to the release of Chapter 4 in September 2016, there was great uncertainty and anticipation with respect to the approach that the Reporters would follow in addressing bad faith law. Given the ambitious innovations that Professors Baker and Logue had experimented with during the *Principles* phase of this project and the broad scope of the project as a whole, insurers feared, with some justice, that Chapter 4 would set forth broad and controversial rules seeking to transform the terrain upon which bad faith claims would be litigated in the years to come.

In the event, the discussion of bad faith in Chapter 4 is something of an anti-climax, consisting of only Section 49 (what is bad faith) and Section 50 (bad faith damages). The brevity of this analysis may have reflected fatigue on the part of the Reporters after seven years of labor on this project or, more likely, the Reporters' sense that some of the more complex issues presented by extra-contractual lability claims are not susceptible to a *Restatement*. For instance, this *Restatement* does not address the nature of the duty that liability insurers owe to their policyholders and whether there is some sort of actual or quasi-fiduciary obligation that insurers take on.

It is also clearly the case that many of the topics that are commonly viewed as involving "bad faith" are dealt with elsewhere in Chapter 2 ("Management of Potentially Insured Liability Claims") and Chapter 3 ("General Principals Regarding the Risks Insured"). In particular, the issue of whether and when insurers may be liable for failing to settle within policy limits is separately dealt with in Section 24 of Chapter 3. Similarly, the problem of how insurers should act when there are more claimants than limits is dealt with in Section 26.

Other topics that often engender bad faith disputes are likewise addressed as non-bad faith topics and discussed in the claims management sections of Chapter 2, including whether insurers can be sued for the misfeasance of appointed defense counsel (Section 12); the insured's right to independent counsel (Section 16) and the consequences of wrongfully failing to defend (Section 19).

Sections 47 and 48 set forth the remedies available to policyholders and, in particular, the circumstances in which policyholders can recover their fees for litigating coverage disputes. Section 47 states that insurers that substantial prevail in coverage suits commenced by insurers seeking to terminate a defense obligation may recover their fees, whereas Section 48 allows fees if the insurer has declined to defend and the insured obtains a ruling finding a duty to defend. At the September 7, 2018 Advisers meeting, insurer advocates protested that Section 47, while consistent with the *Mighty Midgets* rule in New York, unfairly penalized insurers for bringing DJs to clarify their obligations, especially in states like Illinois where the failure to bring a DJ may estop the insurer from contesting its indemnity obligations.

Section 49 defines when insurers may be liable for "bad faith." It provides that:

> An insurer is subject to liability to the insured for insurance bad faith when it fails to perform its duties under a liability insurance policy:
>
> (a) Without a reasonable basis for its conduct; and
>
> (b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

The Reporters observe in Comment a. that the rule that they are proposing contains both an objective and a subjective element. The objective element is the requirement that insurers have a "fairly debatable" basis for their coverage position. Instead of merely relying on this element, however, the reporters have also required that the insurer act "with knowledge or reckless disregard" of a lack of a good faith basis for its position.

Policyholder advocates criticized the Reporters for setting the bar too high and requiring them to prove both subjective and an objective elements of liability in order to recover. In response, the Reporters defended their position in Comment a., setting forth three reasons why they chose not to adopt a purely objective standard. First, they felt that the objective approach was already embodied in other insurance law rules requiring that the insurer act reasonably as set forth in Sections 19, 24 and 27. Second, they take the viewpoint that the insured's right to attorney's fees as set forth in Sections 49 and 50 mean that the insured will already be receiving fees when their rights to a defense are denied or threatened without regard to whether the insurer's failure to do so is bad faith. Finally, they note that many of the cases in which courts have adopted a purely objective standard involve types of conduct that this Restatement treats as not involving bad faith such as the insurer's failure to settle or defend.

Comment a. to Section 49 identifies the "objective" element as the familiar requirement that the insurer's coverage position be "fairly debatable." Comment a. explains that the Reporters mean to use the same standard for Section 49 as they adopted in 2016, when in compromising the issue of whether insurers are estopped to contest indemnity when they fail to defend, they revised Section 19 of Chapter 2 to limit estoppel to cases in which insurers lack of "reasonable basis" for failing to defend.

In contract to this objective "fairly debatable" element, the subjective element is whether the insurer failed to perform when it knew it was obligated to perform or without regard to

whether it had a reasonable basis for not performing. Comment a. observes that a "reckless disregard" may be found (1) because of lack of investigation of the relevant facts; (2) a failure to conduct the necessary state-specific legal research to evaluate the coverage position or (3) some other circumstance that placed the insurer on notice that it had not done what it needed to do in order to evaluate whether it had a reasonable basis for its position.

Section 50 sets forth the damages that are recoverable in bad faith cases: (1) the attorney's fees and other costs incurred by the insured in the legal action establishing the insurer's breach; (2) any other loss to the insured proximately caused by the insurer's bad-faith conduct; and (3) if the insurer's conduct meets the applicable state-law standard, punitive damages.

IV. Conclusion

Although the membership of the American Law Institute voted to give approval to the text of Proposed Final Draft No. 2 at the May 22, 2018 ALI Annual Meeting, the final text of the Restatement remains to be determined. Not only were a few final compromises agreed to between the release of PFD No. 2 on April 13, 2018 and the May 22 vote but the Reporters also retain discretion under the ALI's so-called "Boskey Rule" to make limited editorial revisions to previously-approved sections. Accordingly, the final text of the *Restatement of Law, Liability Insurance* will not appear until it is finally published by the American Law Institute, which is unlikely to occur before the Fall of 2018 or later.

This *Restatement* is already creating waves, however. In Delaware, a state court ruled in *Catlin Specialty Ins. Co. v. CBL & Assocs. Props.*, 2018 Del. Super. LEXIS 342 (Del. Super. Ct. Aug. 9, 2018) that its conclusion that an insurer could not recoup already-paid defense costs from its policyholder was consistent with Section 17's treatment of the issue.

On the other hand, this Restatement faces political opposition in several states that may limit the ability of courts to follow it. Prior to the 2018 Annual Meeting, the ALI received letters from several state insurance commissioners; the National Conference of Insurance Legislators and a joint letter from Governors of Iowa, Maine, Nebraska, South Carolina, Texas and Utah, all expressing this Restatement ignores common law rules, will destabilize insurance markets and may necessitate legislative action.

In apparent response to the perceived shortcomings of Section 3, Tennessee adopted HB 1977/SB 1862 in early 2018, requiring that "[a] policy of insurance must be interpreted fairly and reasonably, giving the language of the policy of insurance its ordinary meaning."

A few weeks after the ALI's vote to approve the RLLI, Ohio Governor John Kasich signed a public works funding bill in July (SB 239) that contained an amendment that seemed to have little to do with infrastructure funding:

> Sec. 3901.82. The Restatement of the Law, Liability Insurance that was approved at the 2018 annual meeting of the American law institute does not constitute the public policy of this state and is not an appropriate subject of notice.

In short, while the debate over this Restatement is now concluded within the American Law Institute, the debate over its long-term future and implications for the future shape of American insurance law may have only just begun.